

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035062	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/23/2024
NAME OF PROVIDER OR SUPPLIER  Desert Haven Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  2645 East Thomas Road Phoenix, AZ 85016	

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 - Actual harm  Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50116</p> <p>Based on clinical record review, staff interviews, and facility documentation and policy review, the facility failed to ensure adequate supervision was provided to one resident (#1) to prevent elopement. The deficient practice could result in injury or harm to the resident.</p> <p>Findings include:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses that included post-traumatic stress disorder, aphasia following cerebral infarction, mild neurocognitive disorder due to known physiological condition with behavioral disturbance, anoxic brain damage, vascular dementia, mild, with agitation, dysphagia, epilepsy, intractable without status epilepticus.</p> <p>The minimum data set (MDS) assessment was currently in progress for new admission to facility and had not been completed.</p> <p>The elopement risk assessment dated [DATE] revealed a score of 14 indicating the resident was a high risk to wander.</p> <p>Review of the care plan dated August 21, 2024 revealed the resident has a history of eloping. Interventions included to distract resident from wandering by offering pleasant diversions, structured activities, food, conversation and television, identify pattern of wandering, is wandering purposeful, aimless or escapist? Does it indicate the need for more exercise? and to intervene as appropriate.</p> <p>A progress note dated August 16, 2024 at 22:51 stated that the resident#1 was alert, wondering about unit and exit seeking at times.</p> <p>Another progress note dated August 18, 2024 at 17:21 stated that the resident #1 continue on 1:1 monitoring with aide staff on the shift. The note further stated that the resident was noted pushing on the exit doors attempting to leave the facility.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated August 20, 2024 at 20:30 stated approximately at 1830 the nurse heard alarm for exit door. The note stated the medication delivery had just come through door, the nurse then accepted medications and went to turn off alarm. The nurse found alarm to be door by oak dining room. The note stated the nurse immediately went out the door looking to see if anyone had gotten out the door. The note further stated upon coming back inside, another resident stated he saw resident #1 push on this exit door getting it opened and walked out.</p> <p>A progress note dated August 21, 2024 at 15:55 stated that the resident #1 had returned to the facility from a hospital with only clothing that the resident was wearing and no other personal belongings. The note state blisters were present to resident #1's sole of left foot near heel and ball of left foot. The note stated one additional blister was present to sole of right foot near ball of foot.</p> <p>An interview was conducted on August, 23, 2024 at 10:54 AM with Unit Manager(UM)/ Licensed Practical Nurse (LPN/staff #2) who stated that resident #1 was new and they did not know his behaviors. Staff #2 stated resident #1 was on 1 to 1 (one staff member to one resident) monitoring over the weekend and was currently on 1 to 1, for 24 hours and an aide will monitor the resident. Staff #2 stated the facility also has video to help monitor and stated the facility will watch all the time. Staff #2 stated resident #1's feet is doing better and the blisters are drying up.</p> <p>An interview was conducted on August 23, 2024 at 10:58 AM with a certified nursing assistant (CNA/staff #3), who stated that the staffs were familiar with this resident and is currently overseeing the care of the resident while the main CNA scheduled to be on 1 to 1 care is at lunch. Staff #3 stated that the staff was told resident #1 is a 1 to 1, because he had an elopement. Staff #3 stated the way to keep the resident safe is good communication, face forward, stay side by side, try not to leave the room, give them space and always make sure staff have replacement to watch them.</p> <p>An interview was conducted on August 23, 2024 at 1:11 PM with the Director of Nursing (DON/staff #1), who stated that she was not in the facility when the elopement occurred but was told by the nurse that was working that evening, what had occurred. The medication guy came with a delivery. The nurse went to turn the alarm off and noted that the door next to Oak dining room alarm was going off. She stated the nurse then went out and did not see anyone, came back and another resident said they saw the resident push on the door and go out. That is when the search started. The resident was originally on a 1 to 1 and that was removed on Monday morning (August 19, 2024). She stated there are many consequences if a resident elopes and resident could get lost.</p> <p>The resident was found by his sister the next morning and was taken to a local hospital to be assessed. The resident returned to the facility later in the day with blisters on the bottom of both feet.</p> <p>The facility's policy, Elopement Guidelines last reviewed on November 30, 2022, states that all Nursing personnel shall report and investigate all reports of missing residents.</p>		