STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035062	A. Building B. Wing	01/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Haven Care Center	2645 East Thomas Road Phoenix, AZ 85016

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure that one resident (#78) was free from abuse by another resident (#89). The deficient practice could result in residents being physically and emotionally harmed.Findings Include:-Regarding Resident #89:Resident #89 was admitted on [DATE], with diagnoses that included mild neurocognitive disorder, major depressive disorder, iron deficiency anemia, adjustment disorder, chronic kidney disease, anemia, dysphagia, attention-deficit hyperactivity disorder, atherosclerotic heart disease, hypertension, and type 2 diabetes mellitus.A care plan focus initiated on May 29, 2024, revealed the resident having a behavior problem related to psychosis as evidenced by delusions, refusing care, being verbally aggressive/abusive, demanding, intrusive, wandering at times, and inappropriate sexual advances to females, with an intervention to intervene as necessary to protect the rights and safety of others.A care plan focus initiated on September 13, 2024, revealed the resident had shown behaviors of verbal aggression towards activity staff and other residents in group activities, with interventions to provide social visits to the resident throughout the week and offering independent leisure materials.A Quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS also revealed that the resident exhibited verbal behaviors for 4-6 days and other behavioral symptoms for 4-6 days. A behavior progress note dated December 15, 2025, at 8:01 p.m. revealed that the resident was sitting in the hallway when he noticed a peer by the nurses' station. The note also revealed that the resident yelled, Get away from there, you're just bothering them. You need to take your a** back to your room, and staff intervened by trying to redirect the resident. A behavior progress note dated December 19, 2025, at 5:28 p.m. revealed that the resident was observed becoming verbally aggressive and cursing profanities at another resident and activities staff at 3 p.m. The note further revealed that the resident was redirected and monitored during a smoke break, and 30 minutes later, the resident was yelling at another resident for clogging his toilet. The note also revealed that the resident was observed threatening to fight another resident and cursing, and he was redirected and de-escalated. A behavior progress note dated December 21, 2025, at 3:25 p.m. revealed that the resident was observed attempting to redirect one of his closest peers to his room and informed the peer he would assist with cleaning his toilet seat when Resident #89 put his hands on the outside of the peer's bilateral arms to redirect towards his room. The note revealed that the peer was not ready to leave the nurses' station, and so an argument ensued. The note further revealed that staff separated the residents. A behavior progress note dated January 11, 2026, at 10:09 p.m. revealed that a nurse approached the resident regarding a statement he made to a CNA (Certified Nursing Assistant) that seemed threatening, and the resident became upset with the nurse, approached the nurse in a threatening and menacing manner, and stated they should not be approaching or talking to him at all or else he would f*** with them.A (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behavior progress note dated January 13, 2026, at 11:23 p.m. revealed that the resident was observed to be yelling and cursing at peers and threatening to put his hands on one peer, and the nurse was able to redirect and administer as-needed medication to aid with increased anxiety.There was no evidence of documentation completed in the resident's clinical record regarding the resident-to-resident incident on January 20, 2026. -Regarding Resident #78:Resident #78 was admitted [DATE], with diagnoses that included vascular dementia, depression, chronic kidney disease, hypertension, cerebral infarction, chronic viral hepatitis C, pure hypercholesterolemia, chronic obstructive pulmonary disease, hyperlipidemia, aphasia, dysphagia, basal cell carcinoma, adjustment mood disorder, anxiety disorder, and dysphagia.A care plan focus initiated on January 19, 2024, revealed the resident displayed behavioral symptoms related to dementia, including physical aggression like hitting, kicking, and pushing, verbal symptoms like yelling, cursing, and other threatening behaviors, as well as hallucinations, wandering, and refusal of care with interventions to give psychoactive medications as orders, record behavioral symptoms, and educate the resident on appropriate behaviors when on the patio with peers.A Quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment. The MDS also revealed that the resident exhibited verbal behaviors for 4-6 days. There was no evidence of documentation completed in the resident's clinical record regarding the resident-to-resident incident on January 20, 2026. A request was made for the facility's self-reports, grievances, and investigations for the last 4 months, and the facility documented that they had not reported any incidents or had any grievances in the last 4 months. An interview was conducted on January 26, 2026, at 3:27 p.m. with a Certified Nursing Assistant (CNA/Staff #34), who stated that Resident #89 was an aggressive resident who would try to intimidate people. The CNA stated that Resident #89 had behaviors mostly when women were around because he would try to impress them by getting aggressive, yelling, and being rough with staff. The CNA stated that Resident #89 had made threats to residents before, and that within the last week, Resident #89 made a cardboard gun, covered his face with a bandana, and went into Resident #78's room to tell the resident, if you don't be quiet, I'll teach you a lesson. The CNA stated that staff made efforts to get Resident #89 out of the room and calm him down, and that he would consider the incident a resident-to-resident abuse. The CNA also stated that the two nurses who were present at the time of the incident took charge of the situation and reported it to their supervisor. The CNA stated that the cardboard gun appeared to be a long handgun, and he was not sure where the cardboard gun went after the incident. An interview was conducted on January 26, 2026, at 3:50 p.m. with a Licensed Practical Nurse (LPN/Staff #17), who stated that reportable incidents would be considered any form of abuse or what you are seeing such as physical, emotional, and the poor treatment of residents, and that he would report incidents to the unit manager or the Director of Nursing (DON). The LPN stated that Resident #89 was a resident who would get aggressive with other residents, and that he would get upset with Resident #78 sometimes if he was loud.A telephonic interview was conducted on January 26, 2026, at 4:39 p.m. with an LPN, Staff #80, who stated that abuse incidents should have been recorded in the progress notes within the clinical record, and that the timeframe for reporting abuse was immediately to the designated person, the DON, or the administrator. The LPN stated that reportable abuse incidents could be physical, verbal, or resident-to-resident, and that she had a resident-to-resident emotional abuse incident on January 20, 2026, that she had to report. The LPN stated that the incident involved Resident #89 and Resident #78, and that Resident #89 entered Resident #78's room and was holding a pretend gun made out of cardboard. The LPN stated that she witnessed the entire event and that Resident #89 told Resident #78 that he would shoot him if he did not quiet down. The (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN stated she heard Resident #89 say, go to sleep, or I am going to shoot you, and that Resident #78 felt intimidated after the incident. The LPN stated that in the hours following the incident, Resident #78 got into his bed and did not want to do anything, which was not like him. The LPN stated that the cardboard gun was flat, and one side was colored with art supplies to look more realistic, to show a handle on the gun. The LPN stated that at one point, the gun fell from Resident #89's hands, and she picked it up to see it, but gave it back to him because she was scared of what he might do to her. The LPN further stated that she spoke with the LPN unit nurse manager (unit manager/Staff #56) to report the incident and asked her to take the cardboard gun from the resident. Staff #80 further stated that she protected Resident #78 for the rest of her shift by staying at his door because he was intimidated and very frightened. The LPN stated that she reported the incident to the unit manager, and the unit manager told her to write a statement about the incident on paper. The LPN stated that she did not know if the unit manager reported the incident further. A telephonic interview was attempted on January 26, 2026, at 4:50 p.m. with an LPN, Staff #23, with no success.An interview was conducted on January 26, 2026, at 4:57 p.m. with the Director of Nursing (DON/Staff #67), who stated that she expected that nursing staff document allegations of abuse in the clinical record in an incident report and progress note, and that the timeframe for reporting an allegation of abuse was two hours to all applicable state agencies, physicians, case managers, and family. The DON stated that she does the abuse coordination, investigating, and reporting for the facility, and that a resident-to-resident physical or verbal abuse would be considered a reportable abuse. The DON stated that she did not know anything about a recent abuse incident between Resident #89 and Resident #78, but she did know that Resident #89 had a bad weekend where he was verbally aggressive to staff. The DON stated that her process for investigating allegations of abuse was to interview staff and residents, look at the charting, and then report to the applicable state agencies. An interview was conducted on January 26, 2026, at 5:07 p.m. with the LPN unit nurse manager (unit manager/Staff #56), who stated that nursing staff were expected to document all progress notes, including incidents of abuse or allegations. The LPN unit manager stated that the timeframe for reporting an allegation was immediately, but no longer than two hours, and that she would report abuse incidents or allegations to the DON. The LPN unit manager stated that she had not reported anything recently, but she found out just 5-10 minutes before the interview that Resident #89 was really bad, and that he made a cardboard gun and was playing with staff and Resident #78. The LPN unit manager stated that she had no idea who was involved, she did not recall the incident being reported to her, and that she would immediately let the DON know so she could investigate. The LPN unit manager stated that she did not investigate the incident with the cardboard gun.A follow-up telephonic interview was conducted on January 26, 2026, at 5:14 p.m. with the LPN, Staff #80, who stated that the unit manager she reported the abuse incident to was Staff #56, and that there was a camera pointing at the office where they discussed the incident. The LPN also stated that there was another woman present in the office when she reported the incident to the unit manager, but she could not recall the woman's identity. Review of a policy titled, Abuse Guidelines, had a review date of July 2022 and revealed that it was the responsibility of the employees, facility consultants, attending physicians, family members, and visitors to promptly report any incident or suspected incident of resident abuse to facility management. The policy defined abuse as being the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The policy also revealed that the facility would not condone resident abuse by anyone, including other residents, and all personnel were encouraged to report incidents of resident abuse or suspected incidents of abuse without fear of (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	retaliation from the facility or its staff. The policy further revealed that employees, consultants, and physicians must immediately report any suspected abuse to the DON, and in their absence, reports may be made to the nurse supervisor on duty. The policy revealed that the administrator must be immediately notified of suspected abuse or incidents of abuse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure that the abuse policy was implemented following an incident involving resident-to-resident abuse between two residents (#89 and #78). The deficient practice could result in continued abuse of residents and physical or emotional harm to residents. Findings Include:-Regarding Resident #89:Resident #89 was admitted on [DATE], with diagnoses that included mild neurocognitive disorder, major depressive disorder, iron deficiency anemia, adjustment disorder, chronic kidney disease, anemia, dysphagia, attention-deficit hyperactivity disorder, atherosclerotic heart disease, hypertension, and type 2 diabetes mellitus.A care plan focus initiated on May 29, 2024, revealed the resident having a behavior problem related to psychosis as evidenced by delusions, refusing care, being verbally aggressive/abusive, demanding, intrusive, wandering at times, and inappropriate sexual advances to females, with an intervention to intervene as necessary to protect the rights and safety of others.A care plan focus initiated on September 13, 2024, revealed the resident had shown behaviors of verbal aggression towards activity staff and other residents in group activities, with interventions to provide social visits to the resident throughout the week and offering independent leisure materials.A Quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS also revealed that the resident exhibited verbal behaviors for 4-6 days and other behavioral symptoms for 4-6 days. A behavior progress note dated December 15, 2025, at 8:01 p.m. revealed that the resident was sitting in the hallway when he noticed a peer by the nurses' station. The note also revealed that the resident yelled, Get away from there, you're just bothering them. You need to take your a** back to your room, and staff intervened by trying to redirect the resident. A behavior progress note dated December 19, 2025, at 5:28 p.m. revealed that the resident was observed becoming verbally aggressive and cursing profanities at another resident and activities staff at 3 p.m. The note further revealed that the resident was redirected and monitored during a smoke break, and 30 minutes later, the resident was yelling at another resident for clogging his toilet. The note also revealed that the resident was observed threatening to fight another resident and cursing, and he was redirected and de-escalated. A behavior progress note dated December 21, 2025, at 3:25 p.m. revealed that the resident was observed attempting to redirect one of his closest peers to his room and informed the peer he would assist with cleaning his toilet seat when Resident #89 put his hands on the outside of the peer's bilateral arms to redirect towards his room. The note revealed that the peer was not ready to leave the nurses' station, and so an argument ensued. The note further revealed that staff separated the residents. A behavior progress note dated January 11, 2026, at 10:09 p.m. revealed that the resident became upset when the nurse asked him what he said to the CNAs because it sounded like a threat, and he approached the nurse threateningly and menacingly while leaving verbal threats that they should not be approaching or talking to him at all or else he would f*** with them.A behavior progress note dated January 13, 2026, at 11:23 p.m. revealed that the resident was observed to be yelling and cursing at peers and threatening to put his hands on one peer, and the nurse was able to redirect and administer as-needed medication to aid with increased anxiety.There was no evidence of documentation completed in the resident's clinical record regarding the resident-to-resident incident on January 20, 2026. -Regarding Resident #78Resident #78 was admitted [DATE], with diagnoses that included vascular dementia, depression, chronic kidney disease, hypertension, cerebral infarction, chronic viral hepatitis C, pure hypercholesterolemia, chronic obstructive pulmonary disease, hyperlipidemia, aphasia, dysphagia, basal cell carcinoma, adjustment mood disorder, anxiety disorder, and (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dysphagia.A care plan focus initiated on January 19, 2024, revealed the resident displayed behavioral symptoms related to dementia, including physical aggression like hitting, kicking, and pushing, verbal symptoms like yelling, cursing, and other threatening behaviors, as well as hallucinations, wandering, and refusal of care with interventions to give psychoactive medications as orders, record behavioral symptoms, and educate the resident on appropriate behaviors when on the patio with peers. A Quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment. The MDS also revealed that the resident exhibited verbal behaviors for 4-6 days. There was no evidence of documentation completed in the resident's clinical record regarding the resident-to-resident incident on January 20, 2026. A request was made for the facility's self-reports, grievances, and investigations for the last 4 months, and the facility documented that they had not reported any incidents or had any grievances in the last 4 months. An interview was conducted on January 26, 2026, at 3:27 p.m. with a Certified Nursing Assistant (CNA/Staff #34), who stated that Resident #89 was an aggressive resident who would try to intimidate people. The CNA stated that Resident #89 had behaviors mostly when women were around because he would try to impress them by getting aggressive, yelling, and being rough with staff. The CNA stated that Resident #89 had made threats to residents before, and that within the last week, Resident #89 made a cardboard gun, covered his face with a bandana, and went into Resident #78's room to tell the resident, if you don't be quiet, I'll teach you a lesson. The CNA stated that staff made efforts to get Resident #89 out of the room and calm him down, and that he would consider the incident a resident-to-resident abuse. The CNA also stated that the two nurses who were present at the time of the incident took charge of the situation and reported it to their supervisor. The CNA stated that the cardboard gun appeared to be a long handgun, and he was not sure where the cardboard gun went after the incident. An interview was conducted on January 26, 2026, at 3:50 p.m. with a Licensed Practical Nurse (LPN/Staff #17), who stated that reportable incidents would be considered any form of abuse or what you are seeing such as physical, emotional, and the poor treatment of residents, and that he would report incidents to the unit manager or the Director of Nursing (DON). The LPN stated that Resident #89 was a resident who would get aggressive with other residents, and that he would get upset with Resident #78 sometimes if he was loud.A telephonic interview was conducted on January 26, 2026, at 4:39 p.m. with an LPN, Staff #80, who stated that abuse incidents should have been recorded in the progress notes within the clinical record, and that the timeframe for reporting abuse was immediately to the designated person, the DON, or the administrator. The LPN stated that reportable abuse incidents could be physical, verbal, or resident-to-resident, and that she had a resident-to-resident emotional abuse incident on January 20, 2026, that she had to report. The LPN stated that the incident involved Resident #89 and Resident #78, and that Resident #89 entered Resident #78's room and was holding a pretend gun made out of cardboard. The LPN stated that she witnessed the entire event and that Resident #89 told Resident #78 that he would shoot him if he did not quiet down. The LPN stated she heard Resident #89 say, go to sleep, or I am going to shoot you, and that Resident #78 felt intimidated after the incident. The LPN stated that in the hours following the incident, Resident #78 got into his bed and did not want to do anything, which was not like him. The LPN stated that the cardboard gun was flat, and one side was colored with art supplies to look more realistic, to show a handle on the gun. The LPN stated that at one point, the gun fell from Resident #89's hands, and she picked it up to see it, but gave it back to him because she was scared of what he might do to her. The LPN further stated that she spoke with the LPN unit nurse manager (unit manager/Staff #56) to report the incident and asked her to take the cardboard gun from the resident. Staff #80 further (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that she protected Resident #78 for the rest of her shift by staying at his door because he was intimidated and very frightened. The LPN stated that she reported the incident to the unit manager, and the unit manager told her to write a statement about the incident on paper. The LPN stated that she did not know if the unit manager reported the incident further. A telephonic interview was attempted on January 26, 2026, at 4:50 p.m. with an LPN, Staff #23, with no success.An interview was conducted on January 26, 2026, at 4:57 p.m. with the Director of Nursing (DON/Staff #67), who stated that she expected that nursing staff document allegations of abuse in the clinical record in an incident report and progress note, and that the timeframe for reporting an allegation of abuse was two hours to all applicable state agencies, physicians, case managers, and family. The DON stated that she does the abuse coordination, investigating, and reporting for the facility, and that a resident-to-resident physical or verbal abuse would be considered a reportable abuse. The DON stated that she did not know anything about a recent abuse incident between Resident #89 and Resident #78, but she did know that Resident #89 had a bad weekend where he was verbally aggressive to staff. The DON stated that her process for investigating allegations of abuse was to interview staff and residents, look at the charting, and then report to the applicable state agencies. An interview was conducted on January 26, 2026, at 5:07 p.m. with the LPN unit nurse manager (unit manager/Staff #56), who stated that nursing staff were expected to document all progress notes, including abuse incidents or allegations. The LPN unit manager stated that the timeframe for reporting an allegation was immediately, but no longer than two hours, and that she would report abuse incidents or allegations to the DON. The LPN unit manager stated that she had not reported anything recently, but she found out just 5-10 minutes before the interview that Resident #89 was really bad, and that he made a cardboard gun and was playing with staff and Resident #78. The LPN unit manager stated that she had no idea who was involved, she did not recall the incident being reported to her, and that she would immediately let the DON know so she could investigate. The LPN unit manager stated that she did not investigate the incident with the cardboard gun.A follow-up telephonic interview was conducted on January 26, 2026, at 5:14 p.m. with the LPN, Staff #80, who stated that the unit manager she reported the abuse incident to was Staff #56, and that there was a camera pointing at the office where they discussed the incident. The LPN also stated that there was another woman present in the office when she reported the incident to the unit manager, but she could not recall the woman's identity. Review of a policy titled, Abuse Guidelines, had a review date of July 2022 and revealed that it was the responsibility of the employees, facility consultants, attending physicians, family members, and visitors to promptly report any incident or suspected incident of resident abuse to facility management. The policy defined abuse as being the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The policy also revealed that the facility would not condone resident abuse by anyone, including other residents, and all personnel were encouraged to report incidents of resident abuse or suspected incidents of abuse without fear of retaliation from the facility or its staff. The policy further revealed that employees, consultants, and physicians must immediately report any suspected abuse to the DON, and in their absence, reports may be made to the nurse supervisor on duty. The policy revealed that the administrator must be immediately notified of suspected abuse or incidents of abuse. The policy titled, Abuse Guidelines, also revealed that when an allegation or suspected case of mistreatment or abuse was reported, the administrator or his/her designee would immediately notify the state licensing agency, the local/state ombudsman, the resident representative, adult protective services, and the resident's physician. The policy further revealed that the notifications would need to include the name of the resident, the number (continued on next page)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure that an incident involving resident-to-resident abuse between two residents (#89 and #78) was reported. The deficient practice could result in continued abuse and physical or emotional harm to residents.-Regarding Resident #89Resident #89 was admitted on [DATE], with diagnoses that included mild neurocognitive disorder, major depressive disorder, iron deficiency anemia, adjustment disorder, chronic kidney disease, anemia, dysphagia, attention-deficit hyperactivity disorder, atherosclerotic heart disease, hypertension, and type 2 diabetes mellitus.A care plan focus initiated on May 29, 2024, revealed the resident having a behavior problem related to psychosis as evidenced by delusions, refusing care, being verbally aggressive/abusive, demanding, intrusive, wandering at times, and inappropriate sexual advances to females, with an intervention to intervene as necessary to protect the rights and safety of others.A care plan focus initiated on September 13, 2024, revealed the resident had shown behaviors of verbal aggression towards activity staff and other residents in group activities, with interventions to provide social visits to the resident throughout the week and offering independent leisure materials.A Quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS also revealed that the resident exhibited verbal behaviors for 4-6 days and other behavioral symptoms for 4-6 days. A behavior progress note dated December 15, 2025, at 8:01 p.m. revealed that the resident was sitting in the hallway when he noticed a peer by the nurses' station. The note also revealed that the resident yelled, Get away from there, you're just bothering them. You need to take your a** back to your room, and staff intervened by trying to redirect the resident. A behavior progress note dated December 19, 2025, at 5:28 p.m. revealed that the resident was observed becoming verbally aggressive and cursing profanities at another resident and activities staff at 3 p.m. The note further revealed that the resident was redirected and monitored during a smoke break, and 30 minutes later, the resident was yelling at another resident for clogging his toilet. The note also revealed that the resident was observed threatening to fight another resident and cursing, and he was redirected and de-escalated. A behavior progress note dated December 21, 2025, at 3:25 p.m. revealed that the resident was observed attempting to redirect one of his closest peers to his room and informed the peer he would assist with cleaning his toilet seat when Resident #89 put his hands on the outside of the peer's bilateral arms to redirect towards his room. The note revealed that the peer was not ready to leave the nurses' station, and so an argument ensued. The note further revealed that staff separated the residents. A behavior progress note dated January 11, 2026, at 10:09 p.m. revealed that the resident became upset when the nurse asked him what he said to the CNAs because it sounded like a threat, and he approached the nurse threateningly and menacingly while leaving verbal threats that they should not be approaching or talking to him at all or else he would f*** with them.A behavior progress note dated January 13, 2026, at 11:23 p.m. revealed that the resident was observed to be yelling and cursing at peers and threatening to put his hands on one peer, and the nurse was able to redirect and administer as-needed medication to aid with increased anxiety.There was no evidence of documentation completed in the resident's clinical record regarding the resident-to-resident incident on January 20, 2026. -Regarding Resident #78Resident #78 was admitted [DATE], with diagnoses that included vascular dementia, depression, chronic kidney disease, hypertension, cerebral infarction, chronic viral hepatitis C, pure hypercholesterolemia, chronic obstructive pulmonary disease, hyperlipidemia, aphasia, dysphagia, basal cell carcinoma, adjustment mood disorder, anxiety disorder, and dysphagia.A care plan focus (continued on next page)

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	035062	A. Building B. Wing	01/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Haven Care Center	2645 East Thomas Road Phoenix, AZ 85016

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(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	initiated on January 19, 2024, revealed the resident displayed behavioral symptoms related to dementia, including physical aggression like hitting, kicking, and pushing, verbal symptoms like yelling, cursing, and other threatening behaviors, as well as hallucinations, wandering, and refusal of care with interventions to give psychoactive medications as orders, record behavioral symptoms, and educate the resident on appropriate behaviors when on the patio with peers.A Quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment. The MDS also revealed that the resident exhibited verbal behaviors for 4-6 days. There was no evidence of documentation completed in the resident's clinical record regarding the resident-to-resident incident on January 20, 2026. A request was made for the facility's self-reports, grievances, and investigations for the last 4 months, and the facility documented that they had not reported any incidents or had any grievances in the last 4 months.Review of State Agency (SA) complaint database through the date of the survey revealed no evidence that the facility reported the resident-to-resident incident between Resident #89 and Resident #78 on January 20, 2026.An interview was conducted on January 26, 2026, at 3:27 p.m. with a Certified Nursing Assistant (CNA/Staff #34), who stated that Resident #89 was an aggressive resident who would try to intimidate people. The CNA stated that Resident #89 had made threats to residents before, and that within the last week, Resident #89 made a cardboard gun, covered his face with a bandana, and went into Resident #78's room to tell the resident, if you don't be quiet, I'll teach you a lesson. The CNA stated that he would consider the incident a resident-to-resident abuse and that it should have been reported. The CNA also stated that the two nurses who were present at the time of the incident took charge of the situation and reported it to their supervisor. An interview was conducted on January 26, 2026, at 3:50 p.m. with a Licensed Practical Nurse (LPN/Staff #17), who stated that reportable incidents would be considered any form of abuse or what you are seeing such as physical, emotional, and the poor treatment of residents, and that he would report incidents to the unit manager or the Director of Nursing (DON). The LPN stated that the timeframe for reporting an abuse incident or allegation would be immediate. A telephonic interview was conducted on January 26, 2026, at 4:39 p.m. with an LPN, Staff #80, who stated that abuse incidents should have been recorded in the progress notes within the clinical record, and that the timeframe for reporting abuse was immediately to the designated person, the DON, or the administrator. The LPN stated that reportable abuse incidents could be physical, verbal, or resident-to-resident, and that she recently had a resident-to-resident emotional abuse incident that she had to report. The LPN stated that the incident involved Resident #89 and Resident #78, and that Resident #89 entered Resident #78's room and was holding a pretend gun made out of cardboard. The LPN stated that she witnessed the entire event and that Resident #89 told Resident #78 that he would shoot him if he did not quiet down. The LPN stated she heard Resident #89 say go to sleep, or I am going to shoot you, and that Resident #78 felt intimidated after the incident. The LPN stated that in the hours following the incident, Resident #78 got into his bed and did not want to do anything, which was not like him. The LPN stated that at one point, the gun fell from Resident #89's hands, and she picked it up to see it, but gave it back to him because she was scared of what he might do to her. The LPN further stated that she spoke with the LPN unit nurse manager (unit manager/Staff #56) to report the incident and asked her to take the cardboard gun from the resident. The LPN stated that she reported the incident to the unit manager, and the unit manager told her to write a statement about the incident on paper. The LPN stated that she did not know if the unit manager reported the incident further. A telephonic interview was attempted on January 26, 2026, at 4:50 p.m. with an LPN, Staff #23, with no success.An interview was conducted on January 26, 2026, at 4:57 p.m. with (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Director of Nursing (DON/Staff #67), who stated that she expected that nursing staff document allegations of abuse in the clinical record in an incident report and progress note, and that the timeframe for reporting an allegation of abuse was two hours to all applicable state agencies, physicians, case managers, and family. The DON stated that she does the abuse coordination, investigating, and reporting for the facility, and that a resident-to-resident physical or verbal abuse would be considered a reportable abuse. The DON stated that she did not know anything about a recent abuse incident between Resident #89 and Resident #78, but she did know that Resident #89 had a bad weekend where he was verbally aggressive to staff. An interview was conducted on January 26, 2026, at 5:07 p.m. with the LPN unit nurse manager (unit manager/Staff #56), who stated that it was expected of nursing staff to document everything in the progress notes, including abuse incidents or allegations. The LPN unit manager stated that the timeframe for reporting an allegation was immediately, but no longer than two hours, and that she would report abuse incidents or allegations to the DON. The LPN unit manager stated that she had not reported anything recently, but she found out just 5-10 minutes before the interview that Resident #89 was really bad, and that he made a cardboard gun and was playing with staff and Resident #78. The LPN unit manager stated that she had no idea who was involved, she did not recall the incident being reported to her, and that she would immediately let the DON know so she could investigate. The LPN unit manager stated that she did not investigate or report the incident with the cardboard gun.A follow-up telephonic interview was conducted on January 26, 2026, at 5:14 p.m. with the LPN, Staff #80, who stated that the unit manager she reported the abuse incident to was Staff #56, and that there was a camera pointing at the office where they discussed the incident. The LPN also stated that there was another woman present in the office when she reported the incident to the unit manager, but she could not recall the woman's identity. Review of a policy titled, Abuse Guidelines, had a review date of July 2022 and revealed that it was the responsibility of the employees, facility consultants, attending physicians, family members, and visitors to promptly report any incident or suspected incident of resident abuse to facility management. The policy defined abuse as being the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The policy also revealed that the facility would not condone resident abuse by anyone, including other residents, and all personnel were encouraged to report incidents of resident abuse or suspected incidents of abuse without fear of retaliation from the facility or its staff. The policy further revealed that employees, consultants, and physicians must immediately report any suspected abuse to the DON, and in their absence, reports may be made to the nurse supervisor on duty. The policy revealed that the administrator must be immediately notified of suspected abuse or incidents of abuse. The policy titled, Abuse Guidelines, also revealed that when an allegation or suspected case of mistreatment or abuse was reported, the administrator or his/her designee would immediately notify the state licensing agency, the local/state ombudsman, the resident representative, adult protective services, and the resident's physician. The policy further revealed that the notifications would need to include the name of the resident, the number of the room the resident resided in, the type of abuse that was alleged, the date and time the incident occurred, the names of the persons involved, and what immediate action was taken by the facility. The policy further revealed that when an incident of resident abuse was suspected or confirmed, the incident must be immediately reported to facility management regardless of the time lapse since the incident occurred. The policy also revealed that failure to report an incident may result in legal or criminal action being filed against the individuals for withholding such information.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure that an incident involving resident-to-resident abuse between two residents (#89 and #78) was investigated. The deficient practice could result in continued abuse and physical or emotional harm to residents.Findings Include:-Regarding Resident #89:Resident #89 was admitted on [DATE], with diagnoses that included mild neurocognitive disorder, major depressive disorder, iron deficiency anemia, adjustment disorder, chronic kidney disease, anemia, dysphagia, attention-deficit hyperactivity disorder, atherosclerotic heart disease, hypertension, and type 2 diabetes mellitus.A care plan focus initiated on May 29, 2024, revealed the resident having a behavior problem related to psychosis as evidenced by delusions, refusing care, being verbally aggressive/abusive, demanding, intrusive, wandering at times, and inappropriate sexual advances to females, with an intervention to intervene as necessary to protect the rights and safety of others.A care plan focus initiated on September 13, 2024, revealed the resident had shown behaviors of verbal aggression towards activity staff and other residents in group activities, with interventions to provide social visits to the resident throughout the week and offering independent leisure materials.A Quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS also revealed that the resident exhibited verbal behaviors for 4-6 days and other behavioral symptoms for 4-6 days. A behavior progress note dated December 15, 2025, at 8:01 p.m. revealed that the resident was sitting in the hallway when he noticed a peer by the nurses' station. The note also revealed that the resident yelled, Get away from there, you're just bothering them. You need to take your a** back to your room, and staff intervened by trying to redirect the resident. A behavior progress note dated December 19, 2025, at 5:28 p.m. revealed that the resident was observed becoming verbally aggressive and cursing profanities at another resident and activities staff at 3 p.m. The note further revealed that the resident was redirected and monitored during a smoke break, and 30 minutes later, the resident was yelling at another resident for clogging his toilet. The note also revealed that the resident was observed threatening to fight another resident and cursing, and he was redirected and de-escalated. A behavior progress note dated December 21, 2025, at 3:25 p.m. revealed that the resident was observed attempting to redirect one of his closest peers to his room and informed the peer he would assist with cleaning his toilet seat when Resident #89 put his hands on the outside of the peer's bilateral arms to redirect towards his room. The note revealed that the peer was not ready to leave the nurses' station, and so an argument ensued. The note further revealed that staff separated the residents. A behavior progress note dated January 11, 2026, at 10:09 p.m. revealed that the resident became upset when the nurse asked him what he said to the CNAs because it sounded like a threat, and he approached the nurse threateningly and menacingly while leaving verbal threats that they should not be approaching or talking to him at all or else he would f*** with them.A behavior progress note dated January 13, 2026, at 11:23 p.m. revealed that the resident was observed to be yelling and cursing at peers and threatening to put his hands on one peer, and the nurse was able to redirect and administer as-needed medication to aid with increased anxiety.There was no evidence of documentation completed in the resident's clinical record regarding the resident-to-resident incident on January 20, 2026. -Regarding Resident #78Resident #78 was admitted [DATE], with diagnoses that included vascular dementia, depression, chronic kidney disease, hypertension, cerebral infarction, chronic viral hepatitis C, pure hypercholesterolemia, chronic obstructive pulmonary disease, hyperlipidemia, aphasia, dysphagia, basal cell carcinoma, adjustment mood disorder, anxiety disorder, and dysphagia.A care plan focus initiated on January 19, 2024, revealed the (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident displayed behavioral symptoms related to dementia, including physical aggression like hitting, kicking, and pushing, verbal symptoms like yelling, cursing, and other threatening behaviors, as well as hallucinations, wandering, and refusal of care with interventions to give psychoactive medications as orders, record behavioral symptoms, and educate the resident on appropriate behaviors when on the patio with peers.A Quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment. The MDS also revealed that the resident exhibited verbal behaviors for 4-6 days. There was no evidence of documentation completed in the resident's clinical record regarding the resident-to-resident incident on January 20, 2026. A request was made for the facility's self-reports, grievances, and investigations for the last 4 months, and the facility documented that they had not reported any incidents or had any grievances in the last 4 months. An interview was conducted on January 26, 2026, at 3:27 p.m. with a Certified Nursing Assistant (CNA/Staff #34), who stated that Resident #89 was an aggressive resident who would try to intimidate people. The CNA stated that Resident #89 had behaviors mostly when women were around because he would try to impress them by getting aggressive, yelling, and being rough with staff. The CNA stated that Resident #89 had made threats to residents before, and that within the last week, Resident #89 made a cardboard gun, covered his face with a bandana, and went into Resident #78's room to tell the resident, if you don't be quiet, I'll teach you a lesson. The CNA stated that staff made efforts to get Resident #89 out of the room and calm him down, and that he would consider the incident a resident-to-resident abuse. The CNA also stated that the two nurses who were present at the time of the incident took charge of the situation and reported it to their supervisor. An interview was conducted on January 26, 2026, at 3:50 p.m. with a Licensed Practical Nurse (LPN/Staff #17), who stated that reportable incidents would be considered any form of abuse or what you are seeing such as physical, emotional, and the poor treatment of residents, and that he would report incidents to the unit manager or the Director of Nursing (DON) for them to investigate. The LPN stated that Resident #89 was a resident who would get aggressive with other residents, and that he would get upset with Resident #78 sometimes if he was loud.A telephonic interview was conducted on January 26, 2026, at 4:39 p.m. with an LPN, Staff #80, who stated that abuse incidents should have been recorded in the progress notes within the clinical record, and that the timeframe for reporting abuse was immediately to the designated person, the DON, or the administrator for further investigation. The LPN stated that reportable abuse incidents that needed to be investigated could be physical, verbal, or resident-to-resident, and that she had a resident-to-resident emotional abuse incident on January 20, 2026, that she had to report. The LPN stated that the incident involved Resident #89 and Resident #78, and that Resident #89 entered Resident #78's room and was holding a pretend gun made out of cardboard. The LPN stated that she witnessed the entire event and that Resident #89 told Resident #78 that he would shoot him if he did not quiet down. The LPN stated she heard Resident #89 say, go to sleep, or I am going to shoot you, and that Resident #78 felt intimidated after the incident. The LPN further stated that she spoke with the LPN unit nurse manager (unit manager/Staff #56) to report the incident, and the unit manager told her to write a statement about the incident on paper. The LPN stated that she did not know if the unit manager reported the incident to the DON or management, or if it was investigated. A telephonic interview was attempted on January 26, 2026, at 4:50 p.m. with an LPN, Staff #23, with no success.An interview was conducted on January 26, 2026, at 4:57 p.m. with the Director of Nursing (DON/Staff #67), who stated that she was responsible for the abuse coordination, investigating, and reporting for the facility, and that a resident-to-resident physical or verbal abuse would be considered a reportable abuse. The DON stated that she did not know (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anything about a recent abuse incident between Resident #89 and Resident #78, but she did know that Resident #89 had a bad weekend where he was verbally aggressive to staff. The DON stated that her process for investigating allegations of abuse was to interview staff and residents, look at the charting, and then report to the applicable state agencies. An interview was conducted on January 26, 2026, at 5:07 p.m. with the LPN unit nurse manager (unit manager/Staff #56), who stated that she had not reported anything recently, but she found out just 5-10 minutes before the interview that Resident #89 was really bad, and that he made a cardboard gun and was playing with staff and Resident #78. The LPN unit manager stated that she had no idea who was involved, she did not recall the incident being reported to her, and that she would immediately let the DON know so she could investigate. The LPN unit manager stated that she did not investigate the incident with the cardboard gun.A follow-up telephonic interview was conducted on January 26, 2026, at 5:14 p.m. with the LPN, Staff #80, who stated that the unit manager she reported the abuse incident to was Staff #56, and that there was a camera pointing at the office where they discussed the incident. The LPN also stated that there was another woman present in the office when she reported the incident to the unit manager, but she could not recall the woman's identity. Review of a policy titled, Abuse Guidelines, had a review date of July 2022 and revealed that it was the responsibility of the employees, facility consultants, attending physicians, family members, and visitors to promptly report any incident or suspected incident of resident abuse to facility management. The policy defined abuse as being the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. The policy also revealed that the facility would not condone resident abuse by anyone, including other residents, and all personnel were encouraged to report incidents of resident abuse or suspected incidents of abuse without fear of retaliation from the facility or its staff. The policy further revealed that employees, consultants, and physicians must immediately report any suspected abuse to the DON, and in their absence, reports may be made to the nurse supervisor on duty. The policy revealed that the administrator must be immediately notified of suspected abuse or incidents of abuse. The policy titled, Abuse Guidelines, also revealed that when an allegation or suspected case of mistreatment or abuse was reported, the administrator or his/her designee would immediately notify the state licensing agency, the local/state ombudsman, the resident representative, adult protective services, and the resident's physician. The policy further revealed that the physician or licensed nurse would immediately need to examine the resident, record findings in the medical record, complete an unusual occurrence form with written statements from witnesses, and an immediate investigation would be made, and a copy of the investigation would be provided to the administrator.