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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on review of facility documentation and policy, and staff interviews, the facility failed to ensure that daily staff postings were posted accurately regarding actual number of licensed and unlicensed staff that worked each shift and actual hours worked by licensed and unlicensed staff for 17 out of 17 days reviewed. The census was 43. The deficient practice could result in residents, visitors, and facility staff not being informed of accurate and current staffing information. Findings include: Review of 17 randomly selected daily staff postings and corresponding punch details revealed the number of Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nursing Aides (CNAs) that worked each shift and the hours worked by staff were not updated on the daily staff postings to include the actual number of staff that worked each shift and the actual hours worked by staff. The daily staff posting dated October 26, 2024, revealed a census of 44 residents with no evidence of the actual number of nurses and CNAs that worked each shift or the actual number of hours worked by all licensed staff and CNAs each day. The daily staff posting included the following scheduled hours:- 40 RN hours,- 16 LPN hours, and- 64 CNA hoursReview of the punch details requested for that day revealed:- 23.75 RN hours,- 30.87 LPN hours, and- 69.36 CNA hoursThe daily staff posting included a column to include the actual hours worked by staff, but was left blank. The daily staff posting dated November 2, 2024, revealed a census of 48 residents with no evidence of the actual number of nurses and CNAs that worked each shift or the actual number of hours worked by all licensed staff and CNAs each day. The daily staff posting included the following scheduled hours:- 32 RN hours,- 0 LPN hours, and- 88 CNA hoursReview of the punch details requested for that day revealed:- 31.65 RN hours,- 8.38 LPN hours, and- 71.46 CNA hoursThe daily staff posting included a column to include the actual hours worked by staff, but was left blank. The daily staff posting dated November 30, 2024, revealed a census of 47 residents with no evidence of the actual number of nurses and CNAs that worked each shift or the actual number of hours worked by all licensed staff and CNAs each day. The daily staff posting included the following scheduled hours worked:- 24 RN hours,- 24 LPN hours, and- 56 CNA hoursReview of the punch details requested for that day revealed:- 23.99 RN hours,- 33.4 LPN hours, and- 47.43 CNA hoursThe daily staff posting included a column to include the actual hours worked by staff, but was left blank. The daily staff posting dated December 14, 2024, revealed a census of 44 residents with no evidence of the actual number of nurses and CNAs that worked each shift or the actual number of hours worked by all licensed staff and CNAs each day. The daily staff posting included the following scheduled hours worked:- 32 RN hours,- 24 LPN hours, and- 72 CNA hoursReview of the punch details requested for that day revealed:- 34.71 RN hours,- 18.55 LPN hours, and- 75.33 CNA hoursThe daily staff posting included a column to include the actual hours worked by staff, but was left blank. The daily staff posting dated December 28, 2024, revealed a census of 47 residents with no evidence of the actual number of nurses and CNAs that worked each shift or the actual number of hours worked by all licensed staff and CNAs each day. The daily staff posting included the following scheduled hours worked:- 32 RN hours,- 8 LPN hours, and- 88 CNA hoursReview of the punch details requested for that day revealed:- 32.69 RN hours,- 8.1 LPN hours, and- 69.12 CNA hoursThe daily staff posting included a column to include the actual hours worked by staff, but was left blank. The daily staff posting dated April 5, 2025, revealed a census of (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

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	41 residents with no evidence of the actual number of nurses and CNAs that worked each shift or the actual number of hours worked by all licensed staff and CNAs each day. The daily staff posting included the following scheduled hours worked:- 24 RN hours,- 16 LPN hours, and- 72 CNA hours Review of the punch details requested for that day revealed:- 32.22 RN hours,- 0 LPN hours, and- 73.67 CNA hoursThe daily staff posting included a column to include the actual hours worked by staff, but was left blank. The daily staff posting dated April 19, 2025, revealed a census of 45 residents with no evidence of the actual number of nurses and CNAs that worked each shift or the actual number of hours worked by all licensed staff and CNAs each day. The daily staff posting included the following scheduled hours worked:- 16 RN hours,- 24 LPN hours, and- 72 CNA hoursReview of the punch details requested for that day revealed:- 16.8 RN hours,- 23.85 LPN hours, and- 72.15 CNA hoursThe daily staff posting included a column to include the actual hours worked by staff, but was left blank. The daily staff posting dated May 17, 2025, revealed a census of 48 residents with no evidence of the actual number of nurses and CNAs that worked each shift or the actual number of hours worked by all licensed staff and CNAs each day. The daily staff posting included the following scheduled hours worked:- 16 RN hours,- 24 LPN hours, and- 72 CNA hoursReview of the punch details requested for that day revealed:- 24.11 RN hours,- 24.21 LPN hours, and- 83.07 CNA hoursThe daily staff posting included a column to include the actual hours worked by staff, but was left blank. The daily staff posting dated May 25, 2025, revealed a census of 48 residents with no evidence of the actual number of nurses and CNAs that worked each shift or the actual number of hours worked by all licensed staff and CNAs each day. The daily staff posting included the following scheduled hours worked:- 16 RN hours,- 32 LPN hours, and- 64 CNA hoursReview of the punch details requested for that day revealed:- 17.85 RN hours,- 24.12 LPN hours, and- 79.53 CNA hoursThe daily staff posting included a column to include the actual hours worked by staff, but was left blank. The daily staff posting dated June 7, 2025, revealed a census of 50 residents with no evidence of the actual number of nurses and CNAs that worked each shift or the actual number of hours worked by all licensed staff and CNAs each day. The daily staff posting included the following scheduled hours worked:- 24 RN hours,- 24 LPN hours, and- 64 CNA hoursReview of the punch details requested for that day revealed:- 26.17 RN hours,- 25.4 LPN hours, and- 71.55 CNA hoursThe daily staff posting included a column to include the actual hours worked by staff, but was left blank. The daily staff posting dated June 22, 2025, revealed a census of 48 residents with no evidence of the actual number of nurses and CNAs that worked each shift or the actual number of hours worked by all licensed staff and CNAs each day. The daily staff posting included the following scheduled hours worked:- 16 RN hours,- 32 LPN hours, and- 64 CNA hoursReview of the punch details requested for that day revealed:- 18.7 RN hours,- 32.55 LPN hours, and- 65.24 CNA hoursThe daily staff posting included a column to include the actual hours worked by staff, but was left blank. The daily staff posting dated July 5, 2025, revealed a census of 50 residents with no evidence of the actual number of nurses and CNAs that worked each shift or the actual number of hours worked by all licensed staff and CNAs each day. The daily staff posting included the following scheduled hours worked:- 24 RN hours,- 24 LPN hours, and- 72 CNA hoursReview of the punch details requested for that day revealed:- 24.63 RN hours,- 17.48 LPN hours, and- 79.94 CNA hoursThe daily staff posting included a column to include the actual hours worked by staff, but was left blank. The daily staff posting dated July 19, 2025, revealed a census of 50 residents with no evidence of the actual number of nurses and CNAs that worked each shift or the actual number of hours worked by all licensed staff and CNAs each day. The daily staff posting included the following scheduled hours worked:- 32 RN hours,- 24 LPN hours, and- 80 CNA hoursReview of the punch details requested for that day revealed:- 24.32 RN hours,- 29.42 LPN hours, and- 98.88 CNA hoursThe daily staff posting included a column to include the actual hours worked by staff, but was left blank. The daily staff posting dated August 16, 2025, revealed a census of 48 residents with no evidence of the actual number of nurses and CNAs that worked each shift or the actual number of hours worked by all licensed staff and CNAs each day. The daily staff posting included the following scheduled hours (continued on next page)

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	worked:- 24 RN hours,- 16 LPN hours, and- 80 CNA hoursReview of the punch details requested for that day revealed:- 28.78 RN hours,- 8.45 LPN hours, and- 81.58 CNA hoursThe daily staff posting included a column to include the actual hours worked by staff, but was left blank. The daily staff posting dated August 23, 2025, revealed a census of 50 residents with no evidence of the actual number of nurses and CNAs that worked each shift or the actual number of hours worked by all licensed staff and CNAs each day. The daily staff posting included the following scheduled hours worked:- 16 RN hours,- 24 LPN hours, and- 96 CNA hoursReview of the punch details requested for that day revealed:- 16.78 RN hours,- 24.29 LPN hours, and- 88.71 CNA hoursThe daily staff posting included a column to include the actual hours worked by staff, but was left blank. The daily staff posting dated September 13, 2025, revealed a census of 51 residents with no evidence of the actual number of nurses and CNAs that worked each shift or the actual number of hours worked by all licensed staff and CNAs each day. The daily staff posting included the following scheduled hours worked:- 32 RN hours,- 16 LPN hours, and- 80 CNA hoursReview of the punch details requested for that day revealed:- 33 RN hours,- 15.03 LPN hours, and- 73.82 CNA hoursThe daily staff posting included a column to include the actual hours worked by staff, but was left blank. The daily staff posting dated September 21, 2025, revealed a census of 50 residents with no evidence of the actual number of nurses and CNAs that worked each shift or the actual number of hours worked by all licensed staff and CNAs each day. The daily staff posting included the following scheduled hours worked:- 24 RN hours,- 16 LPN hours, and- 80 CNA hoursReview of the punch details requested for that day revealed:- 35.88 RN hours,- 16.57 LPN hours, and- 78.3 CNA hoursThe daily staff posting included a column to include the actual hours worked by staff, but was left blank. An interview was conducted on May 28, 2026, at 12:59 PM, with the staffing coordinator (Staff #64). Staff #64 stated he was responsible for creating the staff schedule, he was not responsible for the daily staff posting. Staff #64 further stated that he provided the staff schedule to the receptionist, who would fill in the number of staff and hours scheduled to work. Staff #63 stated that he was not aware if the daily postings were updated; they would be updated by the receptionist. An interview was conducted on May 28, 2026 at 1:15 PM with the receptionist (Staff #39). Staff #39 stated she had been in the position for six years and had been trained by the receptionist before her. She further stated that she had not been trained to update the daily staff posting throughout the day. Staff #39 further stated the process for completing the daily staff posting involved checking the staff schedule, inputting the numbers based on what was provided, and posting the information on the nursing unit. Staff #39 stated she had never been informed of the need to update the daily staff posting to include the actual number of staff that worked and the actual number of hours worked by staff. An interview was conducted on May 28, 2026 at 1:22 PM, with the Director of Nursing (DON/ Staff #86). Staff #86 stated that she is not responsible for overseeing any part of the daily staff posting. She further stated she was not aware of who would update the daily staff posting with the actual hours worked, but that this information should be updated. Staff #86 stated that the risk of not updating the daily staff posting to include the actual number of staff and hours worked included not being properly staffed to meet the needs of the residents in the building. She stated that, as the DON, she used the daily staff posting to ensure there were an appropriate number of nurses and CNAs, and that she may not be able to accurately assess the need of more staff if the actual hours are not updated. Staff #86 reviewed a daily staff posting and the corresponding punch details for April 5, 2025, and stated that, according to the information provided, there may not have been enough staff on that day to meet the needs of the residents. An interview was conducted on May 28, 2026 at 2:31 PM, with the executive director (Staff #84). Staff #84 stated she was unaware of the need for the actual number of staff and hours worked to be updated on the daily staff posting. She further stated she had never seen an updated daily staff posting, did not see any risk associated with not updating the daily staff posting to include the actual number of staff and hours worked. The facility policy, Administrative Policies: Staffing, Sufficient and Competent Nursing, revised January 2024, revealed that the direct care daily staffing numbers are to (continued on next page)

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be posted in the facility for every shift. Review of the policy further revealed that any staffing concerns are to be directed to the director of nursing services or a designee. Review of Federal regulation CFR S483.35(g)(1)(iii) revealed the facility must post the total and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses, and certified nurse aides.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that care and treatment were provided in accordance with physician orders for 1 of 4 sampled residents. This deficient practice resulted in the implementation of resident safety interventions without physician authorization. Findings Include: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.Review of the clinical record indicated that Resident #77 did not have a hospital order or physician order for a Wander Guard prior to the incident. The physician order authorizing the Wander Guard was subsequently obtained and entered on January 25, 2023. An interview was conducted on May 28, 2026, at 10:16 a.m. with a Registered Nurse (RN, Staff #74). The RN stated that residents at risk for wandering or elopement are identified through information obtained from hospitals or previous facilities, admission assessments, and observations of exit-seeking behaviors. The RN further stated that assessments are generally completed within 24 hours of admission, and residents that are determined to be at risk should have appropriate interventions included in their care plan, such as the use of a Wander Guard when indicated. The RN confirmed that a physician's order must be obtained before a Wander Guard is applied and that staff receive education regarding residents identified as being at risk for wandering or elopement. An interview was conducted on May 28, 2026, at 9:15 a.m. with the Director of Nursing (DON, Staff #86). The DON stated that residents are assessed for wandering and elopement risk upon admission, and the assessment results are documented in both the resident's medical record and PointClickCare (PCC). Residents identified as being at high risk for elopement must have a physician's order and consent from the resident or the resident's Power of Attorney (POA) before a Wander Guard is applied. The DON (Staff #86) further stated that these residents are included in a wander-risk binder maintained at the front desk, and staff are notified of residents at risk for wandering through communication and the use of resident photographs to assist with identification and monitoring. The DON (Staff #86) stated that Wander Guards are typically used (continued on next page)

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for residents who have been assessed as being at high risk for elopement or who demonstrate recurrent exit-seeking behaviors. The DON confirmed that a physician's order must be obtained prior to the application of a Wander Guard and acknowledged that the use of a Wander Guard without a physician's order was not in accordance with facility policy and expectations. 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 and acknowledged that the use of a Wander Guard without a physician's order was not in accordance with facility policy and expectations. A review of the facility policy titled G002 - Orders/Receiving/Transcribing: Medication Orders, revised January 1, 2024, revealed that the facility is responsible for ensuring that all physician orders are accurately received, transcribed, communicated, and implemented as prescribed.

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 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)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility. Upon the return, the Unit Manager and the nurse completed a comprehensive assessment and skin check. No injuries or skin impairments were identified. The resident's (#71) temperature was 98.8 F, mucous membranes were moist and pink, and skin turgor was noted to be normal. The resident's Wander Guard was observed to be in place and functioning on her ankle. Hospice services were notified of the incident and indicated they would contact the resident's family. The Unit Manager and Administrator were also notified.Resident's (#71) 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.A skin assessment completed for Resident # 71 on May 29, 2023, revealed no new injuries related to the elopement incident were noted.An interview was conducted on May 28, 2026, at 10:16 a.m. with a Registered Nurse (RN/Staff #74). The RN (Staff # 74) stated that residents at risk for wandering or elopement are identified through information received from hospitals or prior facilities, admission assessments, or observed exit-seeking behaviors. Assessments are typically completed within 24 hours of admission, and residents identified as at risk should be care planned with appropriate interventions, such as a Wander Guard, implemented based on behavior. The RN confirmed that a physician's order is required prior to using a Wander Guard and that staff are educated regarding residents identified as being at risk. The RN further explained that Wander Guards only activate alarms at the facility's front entrance and do not alert at other exits, and that all staff share responsibility for monitoring residents and facility exits. The RN (Staff # 74) also stated that if a resident at risk for wandering leaves the facility unsupervised, the potential consequences may range from minor injury to serious harm, including being struck by a vehicle or death, emphasizing that wandering and elopement risks are taken seriously due to the significant safety concerns involved. Regarding Resident #71, the RN (Staff # 74) recalled that the resident was very confused, ambulatory, and exhibited wandering behaviors. The RN stated that Resident #71 typically wore a Wander Guard during respite stays and believed the resident had been identified as a wandering risk, with interventions that included placement near the nurses' station and supervision during meals. The RN (Staff # 74) was unable to recall Resident #77 or provide information regarding his wandering risk status or related interventions.An interview was conducted on May 28, 2026, at 9:15 AM with the Director of Nursing (DON/Staff #86), who stated that residents are assessed for wandering and elopement risk upon admission, with the results documented in both the resident's physical chart and PointClickCare (PCC). Residents identified as high risk for elopement require a physician's order and consent from the resident or their Power of Attorney (POA) before a Wander Guard can be applied. These residents are also added to a wander-risk binder maintained at the front desk. Staff are informed of residents who are at risk for wandering and are provided photographs to assist with identification and monitoring. Wander Guards are typically used for residents identified as high risk through assessment or those demonstrating repeated exit-seeking behaviors. The DON (Staff #86) confirmed that a physician's order is required prior to applying a Wander Guard and acknowledged that applying one without an order is not accepted. The DON (Staff #86) further stated that Wander Guards activate alarms only at the front entrance, while two rear exits near the kitchen are not connected to the Wander Guard alarm system. The facility has approximately eight exits, and all staff members share responsibility for monitoring wandering-risk residents and facility exits. The DON (Staff #86) further stated that if a resident at risk for wandering leaves the facility unsupervised, potential consequences include the possibility of injury or harm, inability to locate the resident, and potentially death, particularly given the facility's proximity to a highway. The DON (Staff #86) further indicated that such an event would represent a failure to meet facility expectations. Residents leaving the facility without staff knowledge, particularly when identified as high risk for wandering, would be considered as an elopement.The DON (Staff #86) further stated that she was not working at the facility at the time of the incidents.The DON (Staff #86) reviewed the records for Residents #71 and #77 and acknowledged that an elopement occurred at the facility. The DON (Staff #86) further stated (continued on next page)

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 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.