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	06/29/2026

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 0684 Level of Harm - Minimal harm or potential for 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 staff interviews, clinical record review, facility documentation, and facility's policy and procedure, the facility failed to ensure physician's orders were followed for one out of three sampled residents (Resident #17) related to blood glucose management. The deficient practice could result in residents not receiving treatment as ordered, placing them at risk for potential harm.Findings include:Resident #17 was initially admitted on [DATE], with diagnoses that included Type 1 Diabetes, Tinea Unguium, Hypo-osmolality, and Hyponatremia. An alert chart progress note dated April 04, 2026, revealed that the resident is alert and oriented times 4. A care plan initiated dated April 04, 2026 revealed a focus area noting that Resident #17 had Diabetes Mellitus (dm). The goal is for the resident to have no diabetes-related complications through the review date. Intervention included diabetes medication as ordered by the doctor, and monitor/document for side effects and effectiveness. The intervention further revealed that the resident was dependent on insulin for management of his diabetes.The physician's orders dated April 2026 revealed following orders:- Insulin Aspart FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML(Insulin Aspart)Inject 3 units subcutaneously with meals for type 1 diabetes; Start date 04/04/2026- Insulin Aspart FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 100 - 150 = 2 units; 151 - 200 = 4 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 12 units; 401 - 500 = Call MD Call MD, subcutaneously before meals for diabetes; Start date 04/04/2026 - Accucheck: Notify MD if < 65 or > 400 before meals and at bedtime for dm ; start date 04/06/2026 The Medication Administration Record (MAR) for April 2026 revealed the following blood sugar levels:- April 06, 2026 (PM/HS Shift): Blood Glucose was 406 mg/dl. - April 08, 2026 (NOON Shift): Blood Glucose was 401 mg/dl.- April 09, 2026 (NOON Shift): Blood Glucose was 478 mg/dl - April 09, 2026 (PM/HS Shift): Blood Glucose was 47 mg/dlHowever, the clinical record revealed no documentation that the provider was notified of any of the above-listed blood glucose result, as required by the physician's orders. The April 2026 MAR revealed the resident did not receive the scheduled 1800 dose of Insulin Aspart FlexPen on April 5, 2026.The clinical record revealed no documentation pertaining to why the medication was not administered. The April 2026 MAR further revealed the resident did not receive the ordered sliding-scale insulin, and no blood glucose result was documented on April 5, 2026 for Evening Shift. The clinical record had no documentation pertaining to why the medication was not administered. An interview was conducted on June 29, 2026, at 12:00 pm with Certified Nursing Assistant (CNA/#45), who stated that it is important to obtain the resident's complete set of vital signs because certain medications require the resident's vital signs to meet specific parameters before administering the medication. The CNA then stated they will take the resident's vitals sheet and provide it to the nurse to document on the resident's chart. The CNA also stated that documenting the resident's vital signs is important to maintain an accurate record and to monitor for any changes in condition.An interview was conducted on June 29, 2026, at 12:24 PM with Registered Nurse (RN/Staff #75), who stated that she follows the physician's orders by reviewing the order, verifying that the insulin pen matches the order, and cleaning the injection site before administration. She also stated that the assessment for change of condition would include: time of event, observation, vital signs, blood sugar levels, (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 - Minimal harm or potential for actual harm Residents Affected - Few	documentation of contracting provider, follow-up, and outcome of the intervention. She further stated that it is important to recognize and respond to a change of condition in a timely manner because it could result in residents falling and hurting themselves and, in the worst-case scenario, death. Staff #75 stated that if a resident's blood sugar is below 65 mg/dL and greater than 400 mg/dL, she would contact the provider prior to administering the insulin, and if blood glucose is under 65 she would provide the resident with juice. She then stated that she would document on the MAR for medication administration. She stated that it is important to notify the provider for a change in condition because adjustments can be made to keep the resident safe. She then stated it is important to follow the physician's orders because if they don't, they are basically practicing without a license, and it is the law. An interview was conducted on June 29, 2026, with a Licensed Practical Nurse (LPN/Staff #78), who stated that when following the physician's order, he would verify the resident's name, confirm whether a sliding scale was in place, and administer the appropriate amount based on the sliding scale. He then stated that if provider orders were not followed, it could be catastrophic. He further stated that it was important to follow the physician's orders to maintain the resident's health and safety.An interview was conducted on June 29, 2026, at 2:46 pm with the Director of Nursing (DON/Staff#33). The DON reviewed the April 2026 MAR and confirmed that the ordered sliding scale Insulin Aspart FlexPen was not administered on April 5, 2026. The DON further confirmed there was no documentation explaining why the medication was not administered. The DON also confirmed the physician's order required staff to notify the physician of blood glucose readings below 65 mg/dL or above 400 mg/dL before meals and at bedtime. The DON reviewed April 2026 MAR and confirmed blood glucose readings of 406 mg/dL on April 6, 401 mg/dL on April 8, and 478 mg/dL on April 9, with no documentation that the provider was notified. The DON further confirmed that the scheduled 1800 dose of insulin Aspart FlexPen, 3 units subcutaneously with meals, was not administered on April 5, 2026, and there was no documentation explaining why the medication was not administered. The DON stated that failure to follow the physician's orders does not meet the facility's expectations and could result in potential harm to the resident. The DON further stated that staff are expected to follow physician's orders because failure to do so is equivalent to practicing outside their scope of authority, as staff do not have the authority to change, dismiss, or write physician's orders.A policy titled Orders/ Receiving/Transcribing: Medication and Treatment Orders revealed Medication shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medication in the state