STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035118	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Camp Verde	86 West Salt Mine Road Camp Verde, AZ 86322

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, review of records, and review of facility policy and procedure, the facility failed to protect the rights of one resident (#2) to be free from physical abuse by another resident (#4). The deficient practice could lead to physical or psychosocial harm of a resident. Findings include: -Resident #2 was admitted to the facility March 28, 2025, and re-admitted to the facility on [DATE], with diagnoses that included cognitive communication deficit, pressure ulcer of sacrum, laceration of right foot with foreign body, and unspecified dementia. An admission minimum data set (MDS) assessment dated [DATE], revealed the resident had a brief interview for mental status (BIMS) score of 6, indicating severe cognitive impairment. The clinical record review revealed no evidence of a description of a resident to resident incident on May 6, 2025, notification of the incident to the medical provider, and any assessment for injury following the incident. -Resident #4 was admitted to the facility on [DATE], with diagnoses that included alcohol dependence, alcoholic cirrhosis of liver, nontraumatic subdural hemorrhage, type 2 diabetes mellitus, osteomyelitis of vertebra of lumbar region, acute pancreatitis, and other toxic metabolic encephalopathy. A quarterly MDS assessment dated [DATE], revealed the resident had a BIMS score of 4, indicating severe cognitive impairment. A BIMS assessment completed May 6, 2025, revealed a score of 14, indicating the resident was cognitively intact. (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	A Late Entry Progress Note created May 9, 2025, effective May 6, 2025, by the Director of Nursing (DON / Staff #16) revealed while helping on the medication cart, the DON was notified by a Certified Nursing Assistant (CNA) that there had been an incident between residents. The CNA and another CNA heard raised voices and immediately responded to the room. The CNA advised that she seen Resident #4 moving his arm but did not see Resident #4 make contact with Resident #2, and advised there was no contact. The CNA advised that the residents had been separated, and both were in safe areas being monitored by staff. The administrator was notified and an investigation was started. The writer assessed both residents and found no signs of injury, no alteration in skin, and both denied injury at the time. A facility self-report submitted to the State Agency, dated May 6, 2025, revealed on May 6, 2025, at approximately 2:45 PM, Resident #2 was calling to the clinical staff in the hall for help. Resident #2's roommate, Resident #4, was bothered by the volume and moved his body closer to Resident #2 from the other side of the room. Resident #4 moved his arm in the direction of Resident #2, and Resident #4's hand made contact with Resident #2's chest and top of head. The CNA intervened and separated the residents. The residents were made safe and were being checked routinely. Both residents were assessed, and no injuries or signs of physical contact were noted on either resident, and the residents have been placed in separate rooms to prevent further interaction. At this time, both residents are doing well with no lingering effects. A full investigation will be completed in the appropriate time frame. A facility Reportable Event Record/Report (5-day Investigation Report) dated May 12, 2025, revealed on May 6, 2025, at approximately 2:45 PM, Resident #2 was calling to the clinical staff in the hall for help. The roommate, Resident #4, was concerned by the volume and walked across the room to Resident #2 from the other side of the room. Resident #4 moved his arm in the direction of Resident #2 in an attempt to get his attention and his hand made contact with Resident #2's chest and top of head. The CNA intervened and separated the residents. This is the first time these residents were involved in an occurrence. A witness statement dated May 13, 2025, and signed by the Administrator (Staff #66) revealed see attached. There was no evidence of any other attached documents of any witness statements. An interview was conducted on May 13, 2025, at 9:28 AM with Resident #4, who stated that there was a disagreement between himself and his former roommate. Resident #4 stated that Resident #2 was yelling, and was nosey. Resident #4 stated that Resident #2 kept yelling, and I told him to press the red button, and that staff will come. Resident #4 stated that there was physical interaction that occurred and that I'm the one that did it and that he pushed Resident #2 in the head. Resident #4 stated I was mad, and I kind of lost my mind. Resident #4 then demonstrated the motion of pushing his hand out in front of him. Resident #4 stated I pushed him in the head. I didn't slap or hit, just pushed. An interview was conducted on May 13, 2025, at 9:43 AM with Resident #2, who stated that this was his second room at the facility and that he thought that he remembered getting into a disagreement with his roommate. Resident #2 stated that he made a statement that his roommate did not agree with, and that his roommate yelled at him and threw something at him, and he may have pushed him, but he could not recall specifically. A telephonic interview was attempted on May 13, 2025, at 11:13 AM with a Registered Nurse (RN / Staff #30). A voicemail was left for a return phone call. The staff did not return the phone call. (continued on next page)

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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	An interview was conducted on May 13, 2025, at 11:25 AM, with a CNA (Staff #20) who stated she was aware of the incident between Resident #2 and #4. Staff #20 stated that it was about 2:45 PM, and she was on the floor and heard yelling. She stated she made her way over to the room, and heard Resident #4 moving toward Resident #2. Staff #20 stated she looked into the residents' room, and that is when she saw Resident #4 swing out and then swing down with his hand and strike Resident #2, once with a backhanded motion that struck Resident #2 on the chin, and once in a downward motion that hit Resident #2 on top of the head. Staff #20 stated it was aggressive in nature, he hit him. Staff #20 stated that she made sure Resident #2 was ok, then redirected Resident #4 out of the room, and then told the nurse, the Administrator, and the charge nurse right away. An interview was conducted on May 13, 2025, at 11:35 AM, with a Licensed Practical Nurse (LPN / Staff #51) who stated that she was aware of an altercation that occurred between Residents #4 and #2. Staff #51 stated that she had arrived for the next shift, and had heard that the incident had already occurred, but was not aware of the details. An interview was conducted on May 13, 2025, at 1:35 PM with the Administrator (Staff #66). The Administrator stated that his understanding of abuse is when someone has the intent to harm another individual, including intended actions of hitting someone and willfully harming them. The Administrator stated that the facility's policy if there is an allegation of abuse is to separate the residents and ensure they feel safe, perform skin checks, complete an investigation, and to report the incident to authorities as required by law within 2 hours. The Administrator stated that he completed the facility's 5-day Investigation Report for the incident. The Administrator stated he was notified immediately from the CNA of the incident and that staff interviewed both residents and that Resident #2 was on his call light and asking staff for help, and Resident #4 was concerned with Resident #2's volume, so he moved over closer to Resident #2. The Administrator stated that the CNA witnessed Resident #4 touch or make contact with Resident #2, and we conducted an investigation. The Administrator stated that Resident #4 was going over to help Resident #2 and brushed him unintentionally on Resident #2's cheek and head. The Administrator stated that Staff #20 witnessed the incident and saw Resident 4 make soft contact with Resident #2, and that it was not aggressive and was not intentional. The Administrator stated that the facility did not substantiate the incident as abuse due to lack of evidence. An interview was conducted with the DON (Staff #16) on May 13, 2025, at 1:58 PM. The DON stated that her understanding of abuse is any threat to life or harm, and could be verbal, physical or sexual. The DON stated that she was passing medication on the hall when the CNA approached her and stated there was an incident, and that Resident #4 and Resident #2 had been separated. Resident #2 was in the recliner and Resident #4 was in the room. The CNA had told the floor nurse (Staff #30) who was assessing the residents. The DON stated she then talked to Resident #2 who stated something hit him on the head. The DON stated she realized then after talking with Resident #2 that he was not cognitively intact. The DON stated that herself and the Administrator talked to the CNA (Staff #20) who stated she saw Resident #4 swing his arm and hit Resident #2 on the chest or the cheek and then again directly on top of the head. The DON stated that swinging arms at another person could be considered abuse. (continued on next page)

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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	Review of the facility policy titled Abuse Policy, dated 2022, revealed the facility strives to prevent the abuse of all their residents. By definition, abuse is the infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. 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 identify the validity of findings and reasonable measures will be implemented to deter further incidents of abuse.

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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 observation, interviews, review of records, and review of facility policy and procedure, the facility failed to ensure the facility abuse policy was implemented for a resident (#2) with an allegation of abuse. The deficient practice could lead to physical or psychosocial harm of a resident. Finidngs include: -Resident #2 was admitted to the facility March 28, 2025, and re-admitted to the facility on [DATE], with diagnoses that included cognitive communication deficit, pressure ulcer of sacrum, laceration of right foot with foreign body, and unspecified dementia. The clinical record review revealed no evidence of a description of a resident to resident incident on May 6, 2025, any monitoring or that the resident was placed on alert charting, notification of the incident to the medical provider, and any assessment for injury following the incident. -Resident #4 was admitted to the facility on [DATE], with diagnoses that included alcohol dependence, alcoholic cirrhosis of liver, nontraumatic subdural hemorrhage, type 2 diabetes mellitus, osteomyelitis of vertebra of lumbar region, acute pancreatitis, and other toxic metabolic encephalopathy. A facility self-report submitted to the State Agency, dated May 6, 2025, revealed on May 6, 2025, at approximately 2:45 PM, Resident #2 was calling to the clinical staff in the hall for help. Resident #2's roommate, Resident #4, was bothered by the volume and moved his body closer to Resident #2 from the other side of the room. Resident #4 moved his arm in the direction of Resident #2, and Resident #4's hand made contact with Resident #2's chest and top of head. The CNA intervened and separated the residents. An interview was conducted on May 13, 2025, at 9:28 AM with Resident #4, who stated that there was a disagreement between himself and his former roommate. Resident #4 stated that Resident #2 was yelling, and was nosey. Resident #4 stated that Resident #2 kept yelling, and I told him to press the red button, and that staff will come. Resident #4 stated that there was physical interaction that occurred and that I'm the one that did it and that he pushed Resident #2 in the head. Resident #4 stated I was mad, and I kind of lost my mind. Resident #4 then demonstrated the motion of pushing his hand out in front of him. Resident #4 stated I pushed him in the head. I didn't slap or hit, just pushed. An interview was conducted on May 13, 2025, at 9:43 AM with Resident #2, who stated that this was his second room at the facility and that he thought that he remembered getting into a disagreement with his roommate. Resident #2 stated that he made a statement that his roommate did not agree with, and that his roommate yelled at him and threw something at him, and he may have pushed him, but he could not recall specifically. A telephonic interview was attempted on May 13, 2025, at 11:13 AM with a Registered Nurse (RN / Staff #30). A voicemail was left for a return phone call. The staff did not return the phone call. (continued on next page)

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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	An interview was conducted on May 13, 2025, at 11:25 AM, with a CNA (Staff #20) who stated she was aware of the incident between Resident #2 and #4. Staff #20 stated that it was about 2:45 PM, and she was on the floor and heard yelling. She stated she made her way over to the room, and heard Resident #4 moving toward Resident #2. Staff #20 stated she looked into the residents' room, and that is when she saw Resident #4 swing out and then swing down with his hand and strike Resident #2, once with a backhanded motion that struck Resident #2 on the chin, and once in a downward motion that hit Resident #2 on top of the head. Staff #20 stated it was aggressive in nature, he hit him. Staff #20 stated that she made sure Resident #2 was ok, then redirected Resident #4 out of the room, and then told the nurse, the Administrator, and the charge nurse right away. An interview was conducted on May 13, 2025, at 1:35 PM with the Administrator (Staff #66). The Administrator stated that his understanding of abuse is when someone has the intent to harm another individual, including intended actions of hitting someone and willfully harming them. The Administrator stated that the facility's policy if there is an allegation of abuse is to separate the residents and ensure they feel safe, perform skin checks, complete an investigation, and to report the incident to authorities as required by law within 2 hours. The Administrator stated that he completed the facility's 5-day Investigation Report for the incident. The Administrator stated he was notified immediately from the CNA of the incident and that staff interviewed both residents and that Resident #2 was on his call light and asking staff for help, and Resident #4 was concerned with Resident #2's volume, so he moved over closer to Resident #2. The Administrator stated that the CNA witnessed Resident #4 touch or make contact with Resident #2, and we conducted an investigation. The Administrator stated that Resident #4 was going over to help Resident #2 and brushed him unintentionally on Resident #2's cheek and head. The Administrator stated that Staff #20 witnessed the incident and saw Resident 4 make soft contact with Resident #2, and that it was not aggressive and was not intentional. The Administrator stated that the facility did not substantiate the incident as abuse due to lack of evidence. An interview was conducted with the DON (Staff #16) on May 13, 2025, at 1:58 PM. The DON stated that her understanding of abuse is any threat to life or harm, and could be verbal, physical or sexual. The DON stated that she was passing medication on the hall when the CNA approached her and stated there was an incident, and that Resident #4 and Resident #2 had been separated. Resident #2 was in the recliner and Resident #4 was in the room. The CNA had told the floor nurse (Staff #30) who was assessing the residents. The DON stated she then talked to Resident #2 who stated something hit him on the head. The DON stated she realized then after talking with Resident #2 that he was not cognitively intact. The DON stated that herself and the Administrator talked to the CNA (Staff #20) who stated she saw Resident #4 swing his arm and hit Resident #2 on the chest or the cheek and then again directly on top of the head. The DON stated that swinging arms at another person could be considered abuse. Review of the facility policy titled Abuse Policy, dated 2022, revealed that if abuse is witnessed or suspected, reporting and investigation will take place in the following manner. The Executive Director (ED) will be notified. The DON will notify the following: Physician, Responsible Party, and [NAME] President of Clinical Operations. The ED will begin investigation immediately and complete within 5 working days. Interviews may also include the alleged perpetrator, witnesses, and staff members as applicable. The resident suspected of being abused will be monitored and placed on alert charting.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, review of records, and review of facility policy and procedure, the facility failed to ensure a baseline care plan was developed to meet the needs of one resident (#2). The deficient practice could lead to care team members not being aware of a resident's medical conditions and/or plan of care to address the resident's individual needs. Findings include: Resident #2 was admitted to the facility March 28, 2025, and re-admitted to the facility on [DATE], with diagnoses that included cognitive communication deficit, pressure ulcer of sacrum, laceration of right foot with foreign body, and unspecified dementia. An admission minimum data set (MDS) assessment dated [DATE], revealed the resident had a brief interview for mental status (BIMS) score of 6, indicating severe cognitive impairment. There was no evidence of a baseline care plan to address the resident's impaired cognition. An interview was conducted with the DON (Staff #16) on May 13, 2025, at 1:58 PM. The DON stated that residents are assessed for risk of having behaviors that are abusive or could contribute to an abusive situation by monitoring behaviors. Additionally, the DON stated aggression is manifested very differently with impaired cognition, and that impaired cognition and dementia are always risk factors for abuse. The DON stated that impaired cognition and dementia are items that should be care planned to ensure that all staff are aware and updated with changes. Review of the facility policy titled Assessments/Care Planning: Care Plans - Baseline, effective January 1, 2024, revealed a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident. The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission). The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, review of records, and review of facility policy and procedure, the facility failed to ensure the medical record was complete and accurate for one resident (#2) following an allegation of abuse. The deficient practice could lead to care team members not being aware of a resident's status, and lead to missed or delayed treatment. Findings include: -Resident #2 was admitted to the facility March 28, 2025, and re-admitted to the facility on [DATE], with diagnoses that included cognitive communication deficit, pressure ulcer of sacrum, laceration of right foot with foreign body, and unspecified dementia. A facility self-report submitted to the State Agency, dated May 6, 2025, revealed on May 6, 2025, at approximately 2:45 PM, Resident #2 was calling to the clinical staff in the hall for help. Resident #2's roommate, Resident #4, was bothered by the volume and moved his body closer to Resident #2 from the other side of the room. Resident #4 moved his arm in the direction of Resident #2, and Resident #4's hand made contact with Resident #2's chest and top of head. The CNA intervened and separated the residents. However, the clinical record revealed no evidence of a description of a resident to resident incident on May 6, 2025, any evidence of monitoring or that the resident was placed on alert charting, notification of the incident to the medical provider, and assessment for injury following the incident. An interview was conducted on May 13, 2025, at 9:28 AM with Resident #4, who stated that there was a disagreement between himself and his former roommate. Resident #4 stated that Resident #2 was yelling, and was nosey. Resident #4 stated that Resident #2 kept yelling, and I told him to press the red button, and that staff will come. Resident #4 stated that there was physical interaction that occurred and that I'm the one that did it and that he pushed Resident #2 in the head. Resident #4 stated I was mad, and I kind of lost my mind. Resident #4 then demonstrated the motion of pushing his hand out in front of him. Resident #4 stated I pushed him in the head. I didn't slap or hit, just pushed. An interview was conducted on May 13, 2025, at 9:43 AM with Resident #2, who stated that this was his second room at the facility and that he thought that he remembered getting into a disagreement with his roommate. Resident #2 stated that he made a statement that his roommate did not agree with, and that his roommate yelled at him and threw something at him, and he may have pushed him, but he could not recall specifically. A telephonic interview was attempted on May 13, 2025, at 11:13 AM with a Registered Nurse (RN / Staff #30). A voicemail was left for a return phone call. The staff did not return the phone call. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on May 13, 2025, at 11:25 AM, with a CNA (Staff #20) who stated she was aware of the incident between Resident #2 and #4. Staff #20 stated that it was about 2:45 PM, and she was on the floor and heard yelling. She stated she made her way over to the room, and heard Resident #4 moving toward Resident #2. Staff #20 stated she looked into the residents' room, and that is when she saw Resident #4 swing out and then swing down with his hand and strike Resident #2, once with a backhanded motion that struck Resident #2 on the chin, and once in a downward motion that hit Resident #2 on top of the head. Staff #20 stated it was aggressive in nature, he hit him. Staff #20 stated that she made sure Resident #2 was ok, then redirected Resident #4 out of the room, and then told the nurse, the Administrator, and the charge nurse right away. An interview was conducted with the DON (Staff #16) on May 13, 2025, at 1:58 PM. The DON stated that residents are assessed following allegations of abuse by completing a head to toe assessment to ensure there are no injuries. Additionally, the DON stated that notifications of the allegation of abuse are made to the administrator, the medical provider, and the resident's family as indicated. The DON stated that the initiation of 15-minute checks to monitor the resident was missed this time. The DON stated that these assessments and notifications are documented in the risk management and progress notes in the resident's record, and that the facility maintains an accurate medical record for residents to ensure something is not missed. Review of the facility policy titled Documentation: Charting and Documentation, effective January 1, 2024, revealed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation of procedures and treatments will include care-specific details, including: the date and time the procedure/treatment was provided; the name and title of the individual(s) who provided the care; the assessment data and/or any unusual findings obtained during the procedure/treatment; notification of family, physician or other staff, if indicated; and the signature and title of the individual documenting.