Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/16/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035085	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Saguaro Valley	6651 East Carondelet Drive Tucson, AZ 85710

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Haven of Saguaro Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 6651 East Carondelet Drive Tucson, AZ 85710	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of the facility policy and procedure, the facility failed to ensure that blood pressure medication was administered in accordance with physician ordered parameters for 1 out of 3 sampled residents (Resident # 1). The deficient practice could result in uncontrolled blood pressure. Findings include: Resident #1 was admitted on [DATE], with diagnoses that include fractures of T11-12, encounter for surgical aftercare following surgery on the nervous system, acute respiratory failure with hypoxia, acute pulmonary edema, other heart failure, and cardiomegaly. A review of the admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Further review of the MDS revealed an active diagnosis of Orthostatic Hypotension and Hypertension.An order initiated on November 13, 2025, for Midodrine HCL 5 milligrams (MG) 2 tablets by mouth every 8 hours for orthostatic hypotension, hold for systolic blood pressure greater than 140. Review of the December 2025 Medical Administration Record (MAR) revealed that the Midodrine was marked administered on:December 5, 2025, at 2:00 p.m., with a blood pressure of 141/83December 10, 2025, at 2:00 p.m., with a blood pressure of 150/89December 12, 2025, at 10:00 p.m., with a blood pressure of 145/70December 15, 2025, at 2:00 p.m., with a blood pressure of 142/60 December 21, 2025, at 2:00 p.m., with a blood pressure of 146/64Review of the Medication Administration Note dated December 10, 2025, at 4:14 p.m. revealed that Midodrine was above parameters.Review of the Medication Administration Note dated December 21, 2025, at 1:39 p.m. revealed that the systolic blood pressure was greater than 140 by Licensed Practical Nurse (LPN/Staff #116)Further review of the Medication Administration notes revealed no notes for the December 5, December 12, and December 15th administrations of the Midodrine.An interview was conducted with LPN (Staff #116) on December 23, 2025 at 2:55 p.m., who revealed that the physician's order of the Midodrine has a parameter that if the systolic blood pressure is above 140, the medication is not to be given. Staff #116 reviewed the December 2025 MAR and stated that a checkmark on the MAR indicates that the medication was administered, and a number 5 means it was outside of parameters and was not given. Staff # 116 reviewed the December 21, 2025, 2:00 p.m. administration of the Midodrine and revealed that the medication was marked as administered and was outside of parameters with a systolic blood pressure of 146. Staff #116 revealed that she made a mistake, and the medication should not have been given. Staff # 116 stated that the concern with giving this medication outside of parameters is that it will cause the blood pressure to go too high. An interview conducted on December 23, 2025, at 3:33 p.m., with the Director of Nursing (DON/Staff #103), revealed that the Midodrine order included a parameter that the medication was not to be administered with a systolic blood pressure above 140. The DON explained that in the MAR, if a medication was administered, there is a checkmark in the box, and if the medication was not administered outside of parameters, then the number 5 is marked meaning hold and see the nurses' medication administration notes for further explanation. The DON reviewed the December 2025 MAR administration of the Midodrine on December 10, 2025, and stated that it was marked administered at 2:00 pm with a systolic blood pressure of 150; however, in reviewing the progress notes, she revealed that it was noted this was above parameters and held. The DON further reviewed the December 21, 2025, 2:00 p.m. administration of Midodrine and stated it was marked as administered, but review of the progress notes showed that the nurse had indicated it was held due to the systolic blood pressure being above 140. The DON goes on to reveal that possibly the nurses had removed the medication from its packaging in preparation for administering and realized the blood pressure was too high, and withheld the medication, and that is why they added the supplementary progress note then disposed of the medication but never changed the administration of the medication in the MAR. The DON then reviewed the December 12, 2025, administration of the Midodrine at 10:00 p.m. and revealed that it was marked administered, and further review could not find a follow-up medication administration note in the progress notes. The DON stated that this indicates the medication was given, and the nurse was not following the physician's order and giving the medication outside of parameters. The DON stated the concern with giving this medication outside of parameters is that it causes the blood pressure to be uncontrolled. A policy and procedure titled, Medications: Administering Medications, dated January 1, 2024, revealed that it is the policy of the facility that medications are administered in accordance with prescriber orders, including any required time frames. The policy also revealed that the individual administering the medication