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	06/10/2026

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** Based on an observation, clinical record review, interviews, facility documentation and policies, and review of the State Agency (SA) database, the facility failed to protect the rights of 3 out of 18 sampled residents (#92, #93, #8) to be free from physical and verbal abuse by another resident. The deficient practice could result in further resident abuse.Findings included:-Regarding Resident #92 (alleged victim) and Resident #12 (alleged perpetrator) -Resident #92 was admitted on [DATE] with diagnosis that included Type 2 Diabetes Mellitus, dementia, and blindness of one eye.Review of clinical records dated December 21, 2022 through December 29, 2022 revealed that the resident had to be redirected back to her room several times, and wandered multiple times throughout residents' rooms and on various hallways. wandering required supervision.A daily skilled evaluation progress note dated December 30, 2022 revealed that the resident required supervision and guidance due to intermittent periods of wandering, redirection and distraction usually effective.A care plan initiated on December 20, 2022, revealed a focus due to: Risk for Functional Self Care and mobility deficits related to dementia, decreased mobility.Risk for falls related to decreased mobility, dementia, right eye blindness, and wandering.A care plan initiated on December 28, 2022, revealed a focus for:Behavior problem related to wandering/exit-seeking, verbal behaviors, with interventions that included if issues arise, remove from situation, explain/reinforce why the behavior is inappropriate and/or unacceptable, intervene as necessary to protect the rights and safety of others. Impaired cognitive function/dementia or impaired thought processes related to dementia, neurological symptomsImpaired visual function related to diabetic retinopathy and right eye blindness.Further record review dated January 1, 2023 through April 29, 2023 revealed dementia with wandering, A care planned intervention was initiated on March 18, 2023 related to the focus for falls related to decreased mobility, dementia, right eye blindness, and wandering. The interventions included to have resident in common areas for closer supervision as often as possible. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status of 99, which indicated that the assessment could not be completed. A Staff Assessment for Mental Status assessment revealed Short-Term and Long-Term memory problems, and severely impaired daily decision making. The MDS also revealed the presence of verbal behavior toward others, and that wandering occurred 1-3 days during the assessment period.An Alert Charting progress note dated April 30, 2023, revealed that it was reported to the nurse by the CNA and [NAME] that a physical altercation took place. The note indicated that the CNA, reported that a scream was heard, and the CNA went to investigate and found Resident #92 in her wheelchair just outside the door of Resident #12's room. The CNA reported that Resident #12 stated that she pulled Resident #92's hair because Resident #92 keeps coming in Resident #12's room. The note included that the two residents were then separated and that neither of the resident's had any visible markings or signs of injury. The note further revealed that the provider, Director of Nursing, case manager and the residents' families were notified. The note included that a police report was initiated, statements were taken, and both residents would be monitored and kept at a safe distance.A behavior care plan revealed on April 30, 2023 that wandering places the resident at (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 - Minimal harm or potential for actual harm Residents Affected - Some	risk for receiving physical aggression from other residents. Interventions initiated on April 30, 2023 included to keep arms-length away from other residents, and minimize potential for disruptive behaviors of wandering into other residents' rooms by offering tasks which divert attention. dated includedA care plan dated June 14, 2023, revealed a focus for communication problem related to dementia. Interventions included to be conscious of the resident's position when in groups, activities, dining room to promote proper communication with others. -Resident #12 was admitted on [DATE] with diagnoses of Dementia, major depressive disorder, schizophrenia, anxiety disorder, hallucinations and blindness.An admission MDS dated [DATE], revealed a BIMS score of 14, which indicted intact cognition. The assessment also revealed no evidence of behavioral symptoms related to physical or verbal behaviors directed toward others.A care planned focus initiated April 1, 2023, revealed a behavior problem related to physical and verbal aggression towards other residents, resident is not to be within arm's reach of other residents at any time, resistive to care, verbal behavior and wandering.A behavior progress note dated April 2, 2023 revealed that a nurse heard the resident raising her voice at another resident, swinging her coffee cup around above her head yelling at the resident. An Alert Charting progress note dated April 30, 2023, revealed that a CNA, reported that a scream was heard, and the CNA went to investigate, and found Resident #92 in her wheelchair just outside the door of Resident #12's room. The CNA reported that Resident #12 stated that she pulled Resident #92's hair because Resident #92 kept coming into Resident #12's room. The note included that the two residents were then separated and that neither of the resident's had any visible markings or signs of injury. The note further revealed that the provider, Director of Nursing, case manager and the residents' families were notified. The note included that a police report was initiated, statements were taken, and both residents would be monitored and kept at a safe distance.A care planned focus for behavior problems revealed updated interventions initiated on May 17, 2023, which revealed: if issues arise, remove from situation, and if reasonable, discuss my behavior and explain/reinforce why the behavior is inappropriate and/or unacceptable, and intervene as necessary to protect the rights and safety of others. An interview was conducted on June 9, 2026 at 11:52 a.m. with a Licensed Practical Nurse (LPN/staff #22), who reviewed the records of Resident #12 and Resident #92 and stated that according to a progress note Resident #12 pulled the hair of Resident #92, at that this would be considered resident to resident abuse. The LPN further stated that Resident #92 is very protective of her space, and was aware of her actions.An interview was conducted on June 9, 2026 at 1:40 p.m. with a Certified Nursing Assistant (CNA/staff #14), who stated that one resident pulling another resident's hair would be considered physical abuse. An interview was conducted on June 9, 2026 at 1:36 p.m. with the Director of Nursing (DON/staff #83), described physical abuse as including pulling hair, kicking or shoving. The DON also stated that the resident's care plan should be updated with new interventions and current interventions evaluated for the perpetrator, but not the victim. The DON reviewed Resident #12's clinical record and stated that there was no evidence that the resident's care plan had been evaluated/updated regarding the incident that occurred on April 30, 2023. - Regarding Resident #8 (alleged victim) and Resident #93 (alleged victim):Resident #8 re-admitted on [DATE] with diagnosis including dementia, Type 2 Diabetes Mellitus, major depressive disorder, and anxiety disorder.An admission MDS dated [DATE] revealed a BIMS score of 99, which indicated that the resident was unable to complete the BIMS assessment. A Staff Assessment for Mental Status assessment revealed that the resident exhibited short and long-term memory problems, and the resident's cognitive skill for daily decision making was severely impaired. A care plan dated November 6, 2023 revealed the following areas of focus:Communication problem related to history of cerebrovascular accident (CVA) and confusionImpaired cognitive function/dementia or impaired thought processes related to BIMS score, history of CVA.Further review of the clinical record revealed no evidence the incident had been reported to a supervisor after it was reported by Resident #93 to a nurse, or documented in nursing progress notes.A Skin assessment dated [DATE] revealed no new or ongoing skin impairments.A late entry Nurse (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Practitioner (NP) progress note dated November 9, 2023, revealed that staff reported an incident with Resident #8's son yesterday, and that the resident did not want to discuss the incident. The note included that the resident denied any symptoms of pain or discomfort.An interview was conducted on June 9, 2026 at 11:52 a.m. with a Licensed Practical Nurse (LPN/staff #22), who reviewed Resident #8's clinical record and stated that there was no evidence that the nurse who received Resident #93's allegation related to Resident #8's son on November 8, 2023, documented the allegation or reported it to the charge nurse. The LPN further stated that Resident #8's special instructions profile in the EMR relayed that Resident #8 was able to go out on pass with her son, and her son can now visit Resident #8.An interview was conducted on June 9, 2026 at 1:36 p.m. with the Director of Nursing (DON/staff #83), who stated that there was no evidence in Resident #8's clinical record regarding the alleged incident that occurred on November 8, 2023, or that the resident's provider had been notified. The DON further stated that she expected there to have been a nursing progress note regarding the incident and of provider notification, however there was an NP note that the incident had been reported. The DON reviewed the clinical record and stated that there was no evidence in #8's progress notes regarding the resident's report to a nurse, and this did not meet the DON's expectations. However, there was a NP progress note that indicated that there had been an incident regarding Resident #8's son.-Resident #93: Resident #93 was re-admitted on [DATE] with diagnoses that included Type 2 Diabetes Mellitus, anemia, major depressive disorder, opioid dependence, and post-traumatic stress disorder (PTSD).A care plan initiated on October 23, 2023 revealed the following areas of focus:Anti-anxiety medications use related to PTSD.Antidepressant medication use related to depression, fibromyalgiaAn admission MDS dated [DATE] revealed a BIMS score of 13, which indicated intact cognitive function. The assessment revealed no evidence of verbal/physical behavioral symptoms directed toward others.A daily skilled evaluation progress note dated November 3, 2023, revealed that the resident refuses to participate in social activities, prefers to stay in her room.Review of the nursing progress notes revealed no evidence related to the incident that occurred on November 8, 2023 related to Resident #93 and Resident #8's son. Despite the resident reporting her concerns several times to nursing.Further review of the clinical record revealed no evidence that the nurse reported Resident #93's concerns to a supervisor or the Director of Nursing.Further review of the Facility 5-day report revealed a type written interviews conducted on November 9, 2023 regarding the incident:Resident #93 reported in an interview statement to the Administrator (staff #300) that on November 8, 2023 she was lying in bed and heard loud yelling and cussing coming from Resident #8's room, and Resident #93 got up and told the nurse. The resident reported that after that she went wheeling around, and as she was on her way back to her room Resident #8's son was walking to the door shaking his head and Resident #93 told him you don't need to talk to your mom that way, and then Resident #8's son stepped towards her and said fuck you bitch don't tell me how to talk to my mom. Resident #93 further stated that she explained to Resident #93's son that they knew each other from the reservation, and the resident further stated that Resident #93's son was angry.Resident #8 reported during an interview statement dated November 9, 2023 to the Administrator (staff #300) that she thought that her son visited her last night, and she stated that her son always talked loudly and cussed. Resident #8 relayed that her son was on a drinking binge, and that there was an incident in the dining room with her son being loud and saying cuss words. The interview included that her sister said that Resident #8's son was drunk and she would take him home.On November 9, 2023 a Certified Nursing Assistant (CNA/staff #310) reported in a written interview statement that on November 8, 2023, while in the dining room Resident #8's son was using the fuck word, and she asked him to stop cussing, that it is not okay.On November 10, 2023 a Registered Nurse (RN/staff #320) wrote a statement and wrote that she was sitting at the nurses' station charting on November 8, 2023 and a visitor of Resident #8 said, hey you go a mop, I spilled shit all over my mom's room. The RN wrote that she stated she did not have a mop but she offered to get the male visitor towels and he said well that's your fucking problem not mine, I don't give a fuck about that shit. The RN also relayed that (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	while she was cleaning up the spill the man continued to use foul language and seemed to be upset.A written witness statement from LPN (staff #57), who wrote that she received noise complaints from Resident #93 and another resident that Resident #8's male visitor was cursing a lot and speaking very loudly. The LPN wrote that when she entered Resident #8's room the male visitor was speaking loudly and using inappropriate language, and she asked them to keep the volume down. The statement included that Resident #93 reported to the LPN that Resident #8's male visitor began to cuss at Resident #93 when Resident #93 told him not to talk to Resident #8 like that.A Licensed Practical Nurse (LPN/staff #305) wrote in an interview statement that as he was escorting Resident #8's son out of the facility on November 8, 2023, Resident #8's son continued to say, fuck you and fuck everyone here, fucking pussy.A written statement dated November 14, 2023 by the Assistant Director of Nursing (ADON/staff #83), relayed that she had received a report from Resident #93's daughter that Resident #93 texted her a message that Resident #8's son was drunk and cussing when he visited on November 8, 2023. The ADON reported that she spoke with Resident #93 who reported that Resident #8's son was in the dining room and was drunk, belligerent and cussing, and Resident #8 told him not to talk like that around the elders. The statement relayed that Resident #93 also reported that she heard Resident #8's son cussing at Resident #8 several times, and that Resident #8's son later approached Resident #93 as she was passing the room and cussed at her, and she felt that Resident #8's son went at her, so she stood up from her wheelchair and backed him down, then reported to the nurse.An interview was conducted on June 8, 2026 at 12:10 p.m. with the Administrator (staff #300), who stated that nurses should document reports of abuse in the resident's clinical records, and should also update the resident's care plan.An interview was conducted on June 9, 2026 at 11:52 a.m. with a Licensed Practical Nurse (LPN/staff #22), who stated that the facility Abuse policy is to separate the residents from danger, and immediately report the incident to the supervisor. The LPN also stated that verbal abuse could include talking down to a resident, calling names, berating and anything that would make a resident feel unsafe. The LPN further stated that anytime alleged abuse is reported the incident should be documented by nursing in the resident's progress notes along with notification of the family and provider. The LPN stated that the resident's care plan should also be updated with any new interventions, and evaluation of current interventions. The LPN relayed that when an incident occurs staff complete 72-hour alert charting, and document in progress notes. The LPN also stated that when a family member or visitor yells at a resident staff would remove the resident from harm, notify the supervisor, social services and that the family/visitor would be removed. The LPN also stated that a family member or visitor calling a resident a stupid bitch would be considered abuse. The reviewed Resident #93's clinical record and stated that there was no evidence in the resident's progress notes regarding her allegation of abuse related to Resident #8's son to the nurse, and that the LPN would have expected the nurse to have documented the allegation in Resident #93's progress notes.An interview was conducted on June 9, 2026 at 1:40 p.m. with a Certified Nursing Assistant (CNA/staff #14), who stated that abuse allegations should be reported to the charge nurse. She further stated that abuse could be verbal or physical, and included restraints and emotional harm. The CNA also stated that abuse could be resident to resident or visitor/family to resident. The CNA stated that a family member was yelling obscenities at a resident would be considered verbal abuse.An interview was conducted on June 9, 2026 at 1:36 p.m. with the Director of Nursing (DON/staff #83), who stated that abuse can be verbal, sexual, physical or misappropriation. She further stated that verbal abuse could include calling a resident a stupid bitch, or other cussing or swearing. The DON also stated that all abuse allegations should be documented in the clinical record in a progress note, and in an incident note, along with documentation of provider/family notification of the allegation. The DON stated that the resident's care plan should be updated with new interventions and current interventions evaluated for the perpetrator, but not the victim. The DON stated that she would have expected there to be a progress note in Resident #93's chart regarding her allegations about Resident #8's son because she reported that the family member was drunk and felt that he was (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	getting aggressive with Resident #8. However, the DON reviewed Resident #93's clinical records and stated that there was no evidence that the nurse documented Resident #93's allegation or notified the charge nurse or DON.A facility policy titled, Resident Rights/Dignity: Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revealed that residents have the right to be free from abuse. The resident abuse prevention program to protect residents from abuse by anyone including other residents, visitors and family members. Identify and investigate all possible incidents of abuse, and report any allegations within timeframes required by federal requirements. A facility policy titled, Abuse Policy, revealed that the facility strives to prevent the abuse of all residents, and that situations may arise where it is not possible to completely prevent all incidents of abuse. Abuse can be verbal physical or mental, and potential abusers can be residents, family members, visitors or any other person who comes into the facility. The policy included that none of the types of abuse are condoned in the facility and the objective is to provide a safe have for the residents. The policy revealed that abuse is the willful infliction of injury, and willful was defined as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Verbal abuse includes yelling, screaming, cursing. Physical abuse includes hitting, kicking, grabbing, scratching, pushing/shoving, biting. Mental abuse is defined as verbal or nonverbal behavior that results in the infliction of anguish, mental pain, fear or distress, such as intent to humiliate, control or threaten.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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 clinical record review, interviews, documentation and policy, the facility failed to report the results of abuse allegation investigations to the state survey agency within 5 working days of the incident for 2 of 18 sampled residents (#12, #92) in accordance to state law. The deficient practice could result in facilities not submitting investigation reports to the State Survey agency within 5 working days.Findings include:Regarding Resident #92-Resident #92 was admitted on [DATE] with diagnosis that included Type 2 Diabetes Mellitus, dementia, and blindness of one eye. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status of 99, which indicated that the assessment could not be completed. A Staff Assessment for Mental Status assessment revealed Short-Term and Long-Term memory problems, and severely impaired daily decision making. Review of clinical records dated December 21, 2022 through December 29, 2022 revealed that the resident had to be redirected back to her room several times, and wandered multiple times throughout residents' rooms and on various hallways, and wandering requires supervision.An Alert Charting progress note dated April 30, 2023, revealed that it was reported to the nurse by the CNA and [NAME] that a physical altercation took place. The note indicated that the CNA, reported that a scream was heard, and the CNA went to investigate and found Resident #92 in her wheelchair just outside the door of Resident #12's room. The CNA reported that Resident #12 stated that she pulled Resident #92's hair because Resident #92 keeps coming in Resident #12's room. The note included that the two residents were then separated and that neither of the resident's had any visible markings or signs of injury. The report further revealed that the provider, Director of Nursing, case manager and the residents' families were notified. The report included that a police report was initiated, statements were taken, and both residents would be monitored and kept at a safe distance. -Regarding Resident #12 (alleged perpetrator) Resident #12 was admitted on [DATE] with diagnoses of Dementia, major depressive disorder, schizophrenia, anxiety disorder, hallucinations and blindness. An admission MDS dated [DATE], revealed a BIMS score of 14, which indicted intact cognition. The assessment also revealed no evidence of behavioral symptoms related to physical or verbal behaviors directed toward others. An Alert Charting progress note dated April 30, 2023, revealed that a CNA, reported that a scream was heard, and the CNA went to investigate, and found Resident #92 in her wheelchair just outside the door of Resident #12's room. The CNA reported that Resident #12 stated that she pulled Resident #92's hair because Resident #92 kept coming into Resident #12's room. The note included that the two residents were then separated and that neither of the resident's had any visible markings or signs of injury. The report further revealed that the provider, Director of Nursing, case manager and the residents' families were notified. The report included that a police report was initiated, statements were taken, and both residents would be monitored and kept at a safe distance. A Facility Reported Incident (FRI) was received by the State Agency on April 30, 2023. The report revealed that a CNA heard Resident #92 holler out, and found that Resident #12 had pulled Resident #92's hair.However, the facility was unable to provide evidence that the investigation results were investigated and submitted to the State Agency within 5 working days of the incident, following the facility's policy. The State Agency Complaint Tracking System revealed no evidence that the facility investigation was submitted within 5 working days of the incident as required. On June 8, 2026 at 12:10 p.m. an interview was conducted with the Administrator (staff #300) who stated that the facility did not keep internal incident reports or risk management reports after 12 months following the completion date. It was reported that the facility policy was to maintain investigation records for 12 months following completion of the 5-day report. An interview was conducted on June 9, 2026 at 1:36 p.m. with the Director of Nursing (DON/Staff #83), who stated that the facility policy included to submit the completed facility investigation 5-day report to the state agency and Adult Protective (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Services. The DON further stated that the facility keeps the completed 5-day reports for a year. The DON also stated that she would not know if an investigation/5-day report had been completed and submitted to the state agency per the facility policy, because the facility keeps the investigation reports for 12 months. The DON stated that if the investigation 5-day report had been completed per their policy, the investigation would have been submitted to the state agency. However, review of the State Agency Complaint Tracking System revealed no evidence that the facility investigation had been submitted to the state agency. A facility policy titled, Resident Rights/Dignity: Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revealed that the facility must identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation. The policy also revealed that the facility must investigate and report any allegations within timeframes required by federal requirements. The policy relayed that the facility-wide program commitment included to develop and implement policies and protocols to prevent and identify abuse. A facility policy titled, Resident Rights/Dignity: Abuse investigation and Reporting revealed that all reports of resident abuse shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. The Administrator or his/her designee will provide the appropriate agencies with a written report of the findings of the investigation within five-working days of the occurrence of the incident. A facility policy titled, Abuse Policy, revealed that if abuse is witnessed or suspected, reporting and investigation will take place, and when the investigation is complete the Executive Director (ED) will submit a summary to Adult Protective Services, Ombudsman, State Survey Agency, and law enforcement.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **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 ensure that in response to allegations of abuse, that all alleged violations are thoroughly investigated, for 2 of 18 sampled residents (#12 and #92). The deficient practice could result in allegations of abuse not being thoroughly investigated. Findings include: -Regarding Resident #92 (alleged victim) and Resident #12 (alleged perpetrator): -Resident #92 was admitted on [DATE] with diagnosis that included Type 2 Diabetes Mellitus, dementia, and blindness of one eye. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status of 99, which indicated that the assessment could not be completed. A Staff Assessment for Mental Status assessment revealed Short-Term and Long-Term memory problems, and severely impaired daily decision making. Review of clinical records dated December 21, 2022 through December 29, 2022 revealed that the resident had to be redirected back to her room several times, and wandered multiple times throughout residents' rooms and on various hallways, and wandering requires supervision.A care plan initiated on December 28, 2022, revealed a focus related to a behavior problem related to wandering/exit-seeking, verbal behaviors, with interventions that included if issues arise, remove from situation, explain/reinforce why the behavior is inappropriate and/or unacceptable, intervene as necessary to protect the rights and safety of others. A quarterly Minimum Data Set (MDS) assessment dated [DATE], A Staff Assessment for Mental Status assessment revealed Short-Term and Long-Term memory problems, and severely impaired daily decision making. The MDS also revealed the presence of verbal behavior toward others, and that wandering occurred 1-3 days during the assessment period An Alert Charting progress note dated April 30, 2023, revealed that it was reported to the nurse by the CNA and [NAME] that a physical altercation took place. The note indicated that the CNA, reported that a scream was heard, and the CNA went to investigate and found Resident #92 in her wheelchair just outside the door of Resident #12's room. The CNA reported that Resident #12 stated that she pulled Resident #92's hair because Resident #92 she keeps coming in Resident #12's room. The note included that the two residents were then separated and that neither of the resident's had any visible markings or signs of injury. The report further revealed that the provider, Director of Nursing, case manager and the residents' families were notified. The report included that a police report was initiated, statements were taken, and both residents would be monitored and kept at a safe distance. -Resident #12 was admitted on [DATE] with diagnoses of Dementia, major depressive disorder, schizophrenia, anxiety disorder, hallucinations and blindness. An admission MDS dated [DATE], revealed a BIMS score of 14, which indicted intact cognition. The assessment also revealed no evidence of behavioral symptoms related to physical or verbal behaviors directed toward others. A care planned focus initiated April 1, 2023, revealed a behavior problem related to physical and verbal aggression towards other residents, resident is not to be within arm's reach of other residents at any time, resistive to care, verbal behavior and wandering. An Alert Charting progress note dated April 30, 2023, revealed that a CNA, reported that a scream was heard, and the CNA went to investigate, and found Resident #92 in her wheelchair just outside the door of Resident #12's room. The CNA reported that Resident #12 stated that she pulled Resident #92's hair because Resident #92 kept coming into Resident #12's room. The note included that the two residents were then separated and that neither of the resident's had any visible markings or signs of injury. The report further revealed that the provider, Director of Nursing, case manager and the residents' families were notified. The report included that a police report was initiated, statements were taken, and both residents would be monitored and kept at a safe distance. A Facility Reported Incident (FRI) was received by the State Agency on April 30, 2023 which revealed that a CNA heard Resident #92 holler out, and found that Resident #12 had pulled Resident #92's hair.However, the facility was unable to provide evidence that the incident had been thoroughly investigated, or that the completed investigation results were (continued on next page)

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	035233	A. Building B. Wing	06/10/2026

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	submitted to the State Agency within 5 working days of the incident. The State Agency Complaint Tracking System revealed no evidence that the facility investigation was submitted within 5 working days of the incident as required. On June 8, 2026 at 12:10 p.m. an interview was conducted with the Administrator (staff #300) who stated that the facility did not keep internal incident reports or risk management reports after 12 months following the completion date. It was reported that the facility policy was to maintain investigation records for 12 months following completion of the 5-day report. An interview was conducted on June 9, 2026 at 1:36 p.m. with the Director of Nursing (DON/Staff #83), who stated that the completed facility investigation 5-day report would be sent to the state agency and Adult Protective Services. The DON further stated that the facility keeps the completed 5-day reports for a year. The DON stated that the only way a person would know that the incident occurred or had been investigated would be through progress notes in the residents' clinical records. The DON also stated that she would not be able to provide proof of a thorough investigation because their investigation reports are not kept over 1 year. The DON stated that if the investigation 5-day report had been completed it would have been submitted to the state agency. The DON further stated that if the State Agency did not have the investigation 5-day report, then she would not be able to prove that the investigation was conducted. However, review of the State Agency Complaint Tracking System revealed no evidence that the facility investigation had been submitted to the state agency. A facility policy titled, Resident Rights/Dignity: Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revealed that the facility must identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation. The policy also revealed that the facility must investigate and report any allegations within timeframes required by federal requirements. The policy relayed that the facility-wide program commitment included to develop and implement policies and protocols to prevent and identify abuse. A facility policy titled, Resident Rights/Dignity: Abuse investigation and Reporting revealed that all reports of resident abuse shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. The Administrator or his/her designee will provide the appropriate agencies with a written report of the findings of the investigation within five-working days of the occurrence of the incident. A facility policy titled, Abuse Policy, revealed that if abuse is witnessed or suspected, reporting and investigation will take place, and when the investigation is complete the Executive Director (ED) will submit a summary to Adult Protective Services, Ombudsman, State Survey Agency, and law enforcement.

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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 review of the facility assessment, facility documentation, interviews, and policy review, the facility failed to ensure there was sufficient staff to meet the needs of the residents. The deficient practice could result in residents not receiving the appropriate care to maintain safety, and the highest practicable physical, mental, and psychological well-being as determined by resident assessments and individual plans of care.Findings include:The PBJ (Payroll-Based Journal) Staffing Data Report revealed that the facility consistently triggered for excessively low weekend staffing for all four quarters in 2025, and the first quarter of 2026. The facility assessment reviewed on June 9,2026, revealed the facility was licensed to provide care for 104 residents, had an average daily census of 78-85, and had an average number of 3-6 weekday admissions and 1-2 weekend admissions, and 2-5 weekday discharges and 0-3 weekend discharges. Staffing plan included the following:-full time Director of Nursing (DON)-full time Assistant Director of Nursing (ADON)-3 full time Registered Nurses (RN)/Licensed Practical Nurse (LPN) on AM shift (6:00 a.m. to 6:00 p.m.)-1 Certified Nursing Aide (CNA) for 10-13 residents on AM shift (6:00 a.m. to 6:00 p.m.)-2 full time RNs/LPNs on PM shift (6:00 p.m. to 6:00 a.m.)-1 CNA for 13-16 residents on PM shift (6:00 p.m. to 6:00 a.m.) The daily staffing assignment for May 9, 2026, revealed the following:-Census of 74:2 RN/LPNs were scheduled for the AM shift, which resulted in 37 residents, per nurse.4 CNAs were scheduled for the PM shift, which resulted in 18 Residents, per CNA.1 Certified Medication Aide (CMA) was scheduled for the AM and PM shifts.No [NAME], (staff who are responsible for answering to call bells, refill water pitchers, restock briefs and gloves, and empty the dirty laundry bins), was scheduled for either AM or PM shift. The daily staffing assignment for May 10, 2026, revealed the following:-Census of 75:2 RN/LPNs were scheduled for the AM shift, which resulted in 37 residents, per nurse.4 CNAs were scheduled for the AM and PM shifts, which resulted in 18 to 19 residents, per CNA.1 CMA was scheduled for the AM and PM shifts.1 [NAME] was scheduled for the AM shift. The daily staffing assignment for May 16, 2026, revealed the following:-Census of 77:2 RN/LPNs were scheduled for the AM shift, which resulted in 38 residents, per nurse.5 CNAs were scheduled for the AM shift, which resulted in 15 residents, per CNA.1 CMA was scheduled for the AM and PM shifts.1 [NAME] was scheduled for the PM shift. The daily staffing assignment for May 17, 2026, revealed the following:-Census of 77:2 RN/LPNs were scheduled for the AM shift, which resulted in 38 residents, per nurse.4 CNAs were scheduled for the AM and PM shifts, which resulted in 19 residents, per CNA.1 CMA was scheduled for the AM and PM shifts.2 Valets were scheduled for the AM shift. The daily staffing assignment for May 23, 2026, revealed the following:-Census of 78:2 RN/LPNs were scheduled for the AM shift, which resulted in 39 residents, per nurse.5 CNAs were scheduled for the AM shift, which resulted in 15 residents, per CNA.1 CMA was scheduled for the AM and PM shifts.1 [NAME] was scheduled for the AM shift. The daily staffing assignment for May 24, 2026, revealed the following:-Census of 77:2 RN/LPNs were scheduled for the AM shift, which resulted in 38 residents, per nurse.5 CNAs were scheduled for the AM shift, which resulted in 15 residents, per CNA.1 CMA was scheduled for the AM and PM shifts.1 [NAME] was scheduled for the AM shift. The daily staffing assignment for May 30, 2026, revealed the following:-Census of 72:2 RN/LPNs were scheduled for the AM shift, which resulted in 36 residents, per nurse.4 CNAs were scheduled for the PM shift, which resulted in 18 residents, per CNA.1 CMA was scheduled for the AM shift.1 [NAME] was scheduled for the PM shift. The daily staffing assignment for May 31, 2026, revealed the following:-Census of 71:2 RN/LPNs were scheduled for the AM shift, which resulted in 35 residents, per nurse.4 CNAs were scheduled for the AM shift, which resulted in 18 residents, per CNA.1 CMA was scheduled for the AM and PM shift.1 [NAME] was scheduled for the AM shift. The daily staffing assignment for June 5, 2026, revealed the following:-Census of 74:4 RN/LPNs were scheduled for the AM shift. The ADON and the DON were (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	also scheduled.4 CNAs were scheduled for the PM shift, which resulted in 18 to 19 residents, per CNA.1 CMA was scheduled for the PM shift.1 [NAME] was scheduled for the AM and PM shift. The daily staffing assignment for June 6, 2026, revealed the following:-Census of 73:3 RN/LPNs were scheduled for the AM shift.5 CNAs were scheduled for the AM shift, which resulted in 14 residents, per CNA.1 CMA was scheduled for the AM and PM shifts.1 [NAME] was scheduled for the PM shift. The daily staffing assignment for June 7, 2026, revealed the following:-Census of 71:2 RN/LPNs were scheduled for the AM shift, which resulted in 35 residents, per nurse.5 CNAs were scheduled for the AM shift, which resulted in 14 residents, per CNA.1 CMA was scheduled for the AM and PM shifts.1 [NAME] was scheduled for the AM shift.On December 15, 2025, the State Agency (SA) received a complaint that stated the facility was so short staffed that CNAs had 4 separate hallways of Residents to care for and Hoyer lifts were used by only 1 staff member, when 2 staff are required.An interview was conducted on June 9, 2026, at 9:39 AM, with the RN, staff #65. The RN stated staffing was low for nurses and CNAs. The RN stated it was typical to have a caseload of 35 plus Residents during a shift. The RN stated some of the CNAs have been trained as a CMA so they could aid the nurses in medication pass. The RN stated there are many tasks that cannot be completed during the shift; for example, a full set of vitals are not always completed, however, if a Resident is on a blood pressure medication, before the RN administered the medication, she would get a blood pressure reading but not have time to complete a full set of vitals. The RN stated getting weights on Residents were missed often due to not having enough time to complete the task. The RN stated on night shift, it was typical to run out of protein ice cream and calcium drinks due to the staff not having access to the supply room. The RN explained that night shift was not always stocked with supplies because day shift would not have enough staff to stock supplies for night shift. The RN stated the CNAs would not take lunch breaks due to not having enough time, however, she would take a lunch because she needed it. The RN stated she had stayed past her shift if there was a new admission or if a Resident sustained a fall.An interview was conducted on June 9, 2026, at 9:58 AM, with LPN, staff #85. The LPN stated there has been a struggle with staffing nurses and CNAs. She stated some CNAs had been trained for CMA to aid the nurses with medication pass. The LPN stated there were times the facility would ask sister facilities to assist with staffing. The LPN stated most times she does not take a break or a lunch break and Administration would ask her why. The LPN stated her response was I don't have time. The LPN stated she had stayed past her shifts to complete tasks she had been too busy to finish during her shift. An interview was conducted on June 9, 2026, at 10:11 AM, with Licensed Nurse Aide (LNA). The LNA stated her tasks were completed by the end of her shift, however there were days when a curveball would be thrown and change things. The LNA stated the protocol for a staff call-off was to notify the Staffing Coordinator/CNA, staff #66, who would contact other staff members. The LNA stated if other staff were not able to work the shift, then staff #66 would cover the shift. She stated she is scheduled for 4-12-hour days a week but typically works 5-12-hour days.An interview was conducted on June 9, 2026, at 10:34 AM, with Staffing Coordinator/CNA, staff #66. She stated the typical staffing plan for weekdays and weekends were as follows:-1 to 2 RNs for AM and PM shifts-1 to 2 LPNs for AM and PM shifts-5 CNAs for the PM shift-6 CNAs for the AM shift-1 [NAME] for the AM and PM shiftsStaff #66 stated staffing is done in my head. Staff #66 stated she had not used a computer program to determine staffing and did not know what the facility assessment was. She stated she thinks staffing is good. She stated if there were call-offs she would begin texting or calling other staff to see if they were able to pick up a shift, if she cannot find anyone she will pick up the shift.An interview was conducted on June 9, 2026, at 10:56 AM with DON, staff #83. The DON stated staffing was adequate. She stated the staff schedule is completed by using the facility assessment and the current census. Review of the staff schedules for weekends revealed the staff numbers dropped compared to during the week, however, the DON stated staffing is adequate due to the Valets and CMAs.An interview was conducted on June 9, 2026, at 1:34 PM, with the Administrator. She stated that staffing was adequate, however, call offs were a (continued on next page)

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