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	05/06/2026

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and facility policy, the facility failed to ensure that medications were administered as ordered for two of five sampled residents (Resident #32 and #56). The deficient practice could result in resident's pain not being controlled.Regarding Resident #32: Resident #32 was readmitted to the facility on [DATE], with a diagnosis that included schizoaffective disorder, bipolar type; bipolar disorder; major depressive disorder; and anxiety disorder. A care plan focus dated February 24, 2025, revealed Resident #32 had polyneuropathy pain. Interventions included that the staff were to anticipate his need for pain relief and respond as soon as possible. A physician's order dated October 8, 2025, revealed Resident #32 is to take one 325 mg tablet of oxycodone-acetaminophen every 5 hours as needed for pain levels of 6 to 10. A quarterly minimum data set (MDS) assessment dated [DATE], revealed that Resident #32 had a BIMS (brief interview of mental status) score of 15, indicating that Resident #32 was cognitively intact. The assessment also revealed that Resident #32 received a scheduled pain medication regimen and received pain medications as needed. The assessment revealed that Resident #32 experienced pain occasionally over the last 5 days. A review of the medication administration record (MAR) for April 2026 revealed that the order of one 325 mg tablet of oxycodone-acetaminophen every 5 hours as needed for pain levels of 6 to 10 had been administered out of parameters on:- April 9, 2026, with an administration of the medication with a pain level of 5- April 19, 2026, with an administration of the medication with a pain level of 2- April 21, 2026, with an administration of the medication with a pain level of 4- April 28, 2026, with an administration of the medication with a pain level of 2- April 29, 2026, with an administration of the medication with a pain level of 5 An interview was conducted on May 5, 2026, at 10:39 AM, with a licensed practical nurse (LPN/Staff #38). Staff #38 stated that when administering medications, staff are expected to confirm the medication, review the vitals, and then review the right medication, right route, right dose, and the right resident for accuracy. Staff #38 stated it was important to give medication as ordered due to the risk of administering medications out of ordered parameters. Staff #38 also stated that she would confirm the order before administering it and would notify the provider if the resident refused to take the medication or requested a change to it. An interview was conducted on May 5, 2026, at 11:34 AM, with a certified nursing assistant (CNA/Staff #16). Staff #16 stated that what she would look for when a resident is in pain would be to (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	see any physical signs, such as wincing, crying, increased anxiety, and not acting at their baseline. Staff #16 also stated that should she observe a resident in pain, she would ask the resident for their pain level and report the pain to the nurse immediately so that their pain level can be addressed appropriately. An interview was conducted on May 5, 2026, at 12:06 PM, with an LPN (Staff #14). Staff #14 stated that when administering pain medications, she would ask a resident their pain level and the location of the pain. Staff #14 stated that she would then check the ordered medications available to the resident per the resident's stated pain level. If the ordered pain medication specified a pain level range within the physician's orders, such as 6 to 10, she would administer the medication. Staff #14 also stated that she would reach out to the physician to confirm if a medication could be given out of parameters, and what other medications could be administered. Staff #14 also stated that orders, changes, or updates received from the physician would need to be documented in the resident's electronic health record. An interview was conducted on May 6, 2026, at 9:54 AM, with the interim director of nursing (DON/Staff #125). Staff #125 stated that when administering pain medications, staff are expected to ask a resident their pain level and the location of the pain. Staff #125 stated that staff are expected to administer the ordered medications per the resident's stated pain level. Staff #125 reviewed the orders and the April MAR of Resident #32. Staff #125 stated that oxycodone-acetaminophen every 5 hours as needed for pain levels of 6 to 10 had been administered out of parameters on April 9, 2026; April 19, 2026; April 21, 2026; April 28, 2026; and April 29, 2026. Staff #125 stated that the physician's orders were not followed on the listed days and that the risk of medications being administered out of parameters could be a lowered blood pressure, respiration, and overall abnormal vital signs. -Regarding Resident #56: Resident #56 was admitted to the facility on [DATE], with diagnosis that included dysphagia, gastro-esophageal reflux disease without esophagitis, hypertension, and anxiety. A quarterly Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment also revealed that the resident received a scheduled pain medication regimen and received pain medications as needed. A physician's order dated July 24, 2025, revealed Resident #56 is to take one 5 milligram tablet of oxycodone-HCl every 6 hours as needed for pain scale 4-6 related to low back pain. A care planned focus dated November 18, 2024, revealed that the resident was at risk for pain related to generalized discomfort with interventions that included to administer analgesia medication as per orders. A Medication Administration Record (MAR) for April 2026 revealed that the order of one 5 mg tablet of oxycodone-HCl every 6 hours as needed for pain levels of 4 to 6 had been administered out of parameters on: - April 3, 2026, with an administration of the medication with a pain level of 7 - April 8, 2026, with an administration of the medication with a pain level of 7 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- April 11, 2026, with an administration of the medication with a pain level of 7 - April 18, 2026, with an administration of the medication with a pain level of 8 - April 20, 2026, with an administration of the medication with a pain level of 7 - April 22, 2026 with an administration of the medication with a pain level of 8 - April 25, 2026 with an administration of the medication with a pain level of 7 - April 26, 2026 with an administration of the medication with a pain level of 8 - April 29, 2026 with an administration of the medication with a pain level of 7 An interview was conducted on May 5, 2026, at 10:04 AM, with a Licensed Practical Nurse (LPN/Staff # 65), who stated that when administering medications, staff are expected to confirm the medication, review the vitals, and the resident's pain level. The LPN further stated that according to the pain scale: 10 means most pain and 0 means no pain. The LPN reviewed the resident's clinical record and stated that Resident #56 had an order of Oxycodone HCl tablet 5 milligrams, to give 1 tablet by mouth every 6 hours as needed for mild pain of 4-6. The LPN then reviewed the MAR for the month of April 2026, and stated that the pain level documented in MAR referred to the resident's pain before the medication was administered to the resident. The LPN further stated that the clinical record revealed that Oxycodone had been administered for pain levels of 7 and 8, which was outside of the ordered pain level of 4 to 6. The LPN also stated that risk of not following physician ordered parameters for pain medication, could result in not controlling resident's pain. An interview was conducted on May 5, 2026, at 10:39 AM, with a LPN (Staff #58), who stated that when administering medications, staff are expected to confirm the medication, review the vitals, and then review the right medication, right route, right dose, and the right resident for accuracy. The LPN reviewed Resident #56's clinical record and stated that the resident had an order of Oxycodone HCl tablet 5 milligrams, to give 1 tablet by mouth every 6 hours as needed for mild pain 4-6. The LPN then reviewed the MAR for the month of April 2026, and stated that the pain level documented in the MAR referred to the resident's pain before the medication was administered to the resident. The LPN further stated that Oxycodone was administered for pan levels of 7 and 8 which was outside of the physician ordered parameters of 4-6. The LPN also stated that risk of not administering pain medication as ordered couls result in the resident's pain not being controlled. An interview was conducted on May 5, 2026, at 1:22 PM, with the interim Director of Nursing (DON/Staff #125, who stated that when administering medications, staff are expected to confirm the medication, review the vitals, and then review the right order, right dose, and the right resident for accuracy. The DON reviewed the resident's physician orders and the April 2026 MAR . The DON stated that oxycodone-acetaminophen every 5 hours as needed for pain levels of 4 to 6 had been administered out of the physician ordered parameters on 9 occasions during April 2026. The DON also stated that the risk of medications being administered outside of the physician ordered parameters could result in resident's not receiving effective pain-relieving medication. A policy titled, Medications: Administering Medications, in effect on January 1, 2024, revealed that medications are to be administered in accordance with the prescriber's orders, including any required time frame.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical records, staff interviews, review of the Blood Glucose Monitoring System User's Guide, and review of the facility's policy and procedure, the facility failed to ensure that staff conducted proper hand sanitizing during a meal service and infection control procedures were performed after a point of care testing for blood sugar check, for one resident (#164) to help prevent a transmission of infections according to acceptable clinical standards of practice. The census was 99. The deficient practice could result in the spread of infectious diseases to other residents and could place the residents at risk for infection.Findings include: -Regarding Following Hand Hygiene: An observation of residents in the dining room was conducted on April 4, 2026 at 7:38 AM. There were a total of five Residents having breakfast and one staff member (#37) a Certified Nursing Assistant (CNA) assisting the residents. Each of the Residents were sitting at their own table. Residents had their breakfast, a cup of coffee and a glass of juice. A resident finished breakfast and left the dining room. Staff #37 removed the resident's plate, silverware and glasses from the table, walked to the garbage can, scraped the plate and placed it on the dirty tray cart. Staff #37 did not perform hand hygiene; however, he went to the tray cart and pulled a new breakfast tray for a resident, placed the dish in front of the resident along with the silverware, sat beside the resident, picked up the fork and placed eggs on it and fed it to the resident. Another resident in the dining area finished breakfast and left the dining room and staff #37 walked to the table, cleared the dishes, walked to the garbage can, scraped the dishes and then placed the dirty dishes onto the dirty tray cart. Another resident in the dining area then asked staff #37 for a refill of coffee. Staff #37 did not perform hand hygiene and took a coffee pot to the resident and filled the coffee cup. Staff #37 then placed his fingers on the top of the coffee mug and gave it back to the resident. An interview was conducted with staff #37 on May 4, 2026, at 7:38 AM. The CNA stated he did not perform hand hygiene during the dining service and the risk was cross contamination and spreading disease. An interview was conducted on May 5, 2026, at 1:02 PM with the Assistant Food Director, staff #97. He stated his expectation during dining service was that staff sanitize their hands between assisting residents. He stated the risks could potentially be foodborne illness, and spreading germs between residents. An interview was conducted on May 5, 2026, at 1:45, with the acting DON. She stated it did not meet expectation for staff to not perform hand hygiene between residents. Based on the observation, she stated we need to do some education. - Regarding Resident #164: Resident #164 was readmitted to the facility on [DATE] with diagnoses that included enterocolitis due to clostridium difficile (C-diff), infection and inflammation reaction due to indwelling urethral catheter, and methicillin resistant staphylococcus aureus infection (MRSA). A review of the Residents active physician's orders revealed that the Resident was placed on Enhanced Barrier Precautions related to wounds, indwelling catheter to drain urine from her bladder, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and a peripherally inserted central catheter for intravenous access; and the Resident was also placed on contact isolation precaution for C-diff. A review of the Resident's care plan initiated on 04/21/2026, revealed that the Resident had C-diff. The interventions included contact isolation precaution by putting on personal protective equipment (PPE) such as gowns and masks when changing contaminated linens; placing soiled linens in bags marked biohazard; bagging linens and closing the bag tightly before taking it to the laundry; disinfecting all equipment used before it leaves the room; educating the resident, family and staff regarding preventive measures to contain the infection; place the resident in a private room with contact isolation precautions; and using as much disposable equipment as possible or use of dedicated equipment such as thermometer and blood pressure cuff. A review of the infection progress note dated 04/22/2026, revealed that the reason for the consultation included C. difficile Infection (CDI) and the Resident was on prophylaxis. Per the document, the Resident developed CDI during a hospitalization in the setting of prolonged, broad-spectrum antimicrobial therapy, and the treatment was transitioned to oral vancomycin prophylaxis through 04/30/2026 given continuation of antibiotics. It was further documented that the Resident denied diarrhea or loose stools. On 05/05/2026, at 7:33 AM, a medication administration observation was conducted with a Registered Nurse (RN/Staff #65) for Resident #164. The RN stated that the Resident was placed on contact isolation precaution for C-diff. On 05/05/2026, the outside of the Resident's room was observed to have a contact isolation precaution signage and a PPE cart. On 05/05/2026, at 7:35 AM, the RN (Staff #65) took a glucometer device from her medication cart, then put on a disposable gown and gloves, and entered the room of Resident #164. The room was observed to have a stethoscope and a blood pressure cuff inside an open square container placed on top of an empty bed; and a glucometer placed on top of a drawer located inside the Resident's room by the doorway. On 05/05/2026, at 7:37 AM, while in Resident #164's room, the RN (Staff #65) wiped one of the Resident's fingers with an alcohol swab to check the Resident's blood sugar, while the glucometer was placed on top of the Resident's bedside table. After the RN pricked the Resident's finger, she applied the blood on the test strip that was inserted in the glucometer to obtain the blood sugar result, and the RN informed the Resident that her blood sugar was 143. The RN removed her disposable gown and gloves and then placed it in a covered trash bin located inside the Resident's room and then washed her hands. On 05/05/2026, at 7:41 AM the RN (Staff #65) exited the Resident's room carrying with her the glucometer. The RN then placed the glucometer on top of a tissue paper, which was located on top of the medication cart. The RN stated that she used a tissue paper with hand sanitizer to wipe down the glucometer. She also said that she wiped the glucometer dry with another tissue paper. It was further observed that she placed the glucometer inside the top drawer of the medication cart. Further, the RN stated that for any isolation precaution, she would put on a gown and gloves; and before exiting the Resident's room, she would take off her gown and gloves, place it inside the trash bin located inside the Resident's room. The RN also stated that regarding a glucometer for a Resident with a contact isolation precaution, that each Resident should have a glucometer device inside the room. She said (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that she brought in a glucometer inside Resident #164's room because she did not want to risk going in the Resident's room and then finding out that there was no glucometer. She said that there should be a glucometer in the Resident's room but instead, used the glucometer from her medication cart. An interview was conducted on 05/05/2026, at 7:55 AM with the acting Director of Nursing/Assistant Director of Nursing (DON/ADON/Staff #125). The acting DON/ADON stated that she came over because -she was trying to find out why Staff #65 was withdrawing insulin from an insulin pen. She said that she was educating Staff #65 not to withdraw insulin from the insulin pen. The acting DON/ADON stated that the process and expectation for a resident on isolation is she will get back to me on that. She said that infection control is preventing the spread of infection by handwashing, using gloves, sanitizing if appropriate, and gowning up when appropriate. She stated that for a resident placed on contact isolation due to C-diff, she expects the staff to gown up and use gloves, and leave devices such as a vital sign machine, glucometer and supplies inside the Resident's room. She said that regarding the glucometer sanitizing, she would use a disinfectant wipe, and would not use a hand sanitizer to disinfect the glucometer because it does not kill the germs. The acting DON/ADON stated that she would remove the glucometer from the medication cart that was used to check Resident #164 's blood sugar and had been improperly disinfected. She stated that she had educated Staff #65. On 05/05/2026, at 8:01 AM, the acting DON/ADON removed the glucometer utilized for Resident #164 from the medication cart. On 05/05/2026, at 8:09 AM, a request was made for the facility's policies on transmission-based precaution and point of care testing; the facility's manufacturer's manual for their glucometer point of care testing device; and Staff #65's employee record. A review of the facility policy titled, D035 - Infection Control: Isolation – Initiating Transmission – Based Precautions, with an effective date of 01/01/2024, revealed that transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Transmission-based precautions may include contact precautions, droplet precautions, or airborne precautions. When transmission-based precautions are implemented, the infection preventionist (or designee) ensures that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained outside the resident's room so that anyone entering the room can apply the appropriate equipment; ensures that protective equipment and supplies needed to maintain precautions during care are in the resident's room; and ensures that an appropriate linen barrel/hamper and waste container, with appropriate liner are placed in or near the resident's room. The transmission-based precautions remain in effect until the attending physician or infection preventionist discontinues them, which occurs after criteria for discontinuation are met. A review of the facility policy titled, Infection Control: Infection Control Guidelines for All Nursing Procedures, version 011526, revealed that the Transmission-Based Precautions will be used whenever measures are more stringent than Standard Precautions are needed to prevent the spread of infection. When there is likely exposure to spores (i.e., C. difficile or Bacillus anthracis) (Note: Alcohol-based hand rubs are inactive against spores. For effective mechanical removal of spores, wash hands for 30-60 seconds with soap and water or 2% chlorhexidine gluconate.) Review of the Blood Glucose Monitoring System User's Guide provided by the Executive Director (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Staff #200) revealed that cleaning is the removal of dust and dirt from the meter and lancing device surface so no dust or dirt gets inside. Cleaning also allows for subsequent disinfection to ensure germs and disease causing are destroyed on the meter and the lancing device surface. Further, the manual guide revealed that the following products are validated for disinfecting the meter and lancing device: Medline micro kill bleach germicidal bleach wipes EPA registration 37549-1. The manual also revealed that to disinfect the meter, clean the meter with one of the validated disinfecting wipes. The facility's policy for Infection Control: Handwashing/Hand Hygiene dated January 1, 2024, stated All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors, to include before and after assisting a resident with meals.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of the clinical records, staff interviews, and from the Arizona Health Care Cost Containment System, the Pre-admission Screening and Resident Review (PASRR), the facility failed to ensure the PASARR (pre-admission screening and resident review) was updated appropriately and accurately submitted, when applicable, for one resident (#32). The census was 99. The deficient practice could result in residents' medically related social and emotional needs not being met. The census was 99.Findings include:Resident #32 was readmitted to the facility on [DATE], with the diagnoses that included Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, and Anxiety Disorder. A review of the Minimum Data Set (MDS) 5-day assessment dated [DATE], revealed that the Resident's Brief Interview for Mental Status (BIMS) was not assessed. The Quarterly MDS assessment dated [DATE], revealed a BIMS score of 15.0, indicating that the Resident was cognitively intact. The assessment also revealed that no behavioral symptoms exhibited, and rejection of care behavior occurred daily. Further, the assessment revealed that the Resident had active psychiatric or mood disorder diagnoses which included Anxiety Disorder, Depression, Bipolar Disorder, and Schizophrenia. The MDFS further noted that the Resident used antianxiety and antidepressant medications. A review of records revealed that the Resident's PASARR was completed on 2/25/2025. The document revealed that Bipolar Disorder (Manic Depression) and Schizoaffective Disorder were selected as serious mental illness (SMI), and Anxiety Disorder and Depression were selected as mental disorders (MD). However, there was no document found in the Resident's medical record that a level 2 referral for determination was submitted to the appropriate state agency program. The Resident's care plan initiated on 5/01/2026, revealed per document that the Resident had a diagnosis of major depressive disorder, Anxiety disorder and Schizoaffective disorder which placed the Resident at risk for behavioral symptoms and the need for ongoing psychiatric oversight. The interventions included to ensure all specialized mental health services are provided or arrange as required, document frequent triggers and respond to interventional for all behavioral episode each shift, and report any changes to the provider. An interview was conducted on 5/05/2026, at 12:23 PM with the Resident Relations Manager (Staff #32). Staff #32 said that she started at the facility 3 weeks ago. She said that regarding the PASARRs, the PASARRs are filled out when admitted to the facility, and if the Resident stayed in the facility for 30 days, she would complete a Level 1 and Level 2 PASARR. She also stated that she would submit the PASARR to the Arizona Health Care Cost Containment System (AHCCCS) website by using her own provided AHCCCS log in identification. A follow up interview was conducted on 05/06/2026, at 9:17 AM with Resident Relations Manager (Staff #32). Staff #32 stated that regarding Resident #32's PASARR, the most recent PASARR was on 2/27/2025, which included a SMI diagnosis of bipolar disorder, schizoaffective disorder, anxiety disorder, and depression. She said that the Resident stayed in the facility for over 30 days. She also said that she was not able to find an email document that would indicate that a referral was sent to AHCCCS. Further, she stated that if she submits a PASARR to AHCCCS, she would use her AHCCCS identification number to login to the AHCCCS website. Then, after submitting the PASARR to AHCCCS, she would receive an email response back from AHCCCS. Staff #32 also stated that, when she started working at the facility, she did an audit for the Residents with SMI. She initiated their care plan. She said that she did not get far in regards to double checking if the residents meet the level 2. On 05/06/2026, at 1:07 PM, the Executive Director (Staff #200) provided a document electronically titled PASRR Documentation of past noncompliance. The document revealed an attachment for their PIP (performance improvement project) on PASRRs. Per the document, they identified and corrected the issue prior to survey completion. Per the document, systems are in placed to prevent recurrence and compliance achieved. Per the document, a Quality (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Team Tracking Form with a date of 1/28-4/28, the problem area included was PASRR, and the quality team was led by Staff #32. Further review of the Quality Team Tracking Form document revealed the following identified problems: -30-day convalescent not done nor completed;-admission PASRR not obtained within 72 hours;-PASRR level 2 not submitted or identified; and-failure to verify and maintain documentation of PASRR level 2 determination. However, a review of Resident #32's PASARR revealed that there was no document found in the medical record or facility document that would indicate that a referral for level 2 determination was submitted to AHCCCS. According to the Arizona Health Care Cost Containment System, the Pre-admission Screening and Resident Review (PASRR) Level I is a preliminary assessment completed for all individuals prior to admission to a Medicaid-certified Nursing Facility in order to determine whether an individual might have a mental illness or intellectual disability. A Level I Screening must be completed before an individual can be admitted into a Medicaid- certified nursing facility and can be completed in a hospital, emergency room, doctor's office or in any community setting. The PASRR Level II is a comprehensive evaluation required as a result of a positive Level I Screening. A Level II is necessary to confirm the indicated diagnosis noted in the Level I Screening and to determine whether placement or continued stay in a Nursing Facility is appropriate. The determination is the outcome of the Level II evaluation which ensures that Nursing Facility placement is, or continues to be, appropriate, and that services provided to individuals with a MI, ID, or related condition meet the individual's needs, including the need for specialized services. Level II evaluations for individuals with ID are performed by the Department of Economic Security (DES) and evaluations for individuals with MI are coordinated by AHCCCS and performed by a designated entity. For individuals requiring admission to a nursing facility for a convalescent period, or respite care (not to exceed 30 consecutive days), do not require a PASRR Level II Evaluation. If it is later determined that the admission will last longer than 30 consecutive days, a new PASRR Level I Screening must be completed as soon as possible or within 40 calendar days of the admission date to the nursing facility.

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and facility policy, the facility failed to ensure that pain management was provided to one resident (#137) consistent with professional standards of practice, and the resident's comprehensive person-centered care plan. The deficient practice could place the resident's health at risk by not adequately treating the resident's pain.Findings include:Resident #137 was admitted to the facility on [DATE], with diagnoses that included aftercare following a joint replacement surgery and fibromyalgia.The assessment for Brief Interview for Mental Status (BIMS) dated 05/03/2026, revealed a score of 12.0, indicating that the Resident was moderately impaired.A review of the physician's pain medication orders revealed an order for Hydrocodone-Acetaminophen oral tablet 5-325 MG (milligram) give 1 tablet by mouth every 4 hours as needed for pain level of 4-6 and give 2 tablets by mouth every 4 hours as needed for pain level of 7-10; and Ibuprofen oral tablet 200 MG give 3 tablets by mouth every 4 hours as needed for pain level of 1-3.A review of the care plan dated 05/02/2026, revealed that the Resident was on an opiate medication. The goal included for the Resident to be free from discomfort or adverse reactions related to the medication use. The intervention included for the staff to administer the medication as ordered.The May 2026 Medication Administration Record (MAR) review revealed a transcribed order dated 05/01/2026 for Hydrocodone-Acetaminophen oral tablet 5-325 MG give 1 tablet by mouth every 4 hours as needed for pain level of 4-6, Hydrocodone-Acetaminophen oral tablet 5-325 MG give 2 tablets by mouth every 4 hours as needed for pain level of 7-10, and Ibuprofen oral tablet 200 MG give 3 tablets by mouth every 4 hours as needed for pain level of 1-3.Further review of the May 2026 MAR revealed that on:-05/2/2026, at 2:28 AM, the Resident's pain level was documented at 7, and per the documentation, the Resident was administered Hydrocodone-Acetaminophen oral tablet 5-325 MG 1 tablet, despite an order to give Hydrocodone-Acetaminophen oral tablet 5-325 MG, give 2 tablets by mouth every 4 hours as needed for pain level of 7-10;-05/2/2026, at 6:32 AM, the Resident's pain level was documented at 7, and per the documentation, the Resident was administered Hydrocodone-Acetaminophen oral tablet 5-325 MG 1 tablet, despite an order to give Hydrocodone-Acetaminophen oral tablet 5-325 MG, give 2 tablets by mouth every 4 hours as needed for pain level of 7-10;-05/2/2026, at 12:01 PM, the Resident's pain level was documented at 7, and per the documentation, the Resident was administered Ibuprofen oral tablet 200 MG give 3 tablet by mouth every 4hours as needed for pain level of 1-3, despite an order to give Hydrocodone-Acetaminophen oral tablet 5-325 MG, give 2 tablets by mouth every 4 hours as needed for pain level of 7-10;-05/2/2026, at 9:50 PM, the Resident's pain level was documented at 8, and per the documentation, the Resident was administered Hydrocodone-Acetaminophen oral tablet 5-325 MG 1 tablet, despite an order to give Hydrocodone-Acetaminophen oral tablet 5-325 MG, give 2 tablets by mouth every 4 hours as needed for pain level of 7-10;-05/3/2026, at 2:00 AM, the Resident's pain level was documented at 8, and per the documentation, the Resident was administered Hydrocodone-Acetaminophen oral tablet 5-325 MG 1 tablet, despite an order to give Hydrocodone-Acetaminophen oral tablet 5-325 MG, give 2 tablets by mouth every 4 hours as needed for pain level of 7-10;-05/3/2026, at 4:44 AM, the Resident's pain level was documented at 6, and per the documentation, the Resident was administered Ibuprofen oral tablet 200 MG give 3 tablets by mouth every 4hours as needed for pain level of 1-3, despite an order to give Hydrocodone-Acetaminophen oral tablet 5-325 MG, give 1 tablet by mouth every 4 hours as needed for pain level of 4-6;On 05/03/2026, at 10:47 AM, Resident #137 stated that her experience so far in the facility was not so good. The Resident stated that she just had a hip surgery. She said that she was screaming in pain. She used her call light every 4 hours to ask for pain medication but the staff comes to her late. She stated that she felt ignored.An interview was conducted on 05/05/2026, at 12:06 PM with Licensed Practical Nurse (LPN/Staff #14). Staff #14 stated that regarding pain medication (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration, she would ask the resident what their pain level was and where the pain was located, she would check what type of pain medication was prescribed, and then she would administer the pain medication as ordered for the resident. She stated that regarding pain medications with parameters, she said that if a parameter order was 6-10 pain level, but the resident reported a pain level of less than 5, she would tell the resident that she would give them a different pain medication for the level of pain they were having. She stated that she would also ask the doctor if it was okay to give the pain medication outside the ordered pain level parameter. She also stated that most of the time, her residents would insist on receiving the medication which was more than what was ordered for the level of pain that the resident reported. Further, she stated that she would chart in the medical record and on the MAR that she contacted the doctor regarding the Resident's request for more or less pain medication. She said that she would follow the pain parameter orders, but she would document if the resident only requested 1 pain pill for a pain level of 9 when the order asked to give 2 pain pills. She said that it's whatever the resident wants.An interview was conducted on 5/5/2026, at 11:34 AM with a Certified Nursing Assistant (CNA/Staff #16). Staff #16 stated that when her resident is in pain, she said that the resident would be crying, anxious, not acting themselves, and she would ask the Resident about their pain level. She said that she would notify the nurse about the Resident's conditionAn interview was conducted won 05/05/2026, at 12:53 PM with the acting Director of Nursing/Assistant Director of Nursing (acting DON/ADON/Staff #125). She stated that the process and her expectation regarding medication administration is to follow the 5 rights, which are, right resident, right medication, right dose, right route, and to make sure that the resident remains safe. She also said that regarding physician's order, she expects the nursing staff to reach out to the provider if they have any questions regarding an order, to clarify the order, and that the physician order should be followed because if the order is not followed, the risk could put the resident at harm. She also stated that regarding pain medication orders, she expects her nursing staff to follow the order, ask the resident what their pain level is, and then determine if the medication is available to manage their pain. She stated that regarding the hydrocodone order with pain parameter, she said that if the resident's pain level was 5, then she expects the staff to give 1 tablet for pain level 4-6, and if the pain level was 7-10, she expects the staff to give the resident 2 tablets of hydrocodone for a pain level between 7-10; as ordered because it would relieve the pain. She would also expect the staff to reach out to the provider if the resident did not want to receive the 2 tablets at the pain level within the specified parameter. Further, she stated that she expects the nurse to document and reach out to the provider and informed them that the resident's pain level was 9 and that the resident just wanted to take 1 tablet for pain relief. She said that if a nurse gave 2 pills of hydrocodone for a pain level of 4, and the order was 1 pill, the staff should reach out to the provider and let the provider know that 2 tabs given for pain level of 4, if the order was not followed. In addition, she would assess the resident including taking their vital signs as it would lower their vital signs. She said that If this was the case, the staff did not follow the physician's order.The acting DON/ADON stated that if Resident #137 received 1 tablet of her ordered pain medication of Hydrocodone-Acetaminophen oral tablet 5-325 MG for a reported pain of 10 on 05/04/2026, at 8:35 AM and on 05/04/2026 at 11:56 AM, per progress note the resident requested to relieve a generalized pain level 8, she said that the pain was relieved from a 10 to 8; the staff did not follow the physician's order, the resident should have received 2 tablets of Hydrocodone-Acetaminophen oral tablet 5-325 MG. She said that the risk was that the resident did not have her pain relieved with just one tablet. She also stated that the pain scale tells staff how to properly medicate the resident and the pain scale of 10 would be severe pain and a 0 would be no pain.A policy titled Medications: Administering Medications, in effect on 01/01 2024, revealed that medications are to be administered in accordance with the prescriber's orders, including any required time frame.A review of the facility policy titled Pain Management: Pain Assessment and Management, in effect on 01/01 2024, revealed the purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and needs and to address the underlying causes of pain. It further noted that the pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, staff interviews, and policy documentation, the facility failed to ensure that the daily nurse staffing information posted included all data requirements. The deficient practice could result in residents and visitors not being informed of accurate and current staffing information. Findings include:An observation on May 3, 2026, at 6:59 AM, of the staff postings for May 3, 2026, included the number of certified nursing assistants (CNAs), the number of restorative nursing assistants (RNAs), the number of registered nurses (RNs), the number of licensed practical nurses (LPNs), and the number of medication technicians, categorized by shift. There was no evidence of an area where the actual hours worked by staff could be completed. A review of randomly chosen days of staff postings compared with the staff assignment sheets revealed that none of the staff postings matched the actual number of staffs that worked.Review of the Daily Staffing reports revealed the following missing data requirements.- May 23, 2025, revealed no evidence of the calculation of actual hours reflected on the staff posting.- May 24, 2025, revealed no evidence of the calculation of actual hours reflected on the staff posting.- May 25, 2025, revealed no evidence of the calculation of actual hours reflected on the staff posting.- May 26, 2025, revealed no evidence of the calculation of actual hours reflected on the staff posting.- May 27, 2025, revealed no evidence of the calculation of actual hours reflected on the staff posting.- August 29, 2025, revealed no evidence of the calculation of actual hours reflected on the staff posting.- August 30, 2025, revealed no evidence of the calculation of actual hours reflected on the staff posting.- August 31, 2025, revealed no evidence of the calculation of actual hours reflected on the staff posting.- September 1, 2025, revealed no evidence of the calculation of actual hours reflected on the staff posting.- September 2, 2025, revealed no evidence of the calculation of actual hours reflected on the staff posting.- January 16, 2026, revealed no evidence of the calculation of actual hours reflected on the staff posting.- January 17, 2026, revealed no evidence of the calculation of actual hours reflected on the staff posting.- January 18, 2026, revealed no evidence of the calculation of actual hours reflected on the staff posting.- January 19, 2026, revealed no evidence of the calculation of actual hours reflected on the staff posting.- January 20, 2026, revealed no evidence of the calculation of actual hours reflected on the staff posting.An interview was conducted on May 5, 2026, at 1:33 PM with the Staffing Coordinator (Staff #4). Staff #4 stated that the current staff postings included the number of CNAs, the number of RNAs, the number of RNs, the number of LPNs, and the number of medication technicians. Staff #4 also stated that the data requirements included the date and the resident census for the day, as well as the projected hours. Staff #4 had also stated that any evidence of actual hours would not be located on the staff postings and is stored on an internal database. Staff #4 also stated that once she creates the schedule, she will provide a printed copy to the receptionist the day before, and the receptionist is expected to place the posting in an easily accessible area the next day. Staff #4 stated that no changes or additions are made to the staff postings, and the receptionist will place the old staff postings into a binder for proper storage. Staff #4 stated that she had been unsure if the data required for staff postings included the evidence of the actual hours that the staff had worked for the day.An interview was conducted on May 5, 2026, at 1:50 PM with the interim director of nursing (DON/Staff #125), who stated that she had been unsure what data requirements were to be included on the staff postings and had been unsure what the risk of missing information on the staff posting could present. Staff #125 stated that she would ask the executive director (ED/Staff #200) for clarity on tasks and questions she had been unsure of.A policy request was made to the ED (Staff #200) on May 5, 2026, at 2:31 PM, to request the staff posting policies and procedural guidelines. On May 5, 2026, at approximately 3:30 PM, an interview was conducted with Staff #200. The ED stated that there had been no policy or procedure in place regarding the staff posting data requirements. Staff #200 stated that the current staff postings included the number of CNAs, the number of RNAs, the number of RNs, the number of LPNs, and the number of medication technicians. Staff #200 further stated that she had (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been unaware that the staff postings were to include the actual hours worked by the staff due to the tracking on an internal database. Staff #200 stated that she had been unsure what the risk would be should staff postings have missing information, such as the actual hours that the staff had worked for the day.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and policy review, the facility failed to ensure that medications were not left at the bedside for one (#56) of 29 sampled residents. The deficient practice could result in harm to the residents, and/or visitors who have access to medications.Findings include:Resident #56 was admitted to the facility on [DATE], with diagnoses that included dysphagia, gastro-esophageal reflux disease without esophagitis, hypertension, and anxiety.An admission evaluation record dated November 18, 2026, revealed that the resident did not desire to self-administer drugs.A quarterly Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition.There was no evidence in the progress notes of an interdisciplinary team (IDT) meeting related to medication self-administration.During an initial observation of Resident #56's room on May 03, 2026, at 08.47 a.m., a bottle of Soursop [NAME] supplement for gut health was observed on the resident's bed side table.An interview was conducted on May 03, 2026, at 8:47 a.m., with Resident #56, who stated that Soursop [NAME] is not a medication and is a supplement. Resident #56 further stated that he ordered the Soursop [NAME] supplement and administered it by himself.An interview was conducted on May 3, 2026 at 11: 44 a.m., with a Licensed Practical Nurse (LPN, staff # 58) who stated that she observed a bottle of Soursop [NAME] supplement for gut health on the Resident #56's bed side table, and that it was not supposed to be left unattended at the bedside. The LPN was then observed to remove the medication from the resident's room and placed it in the medication cart. The LPN then reviewed Resident #56's clinical record and stated that there was no evidence of an order for Soursop [NAME] supplement for gut health. The LPN further stated that residents who wanted to self -administer medication will be assessed, and the IDT (Interdisciplinary Team) will notify the provider for an order for self-administration of medications. The LPN also stated that the resident's care plan would be updated. The LPN further stated that the risks of leaving medications unattended at the bedside could result in residents taking medications that they may be allergic to or may interact with other medications.A physician order dated May 3, 2026, at 11:52 a.m., was written for Soursop [NAME], to give 30 milligrams (ml) after breakfast daily, one time a day for supplement, Administered by clinician only.An interview was conducted on May 4, 2026 at 8:21 a.m., with a LPN (staff # 83) who stated that the facility process for residents who wanted to self-administer medication included: notifying the provider, conducting an IDT assessment regarding medication dosage, storage and how to safely administer medication, and the care plan would be updated. The LPN then reviewed Resident #56's clinical records and stated that there was no document found in the clinical record regarding self-administration of medication. The LPN further stated that Resident #56 had an order dated May 3, 2026, at 11:52 a.m., for Soursop [NAME], to give 30 milligrams (ml) after breakfast daily, one time a day for supplement, administered by clinician only. The LPN further stated that the risks of leaving medications unattended at the bedside could result in resident may be overdose.An interview was conducted on May 5, 2026 at 1:22 p.m. with the interim Director of Nursing (DON/Staff# 125) who stated that facility process for resident self-administration of medications would be that the residents were assessed by the IDT team regarding medication dosage, storage and how to safely administer medication. After, the resident was assessed for self -administration of medication, the IDT team will notify the doctor and get an order for self-administration. The DON then reviewed the Resident #56's clinical records and stated that Resident #56 had an order dated May 3, 2026, at 11:52 a.m., was written: Soursop [NAME], to give 30 milligrams (ml) after breakfast daily, one time a day for supplement. However, the order does not indicate that the Soursop [NAME] medication should be store in Resident #56 room or self-administered by Resident #56 but administered by clinician only. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON further stated that the risks of leaving medications unattended at the bedside could result in resident may take medications incorrectly or another resident could go into the room and take the medication.Review of the policy titled, Medication labeling and storage, revised date January 1, 2024 revealed that the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.Review of the policy titled, Self-Administration of Medications, reviewed date January 1, 2024, revealed that Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so.