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	02/10/2026

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 0600 Level of Harm - 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 clinical record reviews, facility documentation, resident, family, and staff interviews, and policy review, the facility failed to protect the rights of two residents (#10) and (#20) to be free from abuse by another Resident (#50). This deficient practice could result in further incidents of resident to resident abuse. Findings include: -Resident #10 (Victim #1) was admitted to the facility on [DATE], with diagnosis that include hemiplegia, cerebral vascular accident, dementia, urinary tract infection, diabetes mellitus type 2, and sepsis. Review of the Quarterly Minimum Data Set (MDS) assessment dated November December 8, 2025 revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate cognitive impairment. A review of the care-plan for Resident #10 revealed the resident has a behavior problem related to impaired cognitive function, impaired safety awareness, and verbal behaviors with noted interventions of anticipate and meet the resident's needs, allow resident to make decisions about the plan of care, and give resident a clear explanation of all care activities prior to and as they occur during each contact. A review of progress notes for Resident #10 revealed no evidence of any incident involving resident's #20, or #50 in the clinical record. A review of skin assessments for Resident #10 dated January 23, 2026 at 4:05 p.m. revealed the finding for the skin assessment was a small scratch / abrasion noted to right forearm, however there are no other details listed in the assessment as to the cause of the scratch and abrasion. -Resident #20 (Victim #2) was admitted to the facility on [DATE], with diagnoses that include Cerebral ischemia, chronic obstructive pulmonary disease, metabolic acidosis, quadriplegia, transient ischemic attack, and depression. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had no cognitive impairment. A review of the care-plan for Resident #20 revealed the resident has been the recipient of physical and verbal behaviors from another resident, with noted interventions of provide for safety and attempt to prevent interactions from being target of resident behaviors. A review of progress notes for Resident #20 revealed no evidence of any incident involving resident's #10, or #50 in the clinical record. -Resident #50 (Perpetrator) was admitted to the facility on [DATE] with diagnoses that include Vascular dementia, diabetes mellitus type 2, metabolic encephalopathy, urinary tract infection, adjustment disorder with anxiety, and metabolic acidosis. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had no cognitive impairment. A review of the care-plan for Resident #20 revealed the resident has a behavior problem related to impaired cognitive function, impaired safety awareness, physical behaviors, verbal behaviors, and resistance to care. There are noted interventions of administer medications as ordered, monitor and document for side effects and effectiveness, and anticipate and meet the resident's needs. A review of progress notes for Resident #50 dated January 21, 2026 at 2:43 p.m. revealed Resident #50 while being redirected by (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 - Actual harm Residents Affected - Few	staff during a separate elopement incident, and notes Resident #50 was attempting to closed- fist hit a staff member per report, and the note concludes that Resident #50 requires 24-hour supervision for safety. A review of progress notes for Resident #50 dated January 23, 2026 at 2:44 p.m. revealed the executive director called to receive verbal report at 2:35 p.m. The verbal report given to the emergency department (ED), states Resident #50 is stable in the ED at this time, and going to get a urine sample. The RN (registered nurse) was able to answer questions as to events leading up to the incident and states no further concerns / questions at this time. However, there were no details related to the incident before, during, or after what led to the above listed verbal report, or any details as to what occurred during the incident. An observation was made with Resident #20 on February 10, 2026 at 8:35 a.m. during an interview with Resident #20, the resident was observed to be startled and initially withdrawn when surveyor initially entered the room. When the interview began and the initial topic of the incident was broached, resident became visibly distraught, tearful, and began crying. Resident #20's distraught behavior continued through the end of the above interview. An interview was conducted with Resident #20 on February 10, 2026 at 8:35 a.m. The resident stated that Resident #50 grabbed her and started hitting her, and stated that I can't do nothing, I'm disabled. Resident #20 further stated that Resident #50 started making fun of her, and that she was afraid. Resident #20 stated she was praying to God, and that Resident #50 grabbed her and hurt her arm. Resident #20 further stated that she can't even walk, and I can't do anything because my arm doesn't work. Resident #20 stated that I should speak to Resident #10, as she would have further information. Resident #20 stated further that Resident #50 is mean, and the police came and she told them what happened. Resident #20 concluded that she feels abused, and that she is afraid with Resident #50 here. An interview was conducted with a Resident #10 on February 10, 2026 at 8:50 a.m. Resident #10 stated that during the incident Resident #20 was sitting down in the hallway by the corner, and that Resident #50 went looking for her family. Resident #10 stated that everyone likes to sit in that section of the hall because that's where the family likes to come in, and later Resident #50 came back down the hall and started hitting Resident #20 in the head. Resident #10 stated she yelled for help and then staff #25 got between Resident #50 and resident #20. Resident #20 further stated that staff #45 saw this and showed up to help, and then the DON also came. Resident #10 stated that she was sitting in her doorway after the incident and the staff had resident #50 down the hallway. Resident #10 stated that Resident #50 then came back down the hall and initially smiled at her, and then Resident #50 hit me in the arm and in the head, and stated multiple staff members were there. Resident #10 also stated that when Resident #50 hit her the DON grabbed her arm to move it in the way and try to block Resident #50. Resident #10 stated that she was fine after the incident and further stated that she wasn't hurt other than the bruise on her arm, and that the police came and talked to her and took pictures, took her statement, and sent Resident #50 to the hospital. Resident #10 concluded that she felt Resident #50 had the advantage because she was standing up, and Resident #10 stated that she is in a wheelchair and wasn't expecting it. An observation was made during the above interview with Resident #10, the resident's arm was observed to show reddish / grey marks on right forearm, one approximate 1.5-inch reddish mark and one 2-centimeter grey mark, that the resident attributed to the incident. An interview was conducted with the Ombudsman on February 10, 2026 at 10:23 a.m. The Ombudsman stated she was in the building during the incident, and that she was in a care conference with the social worker and a family when the incident occurred. She further stated that during the conference staff members came around the corner as if startled, and that she went into the social worker's office for unrelated issues. The ombudsman stated she heard screaming coming from the hall and that she (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	could hear them talking to Resident #50, and staff #45 came back into the office and said Resident #50 was upset because her family had taken off. The ombudsman stated that a few minutes later staff #45 took off running and when she came back, stated that Resident #50 had struck two other residents, but that they didn't give her the resident's names. The Ombudsman stated that she wasn't aware of any injuries but was aware the police had come into the building after it happened. An interview was conducted with the social services director (staff/#45) on February 10, 2026 at 10:38 a.m. Staff #45 stated that prior to the incident she was in her office in a care conference with a difficult family member when she saw someone run past her office, then she jumped up and stated what is going on and Resident #50's daughter ran past. Staff #45 stated that they were trying to get away from Resident #50 because she was in the bathroom. Staff #45 stated she finished with the ombudsman and heard commotion coming from outside her office and Resident #50 was pushing her wheelchair with blankets in it and said Resident #50 stated fuck this I'm leaving and then started screaming about her daughter, and stating you made them leave. Staff #45 stated that she and one of the nurses got Resident #50 back to her room and went back to her office. Staff #45 stated a few minutes later she heard someone hollering and when she checked in the hallway, Resident #50 was yelling at Resident #20. Staff #45 stated that she told the residents to knock it off and stated that at that point resident #50 started swinging on resident #20. She stated that staff #25 was there and got between them and helped defuse the situation and redirected resident #50 back to her room. Staff #45 stated that while on the way back to her room Resident #10 was sitting in her doorway and saw Resident #50 bundle up her hand and swung at Resident #10. Staff #45 further stated that the DON was standing right there and grabbed Resident #10's arm to try to guard herself. Staff #45 clarified that she tried to pull resident #50 away, and the DON tried to block Resident #50's swing towards resident #10. Staff #45 stated that nothing related to the incident was documented in the chart, and further stated that she is new to the position and was not confident in precisely what to document in the chart with regards to the incident. Staff #45 concluded that the behavior was not appropriate. An interview was attempted with Resident #50 on February 10, 2026 at 11:23 a.m., The resident was not alert and oriented and wasn't able to interview. An interview was conducted with a Certified Nursing Assistant (CNA/staff#25) on February 10, 2026 at 12:00 p.m. The CNA stated that while she was pouring drinks and getting ready for tray pass, Resident #10 got their attention and saw Resident #50 and Resident #20 arguing, and stated they previously don't seem to like each other so they try to keep them separate. The CNA stated that the whole situation escalated really fast. The CNA stated I put myself between them, I go got hit a couple of times but I was trying to be a barrier. The CNA stated that after the initial contact the DON came to check on Resident #20, and staff #45 was taking Resident #50 back to her room, and Resident #10 was sitting in the hallway when Resident #50 stopped and got into Resident #10's face, and then slapped her. The CNA stated that the DON attempted to intervene and that Resident #10 didn't respond at all to being struck. The CNA stated that they then separated all the residents again and took Resident #50 to her room. The CNA stated that Resident #50 really doesn't like Resident #20 for some reason so they tend to argue and it leads to that escalation. The CNA concluded that I don't feel residents should be scared to live where they live, and stated this feels like abuse, and that once it crosses a physical barrier that's too much. An interview was conducted with the Director of Nursing (RN/staff #90) on February 10, 2026 at 2:30 p.m. The DON stated that she was aware of the incident between Residents #50, #20, and #10. She stated that received a call from the receptionist that Resident #50 was upset her family had left, and stated that she redirected Resident #50 back to her room, and waited back up at the front in case Resident #50 attempted to leave the building, so (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	she stayed up at the front expecting her to come back to the front door. The DON stated that she heard a commotion down the hall and that's when she saw Resident #20 initially, and stated that staff #45 and staff #25 were standing between Resident #50 and Resident #20. The DON then stated that staff #45 started to assist Resident #50 back to her room, and out of the corner of her eye saw Resident #50 lunge at Resident #10. The DON stated that she was able to break that contact but there was still an attempt. The DON stated that after the incident the police came and interviewed Resident #20, and that she stayed with Resident #50 until she went to the emergency room. The DON stated that Resident #50 was sent to the emergency room to stabilize and evaluate her, and states she was found to have a urinary tract infection. The DON stated that she did the single skin assessment noted above on Resident #10, but that there was no other documentation in the clinical record related to the incident. The DON stated that she did the self-report, an incident report in risk management, and not in the clinical record. The DON stated that it is not the standard to document that way and that there should have been documentation in the clinical record. The DON stated that abuse is any physical, verbal, financial, or emotional behavior towards a resident, and further stated that yes this was abuse. The DON concluded that their policy was not followed with regards to documentation. A review of facility policy titled 'Resident Rights/Dignity: Abuse, Neglect, Exploitation and Misappropriation Prevention Program effective January 1, 2024 revealed residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, resident, family, and staff interviews, and policy review, the facility failed to protect the rights of a resident (#10) to be free from misappropriation from staff. This deficient practice could result in further incidents of staff to resident abuse. Findings Include: -Resident #10 was admitted to the facility on [DATE], with diagnosis that include hemiplegia, cerebral vascular accident, dementia, urinary tract infection, diabetes mellitus type 2, and sepsis. Review of the Quarterly Minimum Data Set (MDS) assessment dated November December 8, 2025 revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate cognitive impairment. A review of the care-plan for resident #10 revealed the resident is at risk for functional care deficits and functional mobility limitations with noted interventions of requiring assistance with ambulation, and require supervision and assistance with various activities of daily living. A review of the SA complaint system on January 27, 2026 at 4:43 p.m. revealed a facility reported incident that resident #10 needed to speak with the administrator about a concern. At 3:00 p.m. the administrator spoke to resident #10 and reported that a former employee identified as staff #200 was supposed to open a bank account for resident #10, and that resident #10 had set up two transfers to come out monthly of $500, for a total of $1000.An attempt to call and interview staff #200 was made on February 10, 2026 at 1:00 p.m., but there was no answer, and no way to leave a voicemail.An interview was conducted with a registered nurse (RN/staff #65) on February 10, 2026 at 1:40 p.m. The RN stated that she was not involved in the incident but was aware of it. The RN stated that given the details RN agreed that would constitute abuse. The RN stated that abuse is a violation of a resident's rights, either sexual, financial, emotional, or physical. The RN concluded that if abuse is suspected they would notify the administrator, and the Director of Nursing. An interview was conducted with resident #10 on February 10, 2026 at 1:50 p.m. Resident #10 stated that she had money taken from her by an employee in the facility. The staff member was identified as staff #200. Resident #10 identified the staff member by name as staff #200. Resident #10 stated she thinks staff #200 walked out after the incident, and that she trusted staff #200. Resident #10 stated that staff #200 had agreed to help her set up a checking account, and that she set up two transfers for $500 each over 2 months, and then it got stopped. Resident #10 thinks her son is the one who stopped the transfers when he saw it on her accounts. Resident #10 stated that it was in may and June of last year (2025), and that it came to his attention so the police got involved. Resident #10 stated she kept asking staff #200 for the money back and that staff #200 stated that It was only money, and that she had a problem with that. Resident #10 then stated that the law showed up to staff #200's house and then suddenly staff #200 was blowing up her phone and that the police told her not to react if staff #200 called her. Resident #10 stated that she refused to press charges and that she later got the money back in two payments of $500. Resident #10 stated that she felt she was abused and that staff #200 took advantage of her. Resident #10 concluded that she felt embarrassed, and given how much she trusted staff #200 felt the whole thing was a big slap in the face. An interview was conducted with the Director of Nursing (RN/staff #90) on February 10, 2026 at 2:30 p.m. The DON stated that she was aware of the incident with resident #10, and stated that it was staff #200 who was involved. The DON stated that her understanding was that resident #10 had asked staff #200 to set up an account that was not linked to her family. The DON further stated that staff #200 agreed to that and that the payments would be used to set up a new account in resident #10's name. The DON stated that the account was never created, and that when they found out about it they notified the local police department. The DON stated that staff (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#200 had resigned from the facility prior to them being made aware of the incident. The DON also stated that they investigated it and did their due diligence, and confirmed the money was sent to staff #200. The DON stated that the money was returned, but that yes it was financial abuse.A review of facility policy titled 'Resident Rights/Dignity: Abuse, Neglect, Exploitation and Misappropriation Prevention Program effective January 1, 2024 revealed residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.