STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035277	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Lakeside	3401 North Lockwood Drive Lakeside, AZ 85929

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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 - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure that four residents (#24, #68, #10, #12) were free from physical abuse. The deficient practice could result in further incidents of resident to resident abuse. Findings include: Regarding Resident #24 -Resident #24 was admitted to the facility on [DATE] and discharged on [DATE] with a re-admitted [DATE]. Resident passed away on October 9, 2023 with diagnosis including Alzheimer's disease with late onset, dementia in other diseases classified elsewhere, unspecified severity, with mood disturbance, major depressive disorder, single episode, unspecified, anxiety disorder, unspecified, schizoaffective disorder, unspecified. A review of the quarterly MDS (minimum data set) dated June 22, 2023 revealed a BIMS (brief interview of mental status) score of 06, indicating that the resident had severe cognitive impairment. The MDS further indicated that the resident had noted verbal behavioral symptoms directed towards others. A review of the progress notes revealed a nursing note entry for July 28, 2023 at 10:27 p.m. indicating from 6:30pm to 7:15pm resident #24 was cursing at roommate, resident #68, using profanity. The note indicated resident was silent for about an hour then began cursing at the roommate again. A review of the progress notes revealed a nursing behavior note entry for July 30, 2023 at 2:40 p.m. indicating that at approximately 12:05 P.M. Staff #7 reported that resident #68, roommate to resident #24 reported to her that resident #24 had thrown a book at her. Staff # 7 documented resident #68 right arm was bleeding. Staff #7 further documented that a CNA while helping resident #24 lower her bed and picked up her meal tray, resident #24 asked the CNA to pick her book up from the floor. A review of the MAR (medication administration record) for resident #24 revealed that medications were administered as ordered. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the behavioral care plan revealed that the residents target behaviors were verbal aggression directed towards peers and staff and resistive with care. It was further noted on June 12, 2023 resident #24 was prone to becoming verbally aggressive to roommates and peers that enter her space. In order to address this behavior, resident #24 was provided with a TV for her own personal use and a pair of headphones to help her with territorial behavior. It was further noted resident #24 and her roommate, resident #68 had exchanged verbally aggressive comments to each other, but their risk for physical aggression was assessed to be relatively low due to difficulty with mobility, but staff should attempt to provide privacy and independence in their environment, this was to be done with the individual TVs, having the curtain pulled to avoid them being able to see each other, unless they request otherwise. A review of the behavioral care plan revealed that the residents target behaviors were verbal aggression directed towards peers and staff, physical aggression toward peer and resistive with care. It was noted on August 4, 2023 resident #24 demonstrated a behavior of attempting to become physically aggressive to her roommate in times of agitation by throwing things at her. The documentation states resident #24 appeared to make one known connection, when she threw a book at her roommate (#68) while they were having a verbal conflict while she was attempting to use the restroom on her side of the room. -Regarding Resident #68 Resident # 68 was admitted to the facility on [DATE] and passed away on April 14, 2024 with diagnosis including hypertensive heart disease with heart failure, major depressive disorder, recurrent, mild, anxiety disorder, unspecified, dementia in other diseases classified elsewhere, severe, with mood disturbance, psychotic disorder with delusions due to known physiological condition. A review of the quarterly MDS dated [DATE], revealed a BIMS score of 13, indicating cognition intact. Further review of the MDS indicated the resident had physical behavioral symptoms directed towards others, other behavioral symptoms not directed towards others, resident reject evaluation or care and wandering. A review of the behavioral care plan revealed that the residents target behaviors were verbal aggression directed towards peers and staff and resistive with care. It was further noted on June 12, 2023 resident #68 was prone to becoming verbally aggressive to roommates in the past and should be given the opportunity for privacy and personal space to avoid interpersonal conflicts the interventions would include having personal TV's and pulling the curtain for personal space. Consequences for the residents verbally aggressive behaviors included a warning. If the conflict continued the resident was to be removed from the room and engaged with positive distractors. A review of the progress notes revealed a nursing note entry for July 30, 2023 at 2:45 p.m. indicating that a CNA reported that resident had a skin tear on her right forearm. It further notes resident #68 was wheeled out in her wheelchair with the CNA. The note stated the writer observed a new 12-inch skin tear on the upper right forearm. Resident #68 reported my roommate threw a heavy book at me and that's why I have this cut on my arm, First aid was performed and approximated edges cleaned with normal saline and applied a Tegaderm dressing. The resident was placed on fifteen-minute safety checks. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the progress notes following incident on July 30, 2023 indicate continued resident to resident verbal and physical aggression between residents #24 and #68 through second reported incident on September 2, 2023. A review of the facility 5-day investigative report revealed that on July 30, 2023 at approximately 12:30 P.M. resident #68 reported that resident #24 hit her with a book. The report indicates resident #68 has a new skin impairment on her right forearm that appeared to be consistent with being struck by a book. The report states there have been no previous altercations between the residents and no precursors to the event. It was determined neither resident was at risk for a repeat incident. The facility recommended the incident be closed with no further action. A review of the progress notes revealed a nursing note entry for July 31, 2023 at 12:38 p.m. indicating a correction in the size of the skin tear. The note stated the skin tear is about 6 inches long. The note further indicated the incident was reported to the Executive Director and the Clinical Director. The Clinical Director advised that the resident not be moved unless physical harm was displayed by resident or roommate. The clinical Director stated they should be on fifteen-minute checks and the curtain to be drawn across the room so they do not see each other. A skin assessment conducted on July 31, 2023, revealed new skin impairments. A right forearm, skin tear. Further review of the progress notes revealed an alert charting note dated August 3, 2023 at 8:52am indicating resident #68 requested a room change related to roommate throwing things at her. Resident reported that on August 3, 2023 resident #24 threw a cup at her. Resident reported resident #24 is mean and you need to get me out of here. The resident was informed the requested room change would be discussed with administration. Further review of the progress notes revealed a nursing note dated August 3, 2023 at 10:52pm indicating resident #68 was in the bathroom and being assisted with care and back in wheelchair. When resident #68 left the bathroom resident #24 and #68 began yelling and cursing at each other. The CNA reported standing between the two residents. While assisting resident #68 to her side of the room, resident #24 threw books at resident #68. The CNA reported the books hit the floor, but resident #68 stated the book hit her on the arm with the previous injury. Incident #2 Regarding residents #68 and #24 Review of the progress notes revealed an incident nursing note dated September 2, 2023 10:37 pm indicating at approximately 7:25 pm resident #24 was sitting in hall by the doorway and reached out and slapped resident #68 on the left side of her face. The progress note revealed the CNA removed resident #68 from the area. The progress note indicated resident #68 was assessed with no noted redness or discoloration to the face or of pain. The progress notes stated resident #68 was temporarily moved to another room. Further review of the progress notes revealed a nursing note dated September 3, 2023 at 1:44 pm indicating resident sated I want to stay in this room one more night so I don't have to deal with my roommate. The resident was informed she could remain in the room another night. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented skin assessment completed for resident #68 following the incident reported on September 3, 2023. Review of the room/roommate change notice revealed resident #68 was moved to another room effective September 6, 2023. Cited reason; not getting along with (#24) roommate. A review of the facility 5-day investigative report revealed that on September 2, 2023 at approximately 8:00pm resident #68 was being wheeled out of her room when resident #24, who was sitting near the doorway reached out and made contact with resident #68 left cheek. The residents were separated and resident #68 was taken to the nurse for evaluation. Per the nurse's evaluation there was no redness or discoloration and no complaints of pain. Behavioral Unit physician instructed staff to do a room move and place residents on 15-minute safety checks for 24 hours. An interview was conducted on February 20, 2025 at 4:56PM with Certified Nursing Assistant (CNA/Staff #13) who stated she could recall their behaviors- resident #24 always had books at her bedside, she stated resident #68 told her that resident #24 had thrown a book at her. She stated resident #68 had a skin tear on her arm and it was bleeding- took the resident to the nurse and she cleaned and dressed her skin tear. Staff #13 stated resident #68 she was put back in the same room that same day- no room change due to limited availability, Staff #13 stated they did not get along because resident #24 wanted the room to herself-she did not like having a roommate and there were a lot of issues between the two -mostly verbal. Staff #13 stated resident #24 was mean to resident #68 and would laugh at her. Staff #13 stated from what I witnessed resident #24 would call her a c**t and a B***h- they would go at it for a while and we would have to intervene and remove one of the residents-usually resident #68 until she wanted to go back into the room. She stated it would end when they were asleep, they would fight over the TV- we would tell the nurse what was going on and they would talk to them; as far as moving them they didn't. An interview was conducted on February 21, 2025 at 8:24am with Certified Nursing Assistant (CNA/Staff#15). She stated she has worked for the facility since 2010 and on the behavioral unit since 2015. Staff #15 stated the facility process when there is resident to resident altercation is to the let the ED and DON know within 2 hours, move them away from each other for their own safety and let the nurse know. She stated staff are to go by the behavior care plan when there is an incident with any of the residents and if the hurt each other they follow their process and keep them separated and if needed move the other resident to another room. Staff #15 stated resident #68 had dementia, hallucinates, attitude will change and will holler and throw things and never liked having a roommate, and would call resident #68 F*****g B***h, W***e, and S** . She stated both residents #24 and #68 did not like having each other as roommates- they would call each other names and that resident #24 would instigate a lot of the interactions. She stated I do not know why they did not move the residents at the times- they go by the doctor's word, we were told to chart what we see and if there were verbal confrontations they were to separate and either take them to their room or take them out to give them space. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Licensed Practical Nurse (LPN/staff #7) on February 21. 2025 at 10:05 am and has worked for the facility for four years with two of those years on the behavioral unit including 2023. She stated the facility process for reporting abuse is to notify the abuse coordinator/administrator and the medical director for the behavioral unit. Staff #7 stated the residents involved would be separated first and are placed on 15-minute safety monitoring for 24 hours and if needed for another 24 hours. She stated the role of the behavioral unit director and facility psychiatrist is to develop the behavior care plans, disciplinary actions, consequences for the resident's behaviors, such as removal of their favorite items. Staff #7 stated she does not feel removal of the resident's items works and only escalates the resident's behaviors towards staff, because they are the ones who removed the items. Staff #7 stated resident #24 had a sarcastic behavior and when resident #24 and #68 were together they were very volatile towards each other; calling each other names such as B****, witch, anything that was derogatory and were equally abusive towards one another. Staff # 7 stated she reported that the resident's behaviors were increasing and something needed to be done, but the directive from former administrator (Staff #23) and former Director of Nursing (Staff #20) were to keep the residents together and continue to document their behaviors. Staff #7 stated she wanted them to be moved, but they would not move them. Staff #7 stated the first incident involving the book throwing was resident #24 and #68 were in their room and could be heard talking to each other as their tone started to escalate. Staff #7 stated resident #68 informed her that resident #24 threw a book at her. Staff #7 stated she saw a bruise and a skin tear. Staff #7 stated when she reported the incident to the Staff #23, Staff #20, and Clinical Director (Staff #19) she made another recommendation for a room change and that the residents were not compatible with their behaviors continuing to escalate. Staff #7 stated the directive was we'll see what we will do in the next 24-48 hours Staff #7 stated there was no room changes made and the verbal behaviors continued between residents #24 and #68. Staff #7 stated staff # 23, #19 and #20 appeared okay with the residents being verbally abuse towards one another. Staff #7 stated there were open rooms at the time, but they would not move the residents mainly due to the Staff #19 recommendations and wanting to keep the rooms open for prospective admissions. Staff #7 stated the second incident where resident #24 slapped resident #68. Staff # 7 stated the resident was moved to another room due to the incident. Staff #7 stated resident #68 wanted to live by herself, but Staff #19 did not feel she would be successful and would lead to another incident. Staff #7 stated the resident was moved by the nurse for that night because she did not feel they were getting support from administration. Staff #7 stated Staff #19 made recommendations but the final decision came from the former administrator (Staff #23), Former DON (Staff #20) and current Executive Director (Staff #25). A telephonic interview was conducted on February 21, 2025 at 1:44pm with (LPN/Staff #14). Staff #14 stated residents #24 and #68 behaviors were escalated- Stating resident #24 was territorial about the room and resident #68 was antagonistic they did not get along. Staff #4 stated she was unsure why the resident were not separated and not placed in separate rooms. Staff #14 stated the resident's behaviors were well documented and reported to the doctor. Staff #14 stated many of the behaviors displayed were cursing and name calling. Staff #4 stated staff would follow the directives given; sometimes they would work and sometimes they did not. Staff would inform the provider (Staff #19) that the interventions were not working. Staff #14 stated the facility had meetings on every Friday would go over all the residents and any issues or concerns they were having. Staff #14 stated resident #68 requested to be moved, and had moved her one night in the past, but did not feel that she could make the decision for a permanent room change and would need to follow the directive from the doctor, DON and Administrator. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on February 21. 2025 at 8:58am with Unit Manager/CNA (Staff 11). She stated she has worked for the facility for [AGE] years and familiar with resident #24 and #68. Staff #11 stated when there is a resident to resident altercation she has been trained to separate the residents get them out of harm's way and notify the ED, DON, and the provider who oversee the unit for any issues. Staff #11 stated if there are verbal incidents the residents will be separated as it can lead to a physical confrontation. If the language continues or the language gets really bad staff will separate and do 15-minute checks on both residents. Regarding Incident #2 An interview was conducted on February 21. 2025 at 8:58am with Unit Manager/CNA (Staff 11). Staff #11 stated she was present during the incident. She stated resident #68 wanted to go to the bathroom and resident #24 was blocking the door with her wheelchair so staff#11 moved her and when she went to move resident #68, who was also in a wheelchair, resident #24 slapped resident #68 on the cheek when she was going by. Staff #11 stated resident #68 cheek was a little pink, but did not last long. Staff #11 stated she separated them and took resident #68 out of the room because resident #24 kept trying to go on her side of the room. Staff #11 stated she let the nurse know, who contacted the ED and the DON and the provider. Staff #11 stated we kept resident #68 out of the room for a while and resident #24 went to bed and forgot about it and staff ended up moving resident #68 to a different room at that time. Staff #11 stated the relationship between the two residents was very bad. She stated resident #24 was verbally confrontational to any of the roommates she had and that resident #68 would snap back a few times. She stated resident #24 would laugh and make fun of resident #68 when in the room. Staff #11 stated I don't know why she was not moved after the first incident because there were beds available to move her to. Staff #11 stated she would describe the incidents between residents #24 and #68 as abuse-resident to resident. _____ Regarding resident #12 -Resident #12 was admitted on [DATE] June 3, 2023 with diagnosis including unspecified dementia, unspecified severity, with anxiety, anoxic brain damage, not elsewhere classified, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, major depressive disorder, recurrent, in partial remission, generalized anxiety disorder. A review of the quarterly MDS dated [DATE] revealed resident was not assessed for BIMS. The MDS revealed that the resident exhibited other behavioral symptoms not directed towards others. A review of the Care Plan dated December 29, 2023 revealed a focus for behavior problems related to eating other residents' food, wandering, physical behaviors and refusing care. Interventions included administer medications as ordered. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Behavior Care Plan revealed primary target behaviors 11/4/22 Physical Aggression to Peers, 12/15/23 Inciting Peers, 12/15/23 Sexual Behavior to Peers. Secondary behaviors were identified as Intrusive Wandering, Withdrawn; Isolative, Elopement Risk, and Psychotic Thinking on 5/23/22. Further review of the behavior care plan revealed a prior incident involving residents #12 and #10 on June 26, 2023. It states Resident #10 has been observed teasing a peer resident #12 as was his pattern before he is not likely to be the first to initiate an altercation with a peer but he can be aggressive when provoked to aggression. Staff should closely monitor this interaction and separate at the first signs of agitation. A review of the MAR for December 2023 revealed medications administered as ordered. A review of the progress notes revealed an alert note entry for December 25, 2023 at 4:33pm indicate resident #12 keeps teasing resident #10 every time he walks by resident #10 in the hall. It reports that resident #10 gets mad and pushes resident #12 away from him, but resident #12 continues to tease resident #12 while being told not to bother or touch resident #10. Further review of the progress notes revealed a behavior nursing note dated December 31, 2023 at 8:53pm indicates resident #10 was sitting in the hallway. Resident #12 went past the resident and was antagonizing him when resident #10 reached out to grab resident #12 when resident #12 hit resident #10 in the upper arm several times with a closed fist. Resident #12 was redirected to his room. Regarding resident #10 -Resident #10 was admitted on [DATE] and passed away May 11, 2024 with diagnosis including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, encephalopathy, unspecified, unspecified dementia, unspecified severity, with other behavioral disturbance, other symptoms and signs involving appearance and behavior, major depressive disorder, recurrent, mild. A review of the behavior care plan revealed the following documentation dated October 20, 2023. At this time, resident #10 is more likely to have verbal aggression that can lead to potential physical aggression with his roommate, these altercations do not appear particularly dangerous but instead more annoying to each other related to space and items. Staff should monitor this behavior and assess, while they are getting used to each other they are more likely to have periodic agitation but if this appears to increase notify the Clinical Director and Program Manager for further instruction. Whenever residents make physical contact, immediately notify the Clinical Director for further instruction. A review of the Care Plan Date Initiated November 20, 2019 revealed a focus for impaired visual function, impaired functional ability and impaired cognitive function/dementia or impaired thought processes related to short term memory loss. Interventions included administer meds as ordered, report and document any declines in ability, A review of the quarterly MDS dated [DATE] revealed a BIMS score of 00 a severe level of cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the progress notes revealed a nursing note dated December 31, 2023 at 8:38p.m. the note indicated resident was sitting in the hallway, Resident #12 went past resident and was antagonizing him. Resident #10 reached out to grab the resident and resident #12 started hitting resident in the upper left arm several times with a closed fist. Documented Skin Assessment not completed following the resident to resident altercation on December 31, 2023. A review of the facility 5-day investigation dated January 5, 2024 noted that resident #12 struck resident #10 on his arm. The report indicated resident was walking down the hallway of the unit when resident #10 started verbally provoking resident #12. In response resident #12 approached resident #10 and struck him in the arm. The report indicates a skin assessment was conducted and noted some minor redness on resident #10's arm where he was struck, however no complaints of pain or discomfort. Residents were separated and 15-minute checks implemented. The facility report recommended the incident be closed with no further action. An interview was conducted on February 21, 2025 with (LPN/staff #11). Staff #11 stated resident #12 would antagonize resident #10 by grabbing his hand really hard and would go by and tap on him. Staff #11 reported on the day of the incident [AGE] year-old resident #10 was out and had made a fist bump not to hit. Staff #12 disliked him speaking Spanish and was always upset with resident #10. Staff #11 stated resident #10 was in his wheelchair and when he put his arm out resident #12 grabbed his hand and hit him with a closed fist multiple times in his chest and arms. Staff #11 stated she completed a skin assessment and noted redness and bruising on his arm and the chest had some redness to it. resident attacked nurse while trying to take his phone per Dr. l orders and began to punch the nurse- saw it on the cameras and staff came in to assist. Staff #11 stated resident #12 has some extensive behaviors and that resident #10 had mild behaviors, was easily redirected and was unable to defend himself due to visual and hearing issues. Staff #11 stated resident # would get mad and go off on other residents. An interview was conducted with the Director of Nursing (DON/staff #28) on February 21, 2025 at 1:53P.M. Staff #28 stated that he had joined the facility in August 2024 and that resident #68 passed away the first day he was there. In regards to resident #10 and #12 he did not meet resident #10 as he had passed away prior to his arrival. He stated resident # 12 has had elopement issues in the past, self-isolation, instances with inappropriate sexual behaviors, but no resident to resident altercations since he has been there. He stated his expectations for alleged abuse are separate the residents, and initiate 15-minute checks. He stated the facility has provided 1:1 supervision if needed. He stated the protocol if 1:1 supervision is needed they meet for IDT to determine if floor staff or a room change is needed, Staff #28 stated the facility determines a room changes based on id the resident requests a room change, if no rooms are available the facility will offer transfer to another facility. Staff #28 stated once there is an altercation between residents the expectation is to make immediate room changes or 1:1 supervision. The IDT team will meet, but ultimately it would be the administrator to make the final decision for a room change. He stated the risks in not making the room changes are continued abuse. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Administrator/ Abuse Coordinator (admin/staff #25) on February 21, 2025 2024 at 2:03 P.M. Staff #28 stated that he became aware of the first incident between residents #24 and #68 sometime in July 2023 by one of the CAN's, but is aware that the residents were separated the residents. He stated he got as much information possible at the time and made sure they were safe and separated in separate areas. He stated he notified the medical director of the behavioral unit and took instruction from her regarding the care plan and if they were to be kept separated, He stated the staff follow her direction as the doctor. He stated there was a minor skin tear from what he read from the skin assessment, and basic care was provided with no sutures needed. He stated the investigation conducted within the window to meet with the staff and gather information, meet with the residents Staff #28 stated he could not recall the second incident, but to his recollection neither resident recalled the event He stated social services met with the residents to ensure no lasting or lingering effects- and take direction from the medical director. He stated the results of the investigation were that there were no lasting or lingering effects with either resident and they did continue as roommates as directed by the medical director. Staff #28 stated the final decision would come from him as the administrator to make the decision to move the residents, but they do meet as an IDT to go over that and any input from the clinical staff. He stated the floor staff are capable of making the decision and would notify him and the DON e and the DON decide to finalize the move with also taking in the providers decision. Staff #28 stated the provider felt it would be more detrimental to move resident #24 or #68. He stated the residents were placed on 15-minute safety checks to ensure no further incidents and the report was unsubstantiated. A review of the facility policy titled Abuse Policy revealed that Haven Health facilities strive to prevent the abuse of all their residents. Haven Health recognizes that we care for residents with the diagnosis of dementia and other mental illnesses whose behaviors are not always predictable. Haven Health further recognizes that due to the proximity of our residents to one another and an individual's freedom of choice, that situations may arise where it is not possible to completely prevent all incidents of abuse. By definition, abuse is the infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well- being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, neglect, mental abuse including abuse facilitated or enabled through the use of technology, and misappropriation of property. Potential abusers can be residents, employees, family members, visitors, venders, or any other person who comes into the facility. None of these types or sources of abuse are condoned in Haven Health facilities. Our objective is to provide a safe haven for our residents through preventative measures that protect every resident's right to freedom from abuse. If abuse is witnessed or suspected, or an injury of unknown origin is identified, the resident's safety will immediately be secured. Prompt reporting and investigation will be utilized to.