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	11/13/2025

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

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, review of clinical record, and review of facility policy and procedure, the facility failed to ensure an allegation of abuse was reported to mandated entities within 2 hours for one resident (#100). The deficient practice could lead to a delay in the investigation of an allegation of abuse leading to continued harm of a resident.Findings include:Resident #100 was admitted to the facility August 30, 2025, with diagnoses that included malignant neoplasm of colon, difficulty in walking, and atrial fibrillation.An admission minimum data set (MDS) assessment dated [DATE], revealed Resident #100 had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment.A physical therapy (PT) Daily Note dated September 10, 2025, revealed Resident #100's therapy session involved practice transferring from the wheelchair to the restroom as the resident needed to use the restroom.A Communication with Resident note dated September 10, 2025, at 1:27 P.M. revealed that the Director of Nursing (DON) spoke to the resident about concerns. All questions and concerns addressed.A care plan dated September 11, 2025, revealed the resident had a behavior problem of false accusations toward staff, with an intervention added for care in pairs.A Social Services Progress Note dated September 11, 2025, revealed that the social worker spoke with Resident #100 in her room, and that the resident had no concerns and no symptoms of distress or psychosocial harm including changes in mood, appetite, sleep, or activities.A facility self-report submitted to the State Agency on September 11, 2025, at 2:41 P.M. revealed that on September 11, 2025, at 7:30 A.M. a therapy staff stated that Resident #100 was emotionally abused stating that Resident #100's feelings were hurt by a Certified Nursing Assistant (CNA), when the CNA changed her and held the brief close to the resident's face. The report revealed that the CNA was immediately suspended.Review of the clinical record revealed that Resident #100 had a PT visit on September 10, 2025, but no evidence of a PT visit on September 11, 2025. A facility 5-day investigation report revealed that the date of the allegation was September 11, 2025, and that Resident #100 was alert with some confusion, and provided a statement that she felt that the female night staff member did not like her, and that the staff had changed her and held the brief close to the resident's face.The 5-day investigation report additionally revealed a staff statement from the assigned Licensed Practical Nurse (LPN / Staff #97), that on the evening of September 9, 2025, at around 8:00 P.M., Staff #97 entered Resident #100's room to give medication, and a CNA (Staff #143) was just exiting the room. Staff #97's statement revealed that then Resident #100 stated that Resident #100 had just said thank you to the CNA (Staff #143), but Staff #143 did not reply. The statement revealed that Staff #97 then said to Resident #100 that Staff #143 probably didn't hear you. Then, the statement revealed that when Staff #97 saw Staff #143 again, Staff #97 asked if Staff #143 heard Resident #100 say thank you, and that Staff #143 answered that no she had not heard the resident.The 5-day investigation report also revealed a statement from the Director of Nursing (DON / Staff #108). The DON's statement revealed that she had spoken to the CNA (Staff #143) who denied putting a brief in Resident #100's face. Additionally, the DON spoke with the assigned nurse (Staff #97) who stated she did not witness any mistreatment of any residents during her shift. Also, the report revealed that the DON spoke with a Physical Therapy Assistant (PTA / Staff #224), who stated Resident #100 stated that the CNA had put a diaper in her face and that the resident's feelings were hurt.The 5-day report revealed a conclusion that during the thorough investigation, the alleged perpetrator (Staff #143) was suspended, and that post-incident monitoring showed no psychosocial harm of Resident #100, and additionally, that the allegation of abuse was unable to be substantiated.A time punch report for the nurse (Staff #97) and the CNA (Staff #143) revealed the following:September 9, 2025:-Staff #97 punched in at 6:00 P.M. and out for the end of shift at 6:37 A.M. on September 10.-Staff #143 punched in at 6:10 P.M. and out for the end of shift at 6:17 P.M. on September 10.September 10, 2025:-Staff #97 did not punch in for a night shift on September 10-Septmeber 11, 2025-Staff #143 did not punch in for a night shift on September 10-September 11, 2025September 11, 2025:-Staff #97 did not punch in for a night shift on September 11-Septmeber 12, 2025-Staff #143 did not punch in for a night shift on September 11-September 12, 2025Despite no punch in time for Staff #143, the time punch report revealed that Staff #143 received 12 hours of regular pay on the date of September 11, 2025.An interview was conducted with a physical therapy assistant (PTA / Staff #224) on September 22, 2025, at 8:41 A.M. Staff #224 stated that she could not remember the exact date, but that she first heard of the allegation from Resident #100 on the date that Staff #224 was assisting Resident #100 onto the toilet in her room for the resident's therapy session (September

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the clinical record, staff interviews, and a review of policies and procedures, the facility failed to maintain and make accessible complete medical records necessary to investigate the cases of 7 residents reviewed (Resident #137, #138, #139, #140, #141, #142, and #144). The universe was 106, and the sample size was 22. The deficient practice prevented a thorough investigation and posed a potential risk to the current quality and safety of resident care.-Regarding Resident #137Resident #137 was admitted on [DATE], with a diagnosis that included osteomyelitis, pressure ulcer of the right lower back, unspecified stage, and central cord syndrome at C4, subs. An admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 15, indicating that Resident #137's cognition had been intact. This MDS assessment also revealed that Resident #137 had a pressure ulcer present and was determined to be at risk for further pressure ulcer development. This MDS assessment also revealed that this resident had been dependent on staff assistance with toileting and showering/bathing. A quarterly MDS dated [DATE], revealed that Resident #137 had been assessed, and there was no evidence of a pressure ulcer at the time of the assessment. There was no evidence of Resident #137's care plan, progress notes, orders, medication administration records/treatment administration records (MAR/TAR), and Certified Nursing Assistant (CNA) care tasks for transfers and brief changes, shower sheets, pressure ulcer assessments, wound assessments and skin assessments for the necessary months of review required to complete a thorough investigation, December 2022 and January 2023. -Regarding Resident #138Resident #138 was admitted on [DATE], with a diagnosis that included hyperosmolality, other seizures, hereditary ataxia, dysphagia, muscle weakness, delusional disorders, and retention of urine.A quarterly MDS assessment, dated June 16, 2025, revealed that no BIMS score was observed and that a mental status exam had been completed by staff, indicating that Resident #138 experienced memory difficulties. There was no evidence of Resident #138's care plan, progress notes, orders, MAR/TAR, and CNA care tasks for transfers and brief changes, shower sheets, pressure ulcer assessments, change of condition assessments, wound assessments, and skin assessments for the necessary months of review required to complete a thorough investigation, June and July 2022. -Regarding Resident #139Resident #139 was admitted on [DATE], with a diagnosis that included unspecified fracture of the lower end of the left tibia, subsequent encounter for closed fracture with routine healing, unspecified fracture of the shaft of the left fibula, subsequent encounter for closed fracture with routine healing, type 2 diabetes mellitus without complications, and muscle weakness.An admission MDS assessment dated [DATE], revealed a BIMS of 13, indicating that Resident #139's cognition had been intact. The MDS assessment also revealed that Resident #139 requires a 2+ person assist for transfers and bed mobility. The MDS assessment also revealed that Resident #139 required one person assist for eating, locomotion, dressing, and personal hygiene.There was no evidence of Resident #139's care plan, progress notes, orders, MAR/TAR, and CNA care tasks for transfers and brief changes, shower sheets, pressure ulcer assessments, wound assessments, and skin assessments for the necessary months of review required to complete a thorough investigation, November 2022. -Regarding Resident #140Resident #140 was admitted on [DATE], with the diagnosis that included a displaced oblique fracture of the shaft of the left fibula, subsequent encounter for closed fracture with routine healing, other fracture of the upper and lower ends of the left fibula, subsequent encounter for closed fracture with routine healing, type 2 diabetes mellitus without complications, and kidney transplant status.A change of condition MDS assessment dated [DATE], revealed that no BIMS score was observed, and a mental status exam had been completed by staff, indicating Resident #141 experienced memory difficulties.There was no evidence of Resident #140's care plan, progress notes, orders, MAR/TAR, and CNA care tasks for transfers and brief changes, shower sheets, pressure ulcer assessments, wound assessments, skin assessments, and discharge paperwork for the necessary months of review required to complete a thorough investigation, October and November 2022. -Regarding Resident #141Resident #141 was admitted on [DATE], with the diagnosis that included osteomyelitis of the vertebra, sacrum, and sacrococcygeal region; peripheral vascular disease, unspecified; and type 2 diabetes mellitus with hyperglycemia.A quarterly MDS assessment dated [DATE], revealed that no BIMS score was observed, and a mental status exam had been completed by staff, indicating Resident #141 experienced memory difficulties. The quarterly MDS assessment also revealed that a stage 4 pressure ulcer had been present at the time of admission, and had been determined at-risk for further pressure ulcer