STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035096	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Sandpointe, LLC	2222 South Avenue A Yuma, AZ 85364

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** 48932 Based on clinical record review, interviews, review of facility documentation and policy review, the facility failed to ensure resident #1 was free from abuse from resident #2. The deficient practice could result in residents experiencing emotional and mental trauma from abuse. Findings include: Related to resident #1- Resident #1 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes, major depressive disorder, and partial paralysis on the left side following a stroke. Review of a quarterly Minimum Data Set (MDS), dated [DATE] revealed resident #1 completed a Brief Interview for Mental Status (BIMS) and scored a 15 which indicated the resident was cognitively intact. A review resident #1's progress note in her Electronic Health Record (EHR), a progress note dated November 26, 2024 at 4:32 PM indicated that resident #1 had made an inappropriate comment about her roommate's, at the time, mother. The roommate (resident #2) then grabbed resident #1's hair. Related to resident #2- Resident #2 was admitted to the facility on [DATE] with diagnoses of partial paralysis on the left side following a stroke, type 2 diabetes, schizoaffective disorder and major depressive disorder. Review of the admission MDS, dated [DATE] revealed resident #2's BIMS score was 12 which indicated the resident was moderately cognitively intact. The MDS also noted the resident had not exhibited any behaviors during the look-back period. The care plan for Resident #2 did not indicate the resident had a behavior problem towards others. Review of resident #2's progress notes in her EHR (Electronic Health Record) revealed a progress note dated November 26, 2024 at 4:47 PM. The note shared that resident #2 was witnessed pulling her roommate's pony tail because the roommate made an inappropriate comment about resident #2's mother. (continued on next page)

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	An interview was conducted on December 9, 2024 at 4:44 p.m. with resident #1 in her room. Resident #1 indicated that she currently felt safe in the facility. She also shared that the girl next door attacked me. Resident #1 continued to explain that the girl used to be her roommate but she had pulled resident #1's hair which was witnessed by a Certified Nursing Assistant (CNA/Staff #46). An interview was conducted on December 10, 2024 at 8:26 a.m. with resident #2 in her room. She explained that she has changed rooms many times at the facility during her stay because she can't get along with people. She also shared that she pulled the hair of her former roommate because she had called her mom a bitch. An interview was conducted on December 10, 2024 at 4:52 p.m. with a Certified Nursing assistant (CNA/staff #46). She confirmed that she was working on November 26, 2024 and had witnessed the altercation between residents #1 and #2. Staff #46 explained that both residents had returned to their room from an afternoon outing and she had walked into the room to assist resident #2. Both residents were relaxed, in their wheelchairs, and out of the blue, both residents started exchanging words and resident #1 had insulted resident #2's mother. Then resident #2 reached out to grab resident #1's hair bun and staff #46 had grabbed resident #2's hand and the resident released the hair. Staff #46 also added that she then wheeled resident #2 out of the room into the lobby to separate the two residents. Social services staff then pulled resident #2 aside to talk to her. Staff #46 indicated that there had been no other altercations between the two residents in the past and they had gotten along well with each other. An interview was conducted with the Resident Relations Manager (RRM/Staff #50) on December 10, 2024 at 5:08 p.m. When asked to explain what transpired between resident #1 and resident #2, staff #50 explained that resident #2 and grabbed resident #1's hair because resident #1 had made a comment about resident #2's mom who had passed away. Resident #2 had gotten upset and said that no one talks about her mom that way. After the altercation, the residents were put into different rooms. When asked what would the risks to the residents be if they were abused in the facility, staff #50 indicated that residents would be in an unsafe environment and it would cause issues such as behaviors. Staff #50 also added that the facility wants residents to feel safe and they knew if they did not feel safe, they could talk to social services. An interview was conducted with Licensed Practical Nurse (LPN/Staff #49) on December 10, 2024 at 5:26 p. m. Staff #49 shared that she did not witness the altercation between both residents but she was informed about it by staff #46. Once she was notified, she did an assessment with both residents and there were no injuries noted. Staff #49 also reported the incident and the police came to investigate and then social services investigated as well. An interview was conducted on December 10, 2024 at 5:39 p.m. with the Director of Nursing (DON/Staff #54). Staff #54 indicated that there was a verbal incident between resident #1 and #2 due to resident #1 saying something about resident #2's mother. This had caused resident #2 to become upset and grabbed resident #1's hair. She also indicated that a CNA was present during the altercation and was able to respond quickly and separate the two residents. Staff #54 was not aware of any other altercations that involved resident #2 but did note that resident #2 could be mean at times but it usually wasn't directed towards anyone. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a policy titled, Resident Rights/Dignity: Abuse, Neglect, Exploitation, and Misappropriation Prevention Program indicated that residents had a right to be free from abuse. The policy also noted that there was a facility-wide commitment to protect residents from abuse . from other residents.