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	01/09/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, and review of the facility's policies and procedures the facility failed to implement their abuse prohibition policy when there was an allegation of sexual abuse of one resident (#5). The deficient practice could lead to residents not being protected from abuse.Findings include:Resident #5 was admitted to the facility on [DATE] with diagnoses that include early onset Alzheimer's disease, aphasia, and depression.A quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 00 which indicated Resident #5 had severe cognitive impairment.A care plan, initiated on August 11, 2025 indicated Resident #5 had behavior problems that included poor safety awareness, wandering, and exit seeking. Interventions included intervening as necessary to protect the rights and safety of others.The same care plan was updated on January 5, 2026 to include lifting shirt exposing breasts at times. However, there were no revisions made to the interventions related the Resident #5's behaviors. Review of the Progress Notes revealed there were no entries related to the alleged incident or related to Resident #5's tendency to lifting her shirt to expose her breasts.Related to Resident #8:Resident #8 was admitted to the facility on [DATE] with diagnoses that include Dementia with behavioral disturbances, Type 2 Diabetes, and depression.A quarterly MDS, dated [DATE], revealed Resident #8 had a BIMS score of 09 which indicated he had moderate cognitive impairment.Review of a Care Plan, revised on August 14, 2025, indicated Resident #8 had behavior problems related to his cognition status. Identified behaviors included wandering, exit seeking, and sexually inappropriate. Interventions included intervening as necessary to protect the rights and safety of others. However, there was no indication that the Care Plan was revised, post incident, to reflect modified interventions related to sexual behaviors.Review of the Progress Notes revealed a Behavior Note, dated January 1, 2026 at 3:17 P.M. that indicated Resident #8 was on 1:1 activity for increased supervision and monitoring.Review of a second Behavior Note, dated January 2, 2026 at 1:01 A.M. indicated that the resident needed redirection from staff and supervision among being around other residents.Review of a third Behavior Note, dated January 2, 2026 at 10:41 A.M. The note indicated that Resident #8 was noted to be kissing (Resident #5) and that person was reciprocating. However, no other Progress Notes were identified in the chart related to the alleged incident.Additional review of the Progress Notes revealed a Health Status Note, dated January 7, 2026 at 5:49 P.M. that indicated Resident #8 was sent to a hospital due to medical event.An observation was made on January 8, 2026 at 11:57 A.M. of the resident rooms in the unit. It was observed that the room of Resident #5 was directly across the hallway from the room of Resident #8.Review of the State Agency's (SA) complaint portal on January 8, 2025 at 12:00 P.M., revealed no Facility Reported Incident related to Resident #5 and #8.An interview was conducted on January 8, 2026 at 1:26 P.M. with Certified Nursing Assistant (CNA/Staff #22). Staff #22 shared that suspected abuse is reported to the administrator (ADM/Staff #2). She described Resident #5 as someone who isn't verbal but will make sounds. Staff (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communicate with her by verbal and non-verbal gestures such as patting on the hips tells her that staff will be changing her briefs. She also shared that Resident #5 is not able to give consent because she was cognitively impaired. Staff #22 explained that Resident #8 and #5 were residing in rooms directly across from each other. She also shared that she would not consider that safe for resident #5 because of the close proximity to him and he could easily get access to her.An interview was conducted on January 8, 2026 at 1:39 P.M. with Registered Nurse (RN/Staff #83). Staff #83 shared that suspected abuse is reported to the Staff #2 and that he was the abuse coordinator. She revealed that when she came onto shift this morning, she was told, during shift change, that there was inappropriate behavior between Resident #5 and Resident #8 but she was not sure what took place. Staff #83 indicated that Resident #8 was currently in the hospital and she was not sure if and when he was returning to the facility. Staff #83 also added that the residents should be moved because they were both in rooms across the hallway from each other.An interview was conducted on January 8, 2026 at 2:50 P.M. with RN/Staff #40. She stated that she was working two units on January 2nd when it was reported to her that Resident #8 was kissing Resident #5 on the cheek. She said that she had reported to management that both residents should be moved to different rooms away from each other because their rooms were right next to each other. She added that she was told to just keep the residents separated from each other.An interview was conducted on January 9, 2026 at 1:00 P.M. with the Director of Nursing (DON/Staff #17). Staff #17 shared that staff #2 was the abuse officer staff would report suspected abuse to him and if he wasn't available, staff would report it to her. They would then initiate an investigation to see if the situation was needing to be reported to the appropriate agencies. She explained that both residents were found in Resident #8's room and Resident #5 had her shirt up. She added that the residents were separated and they had found that no sexual abuse had occurred. She explained that RN/Staff #9 had witnessed the incident and she reported that the residents had gone into Resident #8's room when she went to the storage closet. Staff #17 shared that staff #9 had lost sight of them for two minutes and that it was highly unlikely that anything happened in those two minutes because both residents are slow moving. When asked if this incident was reported to the State, she stated it wasn't because based on their investigation, there was no sexual contact or abuse based on the staffs' statements. However, Staff #17 couldn't say with 100% certainly that nothing took place between the two residents. When asked to see the facility's investigative report, Staff #17 stated that the report was not a part of the clinical record and it was considered a part of quality measurement and she would need to check with Staff #2 to see if it could be shared with Surveyor.An interview was conducted on January 9, 2026 at 1:28 P.M. with Staff #2. Staff #2 confirmed that staff are to report suspected abuse to him as he is the abuse coordinator. He explained that once something is reported to him, he does a full investigation and then determines if it is something that needs to be reported based on what took place. He also shared that there is a leadership team in the corporate office that they will review situations with and then determine the best plan of action. When asked to describe the situation in question related to Residents #5 and #8, Staff #2 shared that that RN/Staff #9 had reported that Resident #8 was in bed with Resident #5 and they were both separated. He added that staff reported that both residents had their clothes on and they liked to flirt but nothing inappropriate had happened. Staff #2 explained that based on their investigation, they did not believe the situation was considered abuse based on what Staff #9 had described. He did confirm that Resident #5 would not be able to consent to being in bed with another person because she was not alert and oriented. However, he added, he did not feel that the situation was unsafe and he did not believe it needed to be reported. Staff #2 shared the investigative report with Surveyor and was (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked to read the statement written by Staff #9. He stated that the statement indicated Resident #5 was in bed with her shirt up and Resident #8 was hovering or leaning over her. Staff #2 shared that he did not consider Resident #5 having her shirt up and Resident #8 looking at her as abuse even if she could not consent to it.A telephonic interview was conducted on January 14, 2026 at 3:12 P.M. with Staff #9. Staff #9 explained that she was in the activity room and had to leave to go to the medication cart. She had seen both Resident #5 and Resident #8 in the activity room. A few minutes later she heard giggling and went to Resident #8's room where she found Resident #5 in bed with her shift off and Resident #8 hovering over her. She then separated the two residents and then called Staff #17 and reported it to her. She added that she did not consider this situation as sexual abuse because both residents were two consenting adults and both residents were in the room for 2 minutes and there wasn't enough time for them to do anything. Staff #9 admitted that both residents were not alert and oriented and that was why she reported the incident. She then admitted that the residents were not able to consent which is why she separated them. She added that maybe Resident #5 wanted to do something but they are not allowed to because they cannot consent. Staff #9 wasn't sure if the incident was reported to the State and added that her job was to report it to the DON (Staff #17) and it was not her place to determine if this was some type of abuse. She added that once she reports it to the DON, it was their job to determine if they needed to report it.Review of the facility's policy titled, Resident Rights/Dignity: Abuse, Neglect, Exploitation and Misappropriation Prevention Program indicated it took effect on January 1, 2024. The policy indicated that Residents have the right to be free from abuse. It also indicated that abuse included but wasn't limited to .sexual or physical abuse. The policy outlines that the facility needed to investigate and report any allegations within timeframes required by federal requirements and both residents were to be protected from any further harm during investigations.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of the facility's policies and procedures the facility failed to report an allegation of sexual abuse of one resident (#5). The deficient practice could lead to residents not being protected from abuse.Findings include:Resident #5 was admitted to the facility on [DATE] with diagnoses that include early onset Alzheimer's disease, aphasia, and depression.A quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 00 which indicated Resident #5 had severe cognitive impairment.A care plan, initiated on August 11, 2025 indicated Resident #5 had behavior problems that included poor safety awareness, wandering, and exit seeking. Interventions included intervening as necessary to protect the rights and safety of others.The same care plan was updated on January 5, 2026 to include lifting shirt exposing breasts at times. However, there were no revisions made to the interventions related the Resident #5's behaviors. Review of the Progress Notes revealed there were no entries related to the alleged incident or related to Resident #5's tendency to lifting her shirt to expose her breasts.Resident #8 was admitted to the facility on [DATE] with diagnoses that include Dementia with behavioral disturbances, Type 2 Diabetes, and depression.A quarterly MDS, dated [DATE], revealed Resident #8 had a BIMS score of 09 which indicated he had moderate cognitive impairment.Review of a Care Plan, revised on August 14, 2025, indicated Resident #8 had behavior problems related to his cognition status. Identified behaviors included wandering, exit seeking, and sexually inappropriate. Interventions included intervening as necessary to protect the rights and safety of others. However, there was no indication that the Care Plan was revised, post incident, to reflect modified interventions related to sexual behaviors.Review of the Progress Notes revealed a Behavior Note, dated January 1, 2026 at 3:17 P.M. that indicated Resident #8 was on 1:1 activity for increased supervision and monitoring.Review of a second Behavior Note, dated January 2, 2026 at 1:01 A.M. indicated that the resident needed redirection from staff and supervision among being around other residents.Review of a third Behavior Note, dated January 2, 2026 at 10:41 A.M. The note indicated that Resident #8 was noted to be kissing (Resident #5) and that person was reciprocating. However, no other Progress Notes were identified in the chart related to the alleged incident.Additional review of the Progress Notes revealed a Health Status Note, dated January 7, 2026 at 5:49 P.M. that indicated Resident #8 was sent to a hospital due to medical event.An observation was made on January 8, 2026 at 11:57 A.M. of the resident rooms in the unit. It was observed that the room of Resident #5 was directly across the hallway from the room of Resident #8.Review of the State Agency's (SA) complaint portal on January 8, 2025 at 12:00 P.M., revealed no Facility Reported Incident related to Resident #5 and #8.An interview was conducted on January 8, 2026 at 1:26 P.M. with Certified Nursing Assistant (CNA/Staff #22). Staff #22 shared that suspected abuse is reported to the administrator (ADM/Staff #2). She described Resident #5 as someone who isn't verbal but will make sounds. Staff communicate with her by verbal and non-verbal gestures such as patting on the hips tells her that staff will be changing her briefs. She also shared that Resident #5 is not able to give consent because she was cognitively impaired. Staff #22 explained that Resident #8 and #5 were residing in rooms directly across from each other. She also shared that she would not consider that safe for resident #5 because of the close proximity to him and he could easily get access to her.An interview was conducted on January 8, 2026 at 1:39 P.M. with Registered Nurse (RN/Staff #83). Staff #83 shared that suspected abuse is reported to the Staff #2 and that he was the abuse coordinator. She revealed that when she came onto shift this morning, she was told, during shift change, that there was inappropriate behavior between Resident #5 and Resident #8 but she was (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not sure what took place. Staff #83 indicated that Resident #8 was currently in the hospital and she was not sure if and when he was returning to the facility. Staff #83 also added that the residents should be moved because they were both in rooms across the hallway from each other.An interview was conducted on January 8, 2026 at 2:50 P.M. with RN/Staff #40. She stated that she was working two units on January 2nd when it was reported to her that Resident #8 was kissing Resident #5 on the cheek. She said that she had reported to management that both residents should be moved to different rooms away from each other because their rooms were right next to each other. She added that she was told to just keep the residents separated from each other.An interview was conducted on January 9, 2026 at 1:00 P.M. with the Director of Nursing (DON/Staff #17). Staff #17 shared that staff #2 was the abuse officer staff would report suspected abuse to him and if he wasn't available, staff would report it to her. They would then initiate an investigation to see if the situation was needing to be reported to the appropriate agencies. She explained that both residents were found in Resident #8's room and Resident #5 had her shirt up. She added that the residents were separated and they had found that no sexual abuse had occurred. She explained that RN/Staff #9 had witnessed the incident and she reported that the residents had gone into Resident #8's room when she went to the storage closet. Staff #17 shared that staff #9 had lost sight of them for two minutes and that it was highly unlikely that anything happened in those two minutes because both residents are slow moving. When asked if this incident was reported to the State, she stated it wasn't because based on their investigation, there was no sexual contact or abuse based on the staffs' statements. However, Staff #17 couldn't say with 100% certainly that nothing took place between the two residents. When asked to see the facility's investigative report, Staff #17 stated that the report was not a part of the clinical record and it was considered a part of quality measurement and she would need to check with Staff #2 to see if it could be shared with Surveyor.An interview was conducted on January 9, 2026 at 1:28 P.M. with Staff #2. Staff #2 confirmed that staff are to report suspected abuse to him as he is the abuse coordinator. He explained that once something is reported to him, he does a full investigation and then determines if it is something that needs to be reported based on what took place. He also shared that there is a leadership team in the corporate office that they will review situations with and then determine the best plan of action. When asked to describe the situation in question related to Residents #5 and #8, Staff #2 shared that that RN/Staff #9 had reported that Resident #8 was in bed with Resident #5 and they were both separated. He added that staff reported that both residents had their clothes on and they liked to flirt but nothing inappropriate had happened. Staff #2 explained that based on their investigation, they did not believe the situation was considered abuse based on what Staff #9 had described. He did confirm that Resident #5 would not be able to consent to being in bed with another person because she was not alert and oriented. However, he added, he did not feel that the situation was unsafe and he did not believe it needed to be reported. Staff #2 shared the investigative report with Surveyor and was asked to read the statement written by Staff #9. He stated that the statement indicated Resident #5 was in bed with her shirt up and Resident #8 was hovering or leaning over her. Staff #2 shared that he did not consider Resident #5 having her shirt up and Resident #8 looking at her as abuse even if she could not consent to it. When asked why the alleged abuse not reported to the State, he stated that there was no allegation of abuse. This was just a nurse (Staff #9) going to him and telling him that this incident took place. He added that even the nurse was unsure of the situation. A telephonic interview was conducted on January 14, 2026 at 3:12 P.M. with Staff #9. Staff #9 explained that she was in the activity room and had to leave to go to the medication cart. She had seen both Resident #5 and Resident #8 in the activity room. A few minutes (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	later she heard giggling and went to Resident #8's room where she found Resident #5 in bed with her shift off and Resident #8 hovering over her. She then separated the two residents and then called Staff #17 and reported it to her. She added that she did not consider this situation as sexual abuse because both residents were two consenting adults and both residents were in the room for 2 minutes and there wasn't enough time for them to do anything. Staff #9 admitted that both residents were not alert and oriented and that was why she reported the incident. She then admitted that the residents were not able to consent which is why she separated them. She added that maybe Resident #5 wanted to do something but they are not allowed to because they cannot consent. Staff #9 wasn't sure if the incident was reported to the State and added that her job was to report it to the DON (Staff #17) and it was not her place to determine if this was some type of abuse. She added that once she reports it to the DON, it was their job to determine if they needed to report it.Review of the facility's policy titled, Resident Rights/Dignity: Abuse, Neglect, Exploitation and Misappropriation Prevention Program indicated it took effect on January 1, 2024. The policy outlines that the facility needed to investigate and report any allegations within timeframes required by federal requirements.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, and review of the facility's policies and procedures, the facility failed to thoroughly investigate allegations of abuse for one resident (#5) and take steps to correct it. The deficient practice could lead to residents being subjected to continued abuse. Findings include:Resident #5 was admitted to the facility on [DATE] with diagnoses that include early onset Alzheimer's disease, aphasia, and depression.A quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 00 which indicated Resident #5 had severe cognitive impairment.A care plan, initiated on August 11, 2025 indicated Resident #5 had behavior problems that included poor safety awareness, wandering, and exit seeking. Interventions included intervening as necessary to protect the rights and safety of others.The same care plan was updated on January 5, 2026 to include lifting shirt exposing breasts at times. However, there were no revisions made to the interventions related the Resident #5's behaviors. Review of the Progress Notes revealed there were no entries related to the alleged incident or related to Resident #5's tendency to lifting her shirt to expose her breasts.Review of Resident #5's clinical chart reveals a skin assessment was completed on December 22, 2025 and the next assessment was completed on January 5, 2026. There were no skin issues noted. However, there was no other skin assessments done on or around the time of the alleged incident. Related to Resident #8:Resident #8 was admitted to the facility on [DATE] with diagnoses that include Dementia with behavioral disturbances, Type 2 Diabetes, and depression.A quarterly MDS, dated [DATE], revealed Resident #8 had a BIMS score of 09 which indicated he had moderate cognitive impairment.Review of a Care Plan, revised on August 14, 2025, indicated Resident #8 had behavior problems related to his cognition status. Identified behaviors included wandering, exit seeking, and sexually inappropriate. Interventions included intervening as necessary to protect the rights and safety of others. However, there was no indication that the Care Plan was revised, post incident, to reflect modified interventions related to sexual behaviors.Review of the Progress Notes revealed a Behavior Note, dated January 1, 2026 at 3:17 P.M. that indicated Resident #8 was on 1:1 activity for increased supervision and monitoring.Review of a second Behavior Note, dated January 2, 2026 at 1:01 A.M. indicated that the resident needed redirection from staff and supervision among being around other residents.Review of a third Behavior Note, dated January 2, 2026 at 10:41 A.M. The note indicated that Resident #8 was noted to be kissing (Resident #5) and that person was reciprocating. However, no other Progress Notes were identified in the chart related to the alleged incident.Additional review of the Progress Notes revealed a Health Status Note, dated January 7, 2026 at 5:49 P.M. that indicated Resident #8 was sent to a hospital due to medical event.An observation was made on January 8, 2026 at 11:57 A.M. of the resident rooms in the unit. It was observed that the room of Resident #5 was directly across the hallway from the room of Resident #8.Review of the State Agency's (SA) complaint portal on January 8, 2025 at 12:00 P.M., revealed no Facility Reported Incident related to Resident #5 and #8.An interview was conducted on January 8, 2026 at 1:26 P.M. with Certified Nursing Assistant (CNA/Staff #22). Staff #22 shared that suspected abuse is reported to the administrator (ADM/Staff #2). She described Resident #5 as someone who isn't verbal but will make sounds. Staff communicate with her by verbal and non-verbal gestures such as patting on the hips tells her that staff will be changing her briefs. She also shared that Resident #5 is not able to give consent because she was cognitively impaired. Staff #22 explained that Resident #8 and #5 were residing in rooms directly across from each other. She also shared that she would not consider that safe for resident #5 because of the close proximity to him and he could easily get access to her.An interview was conducted on January 8, 2026 at 1:39 P.M. with Registered (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse (RN/Staff #83). Staff #83 shared that suspected abuse is reported to the Staff #2 and that he was the abuse coordinator. She revealed that when she came onto shift this morning, she was told, during shift change, that there was inappropriate behavior between Resident #5 and Resident #8 but she was not sure what took place. Staff #83 indicated that Resident #8 was currently in the hospital and she was not sure if and when he was returning to the facility. Staff #83 also added that the residents should be moved because they were both in rooms across the hallway from each other.An interview was conducted on January 8, 2026 at 2:50 P.M. with RN/Staff #40. She stated that she was working two units on January 2nd when it was reported to her that Resident #8 was kissing Resident #5 on the cheek. She said that she had reported to management that both residents should be moved to different rooms away from each other because their rooms were right next to each other. She added that she was told to just keep the residents separated from each other.An interview was conducted on January 9, 2026 at 1:00 P.M. with the Director of Nursing (DON/Staff #17). Staff #17 shared that staff #2 was the abuse officer staff would report suspected abuse to him and if he wasn't available, staff would report it to her. They would then initiate an investigation to see if the situation was needing to be reported to the appropriate agencies. She explained that both residents were found in Resident #8's room and Resident #5 had her shirt up. She added that the residents were separated and they had found that no sexual abuse had occurred. She explained that RN/Staff #9 had witnessed the incident and she reported that the residents had gone into Resident #8's room when she went to the storage closet. Staff #17 shared that staff #9 had lost sight of them for two minutes and that it was highly unlikely that anything happened in those two minutes because both residents are slow moving. When asked if this incident was reported to the State, she stated it wasn't because based on their investigation, there was no sexual contact or abuse based on the staffs' statements. However, Staff #17 couldn't say with 100% certainly that nothing took place between the two residents. When asked to see the facility's investigative report, Staff #17 stated that the report was not a part of the clinical record and it was considered a part of quality measurement and she would need to check with Staff #2 to see if it could be shared with Surveyor.An interview was conducted on January 9, 2026 at 1:28 P.M. with Staff #2. Staff #2 confirmed that staff are to report suspected abuse to him as he is the abuse coordinator. He explained that once something is reported to him, he does a full investigation and then determines if it is something that needs to be reported based on what took place. He also shared that there is a leadership team in the corporate office that they will review situations with and then determine the best plan of action. When asked to describe the situation in question related to Residents #5 and #8, Staff #2 shared that that RN/Staff #9 had reported that Resident #8 was in bed with Resident #5 and they were both separated. He added that staff reported that both residents had their clothes on and they liked to flirt but nothing inappropriate had happened. Staff #2 explained that based on their investigation, they did not believe the situation was considered abuse based on what Staff #9 had described. He did confirm that Resident #5 would not be able to consent to being in bed with another person because she was not alert and oriented. However, he added, he did not feel that the situation was unsafe and he did not believe it needed to be reported. Staff #2 shared the investigative report with Surveyor. Upon review of the investigative report, it was found to consist of a written statement of Staff #9, who witnessed the incident, CNA/Staff #5 who was working the unit and did not witness it, and Staff #17, who received the initial report. Staff #2 was asked to read the statement written by Staff #9. He stated that the statement indicated Resident #5 was in bed with her shirt up and Resident #8 was hovering or leaning over her. Staff #2 shared that he did not consider Resident #5 having her shirt up and Resident #8 looking at her as abuse even if she could (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not consent to it.A telephonic interview was conducted on January 14, 2026 at 3:12 P.M. with Staff #9. Staff #9 explained that she was in the activity room and had to leave to go to the medication cart. She had seen both Resident #5 and Resident #8 in the activity room. A few minutes later she heard giggling and went to Resident #8's room where she found Resident #5 in bed with her shift off and Resident #8 hovering over her. She then separated the two residents and then called Staff #17 and reported it to her. She added that she did not consider this situation as sexual abuse because both residents were two consenting adults and both residents were in the room for 2 minutes and there wasn't enough time for them to do anything. Staff #9 admitted that both residents were not alert and oriented and that was why she reported the incident. She then admitted that the residents were not able to consent which is why she separated them. She added that maybe Resident #5 wanted to do something but they are not allowed to because they cannot consent. Staff #9 wasn't sure if the incident was reported to the State and added that her job was to report it to the DON (Staff #17) and it was not her place to determine if this was some type of abuse. She added that once she reports it to the DON, it was their job to determine if they needed to report it.Review of the State Operations Manual (SOM), Appendix PP indicates that the facility must thoroughly collect evidence to determine what actions are needed to protect the residents. It continues to highlight that, depending on the type of allegation, while there was no specific investigation process it was expected that the facility collects evidence which would include observations of the residents, interviews, and record reviews for pertinent information. The SOM also explains that the facility must immediately put measures into place to protect the residents from further abuse while the investigation was in process.Review of the facility's policy titled, Resident Rights/Dignity: Abuse, Neglect, Exploitation and Misappropriation Prevention Program indicated it took effect on January 1, 2024. The policy outlines that the facility needed to investigate and report any allegations within timeframes required by federal requirements.