STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035107	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Phoenix	4202 North 20th Avenue Phoenix, AZ 85015

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581 Based on documentation, staff interviews, and the facility policy and process, the facility failed to ensure that care was provided according to professional standards and that the resident's basic needs are being met for one resident (#10). The deficient practice could result in residents not being provided the care needed to maintain or improve health. Findings include: Resident #10 was admitted to the facility on [DATE] with diagnoses that included acute chronic heart failure, pleural effusion, urinary tract infection, cellulitis of left lower limb, severe sepsis without septic shock, hypoxemia, and hypokalemia. The order summary revealed an order dated: -[DATE] for oxygen as needed (PRN) at ,d+[DATE] liters per a minute to keep oxygen saturation above 90% every 8 hours as needed for oxygen therapy. -[DATE] for oxygen at ,d+[DATE] liters per minute as needed to keep saturation above 90% every shift for oxygen therapy. -[DATE] vital signs per facility protocol -[DATE] for full code CPR Review of the care plan dated [DATE] did not reveal a plan for oxygen therapy. Review of the clinical record for vitals revealed documentation for: -oxygen saturation 77% on [DATE] at 7:45 a.m. -temperature 94 degrees on [DATE] at 7:45 a.m. -respiration 18 breaths a minute on [DATE] at 7:45 a.m. -blood pressure ,d+[DATE] on [DATE] at 9:44 p.m. (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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NAME OF PROVIDER OR SUPPLIER: Haven of Phoenix		STREET ADDRESS, CITY, STATE, ZIP CODE: 4202 North 20th Avenue Phoenix, AZ 85015	

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-pulse 82 bpm on [DATE] at 9:44 p.m. Review of the treatment administration record dated [DATE] revealed oxygen as needed (PRN) at ,d+[DATE] liters per minute to keep saturation above 90% every 8 hours as needed for oxygen therapy dated [DATE] was not administered. A physician's note dated [DATE] revealed that the patient is currently awake and resting, not in distress, and no chest pain or palpitation. Vital signs with afebrile: pulse 100, respirate 18, blood pressure ,d+[DATE]. Lungs clear to Osco bilaterally with decreased air entry at the bases. Review of the progress notes did notes did not reveal any documentation of vitals, including oxygen saturation being assessed, or oxygen therapy being administered by staff. A progress note dated [DATE] revealed that the resident was found unresponsive at 5:30 a.m. Cardiopulmonary resuscitation (CPR) was initiated followed by a 911 emergency call. The emergency medical team (EMT) arrived at the facility at 5:38 a.m. The resident was pronounced dead at 5:55 a.m. by the EMT after all efforts to resuscitate the resident failed. The family on record was notified at 6:00 a.m. The medical doctor was notified at 6:05 a.m. and the facility Director of Nursing was equally notified. Review of the Public Requests Form for the City of Phoenix Fire Departement (FD) revealed the date of service, 911 response, was [DATE]. The 911 call was received at 5:38 a.m., and the FD was on scene at 5:44 a.m. Staff initially waited 15 minutes while doing CPR to call 911. Upon arrival, the resident was found supine in bed, while staff was standing behind the resident's head, performing inaccurate CPR (compressions). Staff was bagging the resident with the bag-valve- mask (BVM) inaccurately, with no oropharyngeal airway (OPA) in the resident. The FD took the resident's blood sugar level (BS) and it was LO (hypoglycemic) and administered dextrose 50% via intraosseous (IO). The BS level was rechecked after two minutes and the glucometer reading was 21.The facility staff was asked why he waited 15 minutes to call 911 and did not answer. Once the FD took over, the staff left the resident's room without giving a full report and did not return. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on [DATE] at 11:44 a.m. with a certified nursing assistant (CPR/staff #16), who stated that she knows how to check vitals, which includes blood pressure, pulse, temperature, and oxygen saturation, but she doesn't check vitals because the overnight shift doesn't check vitals. She stated that the CNAs check vitals once during the day shift and once during the evening shift, and the evening shift would give her a status report during shift change if there was a concern regarding a resident's vitals. She stated that if there was a concern, she would check the resident's vitals during the night. She stated that vitals are documented on a piece of paper and given to the nurse and the CNA also documents the results in the electronic record. She stated that she checks the residents every two hours throughout the night and on [DATE], she began her shift at 10:30 p.m. and completed her rounds. She checked the residents again at: 12:30 a.m., 2:30 a.m., and 4:30 a.m. She stated that she found the resident unresponsive at 4:30 a.m. She stated that the resident was not breathing and did not have a pulse, and while she was checking the resident's vitals, she radioed to (LPN/staff #2) that she needed a nurse stat and then stood by the side of the bed and began compressions. She stated that she did not count the compressions and did not provide breaths as she did not have a mouth piece. She stated that (LPN/staff #2) was in the hallway with (LPN/staff #11) immediately after she had called on the radio and staff #2 had called 911. (LPN/staff #11) came into the room and checked the resident's vitals, while she continued with compressions. Then, (LPN/staff #11) took over the compressions, while she stood at the upper right hand corner of the bed to provide breaths via the (BVM). She stated that she was not able to get behind the resident because the resident was short, and then, she stated that she was not able to get behind the resident because the bed was against the wall. She stated that the bed is on wheels and she didn't know if (LPN/staff #11) had tried to move the bed away from the wall, but stated that when she was trained to do CPR, she was trained to position herself behind the resident when using the BVM and to place the mask around the mouth creating a seal to make sure the air doesn't get out. She stated that (LPN/staff #11) did 5 or 6 compressions and told her to press the BVM bag one time. She stated that staff #11 instructed her to press the bag one or two times after every 5 to 6 compressions and when she pushed the bag, the resident's cheeks were puffing up and out, so she knew the air was going into the resident. This continued until the EMTs arrived and she could not remember what time they arrived. (LPN/staff #2) came into the room when the EMTs arrived and the EMTs asked how long the resident had been like this and she told them that she came into the room at 4:30 a.m. She stated that one of the EMTs asked (LPN/staff #2) why it took him so long to call 911 and he didn't answer. Then, (CNA/staff #16) stated that she doesn't know what time (LPN/staff #2) called 911. She stated that the EMTs were angry because no one would open the front door when they arrived. She stated that there was a male staff from the kitchen sitting by the front door and he took his time answering. She thinks the male staff may be a little slow. She stated that she was the only CNA in the resident's room during the entire incident. An interview was conducted on [DATE] at 2:25 p.m. with the Assistant Director of Nursing (ADON/staff #29), who stated that (LPN/staff #2) was responsible for completing the transfer form for the resident and would have called 911 from the nurse's station, but should have returned to the resident's room when he was done. She doesn't know why he didn't return to the resident's room to help. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on [DATE] at 8:41 a.m. with the dietary aide (staff #41). The Director of Nursing (DON/staff #50) was present. Staff #41 stated that he works from 6:00 a.m. to 2:30 p.m., but comes to work early because he doesn't have a car and has to get a ride to work. He stated that he gets dropped off at work about 4:30 a.m. and enters the building through the side door to the right of the main entrance. He stated that he usually goes to the employee lounge to eat breakfast and when it is 5:45 a.m. he walks up to the reception desk and waits until about 5:55 a.m. to clock in for work. On the day of the incident, he stated that he was waiting to clock in and there were two men with a stretcher at the door. He let them in because a stretcher usually means that someone needs help. An interview was conducted on [DATE] at 9:55 a.m. with a licensed practical nurse (LPN/staff #11), who stated that he was at his medication cart between rooms #147 and #150, when (LPN/staff #2) came over to tell him that there was an emergency in room [ROOM NUMBER]. He stated that he was not sure of the time. Staff #11 stated that he was not using a radio because the battery was dead. (LPN/staff #11) went with (LPN/staff #2) to room [ROOM NUMBER] where (CNA/staff #16) was performing compressions on the resident. He stated that there was a board under the resident and the crash cart was present. (LPN/staff #11) stated that he assessed the resident and instructed the (CNA/staff #16) to take the resident's vitals, while he was preparing the BVM bag. Then, he did the compressions and (CNA/staff #16) pumped the BVM bag. Staff #11 stated that he counted and completed 21 compressions to 2 breaths, and then decreased the compression to breath ratio to 15 compressions to 2 breaths because there was white foamy saliva coming out of the resident's mouth. He stated that (CNA/staff #16) tilted the resident's head and swept the mouth and he suctioned the mouth area. Then, (CNA/staff #7) entered the room and she took over the compressions because he had to help (CNA/staff #16) to tilt the resident's head correctly to use the BVM. He stated that normally staff should be positioned behind the head of the resident and (CNA/staff #16) was at the side of the resident. He pushed the bed away from the wall, so he could get behind resident's head and took over the BVM and CPR continued at a ratio of 1 compression to 2 breaths. He stated that (LPN/staff #2) came back and provided the last compression before the EMTs arrived. During a second interview conducted on [DATE] at 10:34 a.m. with the (ADON/staff #29), she stated that staff come running when they know that there is a code blue and they know there is a code blue because they hear the message on the radio. An interview was conducted on [DATE] at 10:45 a.m. with (CNA/staff #7), who stated that there are radios available to communicate with staff, but she doesn't use one because it is noisy and bothers the residents. She saw the certified medication assistant (CMA/staff #35), who told her that a resident was not waking up. She stated that (LPN/staff #2) was at the nurse's station and told her that a resident was not waking up. She stated that she the other nurse (LPN/staff #11) was doing compressions and she stepped in to help because he was so tired. She couldn't remember how many compressions she did because it all happened so fast. While she provided compressions, another CNA was standing next to the resident providing breaths via the BVM. She then stated that she thinks she did about 30 compressions and couldn't remember how breaths were done between compressions. She stated that she was trained to stand next to the resident, place the BVM over the resident's face and squeeze the bag. She stated that there were no other steps prior to placing the BVM on the resident's face and squeezing the bag. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on [DATE]:44 a.m. with the licensed practical nurse (LPN/staff #2), who stated that he was administering medications near rooms #136 and #137 when (CNA/staff #16) came out into the hallway to get him. Staff #16 was completing her last rounds and told him to come and check the resident now. He stated that he assessed the resident who was unresponsive. He did not detect a pulse and the chest was not rising. He went back to the cart to get his radio which was lying on the top of the cart and called for help. He stated that all staff are required to carry a radio. He stated that (LPN/staff #11) was near and all three went to the resident's room. He stated that the other nurse started compressions and the CNA did the BVM. An interview conducted on [DATE] at 2:54 p.m. with a certified medication assistant (CMA/staff #35), who stated that she was passing medications around 5:00 a.m. when staff told her that there was a code blue with one of the residents. She stated that she did not hear a code blue over the radio because her radio was charging. She stated that she went to the resident's room and the nurse asked her to start doing CPR; she and the nurse took turns providing compressions and rescue breathing via the BVM. She stated that rescue breathing was performed by standing at the side of the bed, tilting the resident's head, placing the BVM on the resident's face, but doesn't remember if the resident's cheeks were filling with air. She stated that during the emergency, she did not see any certified nursing assistants (CNAs) in the resident's room. She stated that the other nurse, a licensed practical nurse (LPN/staff #2) was at the nurse's station printing paperwork and when she went to the nurse's station, (LPN/staff #2) told her to take the paperwork and wait by the reception area for the EMTs. She went to reception area at the front of the building and there was male staff sitting there. When the EMTs arrived, at approximately 5:30 to 5:40 a.m., she let them in the building. An interview was conducted on [DATE] at 2:13 p.m. with the (DON/staff #50), who stated that all nurses and CNAs have to be CPR certified. The staff have access to radios, but are not required to use them. He stated that if a resident is unresponsive, the staff must notify at least one other staff by radio or by yelling out in the hall to call 911 and to help with CPR. The CNA can check the vitals and go get help if needed, but the nurse must be there to assess the resident and to see if CPR is required. One nurse should stay there to provide CPR and to supervise the CNA, who should be providing ventilation via the BVM bag. It is expectation that CPR is provided at a ratio of 100 compressions to 2 breaths and should be done immediately after the resident is assessed and unresponsive. He stated that a second nurse should be calling 911 and completing the transfer paperwork. He also stated that when ventilation is provided via BVM, the mask should be placed over the mouth and nose, and the staff should tilt the head. There should be no symptoms, such as the cheeks blowing up. If the cheeks do not fill up, there is no obstruction and the air should go directly to the lungs. He stated that it usually takes the EMTs about 15 minutes, sometimes 20 minutes to arrive. The facility policy, Emergency/First Aid: Emergency Procedure - Cardiopulmonary Resuscitation states that if an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless it is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual; or there are obvious signs of irreversible death (e.g., rigor mortis). The facility ' s procedure for administering CPR shall incorporate the steps covered in the 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care or facility BLS training material. After 30 chest compressions provide 2 breaths via ambu bag or manually (with CPR shield).