STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035172	A. Building B. Wing	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Safford	1933 Peppertree Drive Safford, AZ 85546

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** 47954 Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure that two residents (#15) and (#50) were free from physical abuse resulting in injury by other residents (resident #50, and resident #75). The deficient practice could result in further incidents of resident to resident abuse. Findings include: Regarding resident #15 and resident #50 -Resident #15 was admitted to the facility on [DATE] with diagnoses that include Hemiplegia, sepsis, urinary tract infections, dysphagia, and hypertension. Review of the Quarterly Minimum Data Set (MDS) assessment September 8, 2024 revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate cognitive impairment. A behavioral care plan revised December 6, 2023 revealed the resident was at risk of impaired cognitive function related to dementia with a noted intervention of keeping the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. -Resident #50 was admitted to the facility on [DATE] with diagnoses that include Bipolar disorder, dysphagia, hypertension, depression, and post traumatic stress disorder. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate cognitive impairment. A behavioral care-plan initiated August 31, 2021 revealed the resident has the potential to demonstrate abusive behaviors related to dementia, mental illness, and poor impulse control, with noted interventions for staff to intervene before agitation escalates, and guide away from source of distress. A review of the clinical record progress notes for resident #15 dated October 5, 2024 at 3:53 a.m. revealed the resident was being monitored for a recent one on one incident with another resident, and that the resident #15 was hit in the head with a hairbrush. (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	However, no progress notes detailing the incident in question were noted in resident #15's clinical record. An interview was conducted with resident #15 on October 21, 2024 at 12:55 p.m. The resident stated that resident #50 hit her on her face and pointed to her head. The resident stated there was a little bit of blood after, and that she didn't know what to do. The resident further stated resident #50 had a big bulky brush, an old one, and that was the brush that was used. An interview was conducted with a Certified Nursing Assistant (CNA/staff #5) on October 21, 2024 at 1:01 p. m. The CNA reported that resident #50 has lots of behaviors, and is not really a people person. The CNA stated that resident #50 can be mean to other residents at times and is very bossy. The CNA also stated resident #50 has been physical in the past. The CNA also confirmed the incident happened. An interview with a Registered Nurse (RN/staff #22) was conducted on October 21, 2024 at 1:16 p.m. The RN stated that resident #50 is needy, and doesn't realize she's not the only resident here. The RN stated that when she asked resident #50 why she hit resident #15 with the hair brush, resident #50 didn't want to talk about it. The RN stated resident #50 often gets mad with staff, has verbal outbursts and other behaviors. Regarding resident #50 and resident #75 -Resident #75 was admitted to the facility on [DATE], with diagnoses that include Dementia, heart disease, diabetes mellitus type II, epilepsy, and hypotension. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE]th, 2024 revealed a Brief Interview for Mental Status (BIMS) score of 07 which indicated the resident had significant cognitive impairment. A behavior care-plan initiated April 10, 2024 revealed the resident has a behavior problem related to inappropriate sexual behaviors towards staff and residents, with noted interventions of identifying behavior triggers, and anticipate and meet the resident's needs. Review of information received from the SA complaint tracking system revealed that on May 20, 2024, the facility reported that resident #75 was seen grabbing resident #50's breasts, and that the incident was witnessed by staff. An interview was conducted with resident #50 on October 21, 2024 at 12:42 p.m. The resident stated that in the incident on May 20, 2024 that she was wandering down the hallway when resident #75 touched her. The resident stated she thinks resident #75 did it on purpose. The resident stated it had never happened before and that she did feel abused. An interview was conducted with a Certified Nursing Assistant (CNA/staff #5) on October 21, 2024 at 1:01 p. m. The CNA reported that they have witnessed abuse before, however not recently. The CNA stated that resident #75 has inappropriate behaviors, and that he's touchy feely with other residents. The CNA also stated that he has dementia, and may understand or not. The CNA also stated that he refuses and is resistant to care a lot. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with a Certified Nursing Assistant (CNA/staff #45) was conducted on October 21, 2024 at 12:50 p.m. The CNA stated that resident #90 is very spontaneous, and a few times was aggressive like if he wanted to leave, he would get mad. He further stated resident #60 got an abrasion on their face from resident #90, and that resident #90 gave resident #30 a big black eye. The CNA further stated that they try to redirect him if he's getting angry and if it causes yelling try to do a 1:1 for him. An interview with a Registered Nurse (RN/staff #22) was conducted on October 21, 2024 at 1:16 p.m. The RN stated they were aware of incidents involving resident #75. The RN stated that they were made aware of resident #75 inappropriately touching other residents; but had never witnessed it. The RN stated that they feel this wouldn't be an issue if they were not understaffed. An interview with the Director of Nursing (DON/staff #1) was conducted on August 20, 2024 at 1:53 p.m. The DON stated that resident #50 has been aggressive towards staff a few times. The DON confirmed the incident occurred and stated that after the incident with resident #15 they took her hair brush away, and that when she took it away resident #50 swung at her. The DON also stated that resident #75 has been here about a year and displays sexual behaviors, mostly towards staff. The DON stated the incident was witnessed by a CNA. However the DON stated that the incident occurred; that interventions are in place to prevent it from happening again, and that it was kind of an outlier incident. The DON concluded that the administrator is the abuse coordinator, and that her expectation is that staff report and act on abuse immediately. A review of facility policy titled "Abuse Policy revealed that they strive to prevent the abuse of all residents. They recognize residents with the diagnosis of dementia and other mental illnesses whose behaviors are not always predictable. Further they recognize that due to the proximity of the residents to one another and an individual's freedom of choice, that situations may arise where it is not possible to completely prevent all incidents of abuse.