

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2025
NAME OF PROVIDER OR SUPPLIER Haven Health Sky Harbor, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff and resident interviews, facility documentation and policy reviews, the facility failed to implement their written abuse policies and procedure for two residents (#1, #2). The deficient practice could place resident at risk for further abuse. Findings include:-Regarding Resident #1:Resident #1 was admitted to the facility on [DATE] with a diagnosis that included bilateral primary osteoarthritis of knee, anxiety disorder, syncope and collapse, and Type 2 Diabetes Mellitus (DM).A review of orders revealed Resident had orders for occupational therapy, physical therapy and speech therapy to eval and treat as needed if indicated on orders.A review of Resident's care plan dated June 17, 2025 revealed Resident was at risk for functional self-care deficits and/or functional mobility limitations related to osteoarthritis of the Knee, history of falls, DM, and weakness.A review of admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14.0, cognitively intact, behavioral symptoms not exhibited, and rejection of care and wandering behaviors were not exhibited.Another review of Resident's care plan dated June 22, 2025 revealed Resident had a communication problem related to Resident only speaks Spanish.A review of progress note dated July 22, 2025 at 6:34 AM revealed Resident was due for her morning medication and Staff #249 asked a CNA (certified nursing assistant) to accompany Staff #249 and assist with Spanish translation. The progress notes also revealed that Resident complaint about being forced to take medication and Resident wants the nurse to leave her medication on the table. The nurse stated that Resident had syncope attack when Resident gets upset/mad. Staff #249 progress note revealed that the Resident accused him of grabbing and touching her with the CNA. Staff #249 was just helping Resident put back her gown and just trying to make her safe to prevent her from falling because Resident was sitting at beside. Furthermore, the progress note revealed that after 15 minutes, Staff #249 and another staff tried to give Resident's medication while Resident was talking on the phone, and Resident acted like she fell asleep as soon as she saw the staff knocked and walked inside her room.Another review of care plan dated July 22, 2025 revealed Resident had a behavior problem related to resistive to care, false accusation towards staff and preference for female staff only. Interventions included to anticipate Resident's needs and cares in pairs.A review of rehab therapy progress note dated July 25, 2025 revealed a Spanish interpreter was utilized, at 10:00 AM, Resident #1 reported to physical therapy (PT) that resident was abused by a nurse in the facility. The progress notes revealed that resident was naked while finishing up with a shower, resident was about to fasten gown and resident couldn't because a male nurse came in without knocking and resident was attacked immediately. The progress notes revealed that he shook the resident a lot and the resident could not wake up or move. He grabbed the resident by the arms to put resident in bed. A female nurse came in and put the robe on the resident and left. Resident could not move because of epilepsy. Furthermore, the progress note revealed that the female nurse stated that she did not see anything and he stated that it was only one pill. But when the resident woke up, there were a lot of pills stuffed in the resident's mouth, resident could not swallow, resident spit them out and had a sour taste. The male nurse stated it was only one pill but resident took six tiny pills and three big ones placed in resident's mouth when resident was passed out, resident reported it to a nurse and the Spanish speaking nurse said she needs to apologize. In the morning the male nurse stayed by the door and did not want to enter the resident's room. A female nurse entered the room and Resident #1 stated to report him for bad behavior. The progress notes also revealed that PT was not able to notify the administrator due to the administrator was out on vacation and the other administrative staff were out until 3:00 PM. The progress note revealed that PT had a conversation with a unit manager/Staff #55 on July 25, 2025 at 12:00 PM and PT reported to the DON (director of nursing) and the building administrator.A review of progress notes and a Weekly Skin check and Wound assessment dated [DATE] revealed a registered nurse (RN) and a CNA that speaks Spanish conducted a head to toe assessment and observed Resident's skin to be clean, dry and intact, no open area, no redness, and no area of concerns noted.A review of facility's investigation report with an allegation date of August 4, 2025 revealed that the facility was notified by APS (Adult Protective Services) of an anonymous report of sexual abuse towards Resident #1. The facility report revealed that there was no staff member to suspend as the facility was unable to identify the alleged accuser and there was no staff identified by the accuser. Furthermore, the report revealed two staff statement. First statement was from a unit coordinator/Staff #65. The statement from Staff #65 revealed that the incident happened either</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, facility documentation and policy review, the facility failed to ensure that an allegation of abuse for two resident (#1, #2) was reported to the State Agencies in a timely manner. The deficient practice could place residents at risk for further abuse. Findings include:-Regarding Resident #1:Resident #1 was admitted to the facility on [DATE] with a diagnosis that included bilateral primary osteoarthritis of knee, anxiety disorder, syncope and collapse, and Type 2 Diabetes Mellitus (DM).A review of orders revealed Resident had orders for occupational therapy, physical therapy and speech therapy to eval and treat as needed if indicated on orders.A review of Resident's care plan dated June 17, 2025 revealed Resident was at risk for functional self-care deficits and/or functional mobility limitations related to osteoarthritis of the Knee, history of falls, DM, and weakness.A review of admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14.0, cognitively intact, behavioral symptoms not exhibited, and rejection of care and wandering behaviors were not exhibited.Another review of Resident's care plan dated June 22, 2025 revealed Resident had a communication problem related to Resident only speaks Spanish.A review of progress note dated July 22, 2025 at 6:34 AM revealed Resident was due for her morning medication and Staff #249 asked a CNA (certified nursing assistant) to accompany Staff #249 and assist with Spanish translation. The progress notes also revealed that Resident complaint about being forced to take medication and Resident wants the nurse to leave her medication on the table. The nurse stated that Resident had syncope attack when Resident gets upset/mad. Staff #249 progress note revealed that the Resident accused him of grabbing and touching her with the CNA. Staff #249 was just helping Resident put back her gown and just trying to make her safe to prevent her from falling because Resident was sitting at beside. Furthermore, the progress note revealed that after 15 minutes, Staff #249 and another staff tried to give Resident's medication while Resident was talking on the phone, and Resident acted like she fell asleep as soon as she saw the staff knocked and walked inside her room.Another review of care plan dated July 22, 2025 revealed Resident had a behavior problem related to resistive to care, false accusation towards staff and preference for female staff only. 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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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