

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Haven of Douglas		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 North San Antonio Avenue Douglas, AZ 85607	
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 clinical record reviews, staff interviews, facility documentation, and facility policy, the facility failed to ensure one resident was free from preventable accidents including elopement. This deficient practice could result in life-threatening injuries. Based on clinical record reviews, staff interviews, facility documentation, and facility policy, the facility failed to ensure one resident was free from preventable accidents including elopement. This deficient practice could result in life-threatening injuries. Findings include: -Resident #100 was admitted to the facility on [DATE] with diagnoses that include acute respiratory failure, dementia, hypertension, anxiety, difficulty walking, and weakness. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 6, indicating significant cognitive impairment. A care-plan revised July 30, 2025 revealed the resident has impaired cognitive function related to dementia with noted interventions that resident needs supervision and assistance with all decision making, and to keep resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. A behavior care-plan initiated October 20, 2025 revealed the resident actively exit seeks and makes multiple attempts to leave facility through alarmed doors, with noted interventions of monitor resident closely for any tailing of visitors as the leave the facility and redirect and reorient resident as needed and if appropriate. A wander risk evaluation dated October 16, 2025 revealed the resident was assessed with a score of 14, indicating a high risk for wandering behaviors. It further noted that resident has a known history of wandering at home prior to admission, and ambulation without assistance. A progress note dated October 16, 2025 at 8:31 a.m. revealed at 0800, Receptionist notified this nurse that this resident may have eloped from the facility. Receptionist stated, I was notified by a phone call from the community that it appeared to be one of our residents who was walking down the street. Resident's room was checked and dining room as well, the resident was not noted in either location. This nurse immediately notified all staff in the facility to assist with head count in the building and complete a facility sweep. Resident not accounted for. Staff search of surrounding area was conducted, and resident located several blocks away from the facility. When asked what she was doing, resident stated I am on my way to see the President. Resident was unharmed and not in distress. Resident was easily redirected to vehicle and driven back to facility without any signs or symptoms of acute adverse process or injury. Resident stated I was on my way to see the President. Resident was found and driven back to the facility with no issue. Head to toe assessment completed and no s/sx of injury noted. Resident has no c/o pain or discomfort at this time. Resident is A&Ox1. Resident will be placed on q15 min wandering monitoring for safety. Resident is currently sleeping in bed with call light within reach and bed at lowest position. Care plan updated. MD, DON and Administration notified. Left voicemail to resident's husband/responsible party. A progress note dated October 17, 2025 at 8:30 p.m. revealed the resident continues to be monitored related to an elopement incident. No injuries or impairments noted this shift. Resident is alert and oriented A&Ox2 and is re-oriented and redirected as needed. Resident is currently in bed at lowest position with call light and water within reach. Safety mattress in place. An (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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(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	interview was conducted with a Registered Nurse (RN staff/#20) on October 23, 2025, at 10:58 a.m. The RN stated that during the shift where the resident eloped he got to the facility at 6 in the morning. He stated that he was doing wound care, and the other nurses were doing medication pass at about 8ish, he remembered seeing resident #100 when he went to the dining room. He stated that resident #100 said she was going for a walk and said I'll come back later. Staff #20 further stated it's normal for the resident to wander around the halls of the facility, but that a few minutes later the secretary at the front office notified him that a community member had notified the facility that the resident was walking down the street. He further stated that after doing a head count they went down the street to retrieve the resident who stated she was going to see the president. Staff #20 concluded that the resident did leave the facility and was returned, assessed and found to have no injuries. An interview was conducted with resident #100 on October 23, 2025, at 12:03 p.m. Resident #100 stated so far so good when asked about recent events, and that I'm still dealing with this one while pointing to an abrasion on her leg. The resident stated she doesn't know how it happened, that something was chasing her and she slipped and scraped her knee. Resident #100 stated she does not remember going for a walk, and that it was probably her sister that left. She concluded that she goes for a walk every day. However, it was noted the resident was a poor historian in the interview. An interview was conducted with the Director of Nursing (DON staff/#55) on October 23, 2025 at 12:20 p.m. The DON stated she was aware of the incident with resident #100, and that resident #100 was admitted from home several months ago because the family could no longer take care of her. The DON stated that resident #100 has Alzheimer's dementia, and was behavioral at home, had a fall resulting in a fracture at home, and that's how she ended up in the facility for rehabilitation services. The DON stated that resident #100's sister in law identified that she used to go for morning walks and that's why they had RNA doing supervised walks with the resident. The DON stated that she can't be 100% sure how resident #100 got out but since they didn't see her go out of the front door she thinks it was a side door with an alarm. The DON further stated that the alarm on the door was functioning and did trip the alarm, but that the alarm itself was too quiet for the staff to hear it because it was too quiet. The DON further stated that after the incident the resident was noted to have a urinary tract infection and that resident #100 was placed on 1:1 monitoring with a sitter to prevent further incidents. The DON concluded that it doesn't meet her expectations that the resident eloped and that the alarm was being replaced as part of all their interventions to assure this doesn't happen again. A review of facility policy titled ?Behavior / Mood / Cognition: Wandering and Elopements dated January 1, 2024, revealed that the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. It further revealed that if a resident is identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.		