STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035059	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Scottsdale	3293 North Drinkwater Boulevard Scottsdale, AZ 85251

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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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 policy reviews, the facility failed to ensure that 1 of 3 sampled residents (#1) received the appropriate inhalation powder per physician orders. The deficient practice could result in uncontrolled symptoms related to chronic obstructive pulmonary disease (COPD). Findings include:Resident #1 was admitted on [DATE] with diagnosis that included chronic obstructive pulmonary disease (COPD), acute respiratory failure, an open wound of abdominal wall and sepsis. A comprehensive care plan initiated on September 15, 2025, revealed that Resident # 1 had COPD with intervention that included to give aerosol or bronchodilators as ordered and to monitor and document the side effects and effectiveness. A progress note dated September 15, 2025, revealed that Tyvaso Dry Powder Inhaler (DPI) was on hold pending provider direction. The progress note goes on to reveal that the facility initially did not have the medication and that the resident's family would bring the Tyvaso DPI to the facility and medication will be house stock once received. A Pulmonary progress note dated September 25, 2025, revealed that the resident and family would like the resident to switch from Yupelri to Tyvaso as the resident was supposed to transition to this medication as outpatient. Further review of the pulmonary progress note revealed that the provider approved the Tyvaso with home supply and held the order for Yupelri. A physician order dated September 25, 2025, revealed a prescription for Tyvaso DPI maintenance kit inhalation powder 16 micrograms (mcg). The order directed 16 mcg be inhaled orally four times a day for 1 week starting September 25, 2025. Review of the Order Summary Report revealed a physician order dated September 25, 2025 for Tyvaso DPI maintenance kit inhalation powder 16 MCG. The order indicated 32 mcg be inhaled orally four times a day for 1 week starting October 2, 2025. An order dated September 25, 2025 prescribed Tyvaso DPI maintenance kit inhalation powder 16 MCG. The order directed 64 mcg be inhaled orally four times a day starting October 9, 2025 and was discontinued October 21, 2025.Review of the Medication Administration Record (MAR) Note dated September 27, 2025, revealed that the 12:00pm dosage of Tyvaso DPI was not administered with a note from Licensed Practical Nurse (LPN/Staff #35) stating that the facility was awaiting delivery.Further Review of the MAR on September 27, 2025, revealed that the resident received the 8:00 a.m. dose and the 4:00 pm does, both on September 27, 2025. Review of the MAR for the month of October 2025, revealed that Tyvaso DPI was not administered on:October 1, 2025 at 12:00, 4:00, and 8:00 p.m.October 2, 2025 at 8:00 a.m. October 3, 2025 at 8:00 a.m., 12:00 p.m., and 8:00 p.m.October 5, 2025 at 8:00 p.m.Further review of the October 2025 MAR revealed that the Tyvaso DPI was administered on:October 1, 2025 at 8:00 a.m.October 2, 2025 at 12:00 p.m., 4:00 p.m., and 8:00 p.m.October 3, 2025 at 4:00 p.m.Review of the MAR note dated October 1, 2025 revealed that the missed doses at 12:00, 4:00, and 8:00 p.m. were on order. There was no indication that the pharmacist or the provider were contacted regarding the missing medication. Review of the MAR note dated October 2, 2025 revealed that the missed does at 8:00 a.m. was on order. There was no indication that the pharmacist or the provider were contacted regarding the missing medication. Review of the MAR note dated October 3, 2025 revealed that the missed doses at 8:00 a.m., 12:00 p.m., and 8:00 p.m. were on order and the pharmacy was notified at 9:26 p.m. that the medication was not available, even though the medication was provided by family and stored in house. An interview with a Licensed Practical Nurse (LPN/Staff # 35) on November 5, 2025 at 1:35 p.m. revealed that if there is no medications in the cart or the storage room then they would call the pharmacy and re-order the medication and notify the provider that they don't have the medication on hand. The LPN denied having any residents or family provide their own medications, and revealed that everything is ordered through the pharmacy. Staff #35 revealed that she was unaware that the Tyvaso DPI was provided by he family and not the pharmacist.An interview with the Assistant Director of Nursing (ADON/Staff # 57) on November 5, 2025 at 2:09 p.m. revealed that Resident # 1's family had brought a box of the Tyvaso DPI to the facility and that the facility never ordered the medication through the pharmacy. ADON revealed that they had to wait to administer the Tyvaso until approval from the pulmonologist was received. The facility started a titration of the medication in September but there was an issue with the October titration and the nurses were confused on the amount to administer. The ADON revealed that due to the confusion, she did not have the daughter bring in a second box of the medication because they never finished the first box of Tyvaso DPI, The ADON reviewed the missed doses on the MAR and revealed that she did not know why those missed doses were marked on order when the family had provided the medication and was in house. A policy and procedure