

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  08/05/2025
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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, facility documentation, staff interviews, and policy review, the facility failed to ensure an allegation of abuse for one resident (#5) was thoroughly investigated. The deficient practice could result in the appropriate State Agencies not being notified and allegations of abuse not being thoroughly investigated. Findings include: Findings include: Resident # 5 was admitted to the facility on [DATE], with diagnoses of polyneuritis, protein-calorie malnutrition, adjustment disorder, and insomnia. A comprehensive care plan dated February 7, 2025, revealed that Resident # 5 had behavioral problems due to recent admission including, refusal of care and being verbally abusive to staff. Interventions included all personal care and interactions done in pairs. Review of the Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicates Resident # 5 is cognitively intact. Review of an email dated July 29, 2025, from Resident # 5 sent to Executive Director (ED/Staff # 3) and Resident Relations Manager (Staff # 9), revealed that an interaction with Licensed Practical Nurse (LPN/ Staff # 67) was manipulative. Resident # 5 additionally described the interaction as intimidation and a covert threat disguised as an apology. Review of the Facility Concern Log dated July 29, 2025, revealed a concern raised by Resident # 5 who was upset about a conversation she had with LPN # 67. No resolution date to this concern was given. An interview was conducted with Resident # 5 on August 4, 2025 at 3:00 p.m., revealed that Resident # 5 had made multiple complaints to the Facility regarding LPN # 67. She reported that she was not getting a response so she had sent an email to the corporate office. Resident # 5 stated that on July 29, 2025 LPN # 67 entered her room alone to apologize for the negative feedback, but went on to say he supports a stay-at-home wife and two children and depends on the job and does not want anyone getting him in trouble. Resident # 5 revealed she felt intimidated by the conversation and immediately emailed ED Staff # 3 and Staff # 9 along with the corporate office. Resident # 5 confirmed she felt it was abuse. Resident # 5 also revealed that after she reported the conversation with LPN # 67 she continued to see him in the facility and was concerned with her safety. Resident # 5 also revealed that she secretly recorded the conversation and sent it to the Facility attached to the email. An interview was conducted with a Certified Nurse Assistant (CNA/staff # 57) at 9:27 a.m., who stated that she felt that she worked well with Resident # 5. The CNA stated that Resident # 5 was crying and having a hard day and that she was able to console her but the resident would not tell her what was wrong. The stated that Resident # 5 told her about the concerns with LPN # 67 and that Resident # 5 had reported concerns to the Executive Director (ED Staff # 3) and reported to the State Agency. An interview conducted with a Licensed Practical Nurse (LPN/staff # 67) on August 5, 2025 at 9:39 a.m., who stated that he was aware that Resident # 5 had filed complaints about him regarding taking care of a roommate, sleeping on the job while taking a break, and long wait times. The LPN revealed that Resident # 5 did complain a lot regarding staff care, and that he did go to apologize to Resident # 5 on July 29, 2025. The LPN further revealed that he had a family and needs this job so that is why he apologized. The LPN denied any attempt at intimidation with regards to his apology, but was upset with the fact Resident # 5 had secretly recorded the conversation. An interview conducted with Resident Relations (staff # 9) on August 5, 2025 at 9:55 a.m., who stated that Resident # 5 came to her regarding several complaints regarding roommates that she did not like and other issues with residents. Staff # 9 reported that Resident # 5 informed her that Resident # 5 had a recording of malicious conversation with LPN (staff # 67). Staff # 9 reported that this conversation was also given to the Executive Director ( ED/staff # 3), and the ED addressed Resident # 5's concerns. Staff # 9 revealed that Resident # 5 requested a transfer from the facility on July 29th, 2025, and due to Resident #5's insurance local facilities do not have the availability. Staff # 9 stated that Resident # 5 refused to go away from the area and decided to stay at the facility. During an interview conducted with the Executive Director (ED/staff # 3) on August 5, 2025 at 10:38 a.m., who stated that if a resident claims abuse the Facility will first make sure the resident is safe then report to the appropriate agencies, start the investigation, and if the alleged abuse involves a staff member that staff member is suspended until the conclusion of the investigation. The ED stated that Resident # 5 sent an email on July 29, 2025 stating that she was unhappy with the conversation she had with LPN # 67. The ED stated that Resident # 5 did not claim abuse, however review of the revealed Resident # 5 described the incident as intimidation and a covert threat. The ED also revealed that an investigation of the incident on July 29, 2025 was not conducted because the ED believed there was nothing to investigate because she had the</p>		

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

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> The facility failed to ensure an allegation of resident (#5) abuse was reported to all applicable state agencies. Based on clinical record review, facility documentation, staff interviews, and policy review, the facility failed to ensure an allegation of resident (#5) abuse was reported to all applicable state agencies. The deficient practice could result in further allegations of abuse not being reported and investigated by the appropriate state agencies. Findings include: Resident # 5 was admitted to the facility on [DATE], with diagnoses of polyneuritis, protein-calorie malnutrition, adjustment disorder, and insomnia. A comprehensive care plan dated February 7, 2025, revealed that Resident # 5 had behavioral problems due to recent admission including, refusal of care and being verbally abusive to staff. Interventions included all personal care and interactions done in pairs. Review of the Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicates Resident # 5 is cognitively intact. Review of an email dated July 29, 2025, from Resident # 5 sent to Executive Director (ED/Staff # 3) and Resident Relations Manager (Staff # 9), revealed that an interaction with Licensed Practical Nurse (LPN/ Staff # 67) was manipulative. Resident # 5 additionally described the interaction as intimidation and a covert threat disguised as an apology. Review of the Facility Concern Log dated July 29, 2025, revealed a concern raised by Resident # 5 who was upset about a conversation she had with LPN # 67. No resolution date to this concern was given. An interview was conducted with Resident # 5 on August 4, 2025 at 3:00 p.m., who stated that she made multiple complaints to the Facility regarding LPN # 67. She stated that she was not getting a response, so she sent an email to the corporate office. Resident # 5 stated that on July 29, 2025 LPN # 67 entered her room alone to apologize for the negative feedback, but went on to say he supports a stay-at-home wife and two children and depends on the job, and did not want anyone getting him in trouble. Resident # 5 revealed she felt intimidated by the conversation and immediately emailed the ED (staff # 3) and the Resident Relations Manager (staff # 9) along with the corporate office. Resident # 5 stated that she felt it was abuse. The resident also stated that after she reported the conversation with LPN (staff # 67), she continued to see him in the facility and was concerned with her safety. Resident # 5 also revealed that she secretly recorded the conversation and sent it to the facility attached to the email. An interview was conducted with a Certified Nurse Assistant (CNA/ Staff # 57) at 9:27 a.m., who that she felt that she worked well with Resident # 5. The CNA revealed that Resident # 5 was crying and having a hard day and that she was able to console her but the resident would not tell her what was wrong. The CNA further stated that the resident told her about the concerns with the LPN (staff #67), and that Resident # 5 had reported her concerns to the ED (staff # 3), and to the State Agency. An interview conducted with LPN # 67 on August 5, 2025 at 9:39 a.m., revealed that he was aware that Resident # 5 had filed complaints about him regarding taking care of a roommate, sleeping on the job while taking a break, and long wait times. LPN # 67 revealed that Resident # 5 did complain a lot regarding staff care. LPN # 67 revealed that he did go to apologize to Resident # 5 on July 29, 2025 alone. LPN # 67 revealed that he had a family and needs this job so that is why he apologized. LPN # 67 denied any attempt at intimidation with regards to his apology, but was upset with the fact Resident # 5 had secretly recorded the conversation. An interview conducted with Staff # 9 on August 5, 2025 at 9:55 a.m. revealed that Resident # 5 had come to her regarding several complaints with roommates that she did not like and other issues with residents. Staff # 9 reported that Resident # 5 had informed her that Resident # 5 had a recording of malicious conversation with LPN # 67. Staff # 9 reported that this conversation was also given to ED Staff # 3, and the ED was addressing Resident # 5's concerns. Staff # 9 revealed that Resident # 5 requested a transfer from the facility on July 29th, 2025, and Staff # 9 had been working on however due to her insurance local facilities do not have the availability. Staff # 9 stated that Resident # 5 refused to go away from the area and decided to stay at the facility. During an interview conducted with the ED Staff # 3 on August 5, 2025 at 10:38 a.m., it was revealed that if resident claims abuse the Facility will first make sure the resident is safe then report to the appropriate agencies, start the investigation, and if the alleged abuse involves a staff member that staff member is suspended until the conclusion of the investigation. ED Staff # 3 revealed that Resident # 5 sent an email on July 29, 2025 unhappy with the conversation with LPN # 67. ED Staff # 3 revealed that Resident # 5 did not claim abuse however review of the email it was revealed Resident # 5 described the incident as intimidation and a covert threat. ED Staff # 3 also revealed that an investigation of the incident on July 29, 2025 was not conducted.</p>		

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F 0610  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Respond appropriately to all alleged violations.  (continued on next page)

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> The facility failed to ensure an allegation of resident (#5) abuse was investigated. Based on clinical record review, facility documentation, staff interviews, and policy review, the facility failed to ensure an allegation of resident (#5) abuse was investigated. The deficient practice could result in residents being abused. Findings include: Resident # 5 was admitted to the facility on [DATE], with diagnoses of polyneuritis, protein-calorie malnutrition, adjustment disorder, and insomnia. A comprehensive care plan dated February 7, 2025, revealed that Resident # 5 had behavioral problems due to recent admission including, refusal of care and being verbally abusive to staff. Interventions included all personal care and interactions done in pairs. 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CNA # 57 revealed that Resident # 5 was crying and having a hard day and that she was able to console Resident #5 but Resident # 5 would not tell her what was wrong. CNA # 57 revealed that Resident # 5 had told her about the concerns with LPN # 67 and that Resident # 5 had reported concerns to ED Staff # 3 and reported to the State Agency. An interview conducted with LPN # 67 on August 5, 2025 at 9:39 a.m., revealed that he was aware that Resident # 5 had filed complaints about him regarding taking care of a roommate, sleeping on the job while taking a break, and long wait times. LPN # 67 revealed that Resident # 5 did complain a lot regarding staff care. LPN # 67 revealed that he did go to apologize to Resident # 5 on July 29, 2025 alone. LPN # 67 revealed that he had a family and needs this job so that is why he apologized. LPN # 67 denied any attempt at intimidation with regards to his apology, but was upset with the fact Resident # 5 had secretly recorded the conversation. 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