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	05/20/2026

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 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 staff interviews, review of clinical record and policy review, the facility failed to protect the rights of 2 of 3 residents sampled (#1, #2) to be free from physical and verbal abuse between residents. The deficient practice could result in resident injury, psychological, or behavioral harm as well as continued resident to resident abuse.Findings include:Regarding Resident #1:Resident # 1 was admitted [DATE], with diagnoses that included sepsis due to E. Coli infection, pneumonia, urinary tract infection, and adult failure to thrive. The care plan initiated on August 1, 2025 revealed the resident had potential for mood problems related to medication side effects and depression. Interventions included administering medications as ordered and monitoring for side effects. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15, indicating that the resident's cognition and memory are fully intact. The MDS assessment documented that Resident #1 had feelings of being depressed, trouble falling asleep, and little energy. A behavior note dated April 27, 2026 documented that Resident #1 was involved in a verbal aggressive incident with Resident #2 that escalated into a physical aggressive incident. The behavior note revealed that the staff intervened when they heard yelling but the residents started swinging their fists making contact. The behavior note documented that Resident #1 attempted to hit Resident #2 first, while Resident #2 swung making contact to the left side of Resident #1's face. The behavior note revealed that both residents were separated and the Administrator was notified. Regarding Resident #2:Resident #2 was admitted [DATE] with diagnoses that included acute respiratory failure with hypoxia, sepsis, insomnia, depression, and cognitive communication deficit. A Quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, indicating that the resident's cognition and memory are fully intact. The MDS assessment documented that Resident #2 had episodes of feeling depressed but no behaviors were exhibited. Review of the care plan revealed no behavioral concerns prior to the incident. A behavior note dated April 27, 2026, revealed that Resident #2 was involved in a verbally aggressive incident that escalated into a physical aggressive incident. The behavior note documented that staff intervened immediately to the yelling, but the two residents started to swing their fists at each other. The behavior note documented that Resident #2 reacted to the first punch thrown by Resident #1 by striking Resident #1 in the face. The progress not revealed that staff separated the two residents and reported to the administrator immediately. The behavior noted revealed both residents were assessed with no injuries and were instructed to not to interact with one another. A care plan initiated on May 8, 2026, revealed that Resident #2 had impaired cognitive function or impaired thought processes related to difficulty making decisions and irritability and anger. Interventions included administering medications as ordered by a physician, monitoring, documenting, and reporting any changes in cognitive function to the physician. A care plan initiated on May 8, 2026, documented that Resident #2 had a behavior problem related to impaired cognitive function, irritability and anger, depression, and history of verbal and physical altercations. Interventions included identifying behavior triggers and removing resident from situations if they arise. Review of the facility investigation report dated April 27, 2026 revealed that Resident #1 and (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 got into a verbal argument in the hallway by the smoking courtyard doors. The report documented that the argument began to get heated and before staff could separate them Resident #1 swung at Resident #2 making light contact while Resident #2 swung back at Resident #1 making full contact with Resident #1's face. Further review of the report revealed a witness statement from Nursing Student (Staff #105) who revealed that the residents were arguing when Resident #1 began cussing at Resident #2 and then started throwing punches at each other missing except the last punch thrown by Resident #2 which hit Resident #1 in the jaw. An interview was conducted on May 20, 2026 at 12:50 p.m. with Resident #2. Resident #2 stated that he was in the hallway in his wheelchair talking with another resident when Resident #1 approached quickly in his motorized chair and Resident #1 started to yell at Resident #2. Resident #2 stated that Resident #1 started to swear at Resident #2 calling him a 'no good bastard', and then Resident #1 tried to throw a punch but missed Resident #2. Resident #2 stated that he threw a punch that hit Resident #1 square on the face. Resident #2 stated that the nurse immediately took Resident #2 out of the area. An interview with Resident #1 was conducted on May 20, 2026 at 1:10 p.m. who stated that he was going down the hallway when Resident #2 was blocking the hallway with his wheelchair. Resident #1 stated that Resident #2 did not move or acknowledge that Resident #1 was trying to get by him and Resident #1 said 'don't mind me.' Resident #1 stated that Resident #2 turned to look at Resident #1 and Resident #2 tried to push and swing at Resident #1. Resident #1 stated he did not swing at Resident #2, he was just putting his arms out to block Resident #2 from hitting him. Resident #1 stated that the nurse got in between them but Resident #2 swung around her and hit Resident #1 in the cheek. Resident #1 stated that he was instructed to stay away from Resident #2 but stated that its hard because Resident #2 is always trying to hang around Resident #1. Resident #1 said he does not feel safe around Resident #2 because he does not know when Resident #2 will 'blow up' again. An interview was conducted with Certified Nursing Assistant (CNA/Staff # 78) on May 20, 2026 at 1:31 p.m., who stated that they get training on abuse and neglect at least once a month in their staff meetings. Staff #78 stated that abuse can be verbal or physical and stated that hitting would be considered abuse. Staff #78 stated that she did not witness the altercation but was aware that it took place. Staff #78 stated that both Residents like to instigate each other. Staff #78 stated that one resident will say something to the group and the other resident will say something to try and 'one up' that resident. Staff # 78 stated that now after the altercation they try to keep the residents apart from one another to avoid another incident. An interview was conducted with Nursing Student (Staff #105) on May 20, 2026 at 2:36 p.m. via telephone. Staff #105 stated that on April 27, 2026 she was doing her 'rotations' at the facility. Staff #105 stated that she saw Resident #1 wheel his electric wheelchair past her down the hall. Staff #105 stated that she was giving medication at the time and started to hear Resident #1 and Resident #2 arguing and when she looked up saw both residents swinging at one another. Staff #105 stated that as she started to approach both residents to help break them up she saw Resident #2 swing a punch that hit Resident #1 in the face. An interview was conducted with the Administrator (Staff #98) on May 20, 2026 at 2:59 p.m. who stated that the process of alleged resident to resident abuse is to make sure the residents are separated and are safe then to report the allegation or incident of resident to resident abuse to her as soon as possible so she can start the notifications to the appropriate agencies and start her investigation. Staff #98 stated she was notified on April 27, 2026 that Resident #1 and Resident #2 were involved in a verbal and physical altercation. Staff #98 stated that staff intervened as soon as they heard the Resident's arguing but could not stop the resident's from throwing punches at each other. Staff #98 stated that Resident #2 did make contact with Resident #1's face in the altercation. Staff #98 stated the concern when residents are in physical altercations is they could get hurt. A policy and procedure titled Abuse Policy, Copyrighted 2022, revealed that the facility strives to prevent the abuse of all their residents. The policy also revealed that instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish which included verbal abuse and physical abuse.A policy (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and procedure titled Resident Rights/Dignity: Resident Rights, effective January 1, 2024, revealed that Federal and State laws guarantee certain basic rights to all residents of this facility including being treated with respect, kindness, and dignity and be free from abuse.