STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035169	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Highlands Care Center	1081 Kathleen Ave Kingman, AZ 86401

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. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and facility policy, the facility failed to ensure procedures were activated timely when the the Resident (#11) failed to return to the facility. The deficient practice may result in unidentified residents who eloped. Findings include: Resident #11 was admitted on [DATE] with diagnoses of acute respiratory failure, paroxysmal atrial fibrillation, and alcohol abuse. An admission Minimum Data Set (MDS) dated [DATE] included that this resident was moderately cognitively impaired. A Social Services note dated July 16, 2025 included that this resident stopped by Social Services inquiring if he could get a ride to his home and get his belongings, and that he stated he wants some clean clothes and would like to check on his house. This note included that social services discussed with him that he would need to return back to the facility in a decent time so he could continue his medication regimen and therapy and that this resident stated he understand and would be back in time. A Transportation Log and Acknowledgement Form included that on July 17, this resident was transported home with a pickup time of 1 PM. The return time box was filled in with resident refused. However, review of the clinical record did not find a sign out sheet for this resident on July 17, 2025. Review of the Medication Administration Record (MAR) for July, 2025 included that on July 17, this resident received the AM medication but the 1900 observation was not performed and the resident did not receive the 2100 doses of medication. This record included that some of the MAR records for PM were noted this resident was absent from home without medications. However, review of the clinical record was unable to find attempts to contact the resident or otherwise ensure his safety from until July 18, 205 at 10:37 AM. A Social Services note dated July 18, 2025 at 10:37 AM included that Social Services called this resident to do a welfare check and that this resident did not answer, and that they left a message requesting a return call. A Social Services note dated July 18, 2025 at 11:59 AM included that Social Services called [NAME] Police Department requesting a welfare check be completed and that [NAME] Police Department was able to locate this resident at [NAME] Regional Medical Center in the Cath Lab. A Social Services note dated July 18, 2025 at 12:00 PM included that Social Services submitted an APS report regarding this resident leaving against medical advice. An interview was conducted on July 31, 2025 at 9 AM with a Certified Nursing Assistant (CNA/staff #7) who said that she thought that the facility was supposed to pick this resident back up but that she spoke to the driver who said that he was not scheduled to pick this resident up. This CNA said that the resident left his glasses in his room and that the resident left with 1 tank of oxygen, therefore she was surprised that there was not a return trip planned. This CNA said that this resident wanted to leave at 10 but that she thought he left at 1 PM because the unit coordinator said that the driver would be available at 1 PM. This CNA said that normally people coordinate their own transportation, however this resident seemed alert if you didn't know him but could be confused. An interview was conducted on July 31, 2025 at 10:07 AM with a Unit Coordinator (staff #81) who said that she schedules resident's appointments, setting up to and from trips as well as other duties. This staff said that she remembered this resident and that she scheduled a driver for dropping him off. This staff said that social services would come up and ask when the driver could take him for his trips and that for the last trip she scheduled him for, she was told not to worry about a ride back. This staff said that the social services persons came to her desk together and told her not to schedule the return trip and that she asked if they were sure that they did not want the facility driver (staff #14) to pick him up and that the social services persons said no. This staff said that she did what she was told and scheduled the trip. An interview was conducted on July 31, 2025 at 10:22 AM with the Director of Social Services (staff #39) who said that typically it's staff #81 who coordinates the travel. This staff said that this resident was not in the facility very long and needed to go home to get clothes, and had went once before and came back. This staff said that the resident had on a psychedelic mushroom shirt and hospital pants, and considered that it was undignified, and that the facility could not force the resident to stay. This staff said that they had spoken to staff #81 about transport and that this resident was going to leave at 1:00 PM and be back at 3:00 PM. This staff then said that she did not remember if it was asked to arrange there and back because she did not know it was her or her assistant. This staff said that the resident signed out with the nurses and that as far as she was aware, the resident went home. This staff said that she did not notice that the resident had not returned until the next morning because she was doing her duties. This staff said that she called Adult Protective Services and that she was told that this resident was in the cath lab at the local hospital. An interview was conducted on July 31, 2025 at 3:22 PM with the