STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035165	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Tucson	3705 North Swan Road Tucson, AZ 85718

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 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. (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 0609 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 clinical record review, staff interviews, facility documentation, and policy review, the facility failed to implement its policy to ensure that an allegation of neglect for 1 (Resident #1) out of 5 residents was reported to all applicable state agencies. The deficient practice could result in further allegations of neglect not being reported.Findings include: Resident # 1 was re-admitted on [DATE] with diagnoses that included metabolic encephalopathy, intracerebral hemorrhage, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed that the Brief Interview for Mental Status (BIMS) assessment was not completed due to Resident #1 rarely or never understood and his cognitive skills for daily decision making were severely impaired. The MDS documented that the resident is dependent on staff for toileting hygiene, bathing, upper and lower body dressing, and personal hygiene.A comprehensive care plan revised on November 11, 2025 revealed that the resident had functional self-care deficits and functional mobility limitations. Interventions indicated that the resident required total assistance with bed mobility, toileting hygiene, transferring with Hoyer lift, and to bathe. An email to the Director of Nursing (DON/Staff #118) sent by resident #1's family member, dated November 17, 2025, reported concern that resident was not changed in several hours. Additionally, the email reported that resident was observed with his legs hanging off the bed with no socks, nasal canula off his nose with no oxygen flowing, and mucus all over his shirt and beard. The email stated that this is abuse and neglect. An interview with Resident # 1's family member was conducted on December 1, 2025 at 11:22 a.m. The family member stated that during a visit on November 16, 2025, he witnessed the resident laying uncovered in a low-lying bed with urine-soaked sheets. The family member said he looked for the certified nursing assistant (CNA) assigned to Resident #1 but could not find him and addressed concerns with the nurse in charge. The family member revealed that once the resident was cleaned up, he went home and emailed the facility his observations/concerns. The family member alleged that his dad was being neglected the morning of November 16, 2025. The family member claimed that he had not received a response from the facility regarding the suspected neglect. An interview with a CNA (Staff #43) conducted on December 1, 2025 at 3:23 p.m., revealed that neglect is abuse. If a family member claimed a resident was neglected, she would immediately report the allegation to the Administrator who would then report the allegation and conduct the investigation.An interview with a Registered Nurse (RN/Staff #165) was conducted on December 1, 2025 at 3:40 p.m. Staff #165 stated that forms of abuse included neglect, physical, and verbal. Staff #165 revealed that if a family member claimed resident neglect, she would immediately report the allegation to the Administrator and then conduct an assessment on the resident. An interview with the DON was conducted on December 1, 2025 at 3:59 p.m. Staff #118 revealed that she communicated with Resident #1s family member on November 17, 2025 regarding supplemental medications and request for certain providers not to be assigned to Resident #1. The DON noted that when the family member saw the bill for the resident's care he got upset and voiced concerns regarding Resident #1's care. The DON stated that if any family member alleged neglect, the facility would immediately report the allegation to all appropriate state agencies including police and suspend any identified staff members involved, during the investigation. The DON reviewed her emails from November 17, 2025 from the family member of Resident #1 and discovered that the family member alleged that Resident #1 was abused and neglected. The DON admitted that she missed this part of the email when she initially read it. The DON denied contacting the police and state agency but she confirmed that if she saw the allegation, she would have notified the state agency and police. Review of the Policy and Procedure titled, Resident Rights/Dignity: Abuse, Neglect, Exploitation and Misappropriation Prevention Program, effective January 1, 2024, revealed that residents have the right to be free from neglect. The policy goes on to reveal that if neglect is reported then the facility would investigate and report any allegations within timeframes required by federal requirements.

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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 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, staff interviews, facility documentation, and policy review, the facility failed to ensure an allegation of neglect for 1 (Resident #1) out of 5 residents was investigated. The deficient practice could result in further neglect of residents and appropriate corrective actions not being taken. Findings include: Resident # 1 was re-admitted on [DATE] with diagnoses that included metabolic encephalopathy, intracerebral hemorrhage, hemiplegia and hemiparesis following cerebral infarct affecting left non-dominant side.Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed that the Brief Interview for Mental Status (BIMS) assessment was not completed due to Resident #1 being rarely or never understood. The MDS documented his cognitive skills for daily decision making as severely impaired. The MDS also revealed that the resident was dependent on staff for toileting hygiene, bathing, upper and lower body dressing, and personal hygiene.A comprehensive care plan revised on November 11, 2025 revealed that the resident had functional self-care deficits and functional mobility limitations. Interventions indicated that the resident requiring total assistance with bed mobility, toileting hygiene, transferring with Hoyer lift, and to bathe.An email sent to the Director of Nursing (DON/Staff #118) dated November 17, 2025, revealed that Resident # 1's family member reported that the resident appeared to have not been changed in several hours. Additionally, the resident's legs hung off the bed with no socks, the nasal canula was off his nose with no oxygen running, and mucus was all over his shirt and beard. The email alleged that this is abuse and neglect. An interview with Resident # 1's family member was conducted on December 1, 2025 at 11:22 a.m. The family member stated that during a visit on November 16, 2025, he witnessed his father laying in a low-lying bed with soaked sheets, and uncovered. The family member said he looked for the certified nursing assistant (CNA) assigned to Resident #1 but could not find him and addressed concerns with the nurse in charge. The family member stated that once the resident was cleaned up, he went home and emailed the facility his observations/concerns. The family member alleged that his dad was being neglected the morning of November 16, 2025. The family member noted that he has not received a response from the facility regarding his neglect allegation. An interview with a CNA (Staff #43) was conducted on December 1, 2025 at 3:23 p.m., stated that neglect is abuse. Per the CNA if a family member claimed that a resident was neglected, she would immediately report the allegation to the Administrator who would then conduct an investigation.An interview with a Registered Nurse (RN/Staff #165) was conducted on December 1, 2025 at 3:40 p.m. Staff #165 said that abuse could be neglect, physical and verbal. Staff #165 noted that the administrator and DON would conduct the investigation and the nurse would assist by conducting the resident's skin and neurological assessments. An interview with DON (Staff #118) was conducted on December 1, 2025 at 3:59 p.m. The DON said that if any family member raised concerns of neglect, the facility immediately reports the allegation to all appropriate state agencies including police. Furthermore, the involved staff is suspended during the investigation. The DON reviewed her emails from November 17, 2025 and discovered an email that alleged abuse and neglect of Resident #1. The DON admitted that she missed this part of the email when she initially read it. The DON noted that had she seen the allegation, she would have initiated an investigation. Review of the Policy and Procedure titled, Resident Rights/Dignity: Abuse, Neglect, Exploitation and Misappropriation Prevention Program, effective January 1, 2024, revealed that residents have the right to be free from neglect. The policy goes on to reveal that if neglect is reported the facility would identify and investigate all possible incidents of neglect.