| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035240 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/20/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Haven of Lake Havasu | 2781 Osborne Drive<br>Lake Havasu City, AZ 86406 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff and resident interviews, review of facility documentation, and review of policy and procedures, the facility failed to protect the rights of two residents (#1 and #2) to be free from physical abuse by another resident. The sample size was 4. The deficient practice could result in the resident being in an unsafe environment. Findings Include: -Regarding Resident #1 Resident #1 was admitted on [DATE] with a diagnoses that included attention and concentration deficit, dysphagia, acute respiratory failure, muscle weakness, abnormalities of gait and mobility, and symbolic dysfunctions. A quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 05, indicating severe cognitive impairment. A care plan initiated on February 4, 2025, had a focused area for the Resident #1 having behavioral problems related to taking others' belongings without permission and eating other people's food. It was further documented that he had inappropriate contact with other residents' belongings and pulling on clothing, given food to other residents without permission, refusing medication and care, and initiating a physical altercation with another resident. Interventions updated on March 23, 2026, included one-on-one with staff and an (STAT) immediate psychiatric consult, completed on March 21, 2026. A Health Status Note dated March 21, 2026, at 05:56 PM documented that Resident #2 reported Resident #1 punched him multiple times in the face and twisted his arm. Resident #1 was located in the dining room and denied the allegation. The note documented Resident #1 was placed on one-on-one care, and a STAT psychiatric consult was completed, with new orders obtained and carried out. It was further noted that a full skin check was completed, and the Resident #1 was placed on the alert charting. It was documented that the family was notified. A review of the physician order dated March 21, 2026, for alert charting for every shift for three days related to a resident-to-resident altercation. revealed that Resident #1 was checked for 3 days every shift due to a resident-to-resident altercation. Multiple telephone call attempts were made to Resident #1 and Resident #1's spouse on April 20, 2026 and both were unreachable. -Regarding Resident #2 Resident #2 was admitted on [DATE], with diagnoses that included palliative care, chronic obstructive pulmonary disease, chronic respiratory failure, chronic atrial fibrillation, asthma, adjustment disorder, insomnia, and cellulitis of the left finger. A quarterly MDS dated [DATE], revealed a BIMS score of 14, indicating the resident was cognitively intact. A care plan was initiated on January 06, 2023, with a focused area of behavior problems related to verbal and physical behaviors. It was further documented that verbal altercation with another resident, using profanity directed toward another resident, had occurred. It was noted that the resident and roommate are antagonizing and irritating one another with sarcastic comments. It was further noted that there was a verbal dispute with another resident and that he then struck resident in the head. The care plan noted that Resident #2 also had a history of spitting water on staff members, kicking legs towards the staff during attempts with brief check/change, as well as cursing at the staff. It was documented that the Resident would refuse a brief check and/or change. A weekly skin check and Wound assessment dated [DATE], revealed that Resident #2 had discoloration of the ring finger of the left hand. There was no evidence of other skin-related conditions or injuries. A health<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035240 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/20/2026 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Haven of Lake Havasu | | STREET ADDRESS, CITY, STATE, ZIP CODE 2781 Osborne Drive Lake Havasu City, AZ 86406 | |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | status note dated March 21, 2026, at 5:28 PM revealed that Resident #2 approached the nurses' station with a hematoma to the left eye and a large skin tear to the right forearm, as well as minor cuts to the nose, lip, and right hand, and bruising to the left hand. Resident #2 stated that Resident #1 entered his room and had punched him multiple times in the face, then grabbed his arm and twisted it. It was documented that another staff member approached at his time and dressed the wound while the writer called the administrator and looked for Resident #1. It was noted that resident #1 was located in the dining room. The note revealed that a staff member was assigned to sit one-on-one with Resident #1. The nurse practitioner (NP) was notified with an order to send Resident #2 to the emergency room (ER) for evaluation and the family was notified. A weekly skin check and wound assessment dated [DATE], revealed that Resident #2 had minor skin tear on the back of the right hand, bruise on the back of the left hand, hematoma to left eye, minor scab to left side of bridge of the nose, scab to mid bottom lip, right big toe was black, and that he a had skin tear on right outer forearm with steri-strips in place. A review of the physician order for alert charting for every shift for three days related to a resident-to-resident altercation dated March 21, 2026, revealed that Resident #2 was checked for 3 days every shift due to a resident-to-resident altercation. A review of the five-day investigative reports submitted on March 26, 2026, revealed that the Administrator (staff #6) reviewed the camera footage from March 21, 2026, which revealed Resident #1 went into Resident #2's room and came out within less than a minute, and it was confirmed that a physical altercation occurred in Resident #2's room. A request to review the Camera Footage for March 21, 2026, at 12:53 PM was made, but staff #6 stated that camera footage was not available as it was deleted after 72 hrs. An interview was conducted on April 20, 2026, at 1:19 PM with a Licensed Practical Nurse (LPN/ Staff #1), who stated she worked on March 21, 2026. Staff #1 stated that Resident #2 came to her at the nurses' station with a black eye and skin tear to his eye, and stated that Resident #1 came to his room and punched him and twisted his arm. The LPN stated that she immediately called for help, and another Nurse (Staff #2) helped her. She stated that Resident #1 was located in the dining area. She stated that he was interviewed, but did not remember the incident. The LPN further stated that she did not witness any verbal altercation between these two residents before the event. An interview was conducted on April 20, 2026, at 1:37 PM with a Licensed Practical Nurse (LPN/Staff #7), who stated that she did not remember the exact date, but when she was coming from her lunch break, Staff #1 asked her to check on Resident #1 to see if he was okay due to Resident #2 reporting that Resident #1 had hit him. She stated that she was not there to witness the incident, but Resident #2 stated that Resident #1 had punched him in the face multiple times, grabbed his wrist, twisted his arm, and that he felt a pop in his wrist, and Resident #1 then left the room. The LPN stated that before the incident, she did not observe that either of the residents had any verbal altercation. She also stated that when she saw Resident #2 he had a swollen eye and face and a bruise on his right forearm with laceration, and she applied a bandage to that area. The LPN stated that earlier in the day, Resident #2 did not have any injuries. She stated that after she assessed Resident #2, she notified the charge nurse, administrator, and police. She stated that after the notification, Resident #2 was sent to the emergency room for further evaluation. An interview was conducted on April 20, 2026, at 1:59 PM with Resident #2, who stated that Resident #1 twisted his arm and hit him in the face. Resident #2 stated that he received a black eye and that he broke his glasses, which caused him pain. He stated that he was unaware of why Resident #1 hit him, and he did not talk to him before this incident. Resident #2 further stated that he felt safe since Resident #1 had gone home. An interview was conducted on April 20, 2026, at 2:53 PM with DON (staff #5), who stated that Resident #2 sustained a black eye and skin tears as a result of the resident to resident altercation. Staff #5 stated the Administrator watched the video it was confirmed that Resident #1 went into Resident #2's room. She stated that this physical abuse occurred, and it did not meet her or the facility's expectations. An interview was conducted on April 20, 2026, at 3:06 PM, with the Administrator (Staff #6), who stated that Resident #1 went into Resident #2's room and hit Resident #2's face and then exited the room. He (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035240 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/20/2026 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Haven of Lake Havasu | | STREET ADDRESS, CITY, STATE, ZIP CODE 2781 Osborne Drive Lake Havasu City, AZ 86406 | |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | stated that he reviewed the Camera footage, and it was revealed that Resident #1 went to Resident #2, and a physical altercation occurred. The Administrator stated that these two residents did not have any previous altercations. He stated that a resident-to-resident altercation happened, which did not meet his or the facility's expectations. A Policy titled Abuse policy with a revision date of April 2022, revealed that the objective is to provide a safe haven for the residents through preventative measures that protect every resident's right to freedom from abuse. |