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	03/24/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51006 Based on record reviews, staff interviews, and facility policy and procedure review, the facility failed to maintain accurate documentation surrounding the death of two residents (#2 and #6). The sample size was 3. The deficient practice can result in inadequate records being kept regarding the extent of a resident's death in the facility. Findings include: -Resident #2 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of rectum, secondary and unspecified malignant neoplasm of inguinal and lower limb lymph nodes; other diseases of mediastinum, not elsewhere classified. An admission MDS (minimum data set) dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 12, indicating that Resident #2 may need extra assistance with daily activities or tasks and may be experiencing cognitive decline. A review of a progress note dated [DATE] revealed that the resident expired around 12:10pm, and that the expiration was confirmed by two Licensed Practical Nurses (LPN) and one Registered Nurse, who notified internal and external parties. A discharge evaluation dated [DATE] revealed that a circumstance surrounding the death of Resident #2 was that this resident had been on hospice services. A review of the resident's blood pressure summary revealed that no vitals were recorded on [DATE]. A review of the resident's pulse summary revealed that no vitals were recorded on [DATE]. An interview with the Director of Nursing (DON/Staff #127) was conducted on [DATE] at 11:36AM, where Staff # advised that any documentation surrounding an event where a resident is a code blue or coding, which signifies a life-threatening medical emergency requiring immediate resuscitation efforts, can be found on their electronic health record systems within the progress notes of the specific resident. (continued on next page)

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with an LPN (Staff #52) was conducted on [DATE] at 2:56PM, where Staff # stated that in the event that a resident is a code blue or coding, the facility expects staff to record and document a complete vital check with current blood sugar levels within a change of condition progress note, which is then given to paramedics at time of arrival, to ensure continuity of care. On [DATE] at 5:39PM, an email was received from the DON (Staff #127) to provide a human remains release form and a discharge evaluation for Resident #2. An interview with the DON (Staff #127) was conducted on [DATE] at 10:47AM, where Staff # stated that the facility expects staff to complete documentation within their electronic health record platform, and any other additional documentation surrounding the change of condition and release of human remains is expected to be uploaded to the electronic health record as well. Staff # also stated that they were not able to locate documentation surrounding the death of Resident #6, indicating that the facility has no record of the death of Resident #6 in their electronic health record, or, within their physical paper documentation management system. -Resident #6 was admitted to the facility on [DATE] with diagnoses that included unspecified atrial fibrillation, cerebral infarction, unspecified; chronic obstructive pulmonary disease, unspecified. An admission MDS (minimum data set) dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 09, indicating that Resident #6 may have had difficulty with some cognitive tasks and may have needed assistance with daily activities. A review of the resident's blood pressure summary revealed that no vitals were recorded on [DATE]. However, vitals were recorded at 10:59AM on [DATE]. A review of the resident's pulse summary revealed that no vitals were recorded on [DATE]. However, vitals were recorded at 10:59AM on [DATE]. A review of a progress note dated [DATE] revealed that the resident had been found at 1808 military time (6:08PM), on his back by a Certified Nursing Aide (CNA) who immediately initiated a 'rapid response code' to begin chest compressions due to the resident being observed with no breath and no heartbeat. The note also revealed that 911 emergency services were called, an AED (Automated External Defibrillator) had been used at 1818 (6:18PM), which had stated, no shock advised, indicating that the device had analyzed the heart rhythm and determined that a shock is not necessary or beneficial, and the resident may have a non-shockable rhythm like asystole or pulseless electrical activity (PEA), to which, the facility resumed cardiopulmonary resuscitation until emergency services arrived at 1820 (6:20PM), and pronounced the resident deceased . An interview with the DON (Staff #127) was conducted on [DATE] at 11:36AM, where Staff # advised that any documentation surrounding an event where a resident is a code blue or coding, which signifies a life-threatening medical emergency requiring immediate resuscitation efforts, can be found on their electronic health record systems within the progress notes of the specific resident. An interview with an LPN (Staff #52) was conducted on [DATE] at 2:56PM, where Staff # stated that in the event that a resident is a code blue or coding, the facility expects staff to record and document a complete vital check with current blood sugar levels within a change of condition progress note, which is then given to paramedics at time of arrival, to ensure continuity of care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 5:39PM, an email was received from the DON (Staff #127) to provide clarity regarding Resident #6, stating that the facility was unable to locate any documentation surrounding the death of resident #6. An interview with the DON (Staff #127) was conducted on [DATE] at 10:47AM, where Staff # stated that the facility expects staff to complete documentation within their electronic health record platform, and any other additional documentation surrounding the change of condition and release of human remains is expected to be uploaded to the electronic health record as well. Staff # also stated that they were not able to locate documentation surrounding the death of Resident #6, indicating that the facility has no record of the death of Resident #6 in their electronic health record, or, within their physical paper documentation management system. A facility policy titled, End of life care: death of resident, documenting revealed that all information pertaining to a resident's death must be recorded in the nurses' notes. A facility policy titled, Emergency/first aid: emergency procedure - cardiopulmonary resuscitation revealed the basic life support sequence that staff is expected to utilize. A facility policy titled, Documentation: charting and documentation revealed that any changes in the residents medical, physical, functional or psychosocial condition should be documented in the medical records of the resident to facilitate communication between the interdisciplinary team.