

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035107	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2025
NAME OF PROVIDER OR SUPPLIER Haven of Phoenix		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on documentation, staff and resident interviews, and review of the facility policy and procedures, the facility failed to ensure the safety of one resident (#5) by not properly securing the resident and failing to maintain a safe speed during transport. The deficient practice could result in residents being physically injured. Findings include: Resident #5 was admitted to the facility on [DATE], and discharged on December 28, 2023, with a diagnosis including infection and inflammatory reaction due to internal left knee prosthesis, subsequent encounter, hypertensive chronic kidney disease with stage 5 chronic kidney disease or end-stage renal disease, and dependence on renal dialysis. Review of the Care Plan, date-initiated December 18, 2023, revealed a focus for fall risk related to generalized weakness. Interventions included anticipating and meeting the residents' needs and following the facility's fall protocol. Further review of the care plan identified a focus for anticoagulant therapy. Interventions include having Vitamin K on hand for emergencies. Review of the Medicare-5 Day Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The assessment revealed no indicator for mood or behaviors, the use of a wheelchair for mobility, and was receiving hemodialysis. An Incident Note dated December 28, 2023, included that at 1500, the transporter notified the Nurse that the Rails of the Van lift hit the back of the resident's head. As the resident moved forward, the rails also hit both shoulders and both Knees. The resident had a little lump on the back of her head, complained of pain in both shoulders; no other injuries were noted, vital signs were within normal limits and pain medication was administered. The note included that all other parties were notified and the provider ordered to send the patient to the emergency department for a computed tomography scan of the head. Review of the facility investigation with discovery date of December 28, 2023, revealed the following narrative: On 12/28/23, our van driver, staff #9, was transporting Resident #5 from dialysis to the facility. The van was at a stoplight, the light turned green, and the driver sped up to get on the expressway. As he accelerated to enter the expressway, the driver overheard the resident make a startled verbalization. The driver looked back and observed the resident tipped back in her wheelchair and resting upon the wheelchair lift. The driver then proceeded to safely pull over and was able to get her back upright in the wheelchair, secured her in place, and returned to the facility. Upon return to the facility, nursing did an assessment of the patient and decided it was best to send the patient out to the hospital for further evaluation. On December 29, 2023, the hospital findings include a fractured vertebra. The driver has been suspended pending further investigation. The facility vans and wheelchair equipment have been checked, and all are in proper functioning order. Facility performed education with the drivers on proper driving techniques and use of straps to secure the wheelchair and the resident in place. Continued review of the facility investigation included corrective actions that revealed on December 28, 2023, it was reported that the van driver (staff # 9) failed to ensure the safety of a resident during a transport, resulting in a negative impact for the resident. Staff #9 was immediately placed on administrative leave without pay pending a full investigation. As part of the investigation, Staff #9 was questioned. When asked about this incident by the ED (Executive Director/staff #,10), Staff #9 stated that he was at the stoplight getting on to the expressway, and when the light turned green, he sped up, causing the resident to tilt back because she wasn't strapped down which resulted in her hitting the back of her head and lower neck. Staff #9 reported he wasn't sure what had happened to the strap and admitted that Resident #5 must not have been strapped down properly. Further review of the facility investigation revealed that Staff #9 was terminated effective immediately. A Discharge and Transfer assessment dated [DATE], revealed that the resident had an accident in Haven's transport van while boarding from the hemodialysis center and struck her head against the lift bar. Resident #5 sustained a scalp hematoma and complained of bilateral shoulder, knee, and cervical pain. Provider was notified and ordered to send the patient to the emergency department for further evaluation. A head-to-toe assessment was completed, revealing a right upper chest hemodialysis catheter without signs or symptoms of infection, global skin ecchymosis, and a back-scalp hematoma. Review of the Maintenance Device Review of the transport van dated December 29, 2023, revealed all belts, harnesses, and lift gate were in working order and functioning properly. Review of the employee file for Staff #9 revealed no prior incidents, and was provided with safety training and a clear motor vehicle report on January 22, 2020. An interview was conducted on December 16, 2025, at 1:13 PM with Medical Records Director (Staff #12). Staff #12 stated she is the supervisor for the drivers and that the</p>		