| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035094 | A. Building<br>B. Wing | 08/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Haven of Sedona | 505 Jacks Canyon Road<br>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) |
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| F 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.<br><br>(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 0559<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **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 (#11) was given an advance notice prior to a roommate change. The deficient practice could result in resident's preference to choose her roommate was not considered. -Resident #41 was admitted on [DATE] with diagnoses of metabolic encephalopathy, dementia and need for assistance with personal care.The NP (nurse practitioner note dated July 24, 2025 included that the resident had a BIMS score of 12 which was consistent with moderate cognitive impairment.The room/roommate change notice signed by resident #41 and social services and dated August 11, 2025 revealed that resident #41 was provided the notice that she was moving to the room of resident #11 and this change was effective August 12, 2025.The census list report revealed that resident #41 had room change on August 12, 2025. -Resident #11 was admitted to the facility on [DATE] with diagnoses that included chronic inflammatory demyelinating polyneuritis, calcific tendinitis of the right thigh, adjustment disorder, hypotension, reduced mobility, muscle weakness, need for assistance with personal care, and polyneuropathy.The progress note dated February 3, 2025 included the resident was alert and oriented x 4 and was able to make needs known.A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The census list report revealed that resident #11 had a room change on February 28, April 12, and July 1, 2025. Despite documentation that resident #41 was moving to the room of resident #11, there was no evidence found that resident #11 was notified of the roommate change on August 12, 2025. In a written statement signed by Director of Nursing (DON/Staff#120) and dated August 19, 2025 at 12:35 p.m., the DON wrote the facility did not have room change notifications for Resident #11. An interview was conducted on August 19, 2025, at 12:40 p.m. with Resident #11 who stated that on August 12, 2025, she received a new roommate without prior notice. She said she was not informed of the change until staff asked her, at the time of the new roommate's arrival, whether she had been notified; and, this made her realize that she should have been told in advance, but was not. Resident #11 said that the new roommate was very disruptive and screamed during the first two days, which caused her to have a panic attack. She stated that she informed the Director of Nursing (DON) that she had not been notified about the roommate change, and the DON told her it had slipped through the cracks. The resident also said the facility offered to move her to a different room or pair her with another roommate, if available.An interview with the Resident Relations Manager (RRM/Staff #60) was conducted on August 19, 2025, at 1:55 p.m. The RRM stated that the facility uses a roommate change form to notify residents of a room change, and the form should be provided as soon as the facility is aware of the change. The RRM said that both the resident being moved and the resident receiving a new roommate were required to receive this notification; and, the only exception was for new admissions, who do not receive prior notice. The RRM further stated that not providing this notification could result in the resident being unhappy and losing their right to choose or decline a roommate, as the form includes that option. During the interview, the RRM reviewed the clinical record and stated that there was no documentation of a roommate change notification for Resident #11; and, staff should have completed the notification but failed to do so in this case.During an interview with the DON (Staff #120) conducted on August 19, 2025 at 2:32 p.m., the DON stated that best practice would be to have nursing staff document room changes in the clinical record as a progress note. The DON further stated that her expectation was for social services to complete their documentation for roommate changes and upload the completed form into the record. Review of the facility policy titled, Resident Rights - Room Change/Roommate Assignment, was revised in January of 2024 revealed that resident room or roommate assignments may change if the facility deemed it necessary, but that resident preferences were taken into account when such changes were considered. The policy further revealed that prior to changing a room or roommate assignment, residents should have been given advance written notice of such change, and advance written notice of a roommate change would include why the change was being made. The policy also revealed that documentation of a room change should be recorded in the resident's medical record. |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, facility documentation and policy review and the State Agency complaint tracking system, the facility failed to follow their abuse reporting policy following an allegation of abuse for one resident (#11). The deficient practice could result in continued abuse and neglect to residents. Findings include: Resident #11 was admitted to the facility on [DATE] with diagnoses that included chronic inflammatory demyelinating polyneuritis, calcific tendinitis of the right thigh, adjustment disorder, hypotension, reduced mobility, muscle weakness, need for assistance with personal care, and polyneuropathy.The care plan dated February 3, 2025 included that resident #11 had functional self-care deficits and/or functional mobility limitations related to malnutrition, pain and weakness and required assistance. The care plan revised on February 14, 2025 revealed that the resident had behavior problem related to recent admission, refusal of care and was verbally abusive to staff. Interventions included to administer medications as ordered and all personal care and interaction done in pairs.A late entry NP (nurse practitioner) note dated [DATE] revealed the resident was oriented x3 and had good insight and judgment.A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The late entry NP note dated [DATE] included the resident was oriented x 3, had organized thoughts, cooperative behavior and good insight/judgement.A behavior progress note dated [DATE] revealed that at approximately 9:00 p.m. the resident asked for a shower and when she was assisted in shower, she grew upset, started yelling, cursing, and was verbally abusive and insulting to the Certified Nursing Assistants (CNAs).There were no further documentation of this incident found in the clinical record and facility documentation.Review of the State Agency complaint tracking system revealed no evidence that the facility had submitted a self-report for Resident #11's allegation of staff-to-resident abuse and neglect on or about [DATE].An interview was conducted on [DATE], at 12:40 p.m. with Resident #11 who stated that on [DATE], she repeatedly requested a shower throughout the day, but staff kept telling her it would be done later. The resident said that, that evening, two CNAs (staffs #34 and #46) assisted her into the shower. The resident stated that when she asked for a washcloth, Staff #34 threw it into her lap more aggressively than usual. The resident reported that her showers typically last about 15 minutes, but that night she was left alone in the shower for over 30 minutes while she screamed for help. She said she was crying in pain and no one responded, except for a nurse who briefly entered to hand her an item that had fallen. The resident stated that when the two CNAs returned, the resident stated they began arguing with her; and, one CNA told her that if she continued behaving that way, no one would help her. The resident further stated that the CNAs left her naked in the shower while they went to the nurses' station, where she overheard them telling a nurse they were going to record her. She said that staff #34 mocked her, told her to get dressed on her own despite her pain, and placed her shoes in her lap saying, See, your arms aren't broken. Resident #11 stated that she reported the incident to the Executive Director (ED/Staff #29) by email the same day. However, she said no one from administration responded or visited her room until the afternoon of [DATE]. An interview was conducted on [DATE] at 12:52 p.m. with one of the alleged CNAs (staff #46) who stated that the timeframe for reporting was within 2 hours, and she did recall an incident between herself and Resident #11. Staff #46 said that at the beginning of her shift on [DATE], Resident #11 was already upset, and had requested a shower several times throughout the day. Staff #46 said that the resident was not in her group for showers, but she did shower the residents' roommate thinking that the other CNA (staff #34) would give Resident #11 her shower. Staff #46 stated that the CNA who intended to shower her left early that day, and by the end of the night they realized that Resident #11 had not gotten her shower yet, so they decided to set her up for one. Staff #46 said that they left the resident in the shower for 30 minutes, and at some point she thought that the nurse went into the shower room because the resident dropped something. Staff #46 further stated that after 30 minutes, they returned to the shower room because the resident was screaming, and they got her dressed and in her wheelchair before the resident told them she was going to report them. Staff #46 said that the resident immediately wheeled herself back to her room and sent an email to report them; and, the charge nurse texted the ED, Staff #29, to report it immediately. In an interview with the other CNA (staff #34) conducted on [DATE] at 1:30 p.m., staff #34 stated that allegations of abuse or neglect must be reported within two hours. She said that on [DATE], Resident #11 was not assigned to her shower group, as the CNA assigned to the resident had left early that day. Staff #34 said that the resident's shower was |

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

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and facility documentation and policy review, the facility failed to ensure that an allegation of abuse for one resident (#11) was reported to the State Agency (SA) within the required timeframe. The deficient practice could result in resident not protected from continued abuse. Findings include: Resident #11 was admitted to the facility on [DATE] with diagnoses that included chronic inflammatory demyelinating polyneuritis, calcific tendinitis of the right thigh, adjustment disorder, hypotension, reduced mobility, muscle weakness, need for assistance with personal care, and polyneuropathy.The care plan dated February 3, 2025 included that resident #11 had functional self-care deficits and/or functional mobility limitations related to malnutrition, pain and weakness and required assistance. The care plan revised on February 14, 2025 revealed that the resident had behavior problem related to recent admission, refusal of care and was verbally abusive to staff. 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Staff #34 stated that she reported the resident's allegations to the nurse immediately, who then notified the supervising nurse and the oncoming shift. She also noted that she was |