

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/16/2025
NAME OF PROVIDER OR SUPPLIER  Haven of Sandpointe, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</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 0600</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 interviews, review of clinical record, and facility policy, the facility failed to protect the residents' (#3, and #2) right to be free from physical abuse. The deficient practice could result in physical and psychosocial harm. -Regarding Resident #3: Resident #3 was admitted to the facility on [DATE], and re-admitted [DATE], with diagnoses that included Alzheimer's disease, dementia with agitation, history of falling, anxiety disorder, mental disorder not otherwise specified, and spinal stenosis. A quarterly minimum data set (MDS) assessment dated [DATE], revealed Resident #3 had a Brief Interview for Mental Status (BIMS) assessment score of 5, indicating severe cognitive impairment. A care plan for behaviors revised September 3, 2025, revealed that Resident #3 had a resident to resident altercation, and an additional intervention was initiated on September 3, 2025, which indicated for a medication review. A Behavior Note dated July 24, 2025, revealed that Resident #3 was verbally inappropriate with staff and other residents. Resident #3 attempted to touch a female resident inappropriately, and the staff redirected the resident and spoke to him regarding his behavior. A Behavior Note dated July 28, 2025, revealed Resident #3 continues with sexual comments toward female staff. A Late Entry Incident Note dated September 2, 2025, revealed that Resident #3 was walking to the dining room for lunch pushing his wheelchair, as Resident #3 passed by another resident, the other resident said hi to Resident #3 who did not acknowledge the other resident. The other resident punched Resident #3 on his upper back, and Resident #3 reacted with punching the other resident on the left upper chest. The residents were separated by staff, vitals were taken, assessment completed, and no injuries were noted. Regarding Resident #2: Resident #2 was admitted to the facility April 12, 2024, with diagnoses that included unspecified dementia, anxiety disorder, unspecified hearing loss, and chronic obstructive pulmonary disease. A quarterly MDS assessment dated [DATE], revealed Resident #2 had a BIMS assessment score of 4, indicating severe cognitive impairment. A care plan initiated June 24, 2024, revealed Resident #2 had behaviors of attempting to hit and kick staff, yelling toward other residents, and a resident to resident altercation. An additional intervention was initiated on September 3, 2025 to place Resident #2 close to staff when awake. A Behavior Note dated July 24, 2025, revealed Resident #2 hit a staff on the arm as the staff passed by the resident, and the resident was redirected and asked not to be hitting others. Resident #2 was unable to verbalize understanding due to expressive aphasia. A Behavior Note dated July 30, 2025, revealed a staff opened Resident #2's room door for her, and Resident #2 hit the staff on the left arm, and that later in the day, Resident #2 walked toward her room and stopped in the hallway, pulled her pants and brief down, and squatted and urinated on the floor. Staff helped her dress herself, and took Resident #2 to the restroom to assist with care. A Behavior Note dated August 2, 2025, revealed that after lunch, a Certified Nursing Assistant (CNA) removed Resident #2's lunch plate from in front of her. Resident #2 stood up quickly and started yelling at the CNA and grabbed the CNA's arm tightly. The resident's arm had to be pried off of the CNA. Additionally, the note revealed that Resident #2 was known to be very obsessive and territorial to anything she thinks is hers. A Behavior Note dated August 11, 2025, revealed that Resident #2 was observed to be very agitated throughout the shift. Scheduled medication was administered as ordered; however, it was not effective in reducing agitation. Resident #3 displayed exit-seeking behaviors and became physically aggressive when staff attempted redirection, including attempts to strike staff. A Psych Follow-Up Note dated September 2, 2025, revealed that staff reports that Resident #2 has been aggressive. Resident #2 did hit another resident and has a history of hitting staff as well. Today she is refusing to talk to us, is very flat and guarded, and has isolating behavior. A Late Entry Incident Note dated September 2, 2025, revealed that Resident #2 was sitting in the dining room when another resident walked by. Resident #2 said hi and the other resident did not stop to acknowledge her, and as the other resident continued to walk by, Resident #2 got upset and punched the other resident on his back. The other resident turned around and punched Resident #2 on her chest. The residents were separated by staff, vitals were taken, assessment completed, and no injuries were noted. A facility investigation report submitted to the state agency on September 8, 2025, revealed that following the initial report of the incident on September 2, 2025, Resident #3 and Resident #2 were separated and checked to ensure safety. An investigation was initiated and two staff members were interviewed who were present during the interaction, a CNA and a nurse. According to staff accounts, around lunch time, Resident #3 was walking past Resident #2. Some form of verbal interaction occurred between the two residents. Resident #3</p>		