STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035290	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven Health Sky Harbor, LLC	1880 East Van Buren Street Phoenix, AZ 85006

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** 46606 Based on observation, interviews and policy review, the facility failed to ensure that medications were administered as ordered by the physician for one resident (#400). The deficient practice could result in residents not receiving prescribed doses of medications. Findings include: Resident #400 was admitted on [DATE] with diagnoses of cerebral infarction, myalgia, hyperlipidemia, polyneuropathy, and gastro-esophageal reflux disease. A care plan initiated on April 1, 2024 revealed the resident had a history of stroke. Interventions included to give medications as ordered by the physician. Review of the discharge Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating that the resident had intact cognition. The physician order dated March 28, 2024 revealed the following orders: - Atorvastatin (anticholesterol) calcium oral tablet, give 40 mg (milligram) by mouth one time a day for hyperlipidemia; and, - Gabapentin (anticonvulsant) oral capsule, give 400 mg by mouth three times a day for neuropathy The physician order dated March 29, 2024 included for Methocarbamol (muscle relaxant) oral tablet, give 1000 mg by mouth three times a day for muscle spasms for 5 days 2 tabs. Review of the eMAR (electronic MAR) progress notes for March 29, 2024 revealed the following: - Atorvastatin was awaiting pharmacy. This note was time stamped 9:04 p.m.; - Gabapentin was on order. This note was time stamped 11:00 p.m.; and, - Methocarbamol was on order awaiting pharmacy to deliver. This note was time stamped 11:00 p.m. Review of the March 2024 Medication Administration Record (MAR) revealed the following medications were coded 9 on March 29, 2024.: (continued on next page)

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	-Atorvastatin for the 8:00 p.m. administration; -Gabapentin for 10:00 p.m. administration; and, -Methocarbamol for the 10:00 p.m. Per the documentation, code 9 indicated Other/See Nurse Notes. However, further review of the March 2024 MAR revealed that Gabapentin and Methocarbamol were administered on scheduled administration times of 8:00 a.m. and 2:00 p.m. on March 29; and, The email correspondence from the pharmacy consultant (staff #10) and pharmacy director (staff #20) dated April 11, 2024 revealed that the order for medications for Gabapentin, Methocarbamol, and Atorvastatin was received by the pharmacy on March 28, 2024 at 9:53 p.m. It also included that the received time was after the cutoff for the 11:00 p.m. run, the medications were sent the next morning, March 29, 2024 on the 9:00 a. m. run. Further, the documentation included that to their records the medications were received and signed for by a facility staff member at 12:11 p.m. on March 29, 2024. Review of the text message from the pharmacy consultant (staff #10) dated April 11, 2024 revealed that all the medications for resident #400 were delivered at the same time. It also included that she had seen gabapentin and methocarbamol in e-kits for the pharmacy in the past so she thought it could have been available; but that availability of these medications in the e-kits (emergency kit) were dependent on the facility's needs. Review of the Pyxis machine's medication inventory list revealed that atorvastatin was listed as a medication in stock. An interview was conducted with a licensed practical nurse (LPN/staff #30) on April 11, 2024 at 12:34 p.m. The LPN stated that the process to ensure that newly admitted residents get or have their medication at the facility, the staff check the e-kits for the medications and ensure that the orders for the medications have been sent to the pharmacy. She stated that between the e-kits and the pyxis machine the medication should be available; and that, if the resident's medications have not arrived, they will call the pharmacy and see about getting it STAT (immediately). The LPN said that the provider should be informed to see what needs to be done; or, staff should ask the DON (Director of Nursing) or ADON (Assistant Director of Nursing) for further instructions. She said that staff had to give scheduled medication as ordered unless it was refused by the resident. The LPN also said that it was weird that medication for a new admit to be available earlier in the day but later on be not available. Further, the LPN said that in instances that a medication was not available, there should be a detailed progress note and that provider should be informed. (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 with another LPN (staff #40) on April 11, 2024 at 2:24 p.m. The LPN said that staff receives the paperwork approximately 2 hours prior to the arrival of the new admits. The staff will then fax the orders to the pharmacy to ensure that the medications will be on the next delivery run; and, if the medications have not arrived and there was a scheduled medication administration, staff were supposed to contact the pharmacy to find out the status of the medications and when it was expected to arrive. The LPN said that the staff was supposed to notify the provider that the resident's medication was not available or have not arrived so they can provide further instructions/orders. The LPN also said that when the medication is not available, staff was supposed to check the e-kits and the pyxis machine which contains common medications; and that, the pyxis machine can be accessed with pharmacy approval to obtain a medication. The LPN said that if the medication was not part of the inventory kept in the e-kits/pyxis machine, the medication will be ordered STAT which means that the medication should arrive within 2 hours. Further, the LPN said that it was rare that residents will miss medication since most medications were available in the e-kits/pyxis machine. The LPN stated that it was probably a registry who completed the resident's admission and was unfamiliar with the facility procedures. The LPN further stated that the facility normally had most medications handy; and that, there should be progress note regarding why the medication was still pending/awaiting pharmacy delivery. The LPN said that it can be a problem for a resident to not receive medications as ordered; and that, some medications were life sustaining and if it was not, then the medication can be placed on hold by the provider. However, the LPN said that the provider had to be informed so the provider can decide on what should be done. Regarding resident #400, the LPN said that it was weird to have the medication available for resident #400 earlier in the day and not available later on the same day. The LPN also said that it was hard to speculate what the impact of resident #400 missing the medications; but, there should have been more detailed notes documented to know what, why, and when the medication will be available and can be administered. In an interview conducted with a Nurse Practitioner (NP/staff # 60) on April 11, 2024 at 2:54 p.m., the NP stated that his expectation was that medications are administered according to the order and facility protocols and documented in the MAR. The NP also said that his expectation was that he is notified if a resident's medications becomes unavailable to ensure that he knows if medications are on time or if unable to get it then to be able to get a different one that was similar to the unavailable drug. Further, the NP stated that medications not provided as scheduled can be problematic since these medications were there for a reason and were needed by the resident. An interview was conducted on April 11, 2024 at 3:51 p.m. with the pharmacy consultant (staff #10) who stated that the facility had three delivery runs a day during the week and two on the weekends. Staff #10 said that during the week, the delivery leaves for the route at 9:00 a.m., 2:00 p.m., and 11:00 p.m.; and, on the weekends, the delivery run leaves for the route at 2:00 p.m., and 8:00 p.m. Staff #10 said that the time the facility can expect to receive the medications depends on the time it was placed or if the item was in stock or if there were clarifications needed to be made. However, staff #10 said that delivery of the ordered medications should be in a timely manner closest to the next scheduled run time; and that, if an order was placed as STAT, the medication is delivered within 4 hours. Further, staff #10 said that they encourage the facility to use the e-kit if there were new orders received for a resident. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted with the registry LPN (staff #50) on April 11, 2024 at 4:46 p.m. The registry LPN stated that she was not familiar with the process of ensuring newly admitted resident had their medications available when they arrive. The registry LPN stated that medications were typically already prepped; and, during shift change, a report was given to the oncoming staff that lets them know if a new resident was coming in and if the medications were coming. The registry LPN said that if the medications have not arrived at the facility, that medication was marked as not here on the MAR; and, a call to the previous nurse was made to ask the status of the medication ordered. The registry LPN said that the assigned to the resident will call and check with pharmacy to ensure that the medication will arrive during the next run. Further, the registry LPN said that the facility has the pyxis machine where you can get the medications from if the resident's medication has not arrived or delivered yet from pharmacy. However, the registry LPN said that as a registry nurse, she does not go that route unless it was really needed; and that, the facility were the only ones with access to the e-kits and pyxis machine and not registry staff. The registry LPN said that when it comes to providing medications as scheduled, attempts had to be made to administer the medication; however, if the resident refused then it was okay and the nurse had to document the refusal. Regarding resident #400, the registry LPN said she was vaguely familiar with resident #400; and, it was resident #400 they pulled medications from pyxis the day before. She stated that the medication for resident #400 came before her shift; and, she administered the medication to the resident on time. During an interview with the Assistant Director of Nursing (ADON/staff #70) conducted on April 11, 2024 at 5:08 p.m., the ADON stated that her expectation was that resident medications were administered per physician orders. The ADON said that this was important to continuously give the medication as ordered, with the right dose to the right resident because there was a reason for the order and medication was ordered whatever health diagnoses the resident may have. Regarding medication availability, the ADON stated that if there was a newly admitted resident, staff will try to send the order in as soon as possible to pharmacy; and that, she expected the staff to call pharmacy to make a follow-up on the status of the order and if the medication has not been received. The ADON also said that the expectation was also for staff to check the pyxis machine and the tackle boxes (e-kits) to see if the medication was part of the inventory; and that, if the medication was not part of the inventory, her expectation was that staff would notify the provider immediately and let them know if there was an approved alternative for the medication or if it was okay to put the medication on hold. She stated that it was important in order to ensure medications were given and a dose was not skipped. The ADON said that the impact of missing a medication on the resident can depend on what the medication was for; and that, there were many different things that can happen by not getting the needed medication. She also said that the expectation was for staff to document in the clinical record cares/treatment provided as detailed as possible such as missing dose, how it was handled, and notifications made. The ADON said that if the documentation was not detailed then they cannot see what was happening, what was done, how urgently it was addressed, who was notified and what happened. Further, the ADON said that the impact of missing or lacking information was a delay in care in either mediation, or, the issue can get worse. The ADON said that if multiple doses of medication were missed, it can greatly impact the resident and staff will not know what had been done and staff will not know what to do. A review of the clinical record was conducted with ADON who stated that the NP should have been notified regarding the unavailability of metacarbamol and this should have ordered STAT. The ADON also stated that if atovastatin calcium was available from the pyxis then it should have been used and given. Further, The ADON stated that if unavailable medication could be obtained from the pyxis machine it should have been used. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy on Medications: Administering Oral Medications, dated May 11, 2023 included that for preparation for medication administration, staff is to verify that there is a physician's medication order for the procedure. Staff is to use the Medication Administration Record (MAR) to check the medication and confirm the medication name and dosage. Documentation regarding medication administration follows the Documentation of Medication Administration guidelines. The facility policy on Documentation: Charting and Documentation, dated May 11, 2023 revealed that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation of procedures and treatments will include the name/title of the individual who provided the care and whether the resident refused the procedure/treatment.