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	03/02/2026

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 - 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, facility documentation, and review of facility policies and procedures, the facility failed to protect the rights of one (#5) of three sampled residents to be free from abuse by another resident (#19). This failure resulted in Resident #5 sustaining facial trauma, including bilateral nasal bone fractures and a laceration to the left ear after being repeatedly struck by Resident #19. The deficient practice could result in further abuse of residents.Findings include:-Resident #5 (alleged victim) was admitted to the facility on [DATE], with diagnoses including dementia with other behavioral disturbance, dementia in other diseases classified elsewhere with agitation, essential (primary) hypertension, major depressive disorder, recurrent severe without psychotic features, unsteadiness on feet, history of falling, weakness, brief psychotic disorder, and hearing loss.The quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident #5 had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. The assessment also included that Resident #5 exhibited verbal behavioral symptoms directed toward others and other behavioral symptoms not directed toward others for four to six days, but less than daily during the assessment period.The care plan revised on December 12, 2025 revealed the resident had behavior problems as evidenced by placing himself on the floor, banging his head, yelling, paranoid thoughts, refusing care, verbal and physical aggression, refusing medications, being territorial over his table in the dining room, and making false accusations. Interventions included anticipating his care needs and providing care before Resident #5 became overly stressed, and implementing interventions as needed to protect the rights and safety of others.The psychiatric reevaluation assessment dated [DATE], revealed that Resident #5 displayed relative stability on his current treatment regimen for management of neurocognitive impairment with behavioral disturbances and depression. The provider documented that no medication changes were indicated and recommended adherence to care planned therapeutic interventions in response to episodes of distress and behavioral disturbance.A health status note dated February 11, 2026 included the nurse heard a CNA (Certified Nursing Assistant) scream in the dining room; and that, the resident was found sitting in his wheelchair with blood dripping from his nose, blood coming out of his left ear and a hematoma to the side of his left eyebrow. The documentation also included that the resident had his hearing aids in his hand and there was blood on the surrounding area of his wheelchair. Per the documentation, the provider was notified and the resident was transported to the hospital.The Situation, Background, Assessment, and Recommendation (SBAR) progress note dated February 11, 2026 included that at approximately 3:59 p.m., the registered nurse (RN/Staff #26) heard a CNA yelling in the dining room. Per the documentation the RN ran to the dining room and found Resident #5 sitting in his wheelchair with blood dripping from his nose; and, there was blood present on the floor surrounding the wheelchair. The documentation included that Resident #5 was holding his hearing aids in his hand, there was blood was coming from his left ear and a hematoma to the left eyebrow area. According to the documentation, first aid was administered but the RN was unable to obtain vital signs due to Resident #5's combativeness; and that, the provider was notified and Resident #5 was transferred to (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 0600 Level of Harm - Actual harm Residents Affected - Few	the hospital by ambulance at approximately 4:30 p.m.Review of hospital discharge documentation dated February 11, 2026, revealed that Resident #5 was admitted to the emergency department at 4:47 p.m. for facial trauma; and had computed tomography (CT) imaging and treatment for a 1.5 cm laceration to the left ear. Per the documentation, CT imaging revealed mildly displaced bilateral nasal bone fractures; and that, suture repair was performed to the left ear. A health status note dated February 12, 2026 revealed resident returned to the facility and was noted to have a swollen nose and one stitch to his left ear.Another health status note dated February 12, 2026 revealed the resident visible bruising surrounding nose and left eye related to a recent altercation.A health status note dated February 13, 2026 included that Resident #5 had two black eyes from prior attack by fellow peer, repeatedly made mention of him getting into a fight with a peer and reported that his hearing aids were damaged by his attacker. Review of weekly skin observation assessments dated February 16 and 23, 2026 included bruising and discoloration remained present to the nose and eye area related to the recent incident.-Resident #19 (alleged perpetrator) was admitted to the facility on [DATE], with diagnoses including schizophrenia, mild neurocognitive disorder due to a known physiological condition with behavioral disturbance, psychoactive substance use disorder, anxiety disorder, insomnia, suicidal ideations, homicidal ideations, schizoaffective disorder bipolar type, and drug-induced subacute dyskinesia.The care plan revealed a focus initiated December 10, 2025, for behavioral problems as evidenced by self-isolation, aggression, and a history of suicidal and homicidal ideation. Interventions included intervening as needed to protect the rights and safety of others, approaching the resident in a calm manner, diverting attention, and removing the resident from situations and taking him to another location as needed.The admission MDS assessment dated [DATE], revealed that Resident #19 had a BIMS score of 15, indicating the resident was cognitively intact. The MDS also included that Resident #19 exhibited other behavioral symptoms not directed toward others one to three days during the assessment period.Review of a psychiatry assessment dated [DATE], revealed additional diagnoses of mild neurocognitive disorder due to a known physiological condition with behavioral disturbance and psychoactive substance use disorder. Recommendations included maintaining firm boundaries regarding appropriate and acceptable communication and behavior between patients and staff and consideration of a two-person assist for safety and accountability. No medication changes were recommended.The care plan dated January 14, 2026 revealed the resident had impaired thought processes related to schizoaffective disorder. Intervention included cuing, reorienting and supervising the resident as needed.A behavioral progress note dated February 11, 2026, indicates that at approximately 4:00 p.m., Resident #19 passed by the nurse's station and asked to speak with the unit manager. and he was informed that the unit manager had already left for the day. The documentation included that staff asked if he needed anything, and Resident #19 stated that he was fine and did not need assistance. Further, the documentation revealed Resident #19 then walked into the dining room; and, shortly afterward, a physical altercation was heard, and the CNA (Staff #96) separated the two residents. Per the documentation, Resident #19 was redirected to the hallway to calm down and discuss the incident, and was later escorted to his room.A behavior note dated February 12, 2026 included that at approximately 10:00 p.m. on February 11, 2026, Resident #19 had stated that he wanted to leave the facility; and, at 1:37 a.m. on February 12, 2026, Resident #19 broke a door and left the facility. The documentation included that the guardian was notified and guardian told facility to call the police and have Resident #19 arrested for earlier assault on another resident. The documentation included police arrived at the facility shortly after Resident #19 broke out. Another behavior note dated February 12, 2026 included that resident was presented with risk and benefits of leaving the facility AMA (against medical advice) but the resident refused to sign it. The facility follow-up report dated February 16, 2026 included that the incident was witnessed by one CNA who reported that Resident #19 walked over to Resident #5 and asked Resident #5 a question. Per the documentation, Resident #5 was hard of hearing and responded what; and that, Resident #19 then started hitting Resident #5. It also included that Resident #19 could not (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	remember what happened; and, the police refused to arrest Resident #19 due to cognitive disability. The facility investigation concluded that the allegation was verified by evidence collected during their investigation. Interviews were conducted on March 2, 2026, regarding the February 11, 2026 incident:During a telephone interview a registered nurse (RN/staff #26) conducted on March 2, 2026 at 10:39 a.m. the RN stated that on February 11, 2026, she was the nurse assigned to Resident #5; and, at approximately 4:00 p.m., she was called to the dining room by two CNAs (Staff #96 and Staff #37). She stated that when she got in the dining room, the two residents had already been separated, and she provided first aid to Resident #5. The RN said that Resident #5 was bleeding from the ear and was subsequently transferred to the hospital; and that, Resident #5 did not return to the facility prior to her leaving her shift at 6:15 p.m.An interview with Resident #5 was conducted on March 2, 2026 at 11:03 a.m. Resident #5 stated that he had recently been beat up by another resident; but, he could not recall the specific day, time, or the name of the other resident. Resident #5 stated that he had spoken with the police about the incident and told the police that he wanted to pursue criminal charges against the resident who hit him. Resident #5 stated that he worried about being assaulted again at the facility but was grateful that he was able to receive treatment at the hospital and that the police arrested the other resident.An interview with another RN (staff #31) was conducted on March 2, 2026 at 11:14 a.m. The RN (Staff #31) stated that on February 11, 2026, she was the nurse assigned to Resident #19 who had not exhibited any behaviors earlier in the day prior to the incident. The RN said that at approximately 4:00 p.m., while she was working at the medication cart, Resident #19 approached her asking to speak with the unit manager regarding paperwork he believed the manager was holding. The RN informed him that the unit manager had left for the day and asked if he needed assistance The RN said that Resident #19 responded he did not and then walked into the dining room. The RN said that shortly thereafter, she heard a commotion and when she arrived the residents (#19 and #5) had already been separated by the CNAs (Staffs #37 and #96). The RN stated that Resident #19 was speaking aggressively and accused Resident #5 of holding his paperwork. Further, the RN said that after Resident #5 was transported to the hospital, police arrived at approximately 5:30 p.m. to speak with Resident #19 and staff.In an interview with a CNA (staff #37) conducted on March 2, 2026 at 11:21 a.m., The CNA stated that on February 11, 2026, at approximately 4:00 p.m., she was in the dining room and saw Resident #19 walk in calmly. She stated that Resident #19 approached Resident #5 and asked him for a blue folder; and that, resident #5 responded and told Resident #19 that he did not have the folder. The CNA said that Resident #19 then became agitated and struck Resident #5 with a closed fist; and that, she and another CNA (Staff #96) ran to separate the residents. The CNA further stated that due to the size and strength of Resident #19, it required significant effort to separate them, and Resident #19 was able to strike Resident #5 several additional times before both residents were separated.A telephone interview with another CNA (staff #96) was conducted on March 2, 2026 at 11:32 a.m. The CNA (staff #96) stated that on February 11, 2026, at approximately 4:00 p.m., he was in the dining room while Resident #5 was seated watching television. He stated that Resident #19 walked into the room and initially did not appear agitated; and, Resident #19 approached Resident #5 and began discussing a blue folder. The CNA said that the conversation quickly became confrontational and that he stood up to intervene; and that, as he stood up, he saw Resident #19 strike Resident #5 with a closed fist. The CNA said that Resident #19 struck Resident #5 approximately five times before staff were able to fully separate the residents. The CNA further stated that he continued to monitor Resident #19 for the remainder of his shift, which ended at approximately 10:00 p.m.During an interview with the Director of Nursing (DON/Staff #10) conducted on March 2, 2026 at 12:37 p.m., the DON stated that the incident between Resident #5 and Resident #19 that occurred on February 11, 2026, met the definition of physical abuse. She stated that this incident did not meet the expectations of the facility; and that, when physical abuse occurs, residents were at risk for both physical injuries and psychosocial harm. The DON further stated that Resident #19 had already left the facility before Resident #5 returned from the hospital and that Resident #5's (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	care and needs had been closely monitored since the incident.Review of the facility policy titled Abuse Guidelines, reviewed February 3, 2026, revealed that abuse was defined as the willful infliction of injury resulting in physical harm, pain, or mental anguish. The policy further stated that the facility would assess residents exhibiting signs and symptoms of behavioral problems and develop and implement care plans to address behavioral issues. The policy included that they will not condone resident abuse by anyone, including staff members, physician, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardian, sponsors, other residents, friends and other individuals.