

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/29/2026
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)		
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, interviews, and review of the facility's policies and procedures, the facility failed to provide discharge information to the Resident's Representative (RR) in a language she understood for one of 2 sampled residents (Resident #4) regarding resident's rights. The deficient practice could result in the RR not understanding the resident's post-discharge care needs and instructions, potentially leading to unmet care needs following discharge. Findings include: Resident #4 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia, tracheostomy status, spastic quadriplegic cerebral palsy, a stroke affecting the right side of the brain resulting in loss of movement on the left side of the body, and aphasia. A Care Plan, initiated on February 11, 2026, addressed the goal of establishing a pre-discharge plan. Interventions included coordinating a discharge plan with the interdisciplinary team and providing services according to the care plan. A Social Services Progress Note, dated February 12, 2026 at 12:58 P.M., revealed Social Services met with Resident #4 and the RR to conduct assessments. The note documented that Resident #4 was unable to answer questions and that a language-line interpretation service was utilized because the RR was Spanish-speaking. An admission Minimum Data Set (MDS) assessment, dated February 17, 2026, revealed a Brief Interview for Mental Status (BIMS) was not completed. However, the same MDS noted that Resident #4's cognitive skills for daily decision making were severely impaired. The MDS further noted that Resident #4 had no speech pattern, was rarely/never made himself understood, and rarely/never understood verbal content communicated to him. Review of a Respiratory Therapy Note, dated March 1, 2026, revealed the family was Spanish-speaking. The note documented that the RR was fluent in spoken English and that the resident's father spoke minimal English. Review of email correspondence from the Ombudsman dated May 11, 2026, regarding Resident #4's discharge planning and coordination of durable Medical Equipment (DME), revealed the RR reported that her interactions with the Director of Social Services had been conducted in English without the use of interpretation services. The email identified the RR as having limited English Proficiency and expressed concern that there was a possibility the RR had misunderstood instructions provided by the Director of Social Services. Review of the facility's response to the email, dated May 12, 2026 and sent by the Director of Nursing (Staff #33), revealed that according to the Director of Social Service, a Spanish-speaking interpreter had been with the RR during the interactions. Staff #33 further stated that, going forward, the facility would document the interpreter's identification number. Review of a progress note dated May 13, 2026 revealed staff spoke with the RR regarding caregiver and percutaneous endoscopic gastrostomy (PEG) tube training, including maintaining and programming the pump and cleaning the PEG-tube site. The note documented that a Certified Nursing Assistant (CNA) translated the information from English to Spanish. The RR declined the training and stated she knew how to care for Resident #4. Review of the facility's Discharge form, (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated May 21, 2026 at 3:07 P.M., revealed the discharge information was documented in English. The form contained the RR's signature, dated May 22, 2026. However, the form contained no documented evidence that an interpreter was utilized during the provision of the discharge information and did not identify an interpreter or interpreter identification number. A Discharge summary, dated [DATE] at 3:07 P.M. noted that Resident #4 was to be discharged home with home health services. It also noted that written education regarding tube feeding, tracheotomy care and medications was provided to the RR. The discharge information was documented in English. There was no documented evidence that an interpreter was utilized to communicate the discharge information to the RR in Spanish or documentation identifying an interpreter or interpreter identification number. There was also no evidence that the written information was given to the RR in Spanish. A Progress Note, dated May 22, 2026 at 3:04 P.M. noted that Resident #4 was discharged home with family and that discharge instructions was given to the RR. There was no evidence the discharge instructions were relayed to the RR in Spanish. There was no documented evidence that an interpreter was utilized when discharge instructions were communicated to the RR. A discharge MDS assessment dated [DATE], noted that the resident had a planned discharge and was sent home under the care of an organized home health service organization. A complaint received on July 15, 2026 via the State Agency's complaint portal revealed an allegation that the RR had requested information related to Resident #4's medical care and DME to be communicated to her in Spanish and the facility did not provide Resident #4's discharge information to the RR in Spanish during the resident's discharge. An interview was conducted with the Ombudsman, on July 28, 2026 at 9:49 A.M. She explained that she was assisting the RR due to the RR not receiving an interpreter during the discharge process. She further explained that the RR had shared her concerns with the Ombudsman because she was not able to understand the medical terminology the facility used to explain how to provide care for Resident #4 and to coordinate the ordering and delivery of the necessary medical supplies the resident would need at home. The Ombudsman explained that she was able to communicate with the RR in Spanish. An interview was conducted on July 29, 2026 at 10:33 A.M. with Social Services/Resident Relations Manager (Staff #19). Staff #19 explained that the facility utilizes a language interpretation phone line when they are needing to speak with a resident or RR in a language other than English. He further explained that if a resident wishes to use a family member to interpret for them, staff will then document that. Staff #19 stated that he has never seen a discharge summary presented to a resident or their representative in a language other than English. He further stated that every time language services are utilized, it should be documented. An interview was conducted on July 29, 2026 at 1:20 P.M. with the Director of Nursing/Staff #33. Staff #33 recalled Resident #4 and shared that he had a ventilator and was airway dependent. She further shared that the RR had wanted to take Resident #4 home. Staff #33 also stated that, using an interpreter, it was communicated to the RR that the facility needed to get things in place for the resident before discharging him. She also shared that the RR had reached out and had gotten the resident's Long-Term case manager and the Ombudsman involved in the discharge process. Staff #33 reviewed Resident #4's clinical chart and shared that she only saw one Social Services note indicating a language interpretation services was provided to the RR. She further shared that she was not sure how the resident's discharge information was communicated to the RR leading up to and on the day of discharge. Staff #33 explained that her expectation was for staff to use an interpreter when communicating with non-English speaking residents and/or family, and to document the interpreter number and its use in the chart. A review was conducted of the facility's policy and procedure, titled Resident Rights - Translation and/or Interpretation of Facility Services, dated January 1, 2024. The policy and procedure stated, This facility's language access (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility. It also noted that when written translation of vital information is unavailable, or impractical, the facility shall attempt to provide oral translation of vital documents. The document identified discharge instructions as a piece of vital information.		