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	05/01/2026

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, facility documentation, and review of facility policies and procedures, the facility failed to protect the rights of one (#16) of three sampled residents to be free from physical abuse by another resident (#22). The deficient practice could result in further abuse of residents.Findings include:-Regarding Resident #16:Resident #16 was admitted to the facility on [DATE] with diagnoses including unspecified dementia with other behavioral disturbance, anxiety disorder, delusional disorder, reduced mobility, weakness, homicidal ideations, personal history of traumatic brain injury, drug-induced subacute dyskinesia, and depression.The care plan for Resident #16 revealed a focus initiated on June 26, 2025, for a behavior problem related to physical aggression, hallucinations, and intrusive behaviors. Interventions included to protect the rights and safety of others, diverting attention, and removal of Resident #16 from situations and taking him to another location as needed.The Quarterly Minimum Data Set (MDS), dated [DATE], revealed that Resident #16 had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. The assessment further revealed that Resident #16 exhibited physical and verbal behaviors directed toward others for 1 to 3 days during the assessment period.An incident progress note dated April 15, 2026, revealed Resident #16 was attending an activity that afternoon and attempted to intervene during a verbal disagreement between two residents. The note revealed that one of the arguing residents, who was in a wheelchair, stood up, approached Resident #16, and struck resident #16 in the head, neck, and arms with the resident's prosthetic hand and arm. No injuries were noted; however, Resident #16 complained of minor pain all over. The note further revealed Resident #16 declined to go to the hospital for evaluation.Review of a skin assessment for Resident #16, dated April 15, 2026, revealed no visible injuries.A Situation, Background, Assessment, and Recommendation (SBAR) report for Resident #16, dated April 15, 2026, revealed that an altercation with Resident #22 occurred while Resident #22 was in the activity room. The SBAR report further revealed that Resident #16 reported that he heard Resident #22 yelling, stood up, and attempted to approach him before Resident #22 turned toward him and attempted to hit him, swinging his arm. The SBAR form also revealed that resident #16 stated that he raised his hands to cover his head.A behavior progress note dated April 16, 2026, revealed that Resident #16 told staff that the previous day Resident #22 was swinging at him, and Resident #16 put his hands in the air to protect himself, not to hit Resident #22. The note further revealed that resident #16 was again assessed to have no skin injuries and was observed pacing the hallways.-Regarding Resident #22:Resident #22 was admitted to the facility on [DATE], with diagnoses including post-traumatic stress disorder, chronic stimulant abuse, acquired absence of the right upper limb below the elbow, complete traumatic amputation of the right shoulder and upper arm, complete traumatic metacarpophalangeal amputation of the left thumb, complete traumatic metacarpophalangeal amputation of an unspecified finger, skin transplant, other specified mental disorders due to a known physiological condition, and bipolar disorder.Resident #22's care plan revealed a focus initiated May 21, 2025, for displays of socially inappropriate and manipulative behaviors as evidenced by physical aggression and self-isolation. Interventions included if Resident (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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(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	#22 displays harmful behaviors, approach in a calm manner, divert attention, and take the resident to another location as needed.Resident #22's most recent completed quarterly MDS, dated [DATE], revealed that Resident #22 had a BIMS score of 15, indicating that Resident #22 was cognitively intact. The assessment further revealed that Resident #22 exhibited verbal behaviors directed toward others for 1 to 3 days during the assessment period.A health status progress note dated April 15, 2026, revealed that at approximately 2:00 p.m., Resident #22 was verbally and physically aggressive, threw a pitcher of water and other items, and during activities, punched another resident multiple times, according to staff. The police were called, and the other resident wanted to press charges. Resident #22 was escorted out of the facility by police at 2:54 p.m. As Resident #22 was being escorted from the facility by police, he was observed to be verbally threatening and using profanity.Review of the clinical record for Resident #22 revealed an admission summary progress note dated April 24, 2026. This note indicated that Resident #22 was readmitted to the facility.Review of the facility's 5-day investigation report indicated that the facility interviewed residents and staff and concluded that it was uncertain whether Resident #22 made contact with Resident #16. The facility investigation did not verify the abuse allegation.An interview was conducted on May 1, 2026, at 10:20 a.m., with Resident #16, who stated that he was recently in a physical altercation with Resident #22. He stated that on the day of the incident, he heard Resident #22 speaking loudly, and Resident #22 approached him and hit him in the right temple.An interview was conducted on May 1, 2026, at 10:43 a.m., with a licensed practical nurse (LPN/Staff #85) who stated that he was on duty on April 15, 2026, observed Resident #22 exhibiting verbal behaviors, and made several attempts to de-escalate the situation. Staff #85 stated he did not witness the altercation during activities, but heard yelling coming from the activity room and rushed over to assist. Staff #85 further noted that he called 911, and police interviewed both residents and arrested Resident #22.An interview was conducted on May 1, 2026, at 10:58 a.m., with the activities assistant (Staff #104), who stated that on April 15, 2026, he was assisting with activities and passing out snacks to residents. He stated that Resident #22 came into the room and appeared upset. He observed Resident #22 charge toward Resident #16 and begin taking swings, making contact with Resident #16. During the incident, Staff #104 stated that Resident #22's prosthetic arm fell off. Staff #104 noted that staff rushed into the room to assist with separating the residents.An interview was conducted on May 1, 2026, at 12:25 p.m., with Resident #22, who stated that Resident #16 often provokes him and that both residents regularly exchange tense words and gestures. Resident #22 stated that on April 15, 2026, he approached and slapped Resident #16 during activities.An interview was conducted on May 1, 2026, at 12:33 p.m., with the Director of Nursing (DON/Staff #79), who stated that abuse would be defined as unwanted contact, such as hitting or slapping a resident, and would fail to meet expectations for the facility. Staff #79 stated that the incident between Resident #16 and Resident #22 on April 15, 2026, failed to meet expectations and placed residents at risk for injury or psychosocial harm.Review of the facility policy titled Abuse Guidelines, with a review date of 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 revealed that the facility would assess residents exhibiting signs and symptoms of behavioral problems and develop and implement care plans to address behavioral issues.