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	08/01/2024

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399 Based on closed record review, staff interviews, review of facility documentation and policy, and the State Agency (SA) complaint tracking system, the facility failed to ensure a safe and appropriate transfer of one resident (#1). The deficient practice could result in residents not receiving appropriate care and services during the transition of care. Findings include: Resident #1 was admitted on [DATE] with diagnoses of cerebral palsy, chronic respiratory failure with hypoxia, polyneuropathy, dysphasia, and scabies. The care plan dated April 2, 2024 included that the resident was ventilator dependent related to respiratory failure. Interventions included to assess for signs/symptoms of hypoxia such as altered level of consciousness, irritability, listlessness and cyanosis; chest physio-therapy as ordered; keep head of bed elevated above 30 degrees; maintain spare trach at bedside; maintain ventilator settings as ordered; to monitor oxygen saturation while resident was on mechanical ventilatory support and/or during weaning process; and trach care twice in a 24-hour period. A care plan dated April 3, 2024 revealed the resident required tube feeding and was dependent with tube feeding and water flushes. Interventions included to check for and record tube placement and gastric contents/residual volume per facility protocol; and to see physician orders for current feeding orders The Minimum Data Set (MDS) admission assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 99 indicating the resident was unable to complete the interview. The MDS revealed the resident was on special treatments such as high concentration continuous oxygen therapy, scheduled and as needed suctioning, tracheotomy care, and invasive mechanical ventilator. The care plan dated April 15, 2024 included that the resident had impaired cognitive function, dementia or impaired thought processes. Interventions included to administer medications as ordered; communicate regarding resident's capabilities and needs; and to engage the resident in simple, structured activities that avoid overly demanding tasks. (continued on next page)

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

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another care plan dated April 15, 2024 revealed that the resident had a communication problem related to confusion. Interventions included to anticipate and meet needs; and, to use effective strategies and communication techniques which enhance interaction. The social service progress note dated May 6, 2004 revealed that the state insurance prescreens, benefits, covered services and application process for continued placement was discussed resident #1 who did not want the insurance and would like to return back to the out-of-state facility where he came from. The social service progress note dated May 8, 2024 included resident #1 came from an out-of-state facility that was closed due to flooding. Per the documentation, the out of state facility where resident #1 transferred out from was still not in operation and had no plans to open until December 2024. The social service progress note dated May 8, 2024 revealed the resident would like to go back to the state where he came from due to having his whole family residing there; and, he wanted to go to a sister facility of the old out-of-state facility where he came from. The social service progress note dated June 28, 2024 included a discussion with the resident family about having resident #1 closer to home so family can visit. The social service progress note dated June 28, 2024 revealed that social service reached out to the out-of-state facility for bed availability. Another progress note dated June 28, 2024 revealed that social service reached out to another out-of-state facility for bed availability. The social service progress note dated July 8, 2024 revealed that the social service reached out to the out-of-state facility (where the resident came from) via phone and through email asking for assistance to relocate the resident back. Another social service progress note dated July 8, 2024 included that social service reached out to another out-of-state facility requesting any update on accepting resident #1; and that, social services was told that the out-of-state facility did not have an available bed for the resident. Another social service progress note dated July 8, 2024 revealed that social service reached out to additional eight out-of-state facilities provided by resident's family. Per the documentation, three facilities were not accepting residents on vents or trachs (tracheostomy); one facility not taking admissions due to full capacity; one facility had no male beds available; and three facilities did not answer the call and a message to call back was left. The interdisciplinary team (IDT) care plan conference note dated July 8, 2024 included that the family of resident #1 would like the resident to stay at the facility until the resident was able to be placed in the out-of-state facility where he came from. The social service progress note dated July 18, 2024 included that social service reached out to another out-of-state facility. The documentation included that the out-of-state facility did not have a subacute rehab and were unable to take the resident. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse practitioner (NP) note dated July 18, 2024 included that the resident looked chronically ill, was alert, nodded in response to questions, had nonlabored breathing and was on a ventilator via trach (tracheostomy). Assessments included cerebral palsy, quadriplegia and chronic respiratory failure s/p (status post) trach. Another social service progress note dated July 18, 2024 revealed that case management discussed the transfer update with the resident. The documentation included that during the discussion, the resident moved his head up and down indicating yes confirmation to go back to the state where he came from; and when asked about state insurance application option, the resident moved his head from side to side indicating no. Further, the documentation included that the resident was asked whether he would go back to a hospital out-of-state (where he came from) if no facilities would accept his transfer; and that, the resident moved his head up and down indicating a yes confirmation in response. The physician progress note dated July 19, 2024 revealed that the resident had a known history of ventilator dependent respiratory failure, was tetraplegic with spasticity and cerebral palsy. Plan included adjust ventilator settings as needed, tracheostomy care twice daily, aspiration precautions and suction as needed A daily skilled evaluation note dated July 20, 2024 revealed that skilled care services provided were wound care, respiratory therapy/services, respiratory aspiration, gastrostomy feeding, physical and occupational therapy services; and tracheostomy care. Per the documentation, the resident had shortness of breath while lying flat, oxygen and ventilator were in use and the resident had a Foley catheter in place. The social service progress note dated July 22, 2024 revealed that all placement options were exhausted in the resident's home state. Per the documentation, to honor the resident wishes to go back to his home state, resident was willing to go to the hospital in his home state. It also included that the resident was asked one more time if he was willing to stay and apply for state insurance and the resident signal 'NO' with the movement of his side to side. Further, the note included that to honor resident wishes the facility paid for the resident's transport to his home state; and that, the resident was aware and understood that he will be transported per his wishes to the hospital in his home state. The skilled needs review note dated July 23, 2024 included that resident expected to be discharged to community; and that the resident needed long term care (LTC) placement. Per the documentation, application to state insurance for LTC placement was submitted but the resident did not want the state insurance and wanted to be discharged to his home state. Further, the documentation included that the anticipated discharge date was July 25, 2024 and the resident will be discharged to another facility. The social service note dated July 24, 2024 included that the resident was informed per his wishes will be sent to a hospital in his home state today and the facility would pay for transportation; and that, the resident acknowledged understanding signal 'yes' by moving his head up and down. Per the documentation, multiple options were attempted including applying for state insurance, sending referrals to facilities in the resident's home state per the resident and family request, and communication with the social worker from the resident's previous facility; but, were all unsuccessful. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another social service note dated July 24, 2024 revealed that the resident was informed that the transfer will happen on July 25, 2024 with a pick-up time of 7:30 a.m. with a non-emergent ambulance. Per the documentation, the resident acknowledged and understood by moving his head up and down indicating a yes response. A late entry social service note dated July 24, 2024 included that the resident was notified that his last covered day for skilled services was July 25, 2024 due to exhausting his skilled nursing facility benefits days. Per the documentation, resident confirmed wanting to discharge to his home state. Despite documentation that the resident had an anticipated discharge scheduled on July 25, 2024, the clinical record revealed no physician order for the resident's discharge or transfer. The discharge summary dated July 24, 2024 revealed that resident was transferred to a hospital via non-emergent transport. Per the documentation, the physician, director of nursing (DON) and executive director (ED were notified. According to the documentation, resident self-initiated the hospital transfer to his home state; and, measures were taken to stabilize resident prior to the determination to transfer. It also included that the current reconciled medication list was provided to the resident/representative and the subsequent provider via paper based method (e.g. fax, copies, printouts). The documentation did not include which paper based method was used. The discharge and transfer assessment completed by the administrator dated July 24, 2024 included that the resident was transferred to an out of state short term general hospital; and the responsible party, physician, DON and ED were notified. The documentation also included that transportation was arranged through a non-emergent transportation. It also included that the resident was on contact precautions for C. aureus (fungus) and CRE (Carbapenem-resistant Enterobacterales-bacteria). the section on the name of the nurse report was given at the hospital was blank. There was also no documentation found in the clinical record of the name of the receiving provider; and, any communication made by the facility to the receiving provider regarding resident's assessed needs and condition at the time of transfer. There was also no evidence of any confirmation that a discharge summary and/or instruction were received by the receiving provider. The social service progress note dated July 29, 2024 revealed that a staff from the out-of-state hospital where resident transferred to was asking how the decision to discharge the resident to the out-of-state hospital was made. Per the documentation, the facility the hospital staff that resident had requested multiple times to go back to his home state and declined applying for the state insurance. Further, the documentation included that to honor his wishes, the facility sent the resident to his home state so he could continue with his LTC benefits. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SA complaint tracking system included that a report was submitted on July 30, 2024 that resident#1 was brought to the hospital emergency department on July 26, 2024; and that, the ambulance called the emergency department 10 minutes to arrival. The documentation included that the hospital was not notified by the facility that they were sending the resident to the hospital; and that, the facility provided a letter, admission record and medication list that was given to the emergency department staff by the ambulance crew. It also included that the ambulance crew told the hospital nurse that the facility's discharge planner called and told the ambulance crew to send the resident to the hospital as the final destination. Further, the documentation included that there was no accepting physician at the hospital, there was no report called to the hospital and it was unknown to the hospital that the resident was coming until the ambulance notified the hospital in route. It also included that at the date and time of the report, the resident was taking up a bed in the intensive care unit (ICU) for ventilation management; and, the hospital notified the resident's family who was not aware of the resident's transfer to the hospital. An interview with the social worker (SW/staff #14) and the case management (CM/staff #16) was conducted on August 1, 2024 at 10:14 a.m. The SW stated that discharge planning was discussed with team members such as providers to ensure residents are discharged appropriately with services and medical equipment they need. The CM stated that a discharge was dependent on the IDT meeting and the equipment needed upon discharge was consulted with therapy; and that, the facility work with a placement agency to find a place that specializes with trachs or vent residents for appropriate placement. The CM said that once resident placement was approved, the facility would coordinate with a group home or the facility the resident was going and make sure the paperwork such as medication, disposition, face sheet, all clinical record was in line. Both the SW and CM stated that residents were transferred out to a hospital for critical needs with physician approval; but, if residents transferring out to another facility are due to family or resident request. An interview was conducted on August 1, 2024 at 3:00 pm with a licensed practical nurse (LPN/staff #10) who stated that resident discharge happens when residents were stable enough; or, when facility was not equipped to handle care; or, the resident required more advanced care so they go to the hospital. The LPN said that when the residents were discharged , the resident had to be safe to leave the building; and that, she would give a report to the receiving nurse and ensure that the receiving facility are able to provide the necessary care for the resident needed. The LPN said that when giving the report to the receiving nurse, she would give the following information: code status, allergy, history, current treatments, any precautions, mobility/transfer, information regarding care of the resident, and MAR (medication administration record) when the last time the patient was medicated and with what medication received. The LPN said that the CM informs staff where the resident was discharging or when a patient was being admitted or arriving. She stated that for a hospital discharge/transfer, the facility uses the eInteract/Transfer form; and that, residents were only transferred to the hospital for true emergencies and higher level of care needed. The LPN said that in these cases, she would call and give a verbal report to the receiving facility so the receiving facility have an idea on how to take care of the resident and for continuity of care. She stated that the eInteract has a spot to fill out and document who she gave the report to, to what hospital the resident went; and, the receiving facility gets a paper upload/fax of the discharge documents. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on August 1, 2024 at 3:09 pm with another LPN (staff #12) who stated that the case manager would let her know when patient was getting discharged . She stated that if patient was going to another facility and this was prearranged, she would contact the receiving facility to provide report on the resident's status. The LPN said that if she was unable to get a hold of the receiving nurse, she will leave her direct number for the receiving nurse to call back. She stated that once the resident leaves the facility, she would document everything such as who she spoke to, what the resident left with as far as belongings and document everything in the progress notes. The LPN stated that the facility uses a transportation company specialized on trachs and vents; and, when transferring residents with vent or trach, the nurse and the respiratory therapist are in the room to ensure the correct settings of the airway equipment. She stated that she would then call the family or responsible party and document in the progress note what time the resident left or was picked up, who she contacted at the receiving facility. Regarding resident #1, the LPN stated that the resident was sent to the hospital twice for having a hard time breathing. She stated that the resident was alert, unable to sign a consent, was nonverbal, was able to read his lips when he is talking, speaks in low whisper, nods his head, and can give a verbal consent. In another interview conducted with CM (staff #16) and discharge coordinator (staff #28) on August 1, 2024 at 4:23 p.m., the CM stated that her role included assessment and screening of all the needs of the resident, speaking to the resident and family and honor their wishes regarding the discharge. Regarding resident #1, the CM stated that the resident's discharge was difficult; and that, she had care conference with resident's family and was informed that out-of-state facility where the resident came from was flooded. The CM said that the resident was then sent to the facility via a paid transport from the out-of-state hospital. The CM said that the resident's family wanted resident #1 to be back in his home state; and, she told the family that the facility can attempt to apply for the state insurance for resident #1. The CMA also said that had no NOMNC (Notice of Medicare Non-Coverage) because his benefits were exhausted; and that, the resident was adamant to going back to his home state. The CM also said that the discharge assessment dated [DATE] was done by the administrator (staff #26); and that, the documentation in the discharge assessment only have the name of the out-of-state hospital the resident was transferred to and did not include the name of nurse that was given a report to. The discharge coordinator (staff #28) stated that she ensures that all discharges were executed for all residents; and, all resident has a safe discharge. The discharge coordinator said that she was the one who set up the transportation which specialized with trachs and vents for resident #1. The discharge coordinator also said that the discharge for resident #1 was resident-driven; and, it was the resident's choice to return to the out-of-state hospital where he came from prior to admission at the facility. Further, the discharge coordinator said that there was no report given to the receiving facility; and, the only document with resident's history was in a packet and was sent with the transportation crew when the resident left the facility. The discharge coordinator also said that the discharging nurse did not give a report regarding the resident's discharge to the receiving out-of-state hospital. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted with the director of nursing (DON/staff #18), the assistant DON (ADON/staff #20) and the clinical compliance specialist (staff #22) conducted on August 1, 2024 at 5:10 p.m., the DON stated that residents were assessed for adequate and safe discharge before a discharge/transfer; and, the case management manages the resident's discharge from beginning to end and in between and ensures that transportation provides the services required for the patient. The DON stated that the expectation was that the discharging nurse would give a report to the receiving facility or give their number to receive a call back from the receiving facility. A review of the clinical record was conducted with the DON and ADON during the interview. The DON and the ADON both stated that there was no documentation found in the clinical record that a report regarding the transfer of resident #1 was given to the receiving out-of-state hospital. A phone interview was conducted with resident's family member on August 2, 2024 at 8:41 a.m. The family member stated that he received a call on July 25, 2024 from the emergency room of the out-of-state hospital; and that, he was not aware of the transfer and this was the first time he heard about this. The family member also said that the resident was transported via the ambulance for 5 hours to the out-of-state hospital. He stated that the facility did not contact him regarding transferring the resident out; and, the last time he spoke with the facility was in the first week of July but never heard back since. Review of facility policy on Admissions/Transfers/Discharges: Transfer or Discharge Notice effective date January 1, 2024 revealed the residents and/or representatives are notified in writing, and in a language and format they understand, at least thirty (30) days prior to a transfer or discharge. The policy also included that the resident and representative are notified in writing of the following information: -The specific reason for the transfer or discharge; -The effective date of the transfer or discharge; -The location to which the resident is being transferred or discharge -An explanation of the resident's rights to appeal the transfer or discharge to the state, including the name, address, email and telephone number of the entity which receives appeal hearing request; -Information about how to obtain, complete and submit an appeal request; and -How to get assistance completing the appeal process; -The facility bed-hold policy; -The name, address, and telephone number of the Office of the State Long -term Care Ombudsman; -The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental (or related) disabilities (as applies); -The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with a mental disorder or related disabilities (as applies); and (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The name, address, and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices. Review of facility policy titled, Admissions/Transfers/Discharges: Transfer or Discharge Documentation effective date January 1, 2024 revealed that when a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider.