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	05/28/2026

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 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 interviews, clinical record review, and review of facility policies and procedures, the facility failed to protect the rights of one (#75) of eleven sampled residents by failing to ensure the resident was free from abuse by another resident (#74). The census was 43 residents. The deficient practice resulted in resident-to-resident sexual abuse and had the potential to result in ongoing abuse and further harm to other residents.Findings include:Resident #75 (alleged victim) was admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, hyperosmolality and hypernatremia, acute kidney failure, morbid obesity due to excess calories, obstructive sleep apnea, essential hypertension, hyperlipidemia, and benign prostatic hyperplasia without lower urinary tract symptoms.A care plan focus for Resident #75, initiated [DATE], revealed that Resident #75 was at risk for an activities of daily living (ADL) self-care performance deficit. Interventions included encouraging the resident to use the call light for assistance.Resident #75's Medicare 5-Day Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The MDS further revealed that Resident #75 required the assistance of two staff members for dressing, personal hygiene, and toilet use and utilized a wheelchair for mobility.Resident #74 (alleged perpetrator) was readmitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease, chronic kidney disease, dysphagia, cognitive communication deficit, major depressive disorder, anxiety disorder, and insomnia.Resident #74's admission MDS, dated [DATE], revealed a BIMS score of 14, indicating that the resident was cognitively intact. The MDS further indicated that Resident #74 displayed no behaviors directed toward others and exhibited no evidence of psychosis during the assessment period.A census review for Residents #74 and #75 revealed that the residents began sharing a semi-private room on [DATE].Regarding the [DATE] incident:On [DATE], at 9:30 p.m., an alert progress note was entered into the clinical record for Resident #75. The note indicated that a Licensed Practical Nurse (LPN), Staff #105, entered the room to attend to the needs of Resident #75. Staff #105 documented observing Resident #74 inappropriately touching Resident #75's genital area. Staff #105 shouted for Resident #74 to remove his hands from Resident #75. The note further indicated that Resident #75 was asked whether Resident #74 had been touching him inappropriately, and he responded, yes. The note indicated that Resident #74 was transferred to another room and a report was provided to facility management.On [DATE], a skin assessment was entered into the clinical record for Resident #75, indicating that no new skin issues or injuries were noted.On [DATE], at 9:46 p.m., an alert charting progress note was entered into the clinical record for Resident #74. The note indicated that Staff #105 entered the room shared by Residents #74 and #75 and observed Resident #74 inappropriately touching his roommate in the genital area. Staff #105 documented that she shouted for Resident #74 to stop. Resident #74 stopped and appeared confused and unaware of what had occurred. Resident #74 was immediately moved to a private room, and the appropriate parties were notified.On [DATE], at 11:15 p.m., a progress note was entered into the clinical record for Resident #75. The note documented that at 9:15 p.m., Resident #75 (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was found unresponsive, without a pulse or respirations. Emergency medical services were contacted, and cardiopulmonary resuscitation (CPR) was initiated. Resident #75 was pronounced deceased at 9:43 p.m.On [DATE], at 3:07 p.m., an alert charting progress note was entered into the clinical record for Resident #74. The note revealed that a urine specimen had been sent to the laboratory and that an order for Macrobid had been initiated due to symptoms consistent with a urinary tract infection (UTI).Review of the facility's 5-Day Investigation Report, dated [DATE], indicated that the allegation of resident-to-resident abuse was substantiated. An interview conducted with a facility [NAME] (Staff #107), who witnessed the incident, revealed that on [DATE], he entered the room shared by Residents #74 and #75 in response to a call light. He observed Resident #74 attempting to get into his wheelchair and was concerned regarding the amount of medication the resident had received. Staff #107 reported that he went to retrieve the nurse and returned to the room with her. Upon returning, he observed Resident #74 seated in his wheelchair next to Resident #75's bed and touching Resident #75 underneath the blanket. Staff #107 further stated that the room was dark, limiting his ability to observe all details of the incident.The investigation also included an interview with Staff #105. Staff #105 stated that she entered the room with Staff #107 to assess concerns involving Resident #74. Upon entering the room, she observed Resident #74's hand inside Resident #75's brief. She instructed Resident #74 to stop, and Resident #74 appeared confused and unaware of what had occurred. Staff #105 stated that Resident #74 was subsequently relocated to a private room.Interviews were conducted with Resident #75, who stated that he did not ask Resident #74 to touch him and did not want to be touched. Resident #75 further stated that he was too embarrassed to tell his wife and requested that staff notify her on his behalf. Resident #74 was also interviewed and stated that he had no recollection of the event.On [DATE], at 6:57 a.m., a psychiatric progress note was entered into the clinical record for Resident #74. The note indicated that Resident #74 stated he was being framed and had done nothing wrong. He further stated that he knew what was happening and was being used as an experiment. The note also documented that Resident #74 tested positive for a urinary tract infection.On [DATE], at 8:26 p.m., a behavior progress note was entered into the clinical record for Resident #74. The note indicated that a Certified Nursing Assistant (CNA) reported that Resident #74 slapped her buttocks during the evening shift.On [DATE], at 11:20 a.m., an alert progress note was entered into the clinical record for Resident #74. The note indicated that the resident was transferred to the emergency department for evaluation and treatment of altered mental status.On [DATE], at 6:49 a.m., an infection progress note indicated that Resident #74 had returned to the facility and continued oral antibiotic treatment for a urinary tract infection.On [DATE], at 8:40 a.m., an alert charting progress note indicated that on [DATE], a student instructor at the facility reported that Resident #74 stated, he needed to get out of here so he could molest more people.Review of the care plan for Resident #74 revealed a focus initiated on [DATE]. The focus identified an alteration in neurological status related to sexual behaviors. Interventions included providing care in pairs when rendering resident care.Attempts were made to interview Resident #74 by telephone on [DATE]. No return call was received.Requests were made for contact information for former facility employee Staff #105; however, no contact information was available.On [DATE], at 12:29 p.m., an interview was conducted with the Director of Nursing (DON), Staff #86. Staff #86 stated that one resident touching another resident inappropriately would meet the definition of abuse and would not meet her expectations for resident safety and care.On [DATE], at 12:53 p.m., an interview was conducted with the facility Administrator, Staff #84. Staff #84 stated that the incident involving Residents #74 and #75 on [DATE], constituted abuse and could result in physical harm and emotional distress to the victim. Staff #84 further stated that such abuse would not meet her expectations for the facility.Review of the facility policy titled, Resident Rights/Dignity: Abuse and Neglect - Clinical Protocol, effective [DATE], defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. The policy further defined sexual abuse as non-consensual sexual contact of any type with a resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate assessment, monitoring, and supervision to prevent elopement for two of the four sampled residents. The deficient practice could result in injury to residents. Findings Include:About Resident #77:Resident #77 was admitted to the facility on [DATE], with diagnoses including unspecified dementia without behavioral, psychotic, or mood disturbance; anxiety; type 2 diabetes mellitus with diabetic neuropathy and foot ulcer; alcohol abuse; and acquired absence of another left toe.An admission Minimum Data Set (MDS) assessment completed on January 13, 2023, indicated that Resident #77 had a Brief Interview for Mental Status (BIMS) score of 12, reflecting moderate cognitive impairment.Review of a Progress Note (Alert Note) dated January 16, 2023, at 1:22 p.m., documented that Resident #77 remained at risk for elopement. The note indicated that a functioning Wander Guard was in place and that staff continued to closely monitor the resident due to ongoing exit-seeking behaviors.A subsequent Progress Note (Health Status Note) dated January 18, 2023, at 1:24 p.m., documented that Resident #77 continued to exhibit exit-seeking behaviors. The Wander Guard remained in place and operational, and staff were providing frequent redirection. The resident's son had been notified of the resident's behaviors and noncompliance.According to a Progress Note (Alert Charting) dated January 24, 2023, Resident #77 was discovered missing from the facility and was later found on the side of Route 260 across from a gas station. The note documented that the resident was wearing a Wander Guard; however, no alarm sounded when the resident exited the facility. The resident was located by a Certified Nursing Assistant (CNA). Upon return to the facility, a head-to-toe assessment was completed and revealed no new injuries. The resident's family and facility administration were notified of the incident and the resident's continued exit-seeking behaviors.A skin assessment for Resident # 77 completed on January 29, 2023, revealed no new injuries related to the elopement incident were noted.Resident's (#77) care plan related to wandering and exit-seeking behaviors following the elopement incident was updated.The care plan interventions included administering medications as ordered, anticipating and addressing the resident's needs, implementing interventions necessary to protect the resident and others, and approaching the resident in a calm manner while redirecting and diverting attention to alternative locations as needed.Resident # 71 Resident #71 was re-admitted to the facility on [DATE], with diagnoses including Insomnia, encounter for palliative care, alzheimer's disease, dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease(, chronic kidney disease, stage 3, unspecified urinary incontinence, history of falling.An admission Minimum Data Set (MDS) assessment completed on May 31, 2023, indicated that Resident #71 had a Brief Interview for Mental Status (BIMS) score of 3, reflecting severe cognitive impairment.According to the Elopement Risk Evaluation completed in April,2023 the resident was identified as being at risk for elopement, with a score of 12. The resident's care plan (#71) addresses exit-seeking behaviors and includes orders for a Wander Guard. Interventions include notifying the family, responsible party, physician, and social services of any changes in the resident's condition, as well as monitoring and observing for changes in behavior. Review of a Progress Note (Alert Charting) dated May 29, 2023, at 1:13 p.m., documented that at approximately 3:32 p.m., a community member contacted the facility to report seeing a tall, thin, confused woman walking along Salt Mine Road and believed she might be a resident of the facility. Staff immediately checked to determine whether any residents were missing and discovered that Resident # 71 was not present on the unit. Facility staff conducted a search of the building and surrounding grounds and dispatched a staff member to drive along Salt Mine Road. Resident # 71 was located at approximately 3:32 p.m. and returned to the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that this did not reflect good practice. An interview was conducted on May 28, 2026, at 1:55 PM with the executive director (ED / Staff #84) who stated that residents at risk for elopement or wandering are identified through assessments and communicated to all staff. Monitoring varies based on the resident's condition, and Wander Guards may be used depending on assessment findings. The ED (Staff # 84) stated that a physician's order is required prior to application, but also indicated a Wander Guard may not be placed without an order. Wander Guards are not easily removed by residents and typically require cutting to remove. She explained that alarms activate only at the front exit, while other exits are locked and alarmed but not linked to the Wander Guard system; the facility has approximately ten exits. The ED (Staff # 84) further stated that unsupervised elopement can result in serious harm, including falls, dehydration, or being struck by a vehicle, and confirmed that a resident leaving without staff knowledge while at risk for wandering is considered elopement. A review of the facility policy titled N007 - Behavior/Mood/Cognition: Wandering and Elopements, revised January 1, 2024, indicates that the facility is responsible for identifying residents at risk for unsafe wandering and implementing measures to prevent harm while maintaining the least restrictive environment possible for each resident.