STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035139	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Show Low	2401 East Hunt Street Show Low, AZ 85901

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 interviews, review of clinical record, and facility policy, the facility failed to protect the resident's (#2) right to be free from physical abuse by another resident (#4). The deficient practice could result in physical and psychosocial harm.-Regarding Resident #2 (alleged victim): Resident #2 was re-admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic obstructive pulmonary disease, epilepsy, cerebral aneurysm, depression, sarcopenia, and anxiety disorder.A quarterly minimum data set (MDS) assessment dated [DATE], revealed Resident #2 had a brief interview for mental status (BIMS) score of 12, indicating moderately impaired cognition.A nursing note dated October 26, 2025, revealed Resident #2 was in their wheelchair in the center of the hallway blocking the pathway, when another resident (Resident #4) was wandering in the same direction. Resident #2 stopped to receive medications. The aggressive resident (#4) grabbed Resident #2's wheelchair by the handles and attempted to push Resident #2 forward. Resident #2 yelled loudly for the other resident to stop, at which time the other resident did stop, and then proceeded to hit Resident #2 with an open palm to the top of Resident #2's head with medium force. Resident #2 called for the hitting resident to stop, and a certified nursing assistant (CNA) was able to remove the other resident after one hit to the top of Resident #2's head. The note also revealed that the nurse (Staff #19) witnessed the entire interaction.-Regarding Resident #4 (alleged perpetrator):Resident #4 was admitted [DATE], with diagnoses that included cystitis, fetal alcohol syndrome, problem related to social environment, unspecified dementia, depression, alcohol abuse, and unspecified symptoms and signs involving cognitive functions and awareness.A quarterly MDS assessment dated [DATE], revealed a BIMS assessment was not completed for Resident #4 due to the resident being rarely or never understood.A care plan dated May 7, 2025 revealed Resident #4 had a behavior problem of wandering. Interventions included to anticipate and meet the resident's needs and to assist the resident to develop more appropriate methods of coping and interacting.An Alert Charting note dated October 6, 2025, revealed Resident #4 was found outside the building laying on the ground in the parking lot.A Behavior note dated October 22, 2025, revealed Resident #4 was walking down the hallway carrying a brief and a package of wipes. When the nurse approached to attempt to take away the items, Resident #4 threw the items on the floor. The note revealed that the nurse reached down to pick up the items, and Resident #4 slapped the nurse on the nurse's right shoulder, and that the incident was reported to the Director of Nursing (DON).An Alert Charting note dated October 26, 2025, revealed that another resident (#2) was in their wheelchair in the center of the hallway blocking the pathway, and Resident #4 was wandering in the same direction, when the other resident in the wheelchair stopped to receive medications. Resident #4 grabbed the other resident's wheelchair by the handles and attempted to push the resident forward. The resident in the wheelchair yelled loudly for Resident #4 to stop, at which time Resident #4 did stop and then proceeded to hit the other resident (#2) with an open palm to the top of her head with medium force. The resident in the wheelchair called for Resident #4 to stop, and a CNA was able to remove Resident #4 after one hit to the top of the resident's head. The (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	note also revealed that the nurse (Staff #19) witnessed the entire interaction.An interview was conducted on October 27, 2025, at 1:39 P.M., with Resident #2, who stated that she had an incident with a male resident several days ago. Resident #2 stated that she was going to see the nurse in the hallway, and that the male resident came up behind her and started pushing her wheelchair. Resident #2 stated that she told the male resident to stop, and that the male resident started hitting her on the top of her head. Then, she stated that the nurse (Staff #19) witnessed the incident, and called for another staff to separate the two residents, and that after the incident, staff kept the two residents separated. Resident #2 stated that during the incident, she did experience pain, and afterward she was worried because she has aneurysms, which could have caused her harm.A telephonic interview was conducted with a Licensed Practical Nurse (LPN / Staff #19) on October 27, 2025, at 2:16 P.M. Staff #19 stated that he witnessed the incident, and that he was passing medications with his medication cart in the middle of the hallway because the hallway was full of materials due to the floor renovation work. Staff #19 stated that Resident #2 wheeled up to the side of his medication cart in her wheelchair and Resident #4 was wandering behind Resident #2. Staff #19 stated that Resident #4 grabbed the handles of Resident #2's wheelchair and began to push it forward, at which point Resident #2 yelled out loudly because it scared her. Staff #19 stated that then, Resident #4 popped her (Resident #2) on the top of the head. Staff #19 stated that the pop was that Resident #4 raised his open hand approximately one foot above Resident #2's head and then brought his hand downward onto her head. Staff #19 stated that it was not a tap, but it also was not full force either, and that he would describe the hit as medium force. Staff #19 stated that Resident #2 did not voice any pain at the time of the incident but that she complained of a headache about 2 hours later, and then Staff #19 gave her pain medications. Staff #19 stated that Resident #2 called the police regarding the incident, and that the facility's phone system was not functioning at the time, so Staff #19 was unable to make any notifications until approximately 4:00 P.M. Staff #19 stated that after the incident, the facility staff ensured that the residents were kept separated.An interview was conducted with a Certified Medication Assistant (CMA / Staff #31) on October 27, 2025, at 2:27 P.M. Staff #31 stated that she did not witness the incident on October 26, 2025, but that she has witnessed similar situations with Resident #2, because he does not realize what he is doing or understand personal space. Staff #31 stated that after the incident, staff were supervising Resident #2 one on one. Staff #31 stated that the CNA who separated the residents during the incident was Staff #76.A telephonic interview was attempted on October 27, 2025, at 2:33 P.M. with Staff #76. The staff was unable to be reached by phone for interview.An interview was conducted on October 28, 2025, at 9:38 A.M. with a Registered Nurse (RN / Staff #22), who stated that there are different types of abuse, including verbal abuse, physical abuse, and neglect, and that if staff were to see or hear an allegation of abuse, that staff should intervene to separate the resident from abuse, and ensure the resident is safe, then report the incident to the Administrator.An interview was conducted with the Director of Nursing (DON / Staff #40) on October 28, 2025, at approximately 10:00 A.M. The DON stated that if staff see or hear anything that could be abuse, staff are to separate residents from the abuse, perform a head to toe assessment of the resident, assess the resident's physical and mental wellbeing, and report the incident to the DON or the Administrator. Regarding the incident between Resident #2 and Resident #4 on October 26, 2025, the DON stated that she received a call from Staff #19 that there was an incident between the two residents, where Resident #4 was confused and trying to get through the hallway and placed his hands on the back of Resident #2's wheelchair. The DON stated that Resident #2 then yelled at Resident #4. The DON stated that then, Resident #4's hand contacted Resident #2's head. When asked if this incident was determined to be physical abuse, the DON declined to directly state if it was abuse, but did state that it would depend on if the act was intentional. The DON stated that if a resident was intentionally trying to hurt the other resident then that would be considered abuse.An interview was conducted with the Administrator (Staff #50) on October 28, 2025, at 10:15 A.M. Staff #50 stated that abuse is generally an intentional harm or action against another resident. If staff were (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to see or hear an allegation of abuse, Staff #50 stated that he would expect them to report it to the Administrator or DON immediately. Staff #50 stated that if an act of physical abuse were to happen in front of floor staff, that he would expect staff to separate the residents and make sure they are safe, assess the residents, and then report the incident. Staff #50 stated that regarding the incident of Resident #2 and Resident #4 on October 26, 2025, that Staff #50 was notified by the DON, who was notified by Staff #19. Staff #50 stated that he was informed that Resident #2 was in the hallway and Resident #4 came up behind her wheelchair and pushed her wheelchair, and that Resident #2 did not like that and told him to stop. Then, Staff #50 stated that Resident #4 went like this (Staff #50 raised his hand then gestured moving downward with his open hand), on top of Resident #2's head. Staff #50 stated he had an interview with Resident #2 who stated that Resident #4 popped me on top of the head, and an interview with Staff #19, who stated that Resident #2 was bopped on the head by Resident #4. Staff #50 stated that the contact did happen; that Resident #4 did contact Resident #2's head.Review of the facility policy titled Resident Rights/Dignity: Resident Rights, dated January 1, 2024, revealed that Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence, be treated with respect, kindness, and dignity, and be free from abuse, neglect, misappropriation of property, and exploitation.Review of the facility policy titled Resident Rights/Dignity: Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated January 1, 2024, revealed all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management.