STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035180	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Douglas	1400 North San Antonio Avenue Douglas, AZ 85607

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation, and policy review, the facility failed to protect the rights of one resident (# 2) to be free from abuse by another resident (# 1). The deficient practice could result in other residents being abused. Regarding Resident # 1: Resident # 1 was admitted on [DATE], with diagnoses that included [NAME] Syndrome, adjustment disorder, and major depressive disorder.A care plan dated March 19, 2020, revealed that Resident # 1 exhibited behavior problems, including becoming very angry and agitated when another resident or roommate accidentally sits in his chair or accidentally touches personal items. The care plan also revealed that Resident #1 can become angry or agitated with other male residents who speak to my significant other. A Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident # 1 was unable to complete the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. The assessment also revealed that Resident # 1 had physical behavioral symptoms directed toward others in the past 1 to 3 days.An incident note regarding Resident # 1, dated August 16, 2025 at 10:33 p.m., revealed that a Licensed Practical Nurse (LPN/staff # 5) was notified by CNAs about aggressive behavior towards another resident in his room. CNA staff informed the LPN that Resident # 1 was attempting to throw book and physically push the other resident. Staff were able to intervene, and the LPN (staff # 5) was able to separate the two residents. The incident also revealed that the LPN explained to Resident # 1 that their actions were wrong and to avoid them. The LPN described that Resident # 1 was argumentative but nodded when the situation was explained, as if Resident # 1 understood. The LPN also noted that he will continue to monitor.Review of the clinical record revealed no evidence that the incident was reported on August 16, 2025 to administration, family, provider or the state agency and there was no evidence of an investigation regarding the incident. However, during an interview, a Registered Nurse (RN/staff #22) revealed that the incident was reported to her, but she did not investigate as there was no injury.Further review of the clinical record revealed no evidence of additional monitoring after the August 16, 2025 incident.A Behavioral note regarding a second incident that occurred with Resident # 1 and Resident #2 on August 17, 2025. The note relayed that on August 17, 2025 at 4:27 pm, LPN (Staff # 8) heard screaming in the south hall. When staff arrived at Resident # 1's room, they saw Resident # 1 mad and screaming at Resident # 2. Resident # 1 then proceeded to place his hands-on Resident # 2's chest and pushed her out of the room, while Resident # 2 sat her in her wheelchair. Staff managed to separate residents. The LPN stated that he tried to educate Resident # 1 that he could not touch other residents. LPN # 8 did indicate notifying administration, and police. An Incident report regarding Resident #1, dated August 17, 2025 at 10:33 p.m. revealed that police had arrived regarding the incident, and a report was filed. The report revealed that the incident was unsubstantiated because there was no harm. The facility placed a Velcro barricade across the door. Regarding Resident # 2:Resident # 2 was admitted on [DATE], with diagnoses that included fracture of the left femur, dementia, atelectasis, and anxiety disorder. A Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a BIMS score of 6, indicating severe cognitive impairment.Review of Resident #2's comprehensive care plan dated July 30, 2025, revealed that Resident # 2 had impaired cognitive function, dementia, or impaired thought process due to Dementia. Further review of the care plan revealed no evidence of a focus regarding wandering from July 10, 2025 through August 19, 2025.A Behavioral note regarding Resident # 2, dated August 16, 2025, at 7:03 p.m., revealed that Resident # 2 had been observed by Licensed Practical Nurse (LPN / Staff #5) entering many resident rooms. Resident # 2 had to be redirected over 10 times just by LPN Staff #5. The behavioral note revealed that Resident # 2 was unwelcome in many of the rooms and was aggressive to other residents when she was dismissed from their room. An incident note regarding Resident # 2 marked late entry dated August 16, 2025, at 10:30 p.m. revealed that at 6:00 p.m., Certified Nursing Staff (CNA) overheard a commotion in Resident # 1's room. Staff had entered the room and found Resident # 2 attempting to show Resident # 1 a book. The incident report also revealed that Resident # 1 became visibly upset by Resident # 2's presence, and that staff had to remove Resident # 2 from the room in which Resident # 2 obtained a skin tear, described as a 2 cm by 2 cm superficial laceration on her right forearm, which was cleaned and treated. Further review of the clinical record revealed no evidence that the skin tear was assessed by a nurse at the time of the incident on August 16, 2025, or that the incident had been reported to administration, provider or family.A second incident occurred between Resident #1 and Resident #2 on August 17, 2025, per an incident note dated August 17