

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035094	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/18/2025
NAME OF PROVIDER OR SUPPLIER  Haven of Sedona		STREET ADDRESS, CITY, STATE, ZIP CODE  505 Jacks Canyon Road Sedona, AZ 86351	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, review of records, and review of facility policy and procedure, the facility failed to ensure a resident (#10) was not abused by another resident (#15). The deficient practice could lead to psychosocial or physical harm of a resident.</p> <p>-Regarding Resident #10 (alleged victim):</p> <p>Resident #10 was admitted to the facility June 5, 2025, with diagnoses that included alcoholic cirrhosis of liver, hepatic encephalopathy, type 2 diabetes mellitus, portal hypertension, acidosis, hypertension, unspecified head injury, and alcohol dependence.</p> <p>An admission minimum data set (MDS) assessment was still in progress.</p> <p>An Alert Note dated June 15, 2025, revealed a therapist came to the nurse after Resident #10 reported another resident hit her while having lunch in the bistro area on the rehab unit. This writer separated both residents, and ensured everyone was safe. Resident #10 reported being hit in the arm, and having a fork and knife thrown at her, and reports being okay. The nurse observed the area of the arm with no skin issues noted, and no reports of pain or discomfort. The incident was reported to the administrator.</p> <p>-Regarding Resident #15 (alleged perpetrator):</p> <p>Resident #15 was admitted to the facility May 13, 2025, with diagnoses that included displaced intertrochanteric fracture of right femur, chronic obstructive pulmonary disease, atherosclerotic heart disease, left bundle-branch block, anemia, and other reduced mobility.</p> <p>An admission MDS assessment dated [DATE], revealed the resident had a brief interview for mental status (BIMS) score of 3, indicating severe cognitive impairment.</p> <p>A care plan dated May 22, 2025, revealed Resident #15 had impaired cognitive function/dementia or impaired thought processes due to dementia, and impaired decision-making, with interventions to administer medications as ordered and communicate with the resident and family / caregivers regarding the resident's capabilities and needs. There was no evidence in the care plan regarding behaviors.</p> <p>Further review of the care plan revealed no evidence of revised interventions related to behaviors regarding other residents.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Daily Skilled assessment dated [DATE], revealed Resident #15 was alert with confusion to place, time, and situation. The assessment indicated No behavior issues noted. No change of condition was noted today, and there was no evidence of additional notes or follow-up regarding the interaction with Resident #10.</p> <p>Review of Resident #15's clinical record revealed no evidence of a description of a resident-to-resident incident on June 15, 2025 or that the provider and family had been notified.</p> <p>An interview was conducted on June 18, 2025, at 9:17 AM, with Resident #10, who stated that on June 15, 2025, Resident #15 kept her meal tray at another table and kept coming over to Resident #10 and Resident #20 who were eating at a separate table. Resident #10 stated that Resident #15 just kept coming over, and saying I want to go home, and Resident #10 kept saying to her you need to eat to get your strength that way you can go home. Resident #10 stated that Resident #15 kept poking Resident #20, and then stated what's wrong with you? and why are you talking to me that way? Resident #10 stated that Resident #15 just got worse. Resident #10 stated that she got up and pushed Resident #15 in her wheelchair over to the table where Resident #15's meal tray was, and Resident #15 turned around really quickly and took an open hand and hit Resident #10's right arm, and that she did it out of her anger. Resident #10 stated that Resident #15 then came back to the table and said something like I'm going to get you. Resident #10 stated that she has post traumatic stress disorder because she was abused in her past, and that this situation made her feel triggered. Resident #10 stated that she then went to the nurses' station and asked the only staff there, who was a therapist, to move Resident #15 away. Resident #10 stated that she was shaken up, and additionally, that as she was sitting at the table, Resident #15 came back to her table and threw her butter knife and fork at the plate right in front of Resident #10. Resident #10 stated that she does not feel at peace because of this incident, and that she would feel better if Resident #15 stayed in a different part of the building.</p> <p>An interview was conducted with an Occupational Therapist (OT / Staff #41) on June 18, 2025, at 9:50 AM. Staff #41 stated that on Sunday, June 15, 2025, she went to the nurses' station to get records and make copies, when Resident #10 approached her and said she hit me and pointed to Resident #15. Staff #41 stated that she observed the situation, and saw that there was nobody in any immediate danger, and Resident #15 was in her wheelchair, wheeling out of the room. Staff #41 stated that she saw that Resident #10 was safely removed from the alleged perpetrator, approximately 50 feet apart, and then the nurse (Staff #80) came onto the unit and Staff #41 relayed the incident to her.</p> <p>A telephonic interview with a Licensed Practical Nurse (LPN / Staff #80) was attempted on June 18, 2025, at 10:04 AM. A voicemail was left for a return call. The staff did not return the phone call.</p> <p>A telephonic interview was conducted with the facility Administrator (Staff #62) on June 18, 2025, at 10:09 AM. The Administrator stated that she was still in the process of conducting the investigation into the incident between Resident #10 and Resident #15, and had conducted interviews, but that the Administrator was not comfortable with handing anything over to the State Agency at this point, and that she will submit the interviews with the facility 5-day report.</p> <p>A telephonic interview was conducted with a Certified Nursing Assistant (CNA / Staff #25) on June 18, 2025, at 10:11 AM, who stated that he was working in the facility on June 15, 2025, when the altercation between Resident #10 and Resident #15 had occurred. Staff #25 stated that after the altercation, Resident #15 was separated from Resident #10 and was moved to another unit, and at the end of the day, Resident #15 was returned to her original unit.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on June 15, 2025, at 10:17 AM with Resident #20, who stated on June 15, 2025, he was eating with Resident #10 in the dining area, and Resident #15 kept coming over to the table and bothering Resident #10. Resident #20 stated that Resident #10 took Resident #15 back to her table, and then he saw Resident #15 hit Resident #10 in the forearm and tried to hit Resident #10 with the fork and knife. Resident #20 stated that there was one staff behind the nurses' station and that we told her about the incident, and that Resident #20 left the area after that. Resident #20 stated that because of that incident, he does not want to eat in the dining area, that he wants to eat meals in his room and keeps to himself after that.</p> <p>An interview was conducted with the Director of Nursing (DON / Staff #51) on June 18, 2025, at 10:37 AM. The DON stated that she was told by staff that Resident #10 and Resident #15 were in the bistro area eating, and Resident #15 was having dementia-related behaviors and this was bothering Resident #10. Resident #10 told Resident #15 to go eat her food, and then Resident #15 hit Resident #10 in the arm and threw her silverware. The residents were separated, and Resident #15 was moved to another unit for the rest of the day. The DON stated that the residents were assessed and there were no signs of injury. The DON stated there was no doubt that the situation occurred, but that she would not call this incident abuse because Resident #15 is not aware of what she is doing. The DON also stated that the intention of hurting someone is not a requirement for the definition of abuse. The DON stated that the facility defines abuse as an infliction of injury with resulting physical pain or mental anguish, and that examples of abuse include hitting and kicking.</p> <p>Review of the facility policy titled Resident Rights/Dignity: Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated January 1, 2024, revealed residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: protect residents from abuse, neglect, exploitation or misappropriation of property by anyone, identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property, investigate and report any allegations within timeframes required by federal requirements, protect residents from any further harm during investigations.</p>		