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	02/11/2026

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

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility policy and procedure and police report, the facility failed to ensure life-saving measures including cardiopulmonary resuscitation (CPR) were provided according to the advance directives for one resident (#10) who was found unresponsive. The deficient practice resulted in the resident not receiving life-saving measures and death.Findings include:Resident #10 was admitted to the facility on [DATE], with diagnoses of pneumonia due to pseudomonas, other acute osteomyelitis, bacteremia, autistic disorder, bipolar disorder, mood disorder, epilepsy, need for assistance with personal care, and unspecified lack of expected normal physiological development in childhood.An Alert Charting note dated January 22, 2026 revealed Resident #10 arrived to the facility at 1:50 p.m. and was on contact isolation precautions; and that, fall mats were placed on the floor next to the resident's bed for safety.The history & physical note dated January 23, 2026 included that code status and advanced care planning was done and discussed with resident or surrogate; and, reviewed advanced directives at initial visit.A Nursing admission Evaluation dated January 23, 2026, revealed Resident #10 admitted to the facility on [DATE], at 3:50 p.m. from a short-term hospital, with medication orders present on admission that included anticonvulsant, psychotropic, antianxiety, and sedative/hypnotic medications. The discharge plan included that the resident expected to be discharged to the community. Further, the evaluation revealed that the resident did not have an active infection requiring isolation.An Advance Directive signed January 23, 2026 included Resident #10 wanted CPR if his breathing and heart stopped, nutrition by tube feeding, intravenous fluids, pain medication for comfort, antibiotic therapy, and life or death blood transfusions.The fall risk evaluation dated January 23, 2026 included a score of 18 indicating resident was a high risk for fall.An Occupational Therapy (OT) Daily Note dated January 23, 2026, revealed the resident may not be appropriate for the facility due to need for 1 on 1 care; and that, the resident demonstrated aggressive outbursts when desiring something (snacks, boombox). The note included that the resident had a fall out of bed shortly after the OT evaluation and demonstrated significantly decreased ability to follow safety advice and instruction to wait for help when standing.An Alert Charting note dated January 23, 2026, stated that Resident #10 was agitated and frequently calling and yelling out. The documentation noted that he would quiet down when staff responded to see what he needed, but would begin calling out again afterward.A Late Entry Social Services Progress Note dated January 23, 2026 revealed Social Services consulted with the psychiatric nurse practitioner and the Director of Nursing (DON / Staff #66) regarding the resident's current psychiatric and behavioral presentation. The note revealed it was determined that the resident required transfer to a behavioral health facility, as the level of psychiatric and behavioral care required exceeded the capabilities of the facility. This progress note was created on January 24, 2026.A social services progress note dated January 23, 2026, revealed the resident's family agreed to transfer the resident to a behavioral unit; and that, social services was (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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F 0684 Level of Harm - Actual harm Residents Affected - Few	working with a facility to coordinate appropriate transfer of Resident #10.An alert charting note dated January 25, 2026, at 2:30 a.m. revealed that Resident #10 had a witnessed seizure for about 50 seconds; had the following vital signs: blood pressure (BP) was 160/86, heart rate was 63, respiratory rate was 18, temperature was 97.7 degrees, and O2 saturation was 97%; and, was placed on neurological checks. Per the documentation, the nurse notified the DON (Director of Nursing) and attempted to notify the on-call provider but was unsuccessful. The documentation also included another provider who was not the on-call provider was informed; and, this provider discontinued the resident's short-acting benzodiazepine medication, ordered long-acting sedative-hypnotic and instructed to send the resident out to the hospital if the resident had another seizure.A physician order dated January 26, 2026, and entered at 9:24 a.m., revealed the resident was full code and indicated for CPR.An alert charting note signed by the DON (Staff #66) and dated January 26, 2026, at 12:27 p.m., revealed the DON came to assist Resident #10 who was on the floor. According to the documentation, after the DON entered the room, Resident #10 was found leaning slightly against the bed, and was partially on the floor mat placed for his protection. Further, the note included the resident appeared to be deceased ; and that, the DON checked for the resident's pulse 3 times, and attempted CPR until a staff member reported to the DON that police were at the facility. The documentation included that a second nurse attempted to listen for a heartbeat as the police officer arrived in the room.There was no evidence found that CPR was initiated or an AED (automated external defibrillator) was used on Resident #10.An e-MAR (medication administration) note dated January 26, 2026, at 5:50 p.m., revealed the resident was deceased .A death in facility MDS (minimum data set) assessment dated [DATE] revealed Resident #10 was coded as deceased .A facility self-report submitted to the State Agency (SA) on January 26, 2026 revealed that on January 26, 2026, Resident #10 had medication pass completed around 7:00 a.m., received breakfast at 8:30 a.m., and was checked on at 9:30 a.m. The documentation included that at 11:30 a.m. on January 26, 2026, a CNA (certified nurse assistant) found Resident #10 on the fall mat; and the nurse was called to the room. It also included the nurse assessed the resident and attempted three times to find a pulse; and, the resident appeared deceased . According to the documentation, CPR was initiated, 911 was called, and a second nurse was brought in until the police arrived.Review of the transcript of the 911 call initiated by the facility staff on January 26, 2026 included the facility staff reporting that it was a medical emergency and the resident was not responsive and not breathing. The 911 operator asked the reporting facility staff whether CPR was initiated, the staff responded that she was going into the room. The 911 operator asked the reporting staff again if someone is doing CPR and the reporting staff responded No and that the resident was deceased .The Marshal Office (police) incident report dated January 26, 2026, revealed Resident #10 was found unconscious and not breathing at the facility, and was first reported on January 26, 2026, at 11:35 a.m. The report revealed officers were enroute to the scene when they were advised approximately 2 minutes later that the resident was dead. Responding units arrived on scene at approximately 11:39 a.m., and were directed to the resident's room. Upon arrival, officers identified Resident #10 lying on his back, face up, unresponsive, and with his eyes open. The report revealed deputies arrived and checked for a pulse, felt no pulse, and observed Resident #10 was cold to the touch, and the time of death was called at approximately 11:39 a.m. According to the report, the position of Resident #10 position on the floor was unusual, that his head and shoulders were raised above the floor, and his right elbow was up.Continued review of the report revealed that the RN (registered nurse) assigned to Resident #10 for the day was the DON (Staff #66) who reported that Resident #10 was last rounded on at approximately 9:30 a.m. and the resident was known to be well at that time. The DON reported (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	that a CNA (Staff #40) notified her that Resident #10 was on the floor in his room and needed help. The report revealed that the DON said that it was normal to find Resident #10 on the floor inside his room, outside of his bed; and that, when she entered Resident #10's room, she found him seated on the floor, leaning to his left, and against the bed, and was laying half on and half off of a gray fall mat on the floor. The report revealed that the DON stated they identified that (Resident #10) had passed away and did not initiate CPR. The police report also revealed that the CNA (Staff #40) who was assigned to Resident #10 reported that Resident #10's door was closed, so she knocked on the door, and opened the door to find Resident #10 on the floor, with only his legs visible. The report revealed the CNA (Staff #40) reported that she called other medical staff for help, and entered the room and ended up on the opposite side of the bed from Resident #10, and could not see his positioning. Further, the CNA (Staff #40) stated she could not see if the gray fall mat was on the floor underneath Resident #10.The police report included that the scene was investigated and Resident #10 was laying on the ground, slightly turned to his left side, eyes open, staring toward the ceiling. The report revealed Resident #10's skin was cold to the touch, but rigor mortis had not yet set in. The documentation included that Resident #10 had a small laceration on the posterior side of his head, with blood having dripped off of his head, onto the floor, and was dry upon arrival. A gray fall mat was leaning against the wall in the northwest corner of the room, behind a bedside table, empty food tray, and pile of laundry. The pile of laundry was sitting across the rolling wheels of the table, inconsistent with having been moved recently. According to the report, this was interesting as the table would have had to have been moved to access the gray (fall mat). An additional blue fall mat was located on the wall of the south side center portion of the room, but appeared to have been unused recently as it was clean and, in a position, as if it was being stored there.Further review of the police report showed that Resident #10's bed appeared freshly made, suggesting he may not have fallen from it. The report also noted conflicting statements from the DON. In one statement to police, she said CPR was not initiated. In another statement, she said she began life-saving measures but believed the resident was beyond help and did not move him to a flat position on the floor because police and EMS were already present. The report also included that the DON reported that while she was initiating lifesaving measures, staff may have changed and straightened the bed linens.Review of the clinical record revealed no evidence or documentation of any laceration on the posterior side of the head of Resident #10 at the time of the incident.A State Agency Bureau of Vital Records Human Remains Release Form dated January 26, 2026, included that the deceased person was Resident #10, and the time of death was 11:38 a.m.A phone interview was conducted with a licensed practical nurse (LPN / Staff #2) on February 11, 2026, at 11:08 a.m. The LPN stated that he was familiar with Resident #10, who would yell out when he wanted items such as ice cream or when he wanted his television channel changed. He also reported that he had been informed through verbal report that the resident had a history of crawling out of bed. The LPN stated that he was the nurse assigned to Resident #10 on January 25, 2026, at approximately 2:30 a.m., when the resident had a seizure. He stated that he attempted to contact the on-call provider but was unsuccessful. The LPN said that he was able to notify the DON and another provider, who was not the resident's on-call provider, regarding the seizure; and that, the resident's provider eventually contacted him after his shift had ended.A phone interview was conducted with a certified nursing assistant (CNA /Staff #31) on February 11, 2026, at 11:20 a.m. The CNA stated that she was working on Resident #10's unit on the morning of January 26, 2026. She stated that she checked on Resident #10 early in the morning before breakfast, and the resident appeared fine. The CNA stated she was not involved with finding Resident #10 unresponsive. She said that (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	another CNA, Staff #40, who also served as the facility's staff scheduler, found the resident on the floor in his room. The CNA stated that after Staff #40 entered the room and discovered the resident, the DON entered shortly afterward. She indicated that she was not aware of what happened next but later learned that Resident #10 had expired.An interview was conducted on February 11, 2026, at 11:29 a.m. with the staff scheduler/CNA (Staff #40) who stated that she never worked with Resident #10, except on January 26, 2026, the day that he expired. She stated that at approximately noon on January 26, 2026 when she had attempted to deliver the resident his lunch tray to his room. She stated that the resident's door was closed, so she knocked and opened it. Upon entering, she observed the resident's feet on the floor but could not see the rest of his body. She stated that she believed he had fallen. Staff #40 reported that her hands were full with the meal tray, so she stepped back into the hallway and called for the DON (Staff #66), who was nearby. She stated that she then returned the meal tray to the cart. At that time, the DON entered the resident's room and instructed someone to get the registered nurse (RN, Staff #17). Staff #40 stated that when the RN arrived, the RN briefly left to retrieve a stethoscope, returned to the room, and assessed the resident. She reported that the RN then informed her and the DON that Resident #10 was gone. Staff #40 stated that the DON instructed her to get the corporate clinical resource nurse (Staff #83), who was on the other side of the building. She reported that she went to the conference room to notify the corporate nurse and then returned to the resident's room. Staff #40 stated that the DON and another nurse were in the room beside the resident. She further stated that no one was performing CPR and that she did not observe anyone provide CPR at any time during the incident. She reported that after several minutes, approximately four police officers arrived at the resident's room.In an interview conducted on February 11, 2026, at approximately 12:00 p.m., the registered nurse (RN), Staff #17, stated that she was working on January 26, 2026, when a CNA informed her that the DON needed her in Resident #10's room. The RN stated that when she entered the room, she believed the resident was expired because his eyes were open, he was looking at nothing, and he was unresponsive. She reported that no one was performing CPR and that the DON was present in the room beside the resident. The RN stated that she left briefly to retrieve her stethoscope, then returned to assess the resident. She reported that she listened to the resident's heart, lungs, and abdomen and did not hear any sounds. Based on her assessment, she believed the resident was deceased . The RN stated that she was aware emergency medical services (EMS) had been called but did not know who contacted 911. She reported that she then returned to her unit, and within several minutes, she observed officers from the marshal's office (police) walking down the hall toward the resident's room.During an interview with the DON (Staff #66) conducted on February 11, 2026, at 12:58 p.m., the DON stated that if a resident with full code status becomes unresponsive, staff were expected to remain with the resident, call out for someone to contact 911, check for a pulse, and initiate life-saving measures, including CPR. The DON stated that on January 26, 2026, she was assisting on the unit when, at approximately 11:30 a.m., a CNA (Staff #40) informed her that Resident #10 was on the floor. She reported that upon entering the room, Resident #10 was seated on his buttocks on the fall mat, with his legs extended in front of him, his shoulders were leaning against the bedframe, and his head was upright but slightly tilted to the left. She stated that the resident was not breathing, was unresponsive, and had his eyes open. The DON said that she checked for a pulse and was unable to detect one. She stated that she called out for someone to dial 911 but did not know who made the call. She said she was unsure whether the resident exhibited rigor mortis. The DON stated that she attempted to move the resident into a flat position on the floor. She described the resident as feeling slightly stiff but noted it was difficult to determine due to his (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	larger size and her smaller frame, which made repositioning him challenging. The DON stated that she initiated CPR and continued performing CPR without stopping, except to check for a pulse, until police arrived and instructed her to stop. She reported that she was the only staff member who provided CPR but could not recall exactly how long CPR was performed.An interview was conducted with a corporate clinical resource nurse (Staff #83) on February 11, 2026, at 1:34 p.m. She stated that on January 26, 2026, she was in the facility's conference room for a meeting when a CNA informed her that the DON needed her in Resident #10's room. She stated that upon entering the room, Resident #10 was seated on his bottom on the floor, with his shoulders leaning against the bedframe, and appeared deceased . She noted that the resident's back was not flat on the floor, making it impossible to perform CPR in that position. She said the DON was kneeling beside the resident and stated that the resident was gone. The corporate clinical resource nurse stated that she then left the room and went to the nurses' station just outside the resident's room to locate the resident's code status and advance directive documents. She said that while she was at the nurses' station, EMS personnel arrived at the resident's room. She stated that after the incident, she confirmed with the DON that Resident #10 was full code status. The DON reportedly said she performed a sternal rub, checked the resident's pulse, found none, and attempted two CPR compressions but stopped because the chest was mushy. The corporate clinical resource nurse told the DON that for a full code resident, CPR should not be stopped until instructed by a physician or EMS. She further stated that she did not know the exact timeline from when Resident #10 was found to when EMS arrived. She also noted that while the facility had an automated external defibrillator (AED), no staff brought it to the room to attempt lifesaving measures on January 26, 2026. She emphasized that failure to provide CPR or other lifesaving measures for a full code resident could result in harm or death and stated that an unresponsive resident could be in cardiac arrest, in which case staff could use an AED as a lifesaving measure.Review of the facility policy titled Emergency/First Aid: Emergency Procedure - Cardiopulmonary Resuscitation, dated January 1, 2024, revealed personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest. Sudden cardiac arrest is a loss of heart function due to abnormal heart rhythms (arrhythmias). Cardiac arrest occurs soon after symptoms appear. It is a leading cause of death among adults. A heart attack refers to impaired blood flow to the heart which leads to damage of the heart muscle. A heart attack can cause sudden cardiac arrest (SCA). Typically, heart attacks are less sudden than SCA. Victims of cardiac arrest may initially have gasping respirations or may appear to be having a seizure. Training in BLS includes recognizing presentations of SCA. The chances of surviving SCA may be increased if CPR is initiated immediately upon collapse. Early delivery of a shock with a defibrillator plus CPR within 3-5 minutes of collapse can further increase chances of survival. If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR unless a. it is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual; or b. there are obvious signs of irreversible death (e.g., rigor mortis).The BLS sequence of events is referred to as C-A-B (chest compressions, airway, breathing). Chest compressions included to push hard to a depth of at least 2 inches (5 cm) at a rate of at least 100 compressions per minute; allow full chest recoil after each compression; and, minimize interruptions in chest compressions. Tilt head back and lift chin to clear airway. After 30 chest compressions provide 2 breaths via ambu-bag or manually (with CPR shield). All rescuers, trained or not, should provide chest compressions to victims of cardiac arrest. Trained rescuers should also provide ventilations with (continued on next page)

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