STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035107	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Phoenix	4202 North 20th Avenue Phoenix, AZ 85015

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 - Some	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 a review of records, observation, interviews, policies and procedures, the facility failed to ensure that two residents (#122 and #163) were not abused by another resident (#121 and #60) out of 11 sampled residents. The Universe was 99. The deficient practice could lead to physical and psychosocial harm to residents.Regarding the altercation between Resident #121 and Resident #122-Regarding #121, (Alleged Perpetrator) Resident #121 was re-admitted to the facility on [DATE], with diagnoses that included encephalopathy, anxiety, and bipolar disorder.A Physical Aggression incident report dated April 27, 2026, at 5:35 p.m., revealed that a Nurse was notified of an incident involving Resident #121 (alleged perpetrator) and #122 (alleged victim), who shared a room. The note included that the nurse entered the room and observed Resident #121 screaming it's my walker, and physically hitting Resident #122 in the right upper extremity. The note indicated that the residents were separated, and Resident #121 was removed from the room and reoriented to calm down. The note also included that Resident #122 was taken to a designated smoking area, the provider was notified, and an order was received to transfer Resident #121 to the hospital for further evaluation and care, and no injuries were noted at the time of the incident.A hospital transfer discharge summary progress note dated April 27, 2026 at 7:06 p.m., revealed that the resident became aggressive towards his roommate and staff, agitated, hard to reorient. Staff tried to reorient to facility, therapeutic communication and nursing sitter.A health status note dated April 27, 2026 at 8:40 p.m., revealed that the resident was transferred to the hospital related to AMS (altered mental status): agitation, restlessness and behaviors. The note indicated that the resident left the facility via ambulance.A review of the quarterly MDS (Minimum Data Set) assessment dated [DATE],revealed that the resident had a BIMS (Brief Interview for Mental Status) score of 02, whichindicated severe cognitive impairment.A care plan for behavioral-problems related to physical behaviors was initiated on April 28, 2026, which revealed that Resident # 121 exhibited behavioral disturbances related to confusion, and episodes of physical aggression including yelling, hitting, striking staff and others.- Regarding #122, (Alleged victim)Resident #122 was re-admitted to the facility on [DATE], with diagnoses that included sepsis, type 2 diabetes, and cellulitis.An admission MDS (Minimum Data Set) assessment dated [DATE], revealed that Resident #122 had a BIMS (Brief Interview for Mental Status) score of 14, which indicated intact cognition. The assessment included that no behaviors were exhibited during the assessment period.A progress note dated April 28, 2026, at 10:58 a.m. revealed that patient was evaluated for involvement in a physical altercation.A shower body check program dated April 28, 2026, revealed that the Resident #122 had no breakdowns, open areas or areas of concerns.A facility report dated April 28, 2026, revealed that Resident #121 struck the left hand and was pulling on the walker of Resident #122, confusing his personal belongings with those of Resident #122. Resident #121 then struck Resident #122 on the chest, and then Resident #121 pushed Resident #121's hand off of the walker, in an attempt to protect himself, causing a skin tear. The report revealed that staff were present in the hallway and responded immediately, and there were no prior behaviors indicating imminent risk. The report also included that the alleged victim, Resident #122 reported mild chest (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 - Some	discomfort, but no acute distress, with no bruising or redness noted. The report also revealed that Resident #121 was identified as initiating the altercation. The report indicated there was no evidence identified to suggest intentional harm, and the incident appeared to have occurred in the context of new admission adjustment and cognitive impairment.An interview was conducted on May 4, 2026, at 8:04 a.m. with a Licensed Practical Nurse (LPN, staff #83), who stated that the types of abuse include verbal, physical, and financial. The LPN further stated that the incident would be reported to the Abuse Coordinator and the Director of Nursing immediately. The LPN stated that the incident between Resident #121 and Resident #122 happened on April 27, 2026, in the evening around 5:30 p.m. to 6 p.m. Per the LPN, a screaming sound was heard coming from the room of Residents #121 and #122. The LPN stated that upon entering the room Resident #121 was anxious, pulling on a walker, screaming it's mine and punching Resident #122. The LPN also stated that both residents were immediately separated and skin assessments were performed with no injury observed for Resident #122, and that Resident #121 was observed to have a skin tear on his left arm. The LPN further stated that the provider was notified and Resident #121 was sent to the hospital. The LPN further stated that he would consider the altercation between Resident #121 and #122 as a physical abuse as Resident #122 physically assaulted by Resident #121.An interview was conducted on May 04, 2026, at 12:29 p.m. with the Resident #122, who stated that he recalled the incident with Resident #121 stating that Resident #121 was his roommate and the incident happened in the evening on the day that Resident #121 was admitted . Resident #122 stated that Resident #121 was using his walker while going to the bathroom, then started pulling Resident #122 and punched him 7 times on right wrist. Resident #122 then stated that he was about to hit Resident #121 with his right hand, when LPN (staff #83) intervened and pulled Resident #121 away. Resident #122 stated that Resident #121 started screaming and stated he did not want to stay in here. Resident #122 further stated that both residents were separated, and assessed by the LPN. Resident #122 also relayed that his right shoulder was hurting and that he would consider the incident as adult abuse because Resident #121 started hitting him and other staff members.An interview was conducted on May 4, 2026, at 2:51 p.m., with a Certified Nursing Assistant (CNA, staff # 24), who stated that the types of abuse include verbal, physical, and financial. The CNA stated that the facility process for a resident-to-resident altercation included separating both residents, notifying the abuse coordinator immediately, and assessing both residents for injuries. The CNA stated that he recalled the incident between Resident #121 and Resident #122. The CAN stated that Resident #121 was confused and using his and Resident #122's walkers to go to the restroom because Resident #121 believed that both walkers were his. The CNA also stated that Resident #122 then called for help and the CNA intervened and explained to Resident #121 which walker was his and then the CNA left the resident's room. The CNA stated that a few minutes later he and another CNA (staff #21) observed Resident #121 and Resident #122 yelling and fighting over a walker, saying threating words to each other, and that both residents got hurt. The CNA stated that the residents were separated and Resident #121 had skin tear on back of his hand. The CNA further stated that he would consider the altercation between Resident #121 and #122 as physical abuse because both residents were physically fighting over the walker and making threats for further violence.An interview was conducted on May 5, 2026, at 1:50 p.m., with the Interim Director of Nursing (DON/Staff #125), who stated that abuse could be verbal, physical, sexual or financial. The DON further stated that any incidents of abuse should be reported to the Abuse Coordinator immediately. The DON then stated that Resident #121 was new to the environment and the incident between Resident #121 and #122 occurred on the day Resident #121 was admitted to the facility. The DON also stated that Resident #121 was trying to take the walker of Resident #122 because he was confused. The DON stated that there were no injuries to either residents and she would not consider the altercation between Resident #121 and #122 as abuse.Regarding the altercation between Resident #60 and Resident #163- Regarding #60 (alleged perpetrator)Resident #60 was initially admitted to the facility on [DATE], with diagnoses that included type 2 diabetes, vascular dementia, unspecified (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mood, and anxiety.The clinical record dated May 4, 2020 through February 15, 2023, revealed the following behaviors: denial of medication administration and placement of left-hand brace, uncooperative with therapy.A review of an annual MDS (Minimum Data Set) assessment dated [DATE], revealed that a BIMS (Brief Interview for Mental Status) score of 15, which indicated intact cognition.A behavior progress note, dated February 16, 2023, revealed that the resident had an altercation with another resident and the police were notified.An incident note dated February 16, 2023, revealed that Resident #60 was witnessed by staff hitting Resident #163 with his fists in the north hall. Per note, Resident #60 ran into Resident #163 by his power wheelchair from the back, then hit him on his right knee and face. Resident #60 was assessed with no injuries, and was placed on observation, the police were notified and investigated the incident.A Shower Body Check Program form dated January 17, 2023, revealed no bruises/skin tears were present.A care planned focus for behavioral problem related physical altercation towards other residents, dated February 17, 2023, revealed interventions that included to identify behavior triggers, and refer to psychiatric provider as ordered A weekly skin assessment dated [DATE], revealed no new or ongoing skin injury.- Regarding #163 (alleged victim)Resident #163 was re-admitted to the facility on [DATE], with diagnoses that included type 2 diabetes, adjustment disorder, and mood (affective) disorder.A care plan dated April 8, 2021, revealed that Resident #163 had behavior problems related to socially and sexually inappropriate, and refusal of care.A review of a quarterly MDS (Minimum Data Set) assessment dated [DATE], revealed a BIMS (Brief Interview for Mental Status) score of 13, which indicated intact cognition. The assessment included that no behaviors were present during the assessment period.A behavior progress note dated February 16, 2023, revealed that the resident had a physical altercation with another resident.A Incident progress note dated February 16, 2023, revealed that staff witnessed Resident #60 hit Resident #163. The note relayed that the residents were assessed with no injuries or bruises.Further review of care plan dated February 17, 2023, revealed that Resident #163 had a behavior problem related to impaired safety awareness. Interventions included that the resident will verbalize understanding of need to control verbal behaviors through the review date, and to identify behavior triggers.A weekly skin assessment dated [DATE], revealed no new or ongoing skin injury.An interview was conducted on May 4, 2026, at 1:40 pm, with an LPN (staff # 58), who stated that the different abuse can be verbal, physical, financial or misappropriation of property. The LPN stated that the facility process regarding resident-to-resident altercations included separating both residents, notifying the Abuse Coordinator immediately, and assessing both residents for injuries. The LPN then stated that she was not working at the facility when the incident occurred between Resident #60 and Resident #163. The LPN further stated that in general it would be considered abuse if one resident hits other resident because one resident was physically harming the other resident.An interview was conducted on May 5, 2026, at 1:50 p.m., with the Interim Director of Nursing (DON/Staff #125), who stated that abuse can be verbal, physical, sexual and financial. The DON further stated that any incidents of abuse should be reported to the abuse coordinator immediately. The DON then reviewed the clinical record for Resident #60 and Resident #163 and stated that she had not witnessed the incident but one resident hitting another resident would be considered physical abuse.Review of the facility policy titled, Resident Rights, dated January 1, 2024, revealed that preventing, recognizing and reporting resident abuseReview of the facility policy titled, Abuse Policy, date 2022, revealed that facilities strive to prevent the abuse of all their residents.