| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 035290 | A. Building<br>B. Wing | 11/13/2025 |

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| Haven Health Sky Harbor, LLC | 1880 East Van Buren Street<br>Phoenix, AZ 85006 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the clinical record, staff interviews, and policies and procedures, the facility failed to ensure that residents were treated with dignity and respect during meal service for four out of six residents observed receiving dining assistance (Residents #10, #61, #72, and #107). The universe was 106, and the sample size was 22. This deficient practice could potentially affect all residents needing meal assistance by diminishing their sense of dignity and personhood.-Regarding Resident #10Resident #10 was admitted on [DATE], with the diagnosis that included chronic respiratory failure with hypoxia, tracheostomy status, quadriplegia, C1-C4 incomplete, hypertensive heart disease without heart failure, generalized anxiety disorder, major depressive disorder, recurrent adjustment disorder, unspecified, and schizoaffective disorder, bipolar type. A review of the care plan intervention initiated on February 21, 2024, revealed that Resident #10 had a focus on nutritional problems and functional self-care deficits related to Quadriplegia. Interventions included assistance with dining.-Regarding Resident #61Resident #61 was admitted on [DATE], with diagnosis that included polyneuropathy, unspecified type 2 diabetes mellitus with hyperglycemia, paroxysmal atrial fibrillation, adjustment disorders, major depressive disorder, recurrent, moderate, and neuromuscular dysfunction of the bladder, unspecified.A review of the care plan, initiated on February 13, 2025, revealed a focus that addressed nutritional problems, swallowing difficulties related to dysphagia, and malnutrition resulting from hemiplegia and functional self-care deficits. Interventions included assisted eating and dining.-Regarding Resident #72Resident #72 was admitted on [DATE], with a diagnosis that included chronic kidney disease, unspecified, dependent on renal dialysis, essential hypertension, hyperlipidemia, unspecified, anemia, unspecified, and thrombocytopenia, unspecified. A review of the care plan, date-initiated April 1, 2025, revealed a focus on nutritional problems and functional self-care deficits. Interventions include assisted dining, with support for eating and meal preparation as needed.-Regarding Resident #107Resident #107 was admitted on [DATE], with the diagnosis that included unspecified psychosis not due to a substance or known physiological condition, cerebral infarction, unspecified hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the left non-dominant side, other paralytic syndrome following cerebral infarction, bilateral muscle weakness, and type 2 diabetes mellitus without complications. A review of the care plan, date-initiated August 29, 2023, revealed a focus on nutritional problems related to Stroke, Quadriplegia, DM-II, Hemiplegia, Muscle Weakness, and functional self-care deficits. Interventions included: one-on-one assistance with dining as needed.A lunch service dining observation was conducted on September 21, 2025, at 12:01 PM. This observation revealed that three staff members (Staff #148, #149, and #181) were observed providing meal assistance to four of six residents while standing. Staff #148 was observed standing between two residents (Residents #10 and #107) and assisted both with their meals. Staff #149 was observed standing while preparing the setup for one resident; however, they proceeded to sit down once the resident was ready. Staff #181 (Resident #61) was observed standing next to the final resident while completing both setup and meal assistance.Following the dining observation, interviews were conducted with the Staff #148, #149,<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | and #181.On September 21, 2025, at 12:41 PM, an interview was conducted with Staff #148 (Restorative Nursing Aide/RNA), who stated that the group of residents within the dining room during dining services is residents on a list called a ?Feeding List'. The RNA identified ?Feeders' as residents who require one-on-one care during meals. The RNA noted that the term ?Feeders' is used when individuals are assisted with their eating. The expectation for residents placed on the ?Feeding List' requires one-on-one assistance with their meals. The RNA described one-on-one assistance with meals as sitting next to the resident to assist with ?feeding', and then to ensure that the resident is not being rushed while being ?fed.' The RNA stated that there had been occasions where they assisted two residents at a time, referencing the day of observation, and that she does her best to go back and forth between the residents.An interview was conducted on September 21, 2025, at 12:50 p.m. with Staff #181 (Licensed Practical Nurse/LPN). The LPN stated that residents located in the dining room are those who are unable to feed themselves and require assistance with eating their meals. The LPN explained that the expectation is that before meal services begin, the floor staff will ?figure out who the feeders are' and then ensure that hand hygiene is practiced between residents. The LPN stated that staff are expected to provide the resident with small bites at a slow pace that does not rush the resident. The LPN stated that the potential risk if dining assistance is not provided as expected from the facility is that the resident may lose their sense of dignity and self-respect if staff were to rush or provide dining assistance in a demeaning manner. An interview was conducted on September 21, 2025, at 1:01 PM with Staff #149 (LPN/Care Coordinator), who stated that within his role, he oversees the assisted dining program that the facility currently enforces. The Care Coordinator noted that there is a list of individuals who are determined to require assistance with dining. The Care Coordinator stated that residents who need one-on-one assisted dining are determined by therapy evaluations, assessments, and any notifications from other nurses and Certified Nursing Assistants (CNAs) regarding changes to their abilities. The Care Coordinator also stated that it is preferred for staff to provide dining assistance while sitting next to the resident; however, he noted that, depending on the device a resident is seated in, staff may need to adjust accordingly to be at the same height as the resident's shoulder. The Care Coordinator also stated that the assisted dining program is important, as it will meet the needs of the resident and ensure that their individual care plan is met, helping them receive all the required nutrients and meet their intake goals. The Care Coordinator stated that the residents who receive dining assistance vary in terms of their swallowing abilities and hand movements, and will undergo evaluations and assessments to determine their eligibility for dining assistance. The Care Coordinator further stated that the term ?feeders' should not be used; the expectation is that staff utilize the term assisted dining, as the usage of the term ?feed' or ?feeders' can pose a concern to a resident's dignity. The Care Coordinator stated that education had been provided to both Staff #148 and #181, as the terms ?feed' and ?feeders' were overheard by the Care Coordinator during the above-mentioned interviews with Staff #148 and #181.On September 21, 2025, at 3:42 PM, the facility provided the survey team with a list of residents who are care-planned with the standard intervention of assisted dining. This list included Residents #10, #61, #72, and #107.A joint resident council interview was conducted on September 22, 2025, at 11:26 AM with Residents #75 and #113. Both residents stated that they have heard the term ?feeders' used by staff. In the joint interview, both residents stated that the term is used when staff advises residents of where they have just come from or if they need to end their current care to provide help to ?feeders'. Both residents stated that although they do not require dining assistance, they feel sorry for residents who are called ?feeders,' as that could not be a good feeling to be perceived as helpless and needing staff to assist with eating. An interview was conducted on September 22, 2025, at 2:12 PM, with the Director of Nursing (DON/Staff #108), who stated that staff who are assisting with the assisted dining program will escort the residents to the dining room, will ensure hand hygiene is being completed in-between residents, and should be at a level with the resident's shoulders. The DON stated that staff are encouraged to provide one-on-one assistance<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | and/or assist multiple residents with their meals. The DON stated that the facility can offer clothing protectors if requested by the resident. Staff should not rush the resident, show respect, and be seated rather than standing over the resident. The DON stated that if a staff member is observed standing next to a resident, or two residents, that is not within the facility's expectations, and will require re-education for the staff to be seated when providing residents with assistance with their meals. The DON stated that the term ?feeder' should not be utilized at all when referencing residents who require dining assistance. The DON further stated that these are the facility's expectations, as any action taken by a staff member that do not meet those expectations can pose a concern regarding the resident's dignity, as the resident may feel that staff are referring to them in a derogatory manner.A review of the facility policy titled Food Services: Assistance with Meals, with an in-effect date of January 1, 2024, revealed that residents shall receive assistance with meals in a manner that meets the individual needs of each resident. This policy also revealed that residents who can not feed themselves will be fed with attention to safety, comfort and dignity, for example: not standing over residents while assisting them with meals; keeping interactions with other staff to a minimum while assisting residents with meals, avoid the use of labels when referring to residents (ex. feeders); and, prevent the use of bibs or clothing protectors instead of napkins, unless requested by the resident. |

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

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | #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 10, 2025), as the resident stated she needed to use the bathroom. Once the resident was on the toilet, Staff #224 stated that the resident told her about an incident that the resident stated occurred the night before. Staff #224 stated that the resident told her that last night, a night staff had taken off the resident's dirty brief and shook it in the resident's face, and that the resident stated that she was emotionally hurt by the incident. Staff #224 stated that this was a possible case of emotional abuse, so she reported it to the DON (Staff #108) because the Administrator was off that date. Staff #224 stated she reported it right after the therapy session (September 10, 2025), and that it was within 2 hours of hearing the resident's allegation. Staff #224 stated that she knew the DON then got a statement from Resident #100.An interview was conducted with a CNA (Staff #143) on September 22, 2025, at 9:09 A.M. Staff #143 stated that she received a text message from the DON on the morning of September 10, 2025, requesting for a phone call. Staff #143 stated that then she had a phone call with the DON on September 10, 2025, where she was notified of the allegation from Resident #100 that Staff #143 had put a dirty brief close to the resident's face on the night shift of September 9-10. Staff #143 stated that she was surprised to hear of the allegation, and that it did not happen, and that she had helped the resident get changed and the nurse had come in the room directly afterward. Staff #143 was requested to review her text and call log on her phone to confirm the date that the Staff #143 had a conversation with the DON about the allegation, and Staff #143 stated that it was September 10, 2025.A telephonic interview was conducted with an LPN (Staff #97) on September 23, 2025, at 10:06 A.M. Staff #97 stated that on the night shift of September 9-10, 2025, that she was passing evening medications and that she entered Resident #100's room, just as Staff #143 was leaving the room with dirty sheets in a bag. Staff #97 stated that Resident #100 stated that she believed Staff #143 was upset with her because she had told the CNA thank you and Staff #143 did not respond. Staff #97 stated that maybe Staff #143 did not hear the resident say thank you. Staff #97 stated that after she left Resident #100's room, she found Staff #143 and asked her if she had heard resident #100 say thank you because the resident believes you're mad at her. Staff #97 stated that Staff #143 said that she had not heard the resident say thank you. Staff #97 stated that the following morning, on September 10, 2025, she received a text message from the DON (Staff #108) requesting a phone call, and that Staff #97 then called the DON that day and the incident was discussed, along with the resident's allegation of the CNA holding a dirty brief near the resident's face. Staff #97 stated that the following day, on September 11, 2025, the Administrator (Staff #309) called her and asked her to write a statement about the incident, and Staff #97 stated that she did write the statement. Staff #97 was requested to review her text message and call log on her phone to confirm the date that Staff #97 had a conversation with the DON about the allegation, and Staff #143 stated that it was September 10, 2025.An interview was conducted with the Director of Nursing (DON / Staff #108) on September 23, 2025, at 10:26 A.M. The DON stated that if there is an allegation of possible abuse, that the facility staff separate the resident from the threat, report the incident within 2 hours to mandated entities, and then complete a thorough investigation. The DON stated that if the alleged perpetrator is a staff member, then the staff member is suspended until the investigation is completed. The DON stated that the importance of timely reporting is to ensure there is a proper investigation completed for the resident. Regarding the allegation of abuse from Resident #100, the DON stated that it was reported to<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | her on September 11 by a therapist (Staff #224), when the resident told the therapist that she felt like the CNA was rude to her and the resident stated that the CNA waived a brief in front of her face. The DON also stated that Staff #143 is a night-shift CNA, and never works day shift, and that she was suspended pending the investigation. The DON stated that after receiving the allegation, the facility completed mandated reporting to the state agency and to non-emergent police. The DON stated that the Administrator-in-Training (AIT / Staff #301) took the first statements for the investigation. The DON stated that she could not recall if she herself had taken any statements from the nurse (Staff #97) or the CNA (Staff #143).An interview was conducted with the Administrator-in-Training (AIT / Staff #301) on September 23, 2025, at 10:44 A.M. Staff #301 stated that regarding the investigation of Resident #100's allegation of a CNA holding a brief near the resident's face, that he was not involved in the investigation at all, and did not take any statements, or ask any questions.An interview was conducted with the facility Administrator (Staff #309) on September 23, 2025, at 10:49 A.M. The Administrator stated that if there is an allegation of abuse, the resident would be separated from the alleged perpetrator and then the facility reports the allegation within 2 hours to mandated entities including to the State Agency, to the police, and to Adult Protective Services. Then, the Administrator stated that an investigation is conducted by the facility and that is submitted to the State Agency in 5 days. Regarding Resident #100's allegation, the Administrator stated that per the therapy staff, Resident #100 stated that her feelings were hurt by a CNA. The Administrator stated that he was out of town, and that the DON interviewed the staff members for their statements, and that Staff #143 was suspended pending the investigation. The Administrator stated that the allegation was reported to the mandated entities the same day that the therapist (Staff #224) brought it to the DON's attention, which was September 11, 2025. Additionally, the Administrator stated that the 12 hours of regular pay on Staff #143's time punch report was because the facility still provides pay to a staff member who is suspended pending an investigation if they are cooperating with the investigation.An interview was conducted on September 23, 2025, at 1:00 P.M. with Resident #100, who stated that she could not recall the date, but that she recalled an incident where a staff member put a dirty brief close to her face. Resident #100 stated that after the incident, that she was completely baffled, and scared of that staff member being so aggressive.An interview was conducted with a CNA (Staff #12) on September 23, 2025, at 1:32 P.M. Staff #12 stated that an allegation of abuse needs to be reported immediately to the Administrator or to the DON. Staff #12 also stated that there would be no reason why a brief should be close to a resident's face.Review of the facility policy titled Resident Rights/Dignity: Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated January 1, 2024, revealed that all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: the state licensing/certification agency responsible for surveying/licensing the facility, adult protective services (where state law provides jurisdiction in long-term care), and law enforcement officials, where Immediately is defined as within two hours of an allegation involving abuse.Review of the facility policy titled: Resident Rights/Dignity: Abuse, Neglect, Exploitation and Misappropriation Prevention Program, effective January 1, 2024, revealed that residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, facility documentation and policy, the facility failed to ensure one resident (#145) received glaucoma medication according to admission orders. The deficient practice could lead to an increase in eye pressure, causing potentially worsening vision. Findings include:Resident # 145 was admitted to the facility on [DATE], with diagnoses that included secondary pulmonary hypertension, essential hypertension, and unspecified glaucoma. A review was conducted of the hospital History and Physical (H&P) report dated September 11, 2025, revealing the resident had a history of glaucoma with home medications that included brimonidine 0.1% ophthalmic solution and bimatoprost 0.01% ophthalmic solution. A review of the hospital discharge orders dated September 16, 2025, revealed the resident was to continue taking both bimatoprost 0.01% ophthalmic solution and brimonidine 0.1% ophthalmic solution. A physician order for brimonidine tartrate 0.1% solution, dated September 16, 2025 directs staff to instill one drop of solution in both eyes twice a day for eye pressure. The Medication Administration Record (MAR) does not support an active, hold, or discontinue order for the bimatoprost ophthalmic 0.01% solution. The admission Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview Mental Status (BIMS) score of 12, indicating the resident was cognitively intact. A review of the care plan revealed no focus for vision impairment or glaucoma needs for resident #145.An interview was conducted with resident #145 on September 21, 2025, at 6:59 a.m. The resident stated, I take eyedrops called Lumigan (bimatoprost ophthalmic 0.01% drops) for my glaucoma for like 15 years. I told them I need my meds, but they wouldn't give them to me! It could be harmful for me to wait for those medications, and I should have a say in what meds I'm taking!An interview was conducted with the resident's admission Licensed Practical Nurse (LPN/Staff #8) on September 23, 2025 at 1:52 p.m. The nurse admitted to being the party that was responsible for entering the resident's hospital discharge orders into the electronic health record. The nurse described that admitting a resident from a hospital involves the nurse reviewing the discharge orders, then transcribing those orders into the electronic clinical record. The nurse voiced the importance of clarifying orders with the reporting nurse and the provider if there are any concerns about the orders. The nurse mentioned that the facility has a pharmacy champion, that serves as a checks and balances system for medication admission orders. The nurse described the pharmacy champion role as identifying and following up on medications that require pre-authorizations, or that are high-cost. During the interview, Staff #8 reviewed the resident's discharge orders and compared it to the Medication Administration Record. The nurse verbalized that the order for the bimatoprost ophthalmic 0.01% drops were inadvertently omitted from the electronic health record, and would immediately correct to reflect the physician's orders. An interview was conducted with the MDS Coordinator/Pharmacy Cost Review Nurse (Staff # 149) on September 23, 2025 at 2:46 pm. Staff #149 revealed also being referred to as the facility's Pharmacy Champion. The nurse explained one function of the position involves finding alternatives for hi-cost medications. The nurse reviewed the order for the bimatoprost ophthalmic solution, and revealed that the eye drops would not have flagged for review, since eyedrops are generally affordable. The nurse further clarified that hi-cost meds and meds requiring prior authorization are medications that will raise an alert for review. A panel interview was conducted with the Director of Nursing (DON/Staff #108) and the Executive Director (ED/Staff # 309) on September 3, 2025 at approximately 2:53 p.m. During review of the resident's clinical record, the DON stated that the expectation that both of the resident's eye drops should have been transcribed over into the electronic clinical record. The DON stated that both drops should have been given as ordered, to avoid disease progression. The DON explained that residents can be a reliable and excellent source for medications taken at home. The DON stated that if a resident report missing a home medication, investigation and further follow-up should have occurred. A review of the facility policy titled Sensory Impairments-Clinical Protocol, effective<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035290 | A. Building<br>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<br>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) |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | January 1, 2024, directs that as part of the initial assessment, the staff and physician will help identify individuals with sensory impairments, including hearing, taste, vision, smell, and touch. In addition, the staff and physician will identify approaches to help the resident improve or compensate for sensory deficits. A review of the facility policy titled Orders/Receiving/Transcribing: Medication and Treatment Orders policy, effective January 1, 2024, calls for drugs and biological orders to be recorded on the physician's order sheet in the resident's chart. |