STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035094	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Sedona	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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, staff interviews, and the review of facility process and policy, the facility failed to ensure that a copy of the transfer/discharge notification was sent to the ombudsman for five of five sampled residents (#12, #100, #102, #8, and #107) for discharge. The census was 87. The deficient practice could leave residents without protection against inappropriate transfers or discharges and without access to an advocate to explain their rights and options. Findings include: -Resident #107 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, systolic (congestive) heart failure, muscle, and abnormalities of gait and mobility. An internal medicine progress note dated [DATE], revealed that Resident #107 was seen and examined by the physician and would be transferring to another skilled nursing facility at the family's request. No barriers to discharge were noted by the provider. A health status progress noted dated [DATE], revealed that he was discharged from the facility via transport van. The discharge Minimum Data Set (MDS) assessment dated [DATE] documented an unplanned discharge to a skilled nursing facility. Review of the clinical record for Resident #107 revealed no evidence that notification of discharge was sent to the Office of the State Long-Term Ombudsman. The undated facility policy titled Admissions, Transfers and Discharges revealed that other information should be reported in accordance with facility policy and professional standard of practice. No information regarding requirements of notification the Office of the State Long-Term Ombudsman. -Resident #8 was admitted on [DATE] with diagnoses of COPD (chronic obstructive pulmonary disease), encounter with palliative care, and paroxysmal atrial fibrillation The care plan dated [DATE] revealed Resident #8 wished to establish an appropriate pre-discharge plan. Interventions included to coordinate discharge plans with IDT (interdisciplinary team) and help to provide services according to care plan in an effort to enhance optimum well-being. The discharge order dated [DATE] included that the resident will be discharged to home with portable oxygen tank, oxygen concentrator, physical therapy and home health services. It also included (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	follow-up appointments with the PCP (primary care physician) in 3 weeks. The discharge-transfer note/summary dated [DATE] provided to and signed by the resident's family on [DATE] revealed the resident will be discharged to home with oxygen concentrator and tank, scheduled appointment with PCP on [DATE] at 1:00 p.m.; and, with narcotic medications. The documentation did not include the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; and, an explanation of their right to appeal the discharge. The discharge MDS (minimum data set) assessment dated [DATE] included the resident had an unplanned discharge to home with return-not anticipated on [DATE]. There was no evidence found in the clinical record that the Ombudsman was notified of the resident's discharge from [DATE] through [DATE]. Review of the email correspondence, including attachments, from the facility's previous Resident Relations Manager (Staff #56), addressed to the Long-Term Care Ombudsman and dated [DATE] (approximately 19 days from the resident's discharge date), included that the attached DC [discharge] Summary for [DATE] was being provided for review. The attached document, titled, Action Summary, in the email included a list of residents that were discharged , deceased , and transferred out to the hospital from [DATE] through [DATE]. Review of the document revealed that Resident #8 was discharged /Transferred to another hospital on [DATE] at 2:53 p.m. This email notification and attachment did not include the reason for discharge of resident #8 and did not include the same information that was provided to the resident family on [DATE]. An interview was conducted on [DATE], at 1:21 p.m. with the current Resident Relations Manager (Staff #89), with the previous Resident Relations Manager (Staff #56) present. Staff #89 stated that discharge planning and goals were discussed during care conferences attended by the resident and/or their representative or family, along with department heads; and that, discharge planning begins at admission, when he completes the initial social services assessment and speaks with the resident to understand their needs, available resources, home setup, location, living situation, preferred pharmacy, and primary care provider. Staff #89 stated that the interdisciplinary team (IDT) meets weekly on Thursdays, and during these meetings he would learn which residents were scheduled for discharge. He said that he then issues the Notice of Medicare Non-Coverage (NOMNC) within 72 hours prior to the discharge date and informs the resident of their appeal rights, who to contact, and their financial responsibility if the appeal was not decided in their favor. He further stated that on the day of discharge, he provides the resident with a physical copy of the discharge summary which included information about durable medical equipment (DME) orders, prescriptions sent to the pharmacy, scheduled follow-up appointments with the primary care provider, and any ordered home health services. Staff #89 said that the document is signed and dated by the resident or their representative and then scanned into the electronic record. An interview with the Corporate MDS (staff #334) was conducted on [DATE] at 4:05 p.m. She stated that the facility does not have no specific policy for discharging residents admitted in the LTC unit; and that, the document, the Notice Requirements Before Transfer/Discharge and Therapeutic LOA (leave of Absence) document was a guide that staff were to follow when discharging a resident. An interview with the MDS Director (staff #334) and the previous Resident Relations Manager (Staff #56) was conducted on [DATE] at 10:23 a.m. The MDS director (staff #334) stated that the facility (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	follow the Notice Requirements before Transfer/Discharge & Therapeutic LOA for notification of Ombudsman and what information needs to be provided to the Ombudsman. The previous resident relations manager (staff #56) stated that the only information she provides the Ombudsman was the facility's discharge log for the month. -Resident #12 was admitted on [DATE] with diagnoses of atherosclerotic heart disease. The discharge MDS assessment dated [DATE] documented an unplanned discharge to hospice (home/non-institutional). Per the MDS the resident was discharged on [DATE]. The NSG/SS Discharge-Transfer-LOA form dated [DATE] indicated the reason for the evaluation as discharge to the community with hospice services. Per the form the discharge was initiated by the resident/representative. Additionally, the form noted that the resident was discharging to a private home/apartment. Review of the resident's Order Summary Report did not reveal a physician's order for discharge. A Discharge Summary progress note dated [DATE] documented that resident was being discharged to the community with hospice services private home/apartment. A Progress Note dated [DATE] documented that resident was discharged home via transport with belongings, medications, and paperwork. Review of the resident's clinical record did not indicate that a copy of the discharge notification was sent to the Office of the State Long-Term Ombudsman. An interview with the Resident Relations Manager (staff #89) and the Business Office Manager (BOM/staff #56) was conducted on [DATE] at 1:51 p.m. According to the BOM, resident #12 was admitted to the facility for 1-week of respite care and was a frequent flyer. The Resident Relations Manager said that a copy of the notification is not sent to the ombudsman. Additionally, the Resident Relations Manager said that he does not provide the ombudsman information to the residents. -Resident #100 was admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease. The Order Summary Report revealed an order dated [DATE] to send the resident to the ED (emergency department) for SOB (shortness of breath). The Discharge Summary progress note dated [DATE] documented that the resident was in respiratory distress and was transported via ambulance to an acute care hospital. A Social Services Progress Note dated [DATE] documented that the resident/resident representative was provided a written notice of transfer, notice of bed hold, readmission policy, ombudsman and appeals information. However, review of the resident's clinical record did not reveal any evidence that a copy of the notice of transfer was sent to the Office of the State Long-Term Care Ombudsman. -Resident #102 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of hepatic encephalopathy, influenza, and cirrhosis of the liver. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Skilled Needs Review note dated [DATE] documented an estimated discharge date of [DATE]. Per the note the resident is expected to be discharged to the community. An NP (Nurse Practitioner) note dated [DATE] documented that resident is being discharged to prior living arrangements unless otherwise set up by case manager. The discharge MDS assessment dated [DATE] documented an unplanned discharge to home/community. The NSG/SS Discharge-Transfer-LOA form dated [DATE] documented the reason for the evaluation as discharge to the community without hospice services. Per the form the discharge was initiated by the resident/resident representative. The form indicated that the resident was discharging to the a private home/apartment. The Order Summary Report did not reveal a physician order for discharge. A Discharge Summary progress note dated [DATE] documented that the resident was discharged to the community without hospice service. A Social Services Progress Note dated [DATE] documented that the resident's family picked him up and took the resident back to the reservation. Review of the resident's clinical record did not indicate that a copy of the discharge notification was sent to the Office of the State Long-Term Ombudsman. A telephonic interview with the Ombudsman (staff #333) was conducted on [DATE] at 11:17 a.m. Staff #333 stated that their office used to receive a list of residents that were discharged /transferred. However, they have not received anything for February and March which he assumed might be related to changes in facility staffing. According to the Ombudsman the list used to go to his boss but lately they have not gotten it. According to staff #333 they were sent a list of residents but not a copy of the discharge/transfer notification. An interview with the Resident Relations Manager (staff #89) and the Business Office Manager (BOM/staff #56) was conducted on [DATE] at 1:51 p.m. Per the BOM, Resident Relations is responsible for presenting the notice of proposed discharge/transfer. Staff #56 said that the notice is presented as early as 72-hours prior to discharge depending on who is proposing the discharge. The Resident Relations Manager stated that the notice is presented to the resident or the responsible part. The Resident Relations Manager said that a copy of the notification is not sent to the ombudsman. However, a list of transferred/discharged residents is sent to the ombudsman on the first of the month via email. The BOM said that the notice of discharge contains the last date of coverage and the appeals info. The Resident Relations Manager said that the notice does not contain the info for the ombudsman. Additionally, the Resident Relations Manager said that he does not provide the ombudsman information to the residents. Both the Resident Relations Manager and the BOM stated that they are not sure if there is a policy/guidance that outlines requirements of what information should be included in the notice of transfer/discharge. A NOMNC (Notice of Medicare Non-Coverage) was presented by both the Resident Relations Manager and BOM as the notice of discharge/transfer. According to the both of them, there is no other for that the facility uses as a notice of transfer/discharge. During review of the NOMNC which the members considered as the notice of discharge/transfer form, they concurred that the form did not contain the ombudsman information. Per (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Resident Relations Manager the ombudsman is the residents' advocate. The Resident Relations Manager stated that the purpose of notifying the ombudsman of the transfer/discharge is to ensure that the ombudsman is aware of the discharged /transferred residents. According to the Resident Relations Manager the purpose of notifying resident/resident representative is to let them know about the discharge, liability and to ensure a safe discharge. The Resident Relations Manager said that the impact of not providing a discharge/transfer notification is that the resident would not know that they are being discharged . Review of the NOMNC (Notice of Medicare Non-Coverage) form that the BOM and Resident Relations Manager presented as the facility's notice of transfer/discharge on [DATE] at 1:57 p.m. revealed that the form did not include the following information: The effective date for the transfer or discharge; The location to which the resident is transferred or discharged ; The name, address and telephone number of the Office of the State Long-Term Care Ombudsman; The contact information for the agency responsible for the protection and advocacy of individual with developmental disabilities (if applicable) The contact information for the agency responsible for the protection and advocacy of individual with mental disorder (if applicable). During a follow-up interview with the Ombudsman (staff #333) conducted on [DATE] at 3:48 p.m., he stated that the notification was supposed to be sent to his boss. Staff #333 said that the notification is important because he used them as verification to double check appeals and other issues that could arise. The Ombudsman indicated that the discharge/transfer notification kept him informed. Per staff #333 harm could arise if their office is not notified of the resident's appeals. Additionally, the Ombudsman noted that he wants to be aware of the appeal process. According to the Resident Relations Manager resident #102 was picked up by his family. The Resident Relations Manager said that resident #102's family informed the facility that the resident will be picked up 3-days prior to when the resident left. An interview with the acting Director of Nursing (DON/102) was conducted on [DATE] at 8:28 a.m. The acting DON stated that she is unfamiliar with the requirements of notification of discharge/transfer as she has not been part of that process and can only speak in the capacity of her involvement with wound care residents. An interview with the Executive Director (ED/staff #40) was conducted on [DATE] at 12:09 p.m. The ED stated that the only form used for discharge/transfer is the NOMNC. Per staff #44 there is no paper notice and the facility is not required to provide paper notice. The ED noted that to her knowledge there is no other notification of discharge/transfer that has to be given to the residents. The ED said that the facility sends a list of residents transferred/discharged to the ombudsman monthly per their policy. According to the ED, the purpose of the notification of discharge/transfer is for the residents to participate in the discharge planning ahead of time and know what is going on. However, if the resident is just deciding that they are going home then they are the ones notifying the facility about the discharge. The ED stated that the ombudsman is the residents' advocate so informing the ombudsman about transfer/discharge is to make the ombudsman aware of what is going (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on, allow the ombudsman to contact the resident and know where the resident is at, and that the resident is no longer at the facility. The ED noted that the impact of not notifying the ombudsman is that it impacts the ombudsman's ability to know what is going on with the resident. Additionally, the ED stated that the facility wants the ombudsman to be aware. The ED indicated that to her knowledge all that had to be provided to the ombudsman was a list of the discharge/transfer. The ED was not aware that a copy of the transfer/discharge notification had to be provided to the ombudsman.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and facility policies and procedures, the facility failed to ensure was ADL (activities of daily living) care such as toileting hygiene was provided for 1 of 2 residents (#55) sampled for ADLs. The census was 87. The deficient practice could result in residents' hygiene needs not being met.Findings include:Resident #55 was admitted on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting his left, non-dominant side, schizophrenia, and major depressive disorder. A care plan initiated on October 15, 2025 revealed that the resident was at risk for functional self-care deficits and/or functional mobility limitations. Interventions indicated that the resident required assistance with toileting hygiene; required assistance to washing/rinsing/drying himself for shower/bathing; indicated to provide a bath/shower per scheduled preference as necessary.The admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status of 15 indicating that the resident was cognitively intact. The MDS noted that the resident did not exhibit indicators of psychosis, behavioral symptoms, or rejection of care during the assessment period. The assessment documented that the resident had bilateral upper and lower extremity impairment which interfered with his daily functions. Per the assessment the resident utilized a wheelchair as a mobility device and was dependent on staff for: toileting hygiene, shower/bathing, oral hygiene, personal hygiene, upper/lower body dressing, and putting on/taking off footwear.The December 2025 CNA (Certified Nursing Assistant) Task log for Bowel and Bladder revealed that following dates/shift was left unmarked/undocumented:December 5: 2:00 p.m. - 10:00 p.m.December 9: 6:00 a.m. - 2:00 p.m.December 11: 10:00 p.m. - 6:00 a.m.December 11: 2:00 p.m. - 10:00 p.m.December 12: 10:00 p.m. - 6:00 a.m.December 18: 2:00 p.m. - 10:00 p.m.December 19: 2:00 p.m. - 10:00 p.m.December 20: 2:00 p.m. - 10:00 p.m.December 21: 10:00 p.m. - 6:00 a.m.The December 2025 CNA Task log for Toilet Use revealed that the following dates/shift were left unmarked/undocumented:December 5: 2:00 p.m. - 10:00 p.m.December 11: 10:00 p.m. - 6:00 a.m.December 11: 2:00 p.m. - 10:00 p.m.December 12: 10:00 p.m. - 6:00 a.m.December 15: 6:00 a.m. - 2:00 p.m.December 18: 2:00 p.m. - 10:00 p.m.December 18: 6:00 a.m. - 2:00 p.m.December 19: 2:00 p.m. - 10:00 p.m.December 20: 2:00 p.m. - 10:00 p.m.December 21: 10:00 p.m. - 6:00 a.m.A NP (Nurse Practitioner) note dated November 3, 2025 documented an initial psychiatric evaluation and treatment recommendation with a PMHNP-BC (Psychiatric-Mental Health Nurse Practitioner-Board Certified). The note indicated that the resident had documented behaviors which included episodes of sexually inappropriate comments directed towards staff, verbal agitation when his requests were not immediately met, and argumentative responses during care interactions. According to the note, the resident exhibited mocking and verbally abusive remarks toward staff, including making derogatory comments and mimicking movements in a taunting manner.A Behavior progress note dated November 22, 2025 documented that it was the resident's shower day. Per the note, the resident was in the shower room half-way undressed and set-up when the resident decided that he no longer wanted his shower. The note indicated that the resident's reason was that he only needed one shower a week.A NP note dated November 24, 2025 revealed that the resident was seen for a follow-up visit with the PMHNP-BC and had been exhibiting impulsive tendencies. According to the note the resident had increased verbal aggression, specifically name calling directed at staff which included uttering profanities. The note indicated that the resident had a documented behavior of resistance to care during scheduled showers. The note documented that the resident had refused to abruptly refused to proceed with a shower after the staff had brought him to the shower room and prepared him. Per the note, the resident had inappropriate sexual behavior, specifically, masturbating outside of private settings. A Behavior note dated November 28, 2025 documented that resident cussed out staff when they tried to get him out of bed. The note indicated that the resident called staff worthless and (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	useless.An Alert Charting progress note dated November 30, 2025 documented that resident was yelling and reported he wanted to get up to eat dinner. The note stated the resident was informed that the CNAs (Certified Nursing Assistants) were in the middle of passing dinner trays. The note indicated that the resident started yelling and cursing at the nurse. When the CNA arrived to and asked if he wanted his dinner, the resident continued to yell after he was told that he was a cares-in-pairs and had to wait until another staff was available to assist in getting him up. According to the note, when a staff member went in the room to get the roommate's tray, the resident threw his urinal at the staff member. The Executive Director, and Director of Nursing (DON) were informed of the resident's behavior. Per the note, the DON contacted the resident's brother who gave permission to move resident to the behavioral unit. During the room change, the resident cursed at the staff and told the nurse that he was going to kill her when he got better. The resident screamed f@$% you, you stupid b!#@$ and tried to throw his phone at the nurse.A NP note dated December 3, 2025 documented a follow-up visit with the PMHNP-BC. The note indicated that the resident had exhibited persistent verbal aggression which included cursing at staff during care, calling staff worthless, yelling demands for medication, and speaking rudely to staff. According to the note, the resident had frequently become loud when his requests are not met immediately, repeatedly activated his call light after staff had already addressed his needs, directed inappropriate and derogatory comments towards female CNAs.A Behavior progress note dated December 13, 2025 documented that resident was upset with CNA because yesterday the CNA did not shower him the way he wanted so the resident refused the shower. The CNA at the time of the documentation informed the resident that he had 6 other showers scheduled which angered the resident. According to the note, the resident told the CNA I hope a car crashes into this building with all the staff inside and the building blows up and the staff all dies.Another Behavior progress note dated December 13, 2025 documented that the resident had a BM (bowel movement) and CNA cleaned him. Per the note, as soon as the CNA left, the resident activated his call light, the nurse came and the resident informed her that the CNA did not clean under my penis. The note indicated that the nurse checked the resident's peri area and brief and both were completely clean and dry.A Behavior progress note also dated December 13, 2025 documented that after asking the CNA for a glove, the resident grabbed a cleaning wipe and demonstrated to the CNA that he was capable of cleaning his peri area. The resident wiped himself then threw the wipe down and told the staff here's all the shit you missed. The nurse entered the room to talk to the resident but the resident told the nurse to get the f@$& out of here.A Social Services Progress Note dated December 15, 2025 documented that the Resident Relations Manager (staff #56) spoke with the resident's brother about a transfer to another facility. Per the note, the resident's brother was onboard with the transfer. The note indicated that the resident's brother understood the resident's continued behaviors and agreed that it was probably best to transfer the resident. A NP note dated December 15, 2026 revealed a follow-up visit with a PMHNP-BC. The note indicated that the resident had exhibited frequent agitation, oppositional behavior, and verbal aggression toward staff and other residents. According to the note, the resident displayed disruptive behavior. The resident yelled, mocked staff, interrupted other resident's care, and expressed frustration over unmet preferences, and hygiene assistanceA Grievance Report and Resolution Form signed by the Resident Relations Manager and Executive Director (staff #40) on December 16, 2025 documented that the resident filed a complaint regarding a concern which occurred on December 15, 2026. The concern was in regards to the resident feeling that he was being ignored by staff and is not getting the care he needs or wants. The form indicated that the response/resolution provided as the Executive Director met with resident and discussed concerns and decision was made to look for more appropriate placement that could better meet the resident's needs. Per the form, the Executive Director would educate staff on resident's care preferences until the placement could be made. The State Agency's complaint/incident tracking system revealed a complaint filed on December 19, 2025 involving the resident. According to the complaint, the resident had diarrhea and the staff only cleaned his bottom but not his front. The (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complaint indicated that the resident asked the staff to clean his front side since he was soiled all over and was unable to clean himself due to his impairment. The complaint alleged that there were multiple incidents when staff refused to clean the resident. The complaint did not indicate when the alleged incident occurred. The IDT (Interdisciplinary Team) GG (Functional Status) assessment dated [DATE] documented that the resident required substantial/maximal assistance for the following tasks: oral hygiene, toileting hygiene, shower/bathing; upper/lower body dressing, personal hygiene, and putting on/taking off footwear.A Discharge Summary progress note dated December 22, 2025 documented that resident was discharged to another long-term care nursing facility.An interview with the acting Director of Nursing (DON/staff #102) was conducted on April 22, 2026 at 8:28 a.m. Staff #102 indicated that she was only the acting DON for the duration of the survey. The acting DON said that with regards to ADL care, there is a fine line between the right to refuse so staff should make multiple attempt to see if there is a person that has a better relationship with the resident who the resident would allow to provide the care. Additionally, she expects that depending on the behavior the resident should see psychiatry. According to the acting DON, working as a wound nurse in the facility, she had never witnessed the staff leave a resident soiled/wet. Each time she came in to work on a resident, the resident is clean. She noted that she is unfamiliar with resident #55 and recommended to speak to staff #107 (CNA) and staff #70 (LPN) who both work in the unit where the resident was located.An interview with a Certified Nursing Assistant (CNA/staff #107) was conducted on April 22, 2026 at 9:51 a.m. Staff #107 stated that care/services provided by CNAs are documented on the resident's electronic health record (EHR). The CNA noted that there is a section specifically for CNA's to document their tasks. The tasks are documented as coded in the system depending on what the task is and what type of assistance is provided. The CNA said that there is a code for refusal, and resident being unavailable. According to the CNA, if the task is left blank then it meant that the staff member did not chart. It could mean that it was not provided. However, normally if a task is not provided then it should be coded as such. Per the CNA, if you did not do the task then you should put NA. Otherwise, if left blank then it becomes questionable whether the care was provided or not. The CNA said that it is important to provide the residents ADL care because it is for the resident's quality of life. The residents are in the facility to get help and the staff are there to help provide the care that the residents need. The CNA noted that the impact of not providing ADL care is that the residents would get angry, especially in the BU (Behavior Unit). The CNA said that you can tell when someone is not taken care. It affects the resident's mood, body, health and the quality of life goes down. According to the CNA, she is familiar with resident #55. Staff #107 said that the resident was a 2-person assist because of his behaviors. The CNA said that the resident did not use the toilet and used briefs. The CNA noted that the resident was very sexual and made the female CNAs wipe him extra, and refused care from men. The resident made you do extra wiping. The CNA indicated that they had to implement cares-in-pairs since the resident would complaint that he was not clean, and asked for extra changes. The CNA admitted that the staff was hesitant but still provided the resident care in the nicest way possible in order to get in and out of there. The CNA said that the staff had to start showing the resident the wipes after each wipe to prove that he was clean. The Bowel and Bladder task log for December 2025 was reviewed with the CNA. Staff #107 said that the blanks probably meant that the CNA did not chart. According to the CNA, the blank areas meant that you would not know if the care was provided. The CNA said that it is a problem because everything should be charted. The CNA said that she is unsure how it would impact the resident. However, for the overall look of the care it would be impactful since when the care conference is conducted, if the data is not there then if the resident for example was refusing care the staff would be unable to discuss since the data is not there for them to determine that that is an issue.During an interview with a Licensed Practical Nurse (LPN/staff #70) conducted on April 22, 2026 at 10:07 a.m., staff #70 stated that with regards to ADL care, her expectation is that residents are rounded on at least every 2-hours. The importance of providing ADL care is for the resident's dignity so that the resident is not sitting in (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035094	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Sedona	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)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	soiled clothing and prevent skin breakdown. The LPN said that the impact of not providing ADL care such as toileting hygiene is that the resident's skin can breakdown, the resident would feel anxious, and feel like they are not being cared for by staff. The LPN confirmed that she was familiar with resident #55. The LPN shared that she had to call the resident's brother and ask for him to talk to the resident regarding peri care. The LPN said that the resident would complain that his peri area was not clean and tell staff to wash my [NAME]. The LPN said that she told the resident to be professional and not call it like that. The LPN noted that the resident had the ability to clean himself, the resident was strong, and could do a lot of things on his own. The LPN shared that the resident did not believe he was clean when the staff wiped him after bowel movements. According to the LPN this was a behavior for that resident. In reviewing the Bowel and Bladder task log for December 2025 with staff #70, she said that the blanks made her think that either someone did not chart or the resident did not have a bowel movement. The LPN said that whoever was on shift should have charted appropriately for that task. Per the LPN, if not charted on that shift then whoever is looking at it would not be able to conclude whether the care was provided or not.The facility policy titled Personal Care: Activities of Daily Living (ADL), Supporting version 051123 in effect January 1, 2024 indicated that residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. Per the policy residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, personal hygiene, and oral hygiene. The policy described total dependence as full staff performance of an activity with no participation by resident for any aspect of the activity. Extensive assistance was described as while resident performed part of the activity, staff provided weight-bearing support. The policy noted that appropriate care and services will be provided for residents who are unable to carry out ADLs independently in accordance with the plan of care, including appropriate support and assistance with bathing, dressing, grooming, oral care, and toileting.The facility policy titled Documentation: Charting and Documentation version 051123 in effect January 1, 2024 indicated that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychological condition shall be documented in the resident's medical record. The policy noted that the medical record should facilitate communication between the IDT (Interdisciplinary Team) regarding the resident's condition and response. Documentation of procedures and treatments will include care-specific details including, whether the resident refused, date/time procedure/treatment was provided, and assessment data or any unusual finding obtained.