STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035233	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Globe	1100 Monroe Street Globe, AZ 85501

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 - Some	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** 49199 Based on clinical record review, interviews, facility documentation and policy review, the facility failed to ensure four residents (#50, #150, #100 and #250) were free from abuse from other residents (#100, #250, #200). The deficient practice could lead to other resident to resident altercations which could result in harm. Findings include: Resident #100 was admitted to the facility on [DATE] with a diagnosis of dementia with behavioral disburbances, chronic kidney disease, alcohol abuse and major depressive disorder. Review of the MDS (Minimum Data Set) dated August 14, 2022 reveals a BIMS (Brief Interview for Mental Status) score of 99, indicating resident #100 to be severely cognitively impaired. Resident #250 was admitted to the facility on [DATE] with a diagnosis of vascular dementia with behavioral disturbance and post-traumatic stress disorder. Review of the MDS dated [DATE] reveals a BIMS score of 99, indicating resident #250 to be severely cognitively impaired. On the morning of March 13, 2022, resident #250 woke up from sleeping in his chair and saw his shoelace was broken lying on the floor next to him. He got out of his chair and started punching resident #100 in the face. Resident #100 began swinging back at resident #250. This incident was witnesssed by a staff member #82, who immediately seperated the residents. Resident #100 sustained minor injury to his lip. Resident #200 was admitted to the facility on [DATE] with a diagnosis of dementia with behavioral disturbances, wandering and difficulty walking. Review of the MDS dated [DATE] reveals a BIMS score of 99, indicating resident #200 to be severely cognitively impaired. Resident #150 admitted to the facility on [DATE] with a diagnosis of vascular dementia with anxiety, wandering, anxiety disorder and major depressive disorder. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the MDS dated [DATE] reveals a BIMS score of 99, indicating resident #150 to be severely cognitively impaired. On June 11, 2022, staff #5 was at the medication cart when he heard resident #200 and #150 speaking to each other. The conversation appeared to be getting louder. Staff #5 told the residents to move away from each other. Resident #200 grabbed the back of resident #150's wheelchair and began slapping resident #150 several times in the back of the head. Staff #5 seperated both residents but resident #200 continued to yell at resident #150 claiming he stole her shoes. Resident #150 did not have any shoes with him and were not found in his room. Resident #50 was admitted to the facility on [DATE] with a diagnosis of dementia with behavioral disturbances, major depressive disorder, age related macular degeneration, adult failure to thrive and alzheimers disease. Review of the MDS dated [DATE] reveals a BIMS score of 99, indication resident #50 to be severely cognitively impaired. On August 15, 2022 as residents were exiting the dining room, resident #50 and resident #100 wheelchairs became caught up on each other. As staff were approaching to seperate the residents, resident #100 punched resident #50 with a closed fist on the right cheek of her face. Staff immediately seperated both residents. Resident #50 was noted to have a reddish/pink discoloration to her face. Review of the facility investigation for all three incidents reveal that each one was substantiated by the facility.