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	02/17/2026

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

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, and facility policy, the facility failed to ensure one (#8) out of the three sample residents received activities of daily living (ADL) care as per facility policy. The deficient practice could result in resident's hygiene needs not being met, skin breakdown, and psychosocial harm.Findings include-Resident #8 was admitted to the facility on [DATE], with diagnosis that included fracture of right femur, type 2 diabetes mellitus with hyperglycemia, muscle weakness, and osteoarthritis on right knee.Orders dated January 16, 2026, revealed a complete skin check weekly.A care plan initiated on January 17, 2026, revealed that the Resident #8 is at risk for functional self-care deficits and mobility. The interventions included Resident #8 required skin inspection during routine cares and per bath schedule, observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. The care plan further revealed that the resident is at risk for skin impairment related to red coccyx, reg thigh rash present during admission. The interventions included administer treatments as ordered and monitor for effectiveness.A quarterly MDS (minimum data set) dated January 21, 2026, revealed that the resident was a BIMS (brief interview for mental status) score of 08 which indicated moderately impaired cognition.Review of the weekly skin check and wound assessment revealed that 1 skin assessment was done on January 16, 2026. However, there was no evidence that weekly skin assessment was done from January 17 through February 11, 2026.A facility document titled, shower schedule, included that Resident #8 was to be provided shower two times a week during evening shift.Review of shower documents included:-One shower was provided on January 30, 2026 and February 7, 2026.-No evidence of showers was provided from January 16 through January 29, February 1 through February 6, and February 8 through February 11, 2026. An interview was conducted on February 17, 2026, at 11:56 a.m., with a licensed practical nurse (LPN, staff # 58) who worked at the facility for about one month and assisted residents with medication administration, vitals, wound care, and daily skilled evaluation. The LPN then stated that she is aware of Resident #8 who needed assistance with activity of daily living (ADLs) including toileting, transferring, and bathing. The LPN then stated that on February 10, 2026, Resident #8 had a change of condition where she was less communicative to staff and refused care including ADLs, vitals. LPN then reviewed the Resident #8 electronic health record and stated that the resident skin was assessed on January 16, 2026, with a red area on coccyx, rash on thigh, and scab on right knee. LPN then stated that on January 30, 2026, the document titled braden scale revealed skin occasionally moist. Then on February 9, 2026 document titled braden scale for predicting pressure ulcer evaluation revealed that Resident #8 revealed skin occasionally moist, activity chairfast, and mobility slightly limited. However, she did not find any document regarding redness in coccyx region nor any documentation regarding weekly skin assessment after January 16, 2026. LPN then stated that she came to know on February 16, 2026, from Interim director of nursing (DON #79) that LPN's are supposed to do weekly skin (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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment. The LPN then stated that DON follow up with nurses regarding resident's skin assessment and shower at least once a week. She stated that the risk if a resident's skin was not assessed weekly then there would be a chance of the resident getting skin injury, tear, or opening. LPN further stated that all residents in the facility get shower twice a week by CNAs (certified nursing assistant) and nurses follow up on any skin condition during showers, review signed shower sheets and notify any skin issue to the provider and the DON (director of nursing). The LPN then review physical copy of shower sheets and stated she could not find Resident #8'shower sheets and that may be DON pulled out Resident#8's binder from the sheet.An interview was conducted on February 17, 2026, at 1:34 p.m., with a certified nursing assistant (CNA staff # 26) who stated that she had worked at the facility for about 7 months and assisted residents with activities of daily living (ADLs) including transferring, bathing, dressing, and oral care. The CNA then stated initially after admission CNA provided ADLs care to resident #8 but after a couple weeks, the resident refused all cares including transferring from bed to wheelchair, toileting, repositioning, and started hitting to staffs. The CNA then stated that Resident #8's change in condition may be due to family, who stopped visiting her at the facility as they lived far away from the facility and Resident #8 did no longer want to stay at the facility. The CNA then stated that during Resident #8's stay, her vitals were normal and she was not aware of any change in Resident#8's conditions or medications. The CNA further stated that Resident #8 was scheduled for showers every Tuesday and Friday and could ask for Sunday if she preferred. The CNA then stated that she did not provide any shower to Resident #8. However, during resident's shower, skin was assessed, and any skin condition or refusal of shower would be charted on the shower sheet and floor nurses would review and sign off on the shower sheets. The CNA further stated that the risk if resident were not provided shower or skin were not assessed then there would be a chance of skin breakdown, irritation and foul smell from resident.An interview was conducted on February 17, 2026, at 2:19 p.m., with the DON (staff # 79) who worked at the facility as interim DON until a new DON is hired. Staff #79 then stated that the Resident #8 was admitted to the facility for therapy due to facture on right femur. The DON then stated that Resident #8 was on maximum assistance for bed mobility and moderate to maximum assistance for sit to stand. The DON further stated that there was a change in condition (COC) for Resident #8 from February 7 through February 9, where Resident refused all ADLs care including transferring, toileting and vitals. She stated that the provider was notified and Resident #8's therapy was put on hold. The DON then stated that Resident was not on any psychotropic medication and the only medication would cause COC may be gabapentin and tramadol that could make her sleepy. The DON also stated that Resident #8 had redness on the coccyx region during admission and on her last shower on February 7, 2026, there was no redness on coccyx found. The DON then reviewed the Resident #8 clinical record and stated that the resident had an order dated January 16, 2026, for a complete weekly skin check and there was only one skin assessment done on January 16, 2026. However, no skin assessments were done after January 16, 2026. Staff #79 then stated that the previous DON (staff # 90) usually followed up with floor nurses on all resident skin assessment every day as resident's name identified. The DON further stated that the risk if skin was not assessed for resident weekly would be a chance of skin breakdown. The DON further stated that all resident was scheduled to receive shower at least twice a week by CNAs and nurses signed out the shower sheet. The DON (staff #90) then follow-up on shower sheet. The DON further stated that if shower was not provided as per schedule then there would be a risk for resident's skin breakdown.Review of the facility policy titled Personal Care: Activities of Daily Living (ADL), revised on January 1, 2024, revealed that appropriate care and services will be provided for the residents and in accordance with (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care).Review of the facility policy titled Bathing and Showers, dated 2022, revealed that the purpose of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. The policy further revealed that upon admission shower schedule will be decided with resident, observe the resident's skin for any redness, rashes, broken skin, tender places, irritation, reddish or blue-grey area of skin over a pressure point, blisters, or skin breakdown.