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	07/16/2025

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

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 - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and facility policy, the facility failed to protect the residents' (#26, #24, #4, and #6) right to be free from physical abuse by a resident. The deficient practice could result in physical and psychosocial harm.Regarding Resident #26 and Resident #24:-Resident #26 was admitted to the facility November 6, 2023, with diagnoses that included unspecified dementia, unspecified severity, with other behavioral disturbance, prediabetes, type 2 diabetes mellitus, chronic kidney disease, cardiomegaly, delirium due to known physiological condition, anxiety disorder, bradycardia, and adult failure to thrive.An admission minimum data set (MDS) assessment dated [DATE], revealed a brief interview for mental status (BIMS) score of 1, indicating severe cognitive impairment. Section C revealed the resident had inattention and disorganized thinking. Section E revealed the resident had wandering behavior that occurred daily.A care plan dated November 15, 2023, revealed the Resident #26 had a behavior problem due to wandering/exit seeking, with interventions for staff to intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, and remove from situation and take to alternate location as needed.An Incident Note, dated December 10, 2023, revealed Resident #26 was in the room of Resident #24 and was standing over Resident #24. Resident #24 became extremely angry and started hitting Resident #26 in the face several times. Resident #24 hit Resident #26 on the left cheek leaving a red mark. The residents were separated by the nurse and a Certified Nursing Assistant (CNA). Resident #26 was assessed and had visible open skin on the left hand fourth finger on both sides. Basic first aid given, and 15-minute checks initiated.An additional Incident Note dated December 10, 2023, revealed Resident #26 was wandering in the hall since start of shift. No redness was noted to face, and middle finger left hand bandages are intact to fingers. Resident remained on every 15-minute checks per provider directions.Despite the documentation of open skin on Resident #26's hand, a Weekly Skin check and Wound assessment dated [DATE], revealed the resident did not have any new or ongoing skin impairments.-Resident #24 was re-admitted to the facility December 28, 2020, with diagnoses that included epilepsy, personal history of traumatic brain injury, unspecified intracranial injury with loss of consciousness of unspecified duration, hypo-osmolality and hyponatremia, anxiety disorder, other specified mental disorders due to known physiological condition, unspecified intellectual disabilities, schizoaffective disorder, and obsessive-compulsive disorder.A quarterly MDS assessment dated [DATE], revealed a BIMS assessment was not conducted for the resident.A care plan dated October 12, 2022, revealed the resident had a behavior problem due to physical behaviors, yelling at staff, pacing, urinating and defecating on bathroom floor to annoy roommates, and touching inappropriately. Interventions included for staff to intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, remove from situation and take to alternate location as needed.An Incident Note dated December 10, 2023, revealed Resident #24 was in his room and Resident #26 was standing over Resident #24. Resident #24 became extremely angry and started hitting Resident #26 in the face several times. Resident #26 hit Resident #24 on the left cheek leaving a red mark. The residents were separated by the nurse (Staff #70) and CNAs. Basic first aid was administered. Notifications were made to the Administrator, Director of Nursing (DON), physician, and resident's family.An additional Incident Note dated December 10, 2023, revealed Resident #24 remained on 15-minute checks per the physician. No redness was noted to the resident's left cheek.A facility Reportable Event Record/Report dated December 15, 2023, revealed that on December 10, 2023, at approximately 5:45 p.m., Resident #26 was walking around the facility's behavioral unit when he walked into Resident #24's room. Staff called out to Resident #26 to redirect him and started working their way toward Resident #24's room. When staff approached the room, they found that Resident #26 and Resident #24 were in an altercation. Staff separated the residents and escorted Resident #26 out of Resident #24's room. When staff asked Resident #24 what happened, he told staff that he was resting and when he opened his eyes, Resident #26 was there at his bedside and it startled Resident #24. Resident #24 stated that he swung at Resident #26 and contacted Resident #26's left cheek. Resident #26 defended himself and contacted Resident #24's cheek. Both residents were assessed by the nurse and found to have no injuries or skin impairments. Residents were separated, made safe, and placed on 15-minute safety checks per medical provider's instructions.A telephonic interview was attempted on July 16, 2025, at 9:04 a.m., with a Licensed Practical Nurse (LPN / Staff #70), however the phone contact provided was a wrong number.An interview