STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035091	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Flagstaff	800 West University Avenue Flagstaff, AZ 86001

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 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 observations, interviews, clinical record reviews, facility documentation, and facility policies, the facility failed to ensure that medications were not diverted for two residents (#13 and #15). This deficient practice could result in Controlled Substance being diverted and not being available to residents as prescribed.Findings Include: -Regarding Resident #15:Resident #15 was admitted to the facility on [DATE], with diagnoses of hyperlipidemia, Gastro-Esophageal Reflux Disease (GERD), and heart failure.A care plan initiated on November 13, 2025, revealed a focus area for the Resident #15 to be on Opiate medications related to post-surgical. The care also revealed a goal to be free of adverse reactions related to opiate medication and an intervention to administer medication as needed. A review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident #15 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact. The MDS further revealed that in Section N, the resident is taking opioids. A Physician's Order dated November 24, 2025, revealed an order for Hydrocodone-Acetaminophen Oral Tablet 10-325 MG (a Controlled Substance/ an Opioid), give 1 tablet by mouth every 4 hours as needed for pain 6-10. The physician's order revealed that the order was discontinued on November 29, 2025.A Medication Administration Record (MAR) for November 2025 for Hydrocodone-Acetaminophen Oral Tablet 10-325 revealed that the medication was not administered on November 27, 2025 and only administered once on November 29, 2025.An Individual Control Drug Record dated November 2025 for Hydrocodone Acetaminophen Oral Tablet 10-325 revealed that Registered Nurse (RN/staff #54) identified that she had administered for the following dates:November 25, 2025November 26, 2025November 28, 2025November 29, 2025 However, the individual Control Record dated November 2025 for Hydrocodone Acetaminophen Oral Tablet 10-325 revealed that from November 29, 2025, through November 30, 2025, it had been signed out by a staff member 5 different times.-Regarding Resident #13:Resident #13 was admitted to the facility on [DATE], with diagnoses of cellulitis, sepsis, and type 2 diabetes. A care plan initiated on November 01, 2025, revealed a focus area for the resident to be on opioid medication related to abscess pain and post-surgical. A Physician's Order dated November 03, 2025, revealed an order for Oxycodone HCL Oral Tablet 5 MG (Oxycodone HCL) MG. A review of the comprehensive MDS assessment dated [DATE], reveals that Resident #13 had a BIMS score of 15, which indicated the resident is cognitively intact. The MDS then further revealed that in Section N, the resident is taking opioids.A Medication Administration Record for November 2025 for Oxycodone HCL Oral Tablet 5 MG revealed that the medication was not administered for the following dates: November 9, 2025 - November 12, 2025 November 14, 2025 - November 29, 2025However, on the Individual Control Drug Record dated November 2025 for Oxycodone HCL Oral Tablet 5 MG revealed that the medication was signed off 17 times by staff member/s, but the MAR revealed that it was only given 3 times. The record further revealed that (Staff # 54) identified that she had given the medication on November 08, 2025.Furthermore, A Job Description: Registered Nurse (RN) sheet had revealed that it had been signed on November 24, 2025, by Staff # 54. A 5-day report for an incident that occurred on November 30, 2025, revealed that Narcotic logs, Medication Administration Records, and Destruction Logs verified for the possibility of diversion of narcotics from Staff # 54. The 5-day report further revealed that a staff member had reported to the Director of Nursing (DON/Staff #75) that Registered Nurse (RN/Staff#54) had potential irregularities involving two controlled-substance accountability sheets, and an audit was initiated. The 5-day audit had also revealed that Resident #13's Medication Administration Record did not correspond with the narcotic sign-out sheet, and there were visible signs of alteration to the sheet. The 5-day further revealed that there were overwritten entries and inconsistent documentation patterns in the Resident #13 narcotic sheet. The 5 days then revealed that for Resident # 15, Hydrocodone-Acetaminophen Oral Tablet 10-325 MG was discontinued, but was continuously signed off on the narcotic sheet. The five-day further revealed that Staff #54 was asked to highlight the Individual Control Drug Record sheets for mediations she administered, but it was not reflected in the MAR. The 5-day period then revealed that the DON informed staff # 54 that the discrepancies were indicative of a potential controlled-substance diversion, and staff #54 denied the allegation and left the facility. A Termination Detail sheet dated December 02, 2025, revealed that Staff #54 was terminated for dishonesty/Fraud. The termination sheet further revealed a note for Drug Diversion. Was found to be stealing drugs after 2 days of shift work. Horrible employee. NOT REHIREABLE. A Final Universal Background check