

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 08/05/2026
NAME OF PROVIDER OR SUPPLIER Haven of Safford		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, facility documentation, staffing records, and policy review, the facility failed to ensure sufficient nursing staff were available to provide care and services to meet residents' needs. The deficient practice could result in delayed or unmet care needs for residents requiring staff assistance. Findings include: Review of the Payroll-Based Journal (PBJ) Staffing Data Report revealed that the facility consistently triggered for excessively low weekend staffing during three reporting quarters in 2025. The facility assessment dated [DATE], revealed that the facility was licensed to provide care for 106 residents and had an average daily census of 70 to 80 residents. The average census included 10 to 25 short-stay residents and 30 to 45 long-stay residents. The facility assessment further identified 65 residents who required at least two-person assistance. The facility assessment staffing plan identified the following nursing staffing structure: Full-time Director of Nursing (DON); Full-time Registered Nurse Assistant Director of Nursing (ADON); Full-time Minimum Data Set Registered Nurse (RN); Full-time wound care Registered Nurse; Full-time direct-care Certified Nursing Assistants (CNAs); CNA staffing ratio of 1:8-15 on days; CNA staffing ratio of 1:8-15 on evenings; CNA staffing ratio of 1:15-20 on nights; One full-time equivalent Lead CNA providing direct care; 1.5 full-time equivalent Restorative Nursing Assistants providing direct care; Five Registered Nurses/Licensed Practical Nurses (RN/LPNs) for the 6:00 AM to 6:00 PM shift; Two RN/LPNs for the 6:00 PM to 6:00 AM shift; Six CNAs for the 6:00 AM to 6:00 PM shift; and Four CNAs for the 6:00 PM to 6:00 AM shift. The staff schedule revealed that the facility consisted of six halls/units: East A, East B, East C, West, Transitional Care Unit, and Protective Care Unit. Clinical staff worked 12-hour shifts. The assignment sheets, Daily Staffing Postings, and punch-in records were conducted for selected dates from January through September 2025. The assignment sheets and Daily Staffing Postings generally reflected scheduled nursing staffing levels. However, comparison of these records with the corresponding punch-in records revealed a pattern of nursing staff call-offs and staff not completing their scheduled 12-hour shifts because they clocked out early. Staffing reviewed included: From January 10 through January 12, 2025, the facility census ranged from 78 to 81 residents. The Daily Staffing Postings reflected between three and four RN/LPNs, up to one Certified Medication Assistant (CMA), and six to eight CNAs on the day shift. The night shift reflected two RN/LPNs and four CNAs. Punch-in records for the three-day period reflected a total of 203.35 RN/LPN hours and 365.67 CNA hours. From February 7 through February 9, 2025, the facility census ranged from 72 to 73 residents. The Daily Staffing Postings reflected four RN/LPNs and six to seven CNAs on the day shift. Night staffing reflected one to two RN/LPNs and four CNAs. Punch-in records for the three-day period reflected 209.30 RN/LPN hours and 430.60 CNA hours. From February 21 through February 23, 2025, the facility census ranged from 72 to 77 residents. Day staffing reflected (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 035172	Facility ID: 035172 If continuation sheet Page 1 of 12

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	four RN/LPNs and five to eight CNAs, while night staffing reflected two RN/LPNs and four to five CNAs. Punch-in records reflected 207.58 RN/LPN hours and 340.60 CNA hours.From March 6 through March 8, 2025, the census ranged from 74 to 76 residents. Day staffing reflected four to five RN/LPNs and six to seven CNAs, while night staffing reflected two RN/LPNs and four to five CNAs. Punch-in records reflected 228.75 RN/LPN hours and 359.38 CNA hours.From March 13 through March 15, 2025, the census ranged from 72 to 75 residents. Day staffing reflected three to four RN/LPNs, up to two CMAs, and five to eight CNAs. Night staffing reflected two to three RN/LPNs and four CNAs. Punch-in records reflected 213.75 RN/LPN hours and 347.67 CNA hours.From May 8 through May 10, 2025, the census ranged from 73 to 75 residents. Day staffing reflected three to four RN/LPNs and six to seven CNAs, while night staffing reflected two RN/LPNs and four CNAs. Punch-in records reflected 216.43 RN/LPN hours and 375.65 CNA hours.From May 22 through May 24, 2025, the census ranged from 70 to 71 residents. Day staffing reflected four RN/LPNs and six to seven CNAs. Night staffing reflected one to two RN/LPNs, up to one CMA, and four CNAs. Punch-in records reflected 204.68 RN/LPN hours and 391.58 CNA hours.From June 5 through June 7, 2025, the census ranged from 68 to 69 residents. Day staffing reflected four RN/LPNs and five to seven CNAs, while night staffing reflected two RN/LPNs and four CNAs. Punch-in records reflected 190.45 RN/LPN hours and 374.98 CNA hours.From June 19 through June 21, 2025, the census ranged from 72 to 75 residents. Day staffing reflected three to four RN/LPNs, up to one CMA, and five CNAs. Night staffing reflected two RN/LPNs and four CNAs. Punch-in records reflected 181.17 RN/LPN hours and 369.07 CNA hours.From July 3 through July 5, 2025, the census ranged from 80 to 82 residents. Day staffing reflected three to four RN/LPNs, up to one CMA, and five to six CNAs. Night staffing reflected one to two RN/LPNs, up to two CMAs, and four CNAs. Punch-in records reflected 207.67 RN/LPN hours and 407.38 CNA hours.From July 17 through July 19, 2025, the census ranged from 77 to 79 residents. Day staffing reflected three RN/LPNs and six CNAs, while night staffing reflected two RN/LPNs and four CNAs. Punch-in records reflected 247.05 RN/LPN hours and 435.15 CNA hours.From August 7 through August 9, 2025, the census was 79 residents. Day staffing reflected three to four RN/LPNs and six CNAs, while night staffing reflected two RN/LPNs and four CNAs. Punch-in records reflected 218.85 RN/LPN hours and 353.93 CNA hours.From August 21 through August 23, 2025, the census ranged from 75 to 77 residents. Day staffing reflected three to four RN/LPNs and five to six CNAs, while night staffing reflected two RN/LPNs and four CNAs. Punch-in records reflected 211.42 RN/LPN hours and 392.28 CNA hours.From September 4 through September 6, 2025, the census ranged from 82 to 84 residents. Day staffing reflected three RN/LPNs and five to six CNAs, while night staffing reflected two RN/LPNs and four CNAs. Punch-in records reflected 219.22 RN/LPN hours and 410.67 CNA hours.From September 25 through September 27, 2025, the census ranged from 77 to 79 residents. Day staffing reflected three to four RN/LPNs, up to one CMA, and six to seven CNAs, while night staffing reflected two RN/LPNs and four CNAs. Punch-in records reflected 178.68 RN/LPN hours and 440.20 CNA hours.Comparison of the Daily Staffing Postings and assignment sheets with the punch-in records revealed that, although the scheduled staffing initially reflected sufficient staffing levels, actual staffing levels identified were affected by a high rate of call-offs among RNs, LPNs, CNAs, LNAs, and CMAs. The punch-in records further revealed that some nursing staff did not complete their scheduled 12-hour shifts because they clocked out early.As evidenced by the comparison of the staffing records with the staffing levels identified in the facility assessment revealed multiple review dates on which actual nursing staffing was below the staffing levels identified in the facility assessment. On August 3, 2026, at 9:46 AM, an interview was conducted with Licensed Nursing Assistant (LNA/Staff #72), who stated there were shortages of CNAs/LNAs on (continued on next page)		

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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 clinical record review, staff interviews, facility documentation, and review of applicable policies and procedures, the facility failed to ensure two of five sampled resident's (Resident #75 and Resident #52) right to be free from physical abuse by another resident (Resident #43 and Resident #6). The deficient practice had the potential to result in additional incidents of abuse and failure to take appropriate measures to protect the residents. Findings included: Regarding resident #75 and Resident #43: -Regarding Resident #75 Resident #75 was admitted to the facility on [DATE] with pertinent diagnoses including dementia, chronic heart disease, anxiety disorder, chronic pain syndrome, visual hallucinations, generalized muscle weakness, and other related comorbidities. A care plan dated June 26, 2025, revealed that Resident #75 had impaired cognitive function related to dementia, which affected her ability to make her own decisions, with noted interventions to reduce distractions, such as television volume, radio, and keeping the door closed, which had been initiated on June 26, 2025. A behavioral care plan dated July 4, 2025, revealed that Resident #75 had psychosocial well-being concerns related to anxiety, dependent behavior, distractibility, and inability to concentrate. The behavioral treatment plan directed staff to encourage participation by Resident #75, who depended on others to assist with decision-making. The targeted goals for these cognitive and behavioral concerns had a target date of March 31, 2026. The quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #75 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. The assessment also indicated that Resident #75 required substantial assistance with sit-to-stand, bed-to-chair, toilet, and shower transfers. A review of a skin assessment for Resident #75 dated July 12, 2026 at 3:13 p.m., identified a new skin impairment consisting of a small scratch on the left hand at the joint of the ring finger. The area was cleansed and left open to air (OTA). An additional skin assessment dated [DATE] at 10:20 a.m., revealed no new skin impairment; however, slight redness was noted under Resident #75's breasts. -Regarding Resident #43 Resident #43 was admitted to the facility on [DATE], with pertinent diagnoses of Wernicke's encephalopathy, generalized muscle weakness, abnormalities of gait and mobility, brachial plexus (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disorders, neuromuscular dysfunction of the bladder, attention-deficit/hyperactivity disorder, anxiety disorder, major depressive disorder, and other related comorbid conditions. At the time of the investigation, Resident #43 remained at the facility. The care plan revealed resident #43 had impaired thought processes related to difficulty initiating activities and making decisions. The care plan also included interventions to reduce distractions, such as television volume, radio, and keeping the door closed, which had been initiated on September 4, 2024. A behavioral care plan initiated on September 9, 2024, revealed resident #43 had behavioral concerns related to impaired cognitive function and thought processes, impaired safety awareness, wandering and exit-seeking behaviors, making false accusations toward staff and the facility, and fabrication of events or fictitious circumstances. The targeted goals for these behavioral and cognitive concerns had a target date of April 27, 2026. The quarterly MDS assessment dated [DATE], indicated that Resident #43 had a BIMS score of 13, which indicated intact cognition with little to no impairment. The MDS also indicated verbal behavioral symptoms, including threatening others, screaming, and cursing directed toward others. A review of intakes from the State Agency (SA) reporting system revealed a facility Incident Report Summary 5-Day Report dated July 12, 2026. The report indicated that Resident #43 attempted to take the TV remote control from Resident #75 during a disagreement regarding the TV volume. During the incident, Resident #43 struck Resident #75 with an open hand while attempting to take the remote control, and Resident #75 responded by scratching Resident #43's arms. The incident report indicated that the disagreement regarding the TV escalated to physical contact between the residents. A nursing note dated July 12, 2026, at 2:30 p.m., indicated that Staff #9 documented an escalation in behavior involving Resident #43 and her roommate, Resident #75, which resulted in a conflict. The note further indicated that both residents were separated to ensure their safety and that 15-minute checks were initiated for both residents. A nursing note by staff #51 dated July 12, 2026, at 3:30 p.m., indicated that Resident #43 reported she had not been sleeping and was frustrated by her roommate's television (TV) volume, which she stated had triggered the resident-to-resident altercation. A nursing note dated July 12, 2026, at 3:30 p.m., documented that Resident #75 no longer wanted to share a room with Resident #43 and had been moved to a different room. A nursing note dated July 12, 2026, at 9:38 p.m., documented that Resident #43 had been moved to a new room and that Staff #50 applied dressings to Resident #43's left forearm and right hand as a result of the altercation. A review of Resident #43's weekly skin-check dated July 12, 2026 at 3:19 p.m., revealed a new skin impairment that detailed 63 mm scratch on the forearm. The area was cleaned and a silicone dressing was applied. Smaller scratches were also noted between the thumb and first finger; these areas were (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleaned and treated with bordered gauze dressings. The skin impairment had not been documented during an earlier assessment and was managed routinely until the wound healed on or about July 21, 2026. An interview was conducted with Certified Nursing Assistant (CNA/staff #180), on August 3, 2026 at 2:58 p.m. Staff #180 stated they had been present on the floor at the time of the altercation on July 12, 2026. Staff #180 stated that she was on the floor when the altercation occurred, and immediately contacted the nurse to report the incident. An interview and observation of Resident #43 in her room was conducted on August 3, 2026, at 3:05 p.m. Resident #43 appeared to be in good spirits and showed the discoloration from a scar that remained on her left hand. She stated that she felt safe and comfortable in her current room. An interview and observation of Resident #75 was conducted on August 3, 2026, at 3:21 p.m. Resident #75 recalled the incident and stated that Resident #43 had come to her bed, struck her left leg, chest, and the left side of her face, and attempted to take the remote control from her. Resident #75 stated that she scratched Resident #43's hands in response. During the observation, Resident #75 stated that she felt safe and that the nursing staff had been helpful. A telephone interview with a Registered Nurse (RN/staff #9) was conducted on August 3, 2026, at 3:53 p.m. Staff #9 stated that she responded with Staff #180 to the resident's room, where they observed a physical altercation accompanied by verbal exchanges and discord between the residents. Staff #9 stated that Resident #43 had an injury to her left arm that was a skin tear, but was not bleeding profusely, which was dressed accordingly and did not require referral to the emergency room. Staff #9 also stated that she conducted a thorough assessment of Resident #75 and did not observe any obvious injury requiring immediate emergency medical care. An interview with the Director of Nursing Services, (DON/Staff #51), was conducted on August 5, 2026, at 9:37 a.m. Staff #51 stated that she had been notified by staff immediately following the altercation on July 12, 2026. Staff #51 stated that the facility conducted an internal investigation and reported the incident to the appropriate authorities within the required timeframe. Staff #51 further stated that Resident #43 had previously made general comments regarding odors but had not directed those comments specifically toward anyone, including her roommate. Staff #51 also stated that room assignments were based on residents' similarities in terms of their needs and care plans. Staff #51 defined abuse as a willful act intended to harm another person and stated that abuse could occur between staff and residents, between residents, or between residents and visitors through verbal, physical, financial, or physical restraint-related actions. Staff #51 agreed that when one resident hit another resident on the head or hands, or scratched or slapped another resident, the action could constitute physical abuse when there was an intent to cause harm. This understanding of physical abuse was consistent among the staff members interviewed during the investigation. -Regarding Resident #6 and Resident #52: -Regarding Resident #6 (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6 (Perpetrator) was admitted to the facility on [DATE], with diagnoses that included dementia, anxiety, hypertension, a history of fractures and malnutrition. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 07, which indicated the resident had significant cognitive impairment. The care-plan revealed the resident had a behavior problem related to impaired safety awareness, verbal behavior, and physically aggressive behaviors, with a goal of maintain resident safety and notable interventions of intervening as necessary to protect the rights and safety of others, approach the resident and speak in a calm manner, divert the resident's attention, and remove from the situation and take to alternate location as needed. The progress notes dated July 26, 2026 at 1:49 p.m. revealed a struck-out note that stated while the nurse was on break, the CNA reported that resident #6 clawed her roommate (resident #52) in the face. Upon assessment, resident #52 was noted to have superficial scratches under the right side of her chin and red marks on the cheek. No active bleeding was observed. Resident #6 was also observed kicking another resident's wheelchair in an apparent attempt to get the other resident to move out of the way. A behavior notes dated July 26, 2026 at 1:56 p.m. revealed resident #6 displayed increased escalated behaviors, redirected, reduced environmental stimuli. However, the behavior note provided no details regarding the incident documented in the struck-out progress note, and no additional details regarding the incident were found in the clinical record. -Regarding resident #52: Resident #52 (Victim) was admitted to the facility on [DATE], with diagnoses that included dementia, heart failure, anemia, malnutrition, and urinary tract infections. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 08 which indicated the resident had significant cognitive impairment. The progress notes dated July 26, 2026 at 2:01 p.m. revealed Resident reported increasing behaviors. Resident was checked. Skin assessment done. However, the note gave no indication as to why the skin assessment was completed. A weekly skin check and wound assessment note dated July 26, 2026 at 3:37 p.m. revealed the resident had a new skin impairment to the face, described as superficial red marks to right chin. A progress note dated July 26, 2026 at 10:11 p.m. revealed resident #52 was on change of condition monitoring for a scratch to the left chin area, that resident #52 had no complaints of pain, was open to air, and that the plan of care was ongoing as tolerated. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that resident #52 had scratch marks on her face. An interview was conducted with a Certified Nursing Assistant (CNA/staff #75) on August 3, 2026 at 3:27 p.m. Staff #75 stated that she was the one that reported the incident between resident #52 and resident #6. Staff #75 stated that she was putting a resident's clothes away, when resident #52 came up to her and stated her neighbor had grabbed her face. Staff #75 stated that she looked at resident #52's face and that it had scratches or red marks on it. Staff #75 stated that she notified the nurse to look at it, and resident #52 had again stated resident #6 had grabbed her. Staff #75 concluded that she notified the management about the incident. An interview was conducted with the Director of Nursing (RN/staff #51) on August 5, 2026 at 8:00 a.m. Staff #51 stated she was familiar with the incident, and that as she understood resident #52 was in her room by her bed, when resident #6 ended up scratching resident #52 on the face. Staff #51 stated that resident #52 had superficial red marks on her chin, so she assumes it did happen. Staff #51 stated that she was aware of the struck out note about the incident and that she didn't instruct the staff to strike the note out. Staff #51 stated the note was already struck out when she found it, and that only the nurse who documented it could strike it out. Staff #51 concluded that the whole incident and the inconsistent documentation is unfortunate and doesn't meet her expectations or meet policy. A review of facility policy titled 'Abuse - Prevention' revised May 6, 2025 revealed it is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation. A review of facility policy titled 'Resident Rights/Dignity: Abuse and Neglect & clinical protocol' effective January, 2024 revealed abuse is defined at 483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.		

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 08/05/2026
NAME OF PROVIDER OR SUPPLIER Haven of Safford		STREET ADDRESS, CITY, STATE, ZIP CODE 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, resident interview, staff interview and facility policy and procedures the facility failed to ensure the facility policy for abuse was followed for 1 of 5 sampled residents. The deficient practice could result in allegations of abuse not being accurately identified, reported, investigated, and addressed, thereby placing residents at risk for further abuse, physical harm, pain, mental anguish, or emotional distress. Findings include: - Regarding resident #6: Resident #6 (Perpetrator) was admitted to the facility on [DATE], with diagnoses that included dementia, anxiety, hypertension, a history of fractures and malnutrition. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 07, which indicated the resident had significant cognitive impairment. The care-plan revealed the resident has a behavior problem related to impaired safety awareness, verbal behavior, and physically aggressive behaviors, with a goal of maintain resident safety and notable interventions of intervening as necessary to protect the rights and safety of others, approach the resident and speak in a calm manner, divert the resident's attention, and remove from the situation and take to alternate location as needed. The progress notes dated July 26, 2026 at 1:49 p.m. revealed a struck-out note that stated while the nurse was on break, the CNA reported that resident #6 clawed her roommate (resident #52) in the face. Upon assessment, resident #52 was noted to have superficial scratches under the right side of her chin, red marks on the cheek, and no active bleeding was observed. Resident #6 was also observed kicking another resident's wheelchair in an apparent attempt to get the other resident to move out of the way. A behavior notes dated July 26, 2026 at 1:56 p.m. revealed resident #6 displayed increased escalated behaviors, redirected, reduced environmental stimuli. However, the behavior note provided no details regarding the incident documented in the struck-out progress note, and no additional details regarding the incident were found in the clinical record. - Regarding resident #52: Resident #52 (Victim) was admitted to the facility on [DATE], with diagnoses that included dementia, heart failure, anemia, malnutrition, and urinary tract infections. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 08 which indicated the resident had significant cognitive impairment. A review of progress notes dated July 26, 2026 at 2:01 p.m. revealed Resident reported increasing behaviors. Resident was checked. Skin assessment done. However, the note gave no indication as to why the skin assessment was completed. A weekly skin check and wound assessment note dated July 26, 2026 at 3:37 p.m. revealed the resident had a new skin impairment to the face, described as superficial red marks to right chin. A progress note dated July 26, 2026 at 10:11 p.m. revealed resident #52 was on change of condition monitoring for a scratch to the left chin area, that resident #52 had no complaints of pain, was open to air, and that the plan of care was ongoing as tolerated. A progress note dated July 27, 2026 at 1:08 p.m. revealed resident #52 was on change of condition monitoring related to scratches on the chin from another resident. It further revealed resident #52 had no complaints of pain, was open to air, and that the plan of care was ongoing as tolerated. A progress note dated July 27, 2026 at 9:35 p.m. revealed resident #52 was on change of condition for scratch on left side of neck area, and that resident #52 had no signs or symptoms of infection, was open to air, had no complaints of pain or discomfort, and that the plan of care was ongoing as tolerated. A weekly skin check and wound assessment note dated July 28, 2026 at 3:37 p.m. revealed resident had a new skin impairment to the face, described as healing red superficial marks to chin A progress note dated July 28, 2026 at 6:56 p.m. revealed resident #52 remains on change of condition monitoring for scratches to the left chin (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sustained from another resident. It further revealed the area remains clean, dry, and intact with no signs or symptoms of infection noted, and that resident #52 tolerated monitoring well and voiced no complaints or concerns this shift. It concludes that the plan of care remains ongoing. An interview was conducted with resident #52 on August 3, 2026 at 1:20 p.m. Resident #52 stated she recalls the incident but was not sure who the perpetrator was. Resident #52 stated she cried when it happened because she did not know why the other resident was being mean to her. Resident #52 concluded that they had gotten up to go to breakfast and the other resident just reached her fingernails up and ran them across her face. Resident #52 pointed to her face and stated right here referencing where she had been scratched. An interview was conducted with a Licensed Practical Nurse (LPN/staff #74) on August 3, 2026 at 1:35 p.m. Staff #74 stated she was familiar with the incident and confirmed the perpetrator was resident #6. Staff #74 stated that there are different types of abuse, like verbal or physical, not allowing residents to do things, especially anything physical. Staff #74 stated that resident #52 was largely not alert and oriented but able to have a conversation, and only confused sometimes. Staff #74 stated that resident #52 is very nice to everyone on the unit, but does have some behaviors. Staff #74 stated that resident #6 was moved onto the secured unit where the incident occurred after some wandering behaviors, and using a bedside table as a walker. Staff #74 stated that after the incident, resident #6 was moved back off the secured unit. Staff #74 concluded that of course the incident is abuse, and that it was reported to management. An interview was conducted with the Resident's Representative (RR) on August 3, 2026 at 2:20 p.m. The RR stated that she is the POA (Power of Attorney) for resident #52. The RR stated that the facility notified her after the incident occurred, and that resident #52's roommate (resident #6) had grabbed ahold of resident #52's face and scratched her. The RR stated that resident #52 always said that resident #6 was mean to her. The RR stated that she told resident #52 if someone is mean to you, you need to report it, and that she wasn't sure if resident #52 did because they are having these issues now. The RR stated that she brings resident #52 snacks she likes, like fruit, and that she was there the very day the incident occurred. The RR stated that she didn't know why it happened, but that she thinks it's because resident #52 had goodies and the other resident didn't. The RR concluded that resident #52 had scratch marks on her face. An interview was conducted with a Certified Nursing Assistant (CNA/staff #75) on August 3, 2026 at 3:27 p.m. Staff #75 stated that she was the one that reported the incident between resident #52 and resident #6. Staff #75 stated that she was putting a resident's clothes away, when resident #52 came up to her and stated her neighbor had grabbed her face. Staff #75 stated that she looked at resident #52's face and that it had scratches or red marks on it. Staff #75 stated that she notified the nurse to look at it, and resident #52 had again stated resident #6 had grabbed her. Staff #75 concluded that she notified the management about the incident. An interview was conducted with the Director of Nursing (RN/staff #51) on August 5, 2026 at 8:00 a.m. Staff #51 stated she was familiar with the incident, and that as she understood resident #52 was in her room by her bed, when resident #6 ended up scratching resident #52 on the face. Staff #51 stated that resident #52 had superficial red marks on her chin, so she assumes it did happen. Staff #51 stated that she was aware of the struck out note about the incident and that she didn't instruct the staff to strike the note out. Staff #51 stated the note was already struck out when she found it, and that only the nurse who documented it could strike it out. Staff #51 concluded that the whole incident and the inconsistent documentation is unfortunate and doesn't meet her expectations or meet policy. A review of facility policy titled 'Abuse - Prevention' revised May 6, 2025 revealed it is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation. A review of facility policy titled 'Resident Rights/Dignity: Abuse and Neglect - clinical (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	protocol' effective January, 2024 under the section titled Treatment / Management revealed the facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. It further states that the management and staff, with physician support, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations.		