

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Winslow Campus of Care		STREET ADDRESS, CITY, STATE, ZIP CODE 826 West Desmond Street Winslow, AZ 86047	
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 staff interviews, clinical record review, and review of facility policy and procedure, the facility failed to ensure adequate assessment, monitoring, and supervision to prevent elopement for one (Resident #7) of the four sampled residents. The deficient practice could result in injury to residents. Findings Include: Resident #7 was readmitted to the facility on [DATE], with diagnoses including obstructive and reflux uropathy (primary admission diagnosis), vitamin D deficiency, dry eye syndrome, a history of influenza A with other respiratory manifestations, a history of pneumonia, a history of Escherichia coli urinary tract infection, benign prostatic hyperplasia with and without lower urinary tract symptoms, hypoxemia, altered mental status, hypo-osmolality and hyponatremia, fever, reduced mobility, long-term drug therapy, depression, dysphagia, alcohol abuse, chronic pain, and constipation. A Quarterly Minimum Data Set (MDS) assessment completed on June 25, 2026, indicated that Resident #7 had a Brief Interview for Mental Status (BIMS) score of 07, reflecting severe cognitive impairment. An Elopement Assessment performed on June 20, 2026 didn't indicate that the resident # 7 is at risk for wandering or elopement. According to a Progress Note July 4, 2026, At 6:45 AM, documented that the resident had eloped out to the front sidewalk all the way to the East side of the building close to the street. The notes documented that the resident stated he wanted to go for a stroll. A skin assessment for Resident # 7 completed after the incident, revealed no new injuries were noted related to the elopement incident. Nursing notes for the next couple dates after the incident did not reveal any significant change in the resident #7's behaviors. The Care plan related to wandering and exit-seeking behaviors following the elopement incident was updated. The care plan interventions included 1:1 approach, social service visits as needed, anticipate basic needs and provide care: i.e. pain, hunger, elimination, rest, follow familiar routines as much as possible, implement safety measures as needed, maintain calm environment and approach towards resident, make sure all staff are aware of elopement risk, provide simple tasks, activities, provide unit activities as diversions: redirect as needed, remind resident to use the gazebo space outside that is designated for residents and remind resident # 7 to use the common outdoor space. An interview was conducted on July 8, 2026, at 8:30 AM with the Certified Nursing Assistant (CNA / Staff # 40), who stated that she arrived at work at approximately 6:00 AM and did not observe anything unusual. Staff # 40 proceeded to her assigned area, Unit 200. Staff # 40 was wearing a facility-provided shirt, but it was too long, so Staff # 40 decided to change into a different shirt. At approximately 6:45-7:00 AM, after changing, the CNA (Staff # 40) was returning to the building when she observed resident # 7 sitting in a wheelchair in the lobby wearing a bright red shirt. Staff # 40 immediately informed the housekeeper, who was cleaning the lobby at the time, and asked her to notify the floor nurse. After informing the housekeeper, Staff # 40 went over to speak with Resident # 7 because he was familiar with staff #40. Resident # 7 smiled (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	when Staff # 40 approached him. Staff # 40 asked, How did you end up here? Resident # 7 pointed toward the exit door and said that the door was open. Resident # 7 did not appear anxious or in distress. Resident #7 was laughing and seemed calm. The night nurse, Licensed Practical Nurse (LPN / Staff # 201) from Unit 100 arrived and asked resident #7 why he was there and whether he was okay. Staff # 40 & Staff # 201 then escorted resident # 7 back into the building through the front entrance, and staff # 40 returned to her assigned hall. Staff # 40 stated that she doesn't recall any previous incidents of this nature involving him. Resident # 7 has never made any comments about wanting to leave the facility. Staff # 40 further stated that all exit doors are equipped with alarms and Staff # 40 believe this incident would be considered an elopement. An interview was conducted with the Maintenance Director (Staff #5) on July 8, 2026, at 9:53 AM. Staff #5 stated that Staff #5 and Staff # 114 were responsible for ensuring that all exit doors were properly secured before the end of each shift. Staff #5 explained that the doors were designed to lock automatically and that all exit doors and alarm systems were inspected at least once a month. Staff #5 stated that the only issues Staff #5 was aware of the Unit 300 exit door and the laundry room door, both of which had been addressed and repaired promptly. Staff #5 stated that he was not aware of any open maintenance requests or work orders related to the Unit 100 exit door. Staff #5 stated that Staff # 114 had inspected the doors the night before the incident and that no concerns had been reported. Staff #5 acknowledged that if an exit door was not properly latched or secured, it created an unsafe condition for residents. Staff #5 agreed that the facility had failed to ensure the doors were properly secured before the end of the shift and acknowledged that the incident was considered an elopement. An interview was conducted with the Director of Nursing (DON/Staff #137) on July 8, 2026, at 11:16 am . The DON (Staff #137) stated that the facility's protocol for elopement began with an admission assessment to determine whether a resident was at risk for wandering or elopement. If a resident was identified as being at risk, an individualized care plan was developed. Residents identified as being at risk for elopement could have a WanderGuard device applied based on a physician's order, and the use of the device was documented in the resident's medical record for ongoing monitoring. The DON (Staff #137) stated that it was not acceptable for any resident, including one with a BIMS score of 6-8 or 99, to wander or elope from the facility. Staff #137 stated that residents who wandered or eloped were at risk for physical injury, mental injury, and other serious bodily harm. The DON (Staff #137) recalled the incident involving Resident #7. The DON (Staff #137) stated that Resident #7 exited through the therapy room door, which led to the sidewalk outside the building. A Certified Nursing Assistant (CNA / Staff # 40), who was returning from her vehicle to the main entrance, observed Resident #7 wheeling himself toward the main entrance. When the CNA asked where he was going, Resident #7 reportedly stated that it was hot outside and that he was coming back inside. Later, when Staff #31, the Behavioral Unit Manager, spoke with Resident #7, Resident #7 stated that he had gone out for a stroll. Staff #31 educated Resident #7 regarding the risks associated with leaving the facility unsupervised. The DON (Staff #137) stated that Staff #31 immediately checked the therapy room exit door and confirmed that it was properly latched and that the alarm system was activated. The DON (Staff #137) stated that the facility believed the door might not have been fully latched when Resident #7 exited. Staff #137 estimated that it had taken approximately two minutes for Resident #7 to exit through that door. The DON (Staff #137) further stated that the exit alarm did not sound when Resident #7 left the building, indicating that the door likely had not been secured as intended. The DON (Staff #137) stated that maintenance staff were responsible for routinely checking all exit doors to ensure they were functioning properly. Staff #137 acknowledged that maintenance staff had failed to perform their responsibilities as expected and that the incident (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not meet the facility's standards. The DON (Staff #137) agreed that the facility had failed to ensure that Resident #7 did not elope from the facility. Following the incident, the facility updated Resident #7's care plan to address the resident's elopement risk. An interview was conducted with the MDS Director (Staff #6) on July 8, 2026, at 12:42 p.m. Staff #6 stated that a baseline care plan was initiated within 48 hours of a resident's admission. Staff #6 further stated that a comprehensive care plan was then developed within 21 days based on the findings of the Minimum Data Set (MDS) assessment and the resident's identified care needs. Staff #6 stated that, within the first 48 hours of admission, the facility completed assessments including fall risk, skin integrity, the Braden Scale, and elopement risk. Staff #6 further stated that any licensed nurse could initiate or revise a care plan following a change in a resident's condition or after an incident, such as wandering or elopement. Staff #6 stated that Staff #6 considered the incident involving Resident #7 to have been an elopement and acknowledged that the facility had failed to ensure that Resident #7 did not elope from the facility. Staff #6 stated that the facility's follow-up interventions after an elopement included notifying the physician, the resident's family, and the case manager; completing skin and neurological assessments as indicated; interviewing the resident regarding the incident; and implementing a WanderGuard device, if appropriate. Telephonic Interview with Licensed Practical Nurse (LPN/Staff #201) on July 8, 2026, at 5:26 PM. LPN (Staff #201) stated that the facility's protocol for an elopement included notifying the supervisor and the Director of Nursing (DON), reporting the incident to the state, notifying the resident's family and physician, and performing a skin assessment and neurological assessments, as indicated. The LPN (Staff #201) stated that residents who wandered or eloped from the facility were at risk for serious harm, including kidnapping, dehydration, and lack of food and nutrition. LPN (Staff #201) further stated that residents at risk for wandering or elopement were identified based on exit-seeking behaviors, repeated statements about wanting to leave the facility, the use of WanderGuard devices, and documentation in the resident's face sheet notes. LPN (Staff #201) stated that all facility exit doors were equipped with alarms. The LPN (Staff #201) stated that she remembered the incident involving Resident #7. The LPN stated that her understanding was that Resident #7 had wandered out through the therapy room. The LPN believed there had been a malfunction with the alarm and that it did not sound. Staff #201 stated that she was fairly certain of this because she had been working on the 100 Unit that day. Staff #201 further stated that at approximately 6:45 AM, she had been notified by another Staff Member # 40 about the incident. LPN (Staff #201) immediately went outside and found Resident #7 in his wheelchair. Staff #201 assessed Resident #7's condition and found him to be stable. Staff #201 stated that Staff #201 educated Resident #7 regarding the risks of leaving the facility without notifying staff, and Resident #7 smiled in response. LPN (Staff #201) agreed that the incident met the definition of an elopement and reflected the facility's failure to ensure that Resident #7 did not leave the premises unsupervised. A review of the facility policy regarding the Elopement Process indicated that the facility was responsible for assessing residents for wandering or elopement risk upon admission and implementing established procedures to prevent and respond to resident elopement, with resident safety and security as a primary priority.		