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	07/01/2026

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

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to protect one resident's (#96) rights to be free from staff-to-resident physical abuse. The deficient practice could result in residents being physically and emotionally harmed.Findings include:Resident #96 was admitted to the facility on [DATE], with a diagnosis that included encounter for palliative care, muscle spasms, atherosclerotic heart disease, malignant neoplasm of the cervix uteri, type 2 diabetes, hypertension, urinary incontinence, pressure ulcer of the sacral region, polyneuropathy, and generalized anxiety disorder.A Medicare 5-Day Minimum Data Set (MDS) dated [DATE], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. A skin assessment dated [DATE], revealed that the resident did not have any skin impairments.Review of an alert charting progress note dated June 15, 2026, at 7:02 p.m. revealed that the resident had activated her call light and that the certified nursing assistant (CNA) had responded and found the resident seated in her wheelchair. The note further revealed that the resident was slipping from her chair with both knees locked, gripping the wheelchair armrests, and demonstrating generalized body rigidity. The note revealed that the CNA attempted to reposition the resident safely, but the resident continued to maintain her rigid posture despite verbal instructions to relax. The note also revealed that the CNA requested nursing assistance, and upon entering the room, the nurse observed the resident continuing to extend her lower extremities while maintaining body rigidity, partially lifting and pushing herself from the wheelchair seat. The note revealed that the CNA remained present while attempting to provide support and prevent loss of balance, and that the resident was instructed multiple times to relax her body and bend her knees for safe repositioning. The note revealed that the resident was informed that maintaining a rigid posture during transfers and repositioning increases the risk of injury to herself and staff assisting her. The note also revealed that following repeated verbal instructions, the resident relaxed her posture and was repositioned back into the wheelchair. The note revealed that when asked what had occurred, the resident stated that her body had become weak. The note revealed that due to the observed behavior creating an increased risk for falls, loss of balance, and potential injury to both the resident and assisting staff, the resident was assisted to bed for safety. The note further revealed that no injuries were noted during assessment, the call light was placed within reach, and staff were advised to continue close monitoring and reinforce safe transfer techniques.A review of a shower skin assessment sheet dated June 16, 2026, revealed that the resident had no indicated skin impairments. A skin assessment dated [DATE], at 11:22 a.m. revealed that the resident had a nickel-sized blue bruise on the center of her right knee and a nickel-sized blue bruise with a 2-millimeter scab over the center of her left lateral knee cap, with both skin impairments having a side note that says patient states she probably bumped it. The skin assessment revealed an additional note of multiple red spots on the resident's bilateral arms, with a side note that says patient states she gets these from bumping into things. A care plan focus initiated on June 17, 2026, revealed that the resident was at risk for misappropriation, neglect, abuse, and/or exploitation related to her decreased mobility and neurological symptoms, with (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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The investigation revealed that the CNA called for assistance from the Licensed Practical Nurse (LPN/Staff#25), who positioned herself on the right side, and the CNA was on the left side. The investigation revealed that both staff members said that the resident's knees were locked and stiff, and that the resident reported feeling weak and unable to bend her knees. The investigation revealed that, according to the CNA, Staff #34, the LPN, Staff #25, tapped the resident's right shin area in an attempt to encourage the resident to bend her legs. The investigation revealed that staff were able to safely reposition the resident in the wheelchair and subsequently transfer the resident to bed without further difficulty. The investigation also revealed that witness interviews were taken from a CNA, Staff #34, the LPN, Staff #25, and another CNA, Staff #21, and that other records reviewed included written statements. The investigation revealed that all appropriate notifications to the family, Arizona Department of Health Services (AZDHS), Adult Protective Services (APS), local police, and the Ombudsman were made according to policy, and that during the investigation, it was determined that the allegation of abuse was unsubstantiated. The investigation revealed that corrective actions included the statement that no policies were broken, and the investigation was signed by the Operations Manager and Abuse Coordinator (OM/Staff #70) on June 22, 2026. A follow-up request was made on July 1, 2026, at 9:55 a.m. for a 5-day investigation with interviews for Resident #96. Review of the facility investigation with interviews revealed that an interview with Resident #96 was conducted on June 16, 2026, at approximately 1:30 p.m. The interview revealed that the resident spoke with the OM (Staff #70) and the Director of Nursing (DON/Staff #17) about the incident on June 15, 2026, and the resident reported that the LPN, Staff #25, touched her left leg at the knee and that the resident made a motion with her hand. The interview revealed that the OM asked the resident if they could assess her left leg, the resident agreed, and the assessment revealed an old bruise with a scab in the center on the left side of the resident's kneecap. The facility investigation further revealed that the OM and the DON met with the CNA, Staff #34, regarding the reported incident, and during the meeting, the CNA was asked to demonstrate the incident as it had been described. The interview revealed that the CNA initially stated that the nurse touched the resident's right leg and touched the OM's lower right shin, and the OM told the CNA that the resident reported that the nurse touched her left knee. The interview revealed that the CNA stated that both legs had been touched and demonstrated the interaction, stating that the nurse was standing in front of the resident, bent over, and touched both legs in the manner she demonstrated on the OM. The facility investigation also revealed an interview on June 16, 2026, at 8:37 a.m. with another CNA, Staff #21, who worked the shift on the incident date, who denied knowing of any incident that occurred on that shift. The facility investigation revealed an interview with the LPN, Staff #25, on June 16, 2026, at 9:17 a.m., during which she stated that she documented the resident's behaviors in a progress note. The interview revealed that the OM informed the LPN that a staff member reported that the LPN struck the resident on the right leg while instructing her to bend her knees, and the LPN denied striking the resident. The interview revealed that the LPN stated they were doing a two-person transfer when the resident stiffened her legs, and that she had her arm under the resident's arm and provided a tactile cue behind the resident's left knee while instructing her to bend this knee.A follow-up request was made on July 1, 2026, at 10:10 a.m. for written witness statements for the incident regarding Resident #96. Review of the requested written witness statements revealed one statement by the CNA, Staff #34, titled Incident Report was signed and (continued on next page)

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A telephonic interview was attempted on July 1, 2026, at 11:03 a.m. with a CNA, Staff #34, who witnessed the incident, with no success. A telephonic interview was attempted on July 1, 2026, at 11:06 a.m. with a Licensed Practical Nurse (LPN/Staff #25), who was accused of hitting the resident, with no success. An interview was conducted on July 1, 2026, at 11:22 a.m. with a Registered Nurse (RN/Staff #56), who stated that physical abuse was defined as hitting, threatening to hit, slapping, or any type of hitting, both closed- or open-hand. The RN stated that verbal abuse was defined as speaking to someone in a way that makes them feel threatened, scared, or unsafe, and that yelling and intimidation with volume were forms of verbal abuse. The RN stated that reportable allegations would be anything that makes her concerned about the possibility of abuse, and that she would tell her supervisor immediately. The RN stated that the risk of failing to report abuse per the facility policy would be that abuse could continue happening, someone could have an injury and the facility wouldn't know about it, and there could be emotional and psychological damage. The RN stated that the same risks were possible regarding reporting allegations of abuse late, and added the risk that residents may continue to work with someone who abused them. The RN stated that she had to report an allegation of abuse one morning when a CNA told her that a resident alleged that they had been abused by the night shift. The RN stated that the incident was reported to her about 2 weeks ago, and that the CNA who reported to her was Staff #40. The RN also stated that she went to check in with the resident, who reported to the RN that the night before, a nurse had hit her in the leg and was telling her to relax it because she was having a muscle spasm and was stiff. The RN stated that the resident told her the nurse hit the resident's leg until it relaxed, and that the RN did a handwritten statement at the time, and that there was a police report. The RN stated that she did not remember if the wording was slap or hit, but that she wrote a statement, and that it was a reportable incident because no resident should ever be hit, slapped or experience aggressive behavior. The RN stated that she did not do the skin assessment, but that she knew the resident was hurt emotionally by the incident because the resident was tearful and stated that it made her feel like no one cared about her and that she wasn't wanted at the facility. The RN opened Resident #96's progress notes and stated that the incident occurred on the night of June 15, 2026, and that it was reported to her on June 16, 2026. The RN stated that the nurse who hit the resident was Staff #25 and that the RN reported the incident to management between 7:45 and 8:30 a.m. on the 16th.An interview was conducted on July 1, 2026, at 11:58 a.m., with a CNA, Staff #32, who stated that physical abuse was defined as putting hands on a resident in a manner that would hurt them, including hitting, slapping, pinching, and poking. The CNA stated that verbal abuse was defined as yelling, cussing, putting someone down, or using negative words towards a person. The CNA stated that any type of abuse was reportable, but especially physical abuse. The CNA stated that the risk of failing to report abuse per the abuse policy was that someone could get an injury, abuse could continue, it could happen to another resident, and it could make the resident scared or not trusting. The CNA also stated that there had been a recent allegation of abuse at the facility where a CNA, Staff #34, witnessed Resident #96 being hit by an LPN, Staff #25. The CNA stated that the CNA who witnessed the incident, Staff #34, mentioned to another CNA, Staff #84, that she witnessed the nurse hitting the resident, and that it was not reported within the required timeframe because she was scared to have to report it to the nurse on the floor that night, whom she accused of hitting the (continued on next page)

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The CNA stated that the risk of failing to report an allegation of abuse, per the facility policy, would be continued abuse to residents, and that the resident might experience a mental or physical decline, might lack trust, and could feel like no one was listening to them and continue to endure abuse because of not wanting to report. The CNA stated that an allegation of abuse was reported to her by another CNA, Staff #32, who was told by a CNA, Staff #84, that CNA, Staff #34, witnessed Resident #96 being hit by LPN, Staff #25. The CNA stated that she asked Resident #96 to take a walk with her, they found a location for privacy, and the CNA told the resident she could be honest and tell her if something happened with the nurse. The CNA stated that the resident began to tear up and told the CNA that the nurse was yelling at her and hitting her in the legs the night before. The CNA stated that the resident told her that she needed help bending her knees, and when they finished talking, the CNA ran to tell the RN, Staff #56, that she had a reportable abuse allegation. The CNA stated that the RN talked with the resident, who reported the same information verbatim and demonstrated where she was punched in the right leg. The CNA stated that after they interviewed the resident, the RN reported the incident further, and the CNA brought the resident back to her room to lie down and have a brief change. The CNA stated that the resident's leg was bruised in the same area that she had pointed to in her demonstration of the hit, and that the CNA had made a handwritten statement regarding the incident that detailed the same information she just shared; however, the facility did not provide the written statement in the facility investigation. The CNA stated that her statement was dated June 16, 2026, and that her interview with the resident was between 7:30 and 8:30 a.m. that day. An interview was conducted on July 1, 2026, at 12:46 a.m., with a CNA, Staff #84, who stated that physical abuse was defined as hitting, punching, physical touch, or hitting with objects, all of which could be with either a closed fist or an open hand. The CNA stated that verbal abuse was defined as yelling, screaming, cussing, degrading someone, or humiliating them. The CNA further stated that all allegations of abuse were reportable, and that the risk of failing to report an allegation of abuse was that the staff could get in trouble, lose their license, and anything could happen to the resident. The CNA also stated that a potential risk of delaying the reporting of an abuse allegation could be that the incident details could be forgotten or twisted, and that residents could lose their sense of security or feel ignored. The CNA stated that another CNA, Staff #34, recently had to report abuse that they had witnessed, and that Staff #34 pulled the CNA into a private room to get her opinion on what she witnessed. The CNA stated that Staff #34 told her that she witnessed a nurse smacking a resident's leg and telling her to bend her knees, and heard the resident saying please stop hitting me. The CNA stated that she told Staff #34 to report the incident right away and make a written statement so nothing was forgotten or lost, and as far as the CNA knew, Staff #34 told the DON and wrote the statement. An interview was conducted on July 1, 2026, at 1:09 p.m. with the DON, Staff #17, who stated that physical abuse was defined as touching someone when they do not want to be touched, and gave examples of physical abuse, such as slapping, hitting, punching, kicking, and grabbing. The DON stated that verbal abuse was defined as screaming, yelling, cussing, and belittling someone. The DON stated that all allegations of abuse were reportable, and further stated that when an allegation was made, their process was to immediately do an investigation, suspend everyone involved, make sure the resident was safe, interview staff, interview residents, and report to APS, local police, the ombudsman, and AZDHS. The DON stated that the only instance in which a written statement would be excluded from the final investigation report would be if the staff member was interviewed and did not know anything (continued on next page)

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The DON stated that administration was out of town for a conference at the time, so they had the CNA send a picture of her note, and when they read the allegation, they started the investigation. The DON stated that the facility reported the incident on June 16, 2026, but that the incident occurred on June 15th around 7:30-8 p.m. The DON further stated that the CNA reported that she witnessed a nurse slap a resident's leg during a two-person transfer from wheelchair to bed, and that the nurse slapped the resident while telling her to bend her leg. The DON stated that the CNA did not report the incident to them until the next day and that the staff's reporting of the incident was not within the facility's expectations or policy, and further stated that, as a result, the facility did not report within the required timeframe. The DON also stated that in their investigation, they talked to the CNA who witnessed the incident, the nurse who was accused, and the nurse who was on shift the next morning, who had called to tell them that there was an allegation of abuse. The DON stated that the accused nurse did not write them a statement and that the result of the investigation was unsubstantiated despite the resident saying she was hit and a CNA witnessing it, because after talking to the accused nurse, the LPN stated that she did not hit the resident, but instead was doing a tactile touch. The DON also stated that they terminated the LPN, Staff #25, on June 17, 2026, because she was not friendly with staff or residents, they had prior concerns about her behavior before the abuse incident, and she was cursing in the hallways, but denied terminating the nurse because of the incident with Resident #96. The DON stated that the resident told other staff members, including the RN, Staff #56, that she was hit by the LPN, and that there were written statements that the facility did not provide in the facility investigation request. An interview was conducted on July 1, 2026, at approximately 1:45 p.m. with the OM/Staff #70, who stated that physical abuse was defined as when someone inflicts physical harm on someone, with examples being hitting, pulling hair, grabbing, and slapping someone with intent to harm. The OM stated that verbal abuse was defined as using vulgar language, curse words, someone's demeanor, and belittling someone. The OM stated that if someone told her that they witnessed a staff member abusing someone, they would look into it, and that the investigation would entail interviewing staff who were around or witnessed the abuse, and residents involved, with the DON present. The OM stated that corporate required them to fill out an abuse form with questions, and that the only instance where the facility would exclude statements from the facility investigation would be if the statements did not pertain to the situation, or if the statement was not first-hand from a witness of the incident. The OM acknowledged that someone interviewing the resident about the incident would be no different from their interviews with the resident, but that she was instructed by corporate higher-ups after the recent reportable incident to not include written statements from staff who did not physically witness the incident. The OM stated that the risk of failing to report abuse as per the facility policy would be a delay in a proper investigation, and not following the policy. The OM stated that failing to include statements in their facility investigation would be that they would not have conducted a thorough investigation. The OM stated that the facility had a reportable incident recently when a CNA, Staff #34, texted her that there was an incident and that she slid a note under the OM's door. The OM stated that they called social services to ask the resident what happened, that they suspended the nurse until they figured out the investigation was completed, and that the social worker and ADON conducted interviews. The OM stated that the incident occurred on the night of June 15, 2026, but (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that it wasn't reported until the morning of June 16, 2026. The OM stated that she talked with the resident on the 17th of June, and the resident told them that a staff member hit her on the leg. The OM further stated that they asked her if she could show them where the nurse hit her, to which the resident visually demonstrated a hit to the left leg and said, She just hit me. The OM stated that the resident told them that a CNA was in the room to witness the incident, but that the resident did not recall her name. The OM stated that they identified that it was CNA, Staff #34, following her report, and that the CNA told them it was the right leg, but that the CNA's demonstration of the incident did not make sense because of the side of the bed she was standing on, which led to the facility unsubstantiating their investigation. The OM stated that the CNA told them that the nurse was telling the resident to bend her knees, and that she was shocked by what she witnessed. The OM stated that she asked the CNA why she did not report the incident in a timely manner, and she got hostile and asked who she was supposed to report to if the nurse whom she would report to was being accused. The OM stated that the CNA quit during their conversation and that they terminated the LPN, Staff #25, on June 17, 2026, because they were getting feedback from staff and residents that the LPN was rude, not friendly, and lacked bedside manner, but denied that the termination was related to the abuse incident. The OM stated that they interviewed the people involved, but that they left pieces out of the facility investigation, and that it was not to hide anything. The OM further stated that it was probably not thoroughly investigated because of what was left out, and that they would change the outcome of their investigation to say it happened because of what they found out in the investigation, and that the resident and the witness both stated that it happened, in combination with the additional written statements from staff who interviewed the resident. The OM stated that the skin assessment showed that the resident did have bruising following the incident, but stated that it was an old, faded bruise that police took a photo of; however, the skin assessments and shower sheets did not show the presence of bruising before the incident. Review of a policy titled, Resident Rights/Dignity: Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, was dated January 1, 2024, and revealed that all reports of resident abuse should have been reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The policy revealed that the findings of all investigations should have been documented and reported, and that the suspicion of abuse must be reported immediately to the administrator and other officials according to state law. The policy revealed that all relevant professional and licensing boards were notified when an employee was found to have committed abuse, and that if the investigation revealed that the allegation(s) of abuse were founded, the employee(s) would be terminated. The policy also revealed that any allegations of abuse would be filed in the accused employee's personnel record along with any statement by the employee disputing the allegation, if the employee chose to make one.Review of a policy titled, Resident Rights/Dignity: Resident Rights, was dated January 1, 2024, and revealed that federal and state laws guarantee certain basic rights to all residents in the facility, including the resident's right to be free from abuse, neglect, misappropriation of property, and exploitation.

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	035233	A. Building B. Wing	07/01/2026

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Haven of Globe	1100 Monroe Street Globe, AZ 85501

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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 clinical record review, resident and staff interviews, and policy review, the facility failed to ensure that the abuse policy was implemented following an incident of staff-to-resident abuse for one resident (#96). The deficient practice could result in residents being physically and emotionally harmed.Findings include:Resident #96 was admitted to the facility on [DATE], with a diagnosis that included encounter for palliative care, muscle spasms, atherosclerotic heart disease, malignant neoplasm of the cervix uteri, type 2 diabetes, hypertension, urinary incontinence, pressure ulcer of the sacral region, polyneuropathy, and generalized anxiety disorder.A Medicare 5-Day Minimum Data Set (MDS) dated [DATE], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. Review of an alert charting progress note dated June 15, 2026, at 7:02 p.m. revealed that the resident had activated her call light and that the certified nursing assistant (CNA) had responded and found the resident seated in her wheelchair. The note further revealed that the resident was slipping from her chair with both knees locked, gripping the wheelchair armrests, and demonstrating generalized body rigidity. The note revealed that the CNA attempted to reposition the resident safely, but the resident continued to maintain her rigid posture despite verbal instructions to relax. The note also revealed that the CNA requested nursing assistance, and upon entering the room, the nurse observed the resident continuing to extend her lower extremities while maintaining body rigidity, partially lifting and pushing herself from the wheelchair seat. The note revealed that the CNA remained present while attempting to provide support and prevent loss of balance, and that the resident was instructed multiple times to relax her body and bend her knees for safe repositioning. The note revealed that the resident was informed that maintaining a rigid posture during transfers and repositioning increases the risk of injury to herself and staff assisting her. The note also revealed that following repeated verbal instructions, the resident relaxed her posture and was repositioned back into the wheelchair. The note revealed that when asked what had occurred, the resident stated that her body had become weak. The note revealed that due to the observed behavior creating an increased risk for falls, loss of balance, and potential injury to both the resident and assisting staff, the resident was assisted to bed for safety. The note further revealed that no injuries were noted during assessment, the call light was placed within reach, and staff were advised to continue close monitoring and reinforce safe transfer techniques.A skin assessment dated [DATE], at 11:22 a.m. revealed that the resident had a nickel-sized blue bruise on the center of her right knee and a nickel-sized blue bruise with a 2-millimeter scab over the center of her left lateral knee cap, with both skin impairments having a side note that says patient states she probably bumped it. The skin assessment revealed an additional note of multiple red spots on the resident's bilateral arms, with a side note that says patient states she gets these from bumping into things. A care plan focus initiated on June 17, 2026, revealed that the resident was at risk for misappropriation, neglect, abuse, and/or exploitation related to her decreased mobility and neurological symptoms, with a goal to not experience misappropriation, neglect, abuse, and/or exploitation through the review date. The care plan revealed interventions to monitor for signs and symptoms of misappropriation, neglect, abuse, and/or exploitation, and report to the facility's abuse officer and medical provider. Review of the facility investigation dated June 18, 2026, revealed that on June 15, 2026, at approximately 7 p.m., a CNA, Staff #34, reported that she responded to the resident's call light and found her slipping out of her wheelchair. The investigation revealed that the CNA called for assistance from the Licensed Practical Nurse (LPN/Staff#25), who positioned herself on the right side, and the CNA was on the left side. The investigation revealed that both staff members said that the resident's knees were locked and stiff, and that the resident reported feeling weak and unable to bend her knees. The investigation revealed that, according to the CNA, Staff #34, the LPN, Staff #25, tapped the resident's right shin area in an attempt to encourage (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident to bend her legs. The investigation revealed that staff were able to safely reposition the resident in the wheelchair and subsequently transfer the resident to bed without further difficulty. The investigation also revealed that witness interviews were taken from a CNA, Staff #34, the LPN, Staff #25, and another CNA, Staff #21, and that other records reviewed included written statements. The investigation revealed that all appropriate notifications to the family, Arizona Department of Health Services (AZDHS), Adult Protective Services (APS), local police, and the Ombudsman were made according to policy, and that during the investigation, it was determined that the allegation of abuse was unsubstantiated. The investigation revealed that corrective actions included the statement that no policies were broken, and the investigation was signed by the Operations Manager and Abuse Coordinator (OM/Staff #70) on June 22, 2026. A follow-up request was made on July 1, 2026, at 9:55 a.m. for a 5-day investigation with interviews for Resident #96. Review of the facility investigation with interviews revealed that an interview with Resident #96 was conducted on June 16, 2026, at approximately 1:30 p.m. The interview revealed that the resident spoke with the OM, Staff #70, and the Director of Nursing (DON/Staff #17) about the incident on June 15, 2026, and the resident reported that the LPN, Staff #25, touched her left leg at the knee and that the resident made a motion with her hand. The interview revealed that the OM asked the resident if they could assess her left leg, the resident agreed, and the assessment revealed an old bruise with a scab in the center on the left side of the resident's kneecap. The facility investigation further revealed that the OM and the DON met with the CNA, Staff #34, regarding the reported incident, and during the meeting, the CNA was asked to demonstrate the incident as it had been described. The interview revealed that the CNA initially stated that the nurse touched the resident's right leg and touched the OM's lower right shin, and the OM told the CNA that the resident reported that the nurse touched her left knee. The interview revealed that the CNA stated that both legs had been touched and demonstrated the interaction, stating that the nurse was standing in front of the resident, bent over, and touched both legs in the manner she demonstrated on the OM. The facility investigation also revealed an interview on June 16, 2026, at 8:37 a.m. with another CNA, Staff #21, who worked the shift on the incident date, who denied knowing of any incident that occurred on that shift. The facility investigation revealed an interview with the LPN, Staff #25, on June 16, 2026, at 9:17 a.m., during which she stated that she documented the resident's behaviors in a progress note. The interview revealed that the OM informed the LPN that a staff member reported that the LPN struck the resident on the right leg while instructing her to bend her knees, and the LPN denied striking the resident. The interview revealed that the LPN stated they were doing a two-person transfer when the resident stiffened her legs, and that she had her arm under the resident's arm and provided a tactile cue behind the resident's left knee while instructing her to bend this knee.A follow-up request was made on July 1, 2026, at 10:10 a.m. for written witness statements for the incident regarding Resident #96. Review of the requested written witness statements revealed that a statement by a CNA, Staff #34, titled Incident Report was signed and dated June 16, 2026. The statement revealed that on the night shift of June 15, 2026, the CNA was putting Resident #96 back into bed as she was slipping out of her chair, and the resident's legs were stiff. The written statements revealed that the nurse on shift, Staff #25, smacked the resident's legs to get her to bend her knees between 6 and 7:20 p.m. The CNA wrote that she was in shock more than angry and to ask resident about last night please. Following an interview with the OM and abuse coordinator, Staff #70, on July 1, 2026, at approximately 1:45 p.m., a request was made for the written witness statements that the facility had not provided with the initial requests for the complete investigation. Review of the written witness statements revealed a statement from a Registered Nurse (RN/Staff #56), signed and dated June 16, 2026. The written statement from the RN revealed that shortly after breakfast, Resident #96's CNA reported to the RN that Resident #96 had described abuse that had happened to her overnight. The written statement further revealed that the RN sat down with the resident in a private place and asked what had happened, and the resident began crying and said that when staff were transferring her the night before, the nurse started yelling at her, (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	saying, relax your legs! The written statement also revealed that the resident stated that she tried to tell the nurse that she couldn't help it and could not relax her legs, and that the nurse began hitting her legs until they relaxed. The written statement revealed that the RN asked the resident if anyone else was there when the incident happened, and the resident said that only the LPN was hitting her, but she thought it happened in front of someone else. The written statement revealed that the resident denied anyone else hitting or hurting her, and that the resident told the RN that the LPN told her that she was mean to staff and that the resident hurts staff with her behavior. The written statement further revealed that the resident told the RN that the LPN told the resident that she hurt a CNA's back by stiffening her legs and made them cry, and the resident told the RN that she was going to report the LPN to social services, but that the nurse told her that all of the nurses document her behavior, which made the resident feel that no one would listen. The written statement revealed that the RN called and reported the incident to the assistant director of nursing (ADON), and that she had spoken with the DON, who verified that the director had been notified. An interview was attempted with Resident #96 on July 1, 2026, at 8:35 a.m., but the resident was not able to answer any questions.An interview was conducted on July 1, 2026, at approximately 9 a.m., with Resident #96's roommate, Resident #14, who revealed that she had been Resident #96's roommate for 3 weeks. The resident stated that she heard a nurse yelling at Resident #96 one time, but she did not know what the nurse was yelling. The resident stated that she had not seen the nurse providing care to them since she yelled at Resident #96. A telephonic interview was attempted on July 1, 2026, at 9:26 a.m. with a CNA, Staff #21, who worked the night shift on the date of the incident, with no success. A telephonic interview was conducted on July 1, 2026, at 9:36 a.m. with Resident #96's responsible party and daughter, who stated that she was made aware of an incident at the facility where a nurse assaulted her mom. The resident's responsible party stated that the incident was reported by a CNA, that they filed a police report, and that the nurse was suspended. The resident's responsible party stated that the nurse was trying to get the resident to straighten her legs, and that the nurse told the resident she knew the resident was faking it before striking her legs to straighten them out. The resident's responsible party stated that her sister would know more about the incident and to give her a call, too. A telephonic interview was conducted on July 1, 2026, at 9:43 a.m. with Resident #96's emergency contact and other daughter, who stated that someone from the facility called her and stated that the incident involved a nurse hitting her mom. The emergency contact stated that she was told that a nurse jabbed her mom's leg and did not leave a mark. The emergency contact stated that her sister told her to visit their mom that evening and when she did go to visit the resident told her that she did not report what happened to her, but that for two nights, the nurse was telling the resident that no one wanted to come into her room to help because she was always asking for help and that they all know that she was pretending. The emergency contact stated that she had asked the resident how the facility found out about the incident if she did not report it, and the resident stated that she was being transferred from her chair to the bed when she had a leg spasm, and that the nurse nudged her knee and told her to quit pretending, but that the resident could not move her leg. The emergency contact further stated that the resident told her that the CNA who was there reported it, and that the resident was asked about the incident, and she told them that it happened. The emergency contact stated that the police went to the facility, and that she called the police to ask about it, and they told her that it was going to be a criminal investigation now. The emergency contact stated that the nurse was identified as the LPN, Staff #25, and that the nurse did not work with her again. The emergency contact stated that since the incident, her mother is not acting like herself, she is not really talking, and she will not eat or drink now. A telephonic interview was attempted on July 1, 2026, at 11:03 a.m. with a CNA, Staff #34, who witnessed the incident, with no success. A telephonic interview was attempted on July 1, 2026, at 11:06 a.m. with a Licensed Practical Nurse (LPN/Staff #25), who was accused of hitting the resident, with no success. An interview was conducted on July 1, 2026, at 11:22 a.m. with a Registered Nurse (RN/Staff #56), who stated that (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physical abuse was defined as hitting, threatening to hit, slapping, or any type of hitting, both closed- or open-hand. The RN stated that verbal abuse was defined as speaking to someone in a way that makes them feel threatened, scared, or unsafe, and that yelling and intimidation with volume were forms of verbal abuse. The RN stated that the timeframe for reporting an allegation of abuse was 4 hours when someone was injured, and that she would report to the DON and administrator. The RN stated that reportable allegations would be anything that makes her concerned about the possibility of abuse, and that she would tell her supervisor immediately. The RN stated that the risk of failing to report abuse per the facility policy would be that abuse could continue happening, someone could have an injury and the facility wouldn't know about it, and there could be emotional and psychological damage. The RN stated that the same risks were possible regarding reporting allegations of abuse late, and added the risk that residents may continue to work with someone who abused them. The RN stated that she had to report an allegation of abuse one morning when a CNA told her that a resident alleged that they had been abused by the night shift. The RN stated that the incident was reported to her about 2 weeks ago, and that the CNA who reported to her was Staff #40. The RN also stated that she went to check in with the resident, who reported to the RN that the night before, a nurse had hit her in the leg and was telling her to relax it because she was having a muscle spasm and was stiff. The RN stated that the resident told her that the nurse hit her leg until it relaxed, and that the RN did a handwritten statement at the time, and that there was a police report. The RN stated that she did not remember if the wording was slap or hit, but that she wrote a statement, and that it was a reportable incident because no resident should ever be hit, slapped or experience aggressive behavior. The RN stated that she did not do the skin assessment, but that she knew the resident was hurt emotionally by the incident because the resident was tearful and stated that it made her feel like no one cared about her and that she wasn't wanted at the facility. The RN opened Resident #96's progress notes and stated that the incident occurred on the night of June 15, 2026, and that it was reported to her on June 16, 2026. The RN stated that the nurse who hit the resident was Staff #25 and that the RN reported the incident to management between 7:45 and 8:30 a.m. on the 16th.An interview was conducted on July 1, 2026, at 11:58 a.m., with a CNA, Staff #32, who stated that physical abuse was defined as putting hands on a resident in a manner that would hurt them, including hitting, slapping, pinching, and poking. The CNA stated that verbal abuse was defined as yelling, cussing, putting someone down, or using negative words towards a person. The CNA stated that the timeframe for reporting an allegation of abuse was two hours and that she would need to report to the DON and ADON. The CNA stated that any type of abuse was reportable, but especially physical abuse. The CNA stated that the risk of failing to report abuse as per the abuse policy was that someone could get an injury, abuse could continue, it could happen to another resident, and it could make the resident scared or not trusting. The CNA also stated that there had been a recent allegation of abuse at the facility where a CNA, Staff #34, witnessed Resident #96 being hit by an LPN, Staff #25. The CNA stated that the CNA who witnessed the incident, Staff #34, mentioned to another CNA, Staff #84, that she witnessed the nurse hitting the resident, and that it was not reported within the required timeframe because she was scared to have to report it to the nurse on the floor that night, whom she accused of hitting the resident. The CNA stated that when Staff #84 told her about the incident, Staff #32 reported the allegation to the resident's CNA, Staff #40, who spoke with the resident the morning after the incident. The CNA stated that when Staff #40 spoke with the resident, the resident was crying and reported to staff that the LPN punched her in the leg. An interview was conducted on July 1, 2026, at 11:40 a.m. with a Licensed Nursing Assistant (LNA/Staff #40), who stated that physical abuse was defined as hitting, being too rough, restraining, and pulling hair. The CNA stated that verbal abuse was defined as screaming, yelling, cussing, demeaning, and belittling a resident. The CNA stated that the timeframe for reporting an allegation of abuse was two hours, but that the expectation was to report immediately to your superior. The CNA stated that the risk of failing to report an allegation of abuse, per the facility policy, would be continued abuse to residents, and that the (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident might experience a mental or physical decline, might lack trust, and could feel like no one was listening to them and continue to endure abuse because of not wanting to report. The CNA stated that an allegation of abuse was reported to her by another CNA, Staff #32, who was told by a CNA, Staff #84, that CNA, Staff #34, witnessed Resident #96 being hit by LPN, Staff #25. The CNA stated that she asked Resident #96 to take a walk with her, they found a location for privacy, and the CNA told the resident she could be honest and tell her if something happened with the nurse. The CNA stated that the resident began to tear up and told the CNA that the nurse was yelling at her and hitting her in the legs the night before. The CNA stated that the resident told her that she needed help bending her knees, and when they finished talking, the CNA ran to tell the RN, Staff #56, that she had a reportable abuse allegation. The CNA stated that the RN talked with the resident, who reported the same information verbatim and demonstrated where she was punched in the right leg. The CNA stated that after they interviewed the resident, the RN reported the incident further, and the CNA brought the resident back to her room to lie down and have a brief change. The CNA stated that the resident's leg was bruised in the same area that she had pointed to in her demonstration of the hit, and that the CNA had made a handwritten statement regarding the incident that detailed the same information she just shared; however, the facility did not provide the written statement in the facility investigation. The CNA stated that her statement was dated June 16, 2026, and that her interview with the resident was between 7:30 and 8:30 a.m. that day. An interview was conducted on July 1, 2026, at 12:46 a.m., with a CNA, Staff #84, who stated that physical abuse was defined as hitting, punching, physical touch, or hitting with objects, all of which could be with either a closed fist or an open hand. The CNA stated that verbal abuse was defined as yelling, screaming, cussing, degrading someone, or humiliating them. The CNA stated that the timeframe for reporting was two hours and that she would have to report to the DON and ADON. The CNA further stated that all allegations of abuse were reportable, and that the risk of failing to report an allegation of abuse was that the staff could get in trouble, lose their license, and anything could happen to the resident. The CNA also stated that a potential risk of delaying the reporting of an abuse allegation could be that the incident details could be forgotten or twisted, and that residents could lose their sense of security or feel ignored. The CNA stated that another CNA, Staff #34, recently had to report abuse that they had witnessed, and that Staff #34 pulled the CNA into a private room to get her opinion on what she witnessed. The CNA stated that Staff #34 told her that she witnessed a nurse smacking a resident's leg and telling her to bend her knees, and heard the resident saying please stop hitting me. The CNA stated that she told Staff #34 to report the incident right away and make a written statement so nothing was forgotten or lost, and as far as the CNA knew, Staff #34 told the DON and wrote the statement. An interview was conducted on July 1, 2026, at 1:09 p.m. with the DON, Staff #17, who stated that physical abuse was defined as touching someone when they do not want to be touched, and gave examples of physical abuse, such as slapping, hitting, punching, kicking, and grabbing. The DON stated that verbal abuse was defined as screaming, yelling, cussing, and belittling someone. The DON stated that the timeframe for reporting an allegation of abuse was immediately to their direct supervisor, and that administration had two hours to report per the facility policy. The DON stated that all allegations of abuse were reportable, and further stated that when an allegation was made, their process was to immediately do an investigation, suspend everyone involved, make sure the resident was safe, interview staff, interview residents, and report to APS, local police, the ombudsman, and AZDHS. The DON stated that the only instance in which a written statement would be excluded from the final investigation report would be if the staff member was interviewed and did not know anything about the incident, and that if the staff member interacted with or spoke to the resident involved, their statement would need to be included. The DON also stated that failure to include those statements in the investigation would mean that it was not a thorough investigation. The DON stated that the risk of failing to report abuse as per the facility policy was that abuse could continue to happen and put residents and staff in harm's way. The DON also stated that the risk of not thoroughly investigating, such as leaving staff (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	statements out of the investigation, would be that the investigation wouldn't be thorough and would also put residents and staff in harm's way. The DON stated that they recently reported an incident that was reported to them by a CNA who slipped a note under the OM's door and texted that she needed to talk to them. The DON stated that administration was out of town for a conference at the time, so they had the CNA send a picture of her note, and when they read the allegation, they started the investigation. The DON stated that the facility reported the incident on June 16, 2026, but that the incident occurred on June 15th around 7:30-8 p.m. The DON further stated that the CNA reported that she witnessed a nurse slap a resident's leg during a two-person transfer from wheelchair to bed, and that the nurse slapped the resident while telling her to bend her leg. The DON stated that the CNA did not report the incident to them until the next day and that the staff's reporting of the incident was not within the facility's expectations or policy, and further stated that, as a result, the facility did not report within the required timeframe. The DON also stated that in their investigation, they talked to the CNA who witnessed the incident, the nurse who was accused, and the nurse who was on shift the next morning, who had called to tell them that there was an allegation of abuse. The DON stated that the accused nurse did not write them a statement and that the result of the investigation was unsubstantiated despite the resident saying she was hit and a CNA witnessing it, because after talking to the accused nurse, the LPN stated that she did not hit the resident, but instead was doing a tactile touch. The DON also stated that they terminated the LPN, Staff #25, on June 17, 2026, because she was not friendly with staff or residents, they had prior concerns about her behavior before the abuse incident, and she was cursing in the hallways, but denied terminating the nurse because of the incident with Resident #96. The DON stated that the resident told other staff members, including the RN, Staff #56, that she was hit by the LPN, and that there were written statements that the facility did not provide in the facility investigation request. An interview was conducted on July 1, 2026, at approximately 1:45 p.m. with the OM/Staff #70, who stated that physical abuse was defined as when someone inflicts physical harm on someone, with examples being hitting, pulling hair, grabbing, and slapping someone with intent to harm. The OM stated that verbal abuse was defined as using vulgar language, curse words, someone's demeanor, and belittling someone. The OM stated that she was the abuse coordinator, and that the timeframe for reporting an allegation was two hours to AZHDS, the ombudsman, local police, the case manager, the administrator, and the Medicaid agency. The OM stated that if someone told her that they witnessed a staff member abusing someone, they would look into it, and that the investigation would entail interviewing staff who were around or witnessed the abuse, and residents involved, with the DON present. The OM stated that corporate required them to fill out an abuse form with questions, and that the only instance where the facility would exclude statements from the facility investigation would be if the statements did not pertain to the situation, or if the statement was not first-hand from a witness of the incident. The OM acknowledged that someone interviewing the resident about the incident would be no different from their interviews with the resident, but that she was instructed by corporate higher-ups after the recent reportable incident to not include written statements from staff who did not physically witness the incident. The OM stated that the risk of failing to report abuse as per the facility policy would be a delay in a proper investigation, and not following the policy. The OM stated that failing to include statements in their facility investigation would be that they would not have conducted a thorough investigation. The OM stated that the facility had a reportable incident recently when a CNA, Staff #34, texted her that there was an incident and that she slid a note under the OM's door. The OM stated that they called social services to ask the resident what happened, that they suspended the nurse until they figured out the investigation was completed, and that the social worker and ADON conducted interviews. The OM stated that the incident occurred on the night of June 15, 2026, but that it wasn't reported until the morning of June 16, 2026. The OM further stated that the reporting of this incident was not within the facility's expectations for reporting. The OM stated that she talked with the resident on the 17th of June, and the resident told them that a staff member hit her on the (continued on next page)

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	07/01/2026

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

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(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	leg. The OM further stated that they asked her if she could show them where the nurse hit her, to which the resident visually demonstrated a hit to the left leg and said, She just hit me. The OM stated that the resident told them that a CNA was in the room to witness the incident, but that the resident did not recall her name. The OM stated that they identified that it was CNA, Staff #34, following her report, and that the CNA told them it was the right leg, but that the CNA's demonstration of the incident did not make sense because of the side of the bed she was standing on, which led to the facility unsubstantiating their investigation. The OM stated that the CNA told them that the nurse was telling the resident to bend her knees, and that she was shocked by what she witnessed. The OM stated that she asked the CNA why she did not report the incident in a timely manner, and she got hostile and asked who she was supposed to report to if the nurse whom she would report to was being accused. The OM stated that the CNA quit during their conversation and that they terminated the LPN, Staff #25, on June 17, 2026, because they were getting feedback from staff and residents that the LPN was rude, not friendly, and lacked bedside manner, but denied that the termination was related to the abuse incident. The OM stated that they interviewed the people involved, but that they left pieces out of the facility investigation, and that it was not to hide anything. The OM further stated that it was probably not thoroughly investigated because of what was left out, and that they would change the outcome of their investigation to say it happened because of what they found out in the investigation, and that the resident and the witness both stated that it happened, in combination with the additional written statements from staff who interviewed the resident. The OM stated that the skin assessment showed that the resident did have bruising following the incident, but stated that it was an old, faded bruise that police took a photo of; however, the skin assessments and shower sheets did not show the presence of bruising before the incident. Review of a policy titled, Resident Rights/Dignity: Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, was dated January 1, 2024, and revealed that all reports of resident abuse should have been reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The policy revealed that the findings of all investigations should have been documented and reported, and that the suspicion of abuse must be reported immediately to the administrator and other officials according to state law. The policy revealed that reporting immediately was defined as within two hours of an allegation involving abuse or an allegation resulting in serious bodily injury. The policy revealed that all allegations should have been thoroughly investigated, and that at a minimum, the investigation would include interviews with staff members (on all shifts) who had contact with the resident during the period of the alleged incident, any witnesses to the incident, the person(s) reporting the incident, the resident (as medically appropriate) or the resident's representative, and observations of the alleged victim, including his or her interactions with staff and other residents. The policy further revealed that witness statements should have been obtained in writing, signed, and dated. The policy also revealed that the witness was able to write his/her statement, or the investigator could obtain a statement. The po

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, resident and staff interviews, and policy review, the facility failed to ensure that an incident of staff-to-resident abuse was reported within the required timeframe for one resident (#96). The deficient practice could result in residents being physically and emotionally harmed. Findings include:Resident #96 was admitted to the facility on [DATE], with a diagnosis that included encounter for palliative care, muscle spasms, atherosclerotic heart disease, malignant neoplasm of the cervix uteri, type 2 diabetes, hypertension, urinary incontinence, pressure ulcer of the sacral region, polyneuropathy, and generalized anxiety disorder.A Medicare 5-Day Minimum Data Set (MDS) dated [DATE], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. Review of an alert charting progress note dated June 15, 2026, at 7:02 p.m. revealed that the resident had activated her call light and that the certified nursing assistant (CNA) had responded and found the resident seated in her wheelchair. The note further revealed that the resident was slipping from her chair with both knees locked, gripping the wheelchair armrests, and demonstrating generalized body rigidity. The note revealed that the CNA attempted to reposition the resident safely, but the resident continued to maintain her rigid posture despite verbal instructions to relax. The note also revealed that the CNA requested nursing assistance, and upon entering the room, the nurse observed the resident continuing to extend her lower extremities while maintaining body rigidity, partially lifting and pushing herself from the wheelchair seat. The note revealed that the CNA remained present while attempting to provide support and prevent loss of balance, and that the resident was instructed multiple times to relax her body and bend her knees for safe repositioning. The note revealed that the resident was informed that maintaining a rigid posture during transfers and repositioning increases the risk of injury to herself and staff assisting her. The note also revealed that following repeated verbal instructions, the resident relaxed her posture and was repositioned back into the wheelchair. The note revealed that when asked what had occurred, the resident stated that her body had become weak. The note revealed that due to the observed behavior creating an increased risk for falls, loss of balance, and potential injury to both the resident and assisting staff, the resident was assisted to bed for safety. The note further revealed that no injuries were noted during assessment, the call light was placed within reach, and staff were advised to continue close monitoring and reinforce safe transfer techniques.A skin assessment dated [DATE], at 11:22 a.m. revealed that the resident had a nickel-sized blue bruise on the center of her right knee and a nickel-sized blue bruise with a 2-millimeter scab over the center of her left lateral knee cap, with both skin impairments having a side note that says patient states she probably bumped it. The skin assessment revealed an additional note of multiple red spots on the resident's bilateral arms, with a side note that says patient states she gets these from bumping into things. A care plan focus initiated on June 17, 2026, revealed that the resident was at risk for misappropriation, neglect, abuse, and/or exploitation related to her decreased mobility and neurological symptoms, with a goal to not experience misappropriation, neglect, abuse, and/or exploitation through the review date. The care plan revealed interventions to monitor for signs and symptoms of misappropriation, neglect, abuse, and/or exploitation, and report to the facility's abuse officer and medical provider. A review of a shower skin assessment sheet dated June 18, 2026, revealed that the resident had no indicated skin impairments.Review of the facility investigation dated June 18, 2026, revealed that on June 15, 2026, at approximately 7 p.m., a CNA, Staff #34, responded to Resident #96's call light and found her slipping out of her wheelchair. The investigation revealed that the CNA called for assistance from the Licensed Practical Nurse (LPN/Staff#25), who positioned herself on the right side, and the CNA was on the left side, and that the resident reported feeling weak and unable to bend her knees. The investigation revealed that, (continued on next page)

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	07/01/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	according to the CNA, Staff #34, the LPN, Staff #25, tapped the resident's right shin area in an attempt to encourage the resident to bend her legs. The investigation revealed that corrective actions included the statement that no policies were broken, and the investigation was signed by the Operations Manager and Abuse Coordinator (OM/Staff #70) on June 22, 2026. The facility investigation did not include when the allegation was reported. An interview was attempted with Resident #96 on July 1, 2026, at 8:35 a.m., but the resident was not able to answer any questions.An interview was conducted on July 1, 2026, at approximately 9 a.m., with Resident #96's roommate, Resident #14, who revealed that she had been Resident #96's roommate for 3 weeks. The resident stated that she heard a nurse yelling at Resident #96 one time, but she did not know what the nurse was yelling. The resident stated that she had not seen the nurse providing care to them since she yelled at Resident #96. A telephonic interview was attempted on July 1, 2026, at 9:26 a.m. with a CNA, Staff #21, who worked the night shift on the date of the incident, with no success. A telephonic interview was conducted on July 1, 2026, at 9:36 a.m. with Resident #96's responsible party and daughter, who stated that she was made aware of an incident at the facility where a nurse assaulted her mom. The resident's responsible party stated that the incident was reported by a CNA, that they filed a police report, and that the nurse was suspended. The resident's responsible party stated that the nurse was trying to get the resident to straighten her legs, and that the nurse told the resident she knew the resident was faking it before striking her legs to straighten them out. The resident's responsible party stated that her sister would know more about the incident and to give her a call, too. A telephonic interview was conducted on July 1, 2026, at 9:43 a.m. with Resident #96's emergency contact and other daughter, who stated that someone from the facility called her and stated that the incident involved a nurse hitting her mom. The emergency contact stated that her sister told her to visit their mom that evening and when she did go to visit the resident told her that she did not report what happened to her, but that for two nights, the nurse was telling the resident that no one wanted to come into her room to help because she was always asking for help and that they all know that she was pretending. The emergency contact stated that she had asked the resident how the facility found out about the incident if she did not report it, and the resident told her that the CNA who was there reported it.A telephonic interview was attempted on July 1, 2026, at 11:03 a.m. with a CNA, Staff #34, who witnessed the incident, with no success. A telephonic interview was attempted on July 1, 2026, at 11:06 a.m. with a Licensed Practical Nurse (LPN/Staff #25), who was accused of hitting the resident, with no success. An interview was conducted on July 1, 2026, at 11:22 a.m. with a Registered Nurse (RN/Staff #56), who stated that physical abuse was defined as hitting, threatening to hit, slapping, or any type of hitting, both closed- or open-hand. The RN stated that verbal abuse was defined as speaking to someone in a way that makes them feel threatened, scared, or unsafe, and that yelling and intimidation with volume were forms of verbal abuse. The RN stated that reportable allegations would be anything that makes her concerned about the possibility of abuse, and that she would tell her supervisor immediately. The RN stated that the risk of failing to report abuse per the facility policy would be that abuse could continue happening, someone could have an injury and the facility wouldn't know about it, and there could be emotional and psychological damage. The RN stated that the same risks were possible regarding reporting allegations of abuse late, and added the risk that residents may continue to work with someone who abused them. The RN stated that she had to report an allegation of abuse one morning when a CNA told her that a resident alleged that they had been abused by the night shift. The RN stated that the incident was reported to her about 2 weeks ago, and that the CNA who reported to her was Staff #40. The RN also stated that she went to check in with the resident, who reported to the RN that the night before, a nurse had hit her in the leg and was telling her to relax it because she was having a muscle spasm and was stiff. The RN stated that the resident told her the nurse hit the resident's leg until it relaxed, and that the RN did a handwritten statement at the time, and that there was a police report. The RN stated that she did not remember if the wording was slap or hit, but that she wrote a statement, and that it was a (continued on next page)

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	07/01/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reportable incident because no resident should ever be hit, slapped or experience aggressive behavior. The RN stated that she did not do the skin assessment, but that she knew the resident was hurt emotionally by the incident because the resident was tearful and stated that it made her feel like no one cared about her and that she wasn't wanted at the facility. The RN opened Resident #96's progress notes and stated that the incident occurred on the night of June 15, 2026, and that it was reported to her on June 16, 2026. The RN stated that the nurse who hit the resident was Staff #25 and that the RN reported the incident to management between 7:45 and 8:30 a.m. on the 16th. An interview was conducted on July 1, 2026, at 11:58 a.m., with a CNA, Staff #32, who stated that the timeframe for reporting an allegation of abuse was two hours and that she would need to report to the DON and ADON. The CNA stated that any type of abuse was reportable, but especially physical abuse. The CNA stated that the risk of failing to report abuse as per the abuse policy was that someone could get an injury, abuse could continue, it could happen to another resident, and it could make the resident scared or not trusting. The CNA also stated that there had been a recent allegation of abuse at the facility where a CNA, Staff #34, witnessed Resident #96 being hit by an LPN, Staff #25. The CNA stated that the CNA who witnessed the incident, Staff #34, mentioned to another CNA, Staff #84, that she witnessed the nurse hitting the resident, and that it was not reported within the required timeframe because she was scared to have to report it to the nurse on the floor that night, whom she accused of hitting the resident. The CNA stated that when Staff #84 told her about the incident, Staff #32 reported the allegation to the resident's CNA, Staff #40, who spoke with the resident the morning after the incident and reported it further.An interview was conducted on July 1, 2026, at 11:40 a.m. with a Licensed Nursing Assistant (LNA/Staff #40), who stated that the timeframe for reporting an allegation of abuse was two hours, but that the expectation was to report immediately to your superior. The CNA stated that the risk of failing to report an allegation of abuse, per the facility policy, would be continued abuse to residents, and that the resident might experience a mental or physical decline, might lack trust, and could feel like no one was listening to them and continue to endure abuse because of not wanting to report. The CNA stated that an allegation of abuse was reported to her by another CNA, Staff #32, who was told by a CNA, Staff #84, that CNA, Staff #34, witnessed Resident #96 being hit by LPN, Staff #25. The CNA stated that she asked Resident #96 to take a walk with her, they found a location for privacy, and the CNA told the resident she could be honest and tell her if something happened with the nurse. The CNA stated that the resident began to tear up and told the CNA that the nurse was yelling at her and hitting her in the legs the night before. The CNA stated that the resident told her that she needed help bending her knees, and when they finished talking, the CNA ran to tell the RN, Staff #56, that she had a reportable abuse allegation. The CNA stated that the RN talked with the resident between 7:30 and 8:30 a.m. on June 16th, 2026, who reported the same information verbatim and demonstrated where she was punched in the right leg. The CNA stated that after they interviewed the resident, the RN reported the incident further, and the CNA brought the resident back to her room to lie down and have a brief change.An interview was conducted on July 1, 2026, at 12:46 a.m., with a CNA, Staff #84, who stated that the timeframe for reporting abuse was two hours and that she would have to report to the DON and ADON. The CNA further stated that all allegations of abuse were reportable, and that the risk of failing to report an allegation of abuse was that the staff could get in trouble, lose their license, and anything could happen to the resident. The CNA also stated that a potential risk of delaying the reporting of an abuse allegation could be that the incident details could be forgotten or twisted, and that residents could lose their sense of security or feel ignored. The CNA stated that another CNA, Staff #34, recently had to report abuse that they had witnessed, and that Staff #34 pulled the CNA into a private room to get her opinion on what she witnessed. The CNA stated that Staff #34 told her that she witnessed a nurse smacking a resident's leg and telling her to bend her knees, and heard the resident saying please stop hitting me. The CNA stated that she told Staff #34 to report the incident right away and make a written statement so nothing was forgotten or lost, and as far as the CNA knew, Staff #34 told the DON about the (continued on next page)

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	07/01/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allegation. An interview was conducted on July 1, 2026, at 1:09 p.m. with the DON, Staff #17, who stated that verbal abuse was defined as screaming, yelling, cussing, and belittling someone. The DON stated that the timeframe for reporting an allegation of abuse was immediately to their direct supervisor, and that administration had two hours to report per the facility policy. The DON stated that all allegations of abuse were reportable, and further stated that when an allegation was made, their process was to immediately do an investigation, suspend everyone involved, make sure the resident was safe, interview staff, interview residents, and report to APS, local police, the ombudsman, and AZDHS. The DON stated that the risk of failing to report abuse as per the facility policy was that abuse could continue to happen and put residents and staff in harm's way. The DON stated that they recently reported an incident that was reported to them by a CNA who slipped a note under the OM's door and texted that she needed to talk to them. The DON stated that administration was out of town for a conference at the time, so they had the CNA send a picture of her note, and when they read the allegation, they started the investigation. The DON stated that the facility reported the incident on June 16, 2026, but that the incident occurred on June 15th around 7:30-8 p.m. The DON further stated that the CNA reported that she witnessed a nurse slap a resident's leg during a two-person transfer from wheelchair to bed, and that the nurse slapped the resident while telling her to bend her leg. The DON stated that the CNA did not report the incident to them until the next day and that the staff's reporting of the incident was not within the facility's expectations or policy, and further stated that, as a result, the facility did not report within the required timeframe. An interview was conducted on July 1, 2026, at approximately 1:45 p.m. with the OM/Staff #70, who stated that physical abuse was defined as when someone inflicts physical harm on someone, with examples being hitting, pulling hair, grabbing, and slapping someone with intent to harm. The OM stated that verbal abuse was defined as using vulgar language, curse words, someone's demeanor, and belittling someone. The OM stated that she was the abuse coordinator, and that the timeframe for reporting an allegation was two hours to AZHDS, the ombudsman, local police, the case manager, the administrator, and the Medicaid agency. The OM stated that if someone told her that they witnessed a staff member abusing someone, they would look into it, and that the investigation would entail interviewing staff who were around or witnessed the abuse, and residents involved, with the DON present. The OM stated that the risk of failing to report abuse as per the facility policy would be a delay in a proper investigation, and not following the policy. The OM stated that the facility had a reportable incident recently when a CNA, Staff #34, texted her that there was an incident and that she slid a note under the OM's door. The OM stated that they called social services to ask the resident what happened, that they suspended the nurse until they figured out the investigation was completed, and that the social worker and ADON conducted interviews. The OM stated that the incident occurred on the night of June 15, 2026, but that it wasn't reported until the morning of June 16, 2026. The OM further stated that the reporting of this incident was not within the facility's expectations for reporting. The OM stated that she asked the CNA why she did not report the incident in a timely manner, and she got hostile and asked who she was supposed to report to if the nurse whom she would report to was being accused. Review of a policy titled, Resident Rights/Dignity: Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, was dated January 1, 2024, and revealed that all reports of resident abuse should have been reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The policy revealed that the findings of all investigations should have been documented and reported, and that the suspicion of abuse must be reported immediately to the administrator and other officials according to state law. The policy revealed that reporting immediately was defined as within two hours of an allegation involving abuse or an allegation resulting in serious bodily injury.

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	035233	A. Building B. Wing	07/01/2026

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure that an incident of staff-to-resident abuse involving one resident (#96) was thoroughly investigated. The deficient practice could result in residents being physically and emotionally harmed.Findings include:Resident #96 was admitted to the facility on [DATE], with a diagnosis that included encounter for palliative care, muscle spasms, atherosclerotic heart disease, malignant neoplasm of the cervix uteri, type 2 diabetes, hypertension, urinary incontinence, pressure ulcer of the sacral region, polyneuropathy, and generalized anxiety disorder.A Medicare 5-Day Minimum Data Set (MDS) dated [DATE], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. Review of an alert charting progress note dated June 15, 2026, at 7:02 p.m. revealed that the resident had activated her call light and that the certified nursing assistant (CNA) had responded and found the resident seated in her wheelchair. The note further revealed that the resident was slipping from her chair with both knees locked, gripping the wheelchair armrests, and demonstrating generalized body rigidity. The note revealed that the CNA attempted to reposition the resident safely, but the resident continued to maintain her rigid posture despite verbal instructions to relax. The note also revealed that the CNA requested nursing assistance, and upon entering the room, the nurse observed the resident continuing to extend her lower extremities while maintaining body rigidity, partially lifting and pushing herself from the wheelchair seat. The note revealed that the CNA remained present while attempting to provide support and prevent loss of balance, and that the resident was instructed multiple times to relax her body and bend her knees for safe repositioning. The note revealed that the resident was informed that maintaining a rigid posture during transfers and repositioning increases the risk of injury to herself and staff assisting her. The note also revealed that following repeated verbal instructions, the resident relaxed her posture and was repositioned back into the wheelchair. The note revealed that when asked what had occurred, the resident stated that her body had become weak. The note revealed that due to the observed behavior creating an increased risk for falls, loss of balance, and potential injury to both the resident and assisting staff, the resident was assisted to bed for safety. The note further revealed that no injuries were noted during assessment, the call light was placed within reach, and staff were advised to continue close monitoring and reinforce safe transfer techniques.A skin assessment dated [DATE], at 11:22 a.m. revealed that the resident had a nickel-sized blue bruise on the center of her right knee and a nickel-sized blue bruise with a 2-millimeter scab over the center of her left lateral knee cap, with both skin impairments having a side note that says patient states she probably bumped it. The skin assessment revealed an additional note of multiple red spots on the resident's bilateral arms, with a side note that says patient states she gets these from bumping into things. A care plan focus initiated on June 17, 2026, revealed that the resident was at risk for misappropriation, neglect, abuse, and/or exploitation related to her decreased mobility and neurological symptoms, with a goal to not experience misappropriation, neglect, abuse, and/or exploitation through the review date. The care plan revealed interventions to monitor for signs and symptoms of misappropriation, neglect, abuse, and/or exploitation, and report to the facility's abuse officer and medical provider. A request was made on July 1, 2026, at 7:14 a.m. for all self-reports and investigations at the facility in the last 4 months. Review of the facility investigation dated June 18, 2026, revealed that on June 15, 2026, at approximately 7 p.m., a CNA, Staff #34, reported that she responded to the resident's call light and found her slipping out of her wheelchair. The investigation revealed that the CNA called for assistance from the Licensed Practical Nurse (LPN/Staff#25), who positioned herself on the right side, and the CNA was on the left side. The investigation revealed that both staff members said that the resident's knees were locked and stiff, and that the resident reported feeling weak and unable to bend her knees. The investigation revealed (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that, according to the CNA, Staff #34, the LPN, Staff #25, tapped the resident's right shin area in an attempt to encourage the resident to bend her legs. The investigation revealed that staff were able to safely reposition the resident in the wheelchair and subsequently transfer the resident to bed without further difficulty. The investigation also revealed that witness interviews were taken from a CNA, Staff #34, the LPN, Staff #25, and another CNA, Staff #21, and that other records reviewed included written statements. The investigation revealed that all appropriate notifications to the family, Arizona Department of Health Services (AZDHS), Adult Protective Services (APS), local police, and the Ombudsman were made according to policy, and that during the investigation, it was determined that the allegation of abuse was unsubstantiated. The investigation revealed that corrective actions included the statement that no policies were broken, and the investigation was signed by the Operations Manager and Abuse Coordinator (OM/Staff #70) on June 22, 2026. A follow-up request was made on July 1, 2026, at 9:55 a.m. for a 5-day investigation with interviews for Resident #96. Review of the facility investigation with interviews revealed that an interview with Resident #96 was conducted on June 16, 2026, at approximately 1:30 p.m. The interview revealed that the resident spoke with the OM (Staff #70) and the Director of Nursing (DON/Staff #17) about the incident on June 15, 2026, and the resident reported that the LPN, Staff #25, touched her left leg at the knee and that the resident made a motion with her hand. The interview revealed that the OM asked the resident if they could assess her left leg, the resident agreed, and the assessment revealed an old bruise with a scab in the center on the left side of the resident's kneecap. The facility investigation further revealed that the OM and the DON met with the CNA, Staff #34, regarding the reported incident, and during the meeting, the CNA was asked to demonstrate the incident as it had been described. The interview revealed that the CNA initially stated that the nurse touched the resident's right leg and touched the OM's lower right shin, and the OM told the CNA that the resident reported that the nurse touched her left knee. The interview revealed that the CNA stated that both legs had been touched and demonstrated the interaction, stating that the nurse was standing in front of the resident, bent over, and touched both legs in the manner she demonstrated on the OM. The facility investigation also revealed an interview on June 16, 2026, at 8:37 a.m. with another CNA, Staff #21, who worked the shift on the incident date, who denied knowing of any incident that occurred on that shift. The facility investigation revealed an interview with the LPN, Staff #25, on June 16, 2026, at 9:17 a.m., during which she stated that she documented the resident's behaviors in a progress note. The interview revealed that the OM informed the LPN that a staff member reported that the LPN struck the resident on the right leg while instructing her to bend her knees, and the LPN denied striking the resident. The interview revealed that the LPN stated they were doing a two-person transfer when the resident stiffened her legs, and that she had her arm under the resident's arm and provided a tactile cue behind the resident's left knee while instructing her to bend this knee. A follow-up request was made on July 1, 2026, at 10:10 a.m. for written witness statements for the incident regarding Resident #96. Review of the requested written witness statements revealed one statement by the CNA, Staff #34, titled Incident Report was signed and dated June 16, 2026. The statement revealed that on the night shift of June 15, 2026, the CNA was putting Resident #96 back into bed as she was slipping out of her chair, and the resident's legs were stiff. The written statements revealed that the nurse on shift, Staff #25, smacked the resident's legs to get her to bend her knees between 6 and 7:20 p.m. The CNA wrote that she was in shock more than angry and to ask resident about last night please. Following an interview with the OM and abuse coordinator, Staff #70, on July 1, 2026, at approximately 1:45 p.m., a request was made for the written witness statements that the facility had not provided with the initial requests for the complete investigation. Review of the written witness statements revealed a statement from a Registered Nurse (RN/Staff #56), signed and dated June 16, 2026. The written statement from the RN revealed that shortly after breakfast, Resident #96's CNA reported to the RN that Resident #96 had described abuse that had happened to her overnight. The written statement further revealed that the RN sat down with the resident in a private place and asked what had (continued on next page)

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	035233	A. Building B. Wing	07/01/2026

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The written statement further revealed that the resident told the RN that the LPN told the resident that she hurt a CNA's back by stiffening her legs and made them cry, and the resident told the RN that she was going to report the LPN to social services, but that the nurse told her that all of the nurses document her behavior, which made the resident feel that no one would listen. The written statement revealed that the RN called and reported the incident to the assistant director of nursing (ADON), and that she had spoken with the DON, who verified that the director had been notified. An interview was attempted with Resident #96 on July 1, 2026, at 8:35 a.m., but the resident was not able to answer any questions.An interview was conducted on July 1, 2026, at approximately 9 a.m., with Resident #96's roommate, Resident #14, who revealed that she had been Resident #96's roommate for 3 weeks. The resident stated that she heard a nurse yelling at Resident #96 one time, but she did not know what the nurse was yelling. The resident stated that she had not seen the nurse providing care to them since she yelled at Resident #96. A telephonic interview was attempted on July 1, 2026, at 9:26 a.m. with a CNA, Staff #21, who worked the night shift on the date of the incident, with no success. A telephonic interview was conducted on July 1, 2026, at 9:36 a.m. with Resident #96's responsible party and daughter, who stated that she was made aware of an incident at the facility where a nurse assaulted her mom. The resident's responsible party stated that the incident was reported by a CNA, that they filed a police report, and that the nurse was suspended. The resident's responsible party stated that her sister would know more about the incident and investigation and to give her a call, too. A telephonic interview was conducted on July 1, 2026, at 9:43 a.m. with Resident #96's emergency contact and other daughter, who stated that someone from the facility called her and stated that the incident involved a nurse hitting her mom. The emergency contact further stated that the resident told her that the CNA who was there reported it, and that the resident was asked about the incident, and she told them that it happened. The emergency contact stated that the police went to the facility, and that she called the police to ask about it, and they told her that it was going to be a criminal investigation now. The emergency contact stated that the nurse was identified as the LPN, Staff #25, and that the nurse did not work with her again. A telephonic interview was attempted on July 1, 2026, at 11:03 a.m. with a CNA, Staff #34, who witnessed the incident, with no success. A telephonic interview was attempted on July 1, 2026, at 11:06 a.m. with a Licensed Practical Nurse (LPN/Staff #25), who was accused of hitting the resident, with no success. An interview was conducted on July 1, 2026, at 11:22 a.m. with a Registered Nurse (RN/Staff #56), who stated that physical abuse was defined as hitting, threatening to hit, slapping, or any type of hitting, both closed- or open-hand. The RN stated that verbal abuse was defined as speaking to someone in a way that makes them feel threatened, scared, or unsafe, and that yelling and intimidation with volume were forms of verbal abuse. The RN stated that reportable allegations would be anything that makes her concerned about the possibility of abuse, and that she would tell her supervisor immediately. The RN stated that the risk of failing to report abuse per the facility policy would be that abuse could continue happening, someone could have an injury and the facility wouldn't know about it, and there could be emotional and psychological damage. The RN stated that the same risks were possible regarding reporting allegations of abuse late, and added the risk that residents may continue to work with someone who abused them. The RN stated that she had to report an allegation of abuse one morning when a CNA told her that a resident alleged that they had been (continued on next page)

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The RN stated that she did not do the skin assessment, but that she knew the resident was hurt emotionally by the incident because the resident was tearful and stated that it made her feel like no one cared about her and that she wasn't wanted at the facility. The RN opened Resident #96's progress notes and stated that the incident occurred on the night of June 15, 2026, and that it was reported to her on June 16, 2026. The RN stated that the nurse who hit the resident was Staff #25 and that the RN reported the incident to management between 7:45 and 8:30 a.m. on the 16th. An interview was conducted on July 1, 2026, at 11:58 a.m., with a CNA, Staff #32, who stated that there had been a recent allegation of abuse at the facility where a CNA, Staff #34, witnessed Resident #96 being hit by an LPN, Staff #25. The CNA stated that the CNA who witnessed the incident, Staff #34, mentioned to another CNA, Staff #84, that she witnessed the nurse hitting the resident. The CNA stated that when Staff #84 told her about the incident, Staff #32 reported the allegation to the resident's CNA, Staff #40, who spoke with the resident the morning after the incident. The CNA stated that when Staff #40 spoke with the resident, the resident was crying and reported to staff that the LPN punched her in the leg. An interview was conducted on July 1, 2026, at 11:40 a.m. with a Licensed Nursing Assistant (LNA/Staff #40), who stated that an allegation of abuse was reported to her by another CNA, Staff #32, who was told by a CNA, Staff #84, that CNA, Staff #34, witnessed Resident #96 being hit by LPN, Staff #25. The CNA stated that she asked Resident #96 to take a walk with her, they found a location for privacy, and the CNA told the resident she could be honest and tell her if something happened with the nurse. The CNA stated that the resident began to tear up and told the CNA that the nurse was yelling at her and hitting her in the legs the night before. The CNA stated that the resident told her that she needed help bending her knees, and when they finished talking, the CNA ran to tell the RN, Staff #56, that she had a reportable abuse allegation. The CNA stated that the RN talked with the resident, who reported the same information verbatim and demonstrated where she was punched in the right leg. The CNA stated that after they interviewed the resident, the RN reported the incident further, and the CNA brought the resident back to her room to lie down and have a brief change. The CNA stated that the resident's leg was bruised in the same area that she had pointed to in her demonstration of the hit, and that the CNA had made a handwritten statement regarding the incident that detailed the same information she just shared; however, the facility did not provide the written statement in the facility investigation. The CNA stated that her statement was dated June 16, 2026, and that her interview with the resident was between 7:30 and 8:30 a.m. that day. An interview was conducted on July 1, 2026, at 12:46 a.m., with a CNA, Staff #84, who stated that another CNA, Staff #34, recently had to report abuse that she had witnessed, and that Staff #34 pulled the CNA into a private room to get her opinion on what she witnessed. The CNA stated that Staff #34 told her that she witnessed a nurse smacking a resident's leg and telling her to bend her knees, and heard the resident saying please stop hitting me. The CNA stated that she told Staff #34 to report the incident right away and make a written statement so nothing was forgotten or lost, and as far as the CNA knew, Staff #34 told the DON and wrote the statement. An interview was conducted on July 1, 2026, at 1:09 p.m. with the DON, Staff #17, who stated that all allegations of abuse were reportable, and further stated that when an allegation was made, their process was to immediately do an investigation, suspend everyone involved, make sure the resident was safe, interview staff, interview residents, and report to APS, local police, the ombudsman, and AZDHS. The DON stated that the only instance in which a written (continued on next page)

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