STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035106	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tempe Post Acute	6100 South Rural Road Tempe, AZ 85283

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 Note: The nursing home is disputing this citation.	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 documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that adequate supervision was provided to ensure that Resident #11 did not elope. The deficient practice could result in residents being injured, abused, or lost.Findings include:Resident #11 was admitted to the facility on [DATE], and discharged on May 9, 2026, with diagnosis that included aphasia, depression, and anxiety.A physician order dated April 13, 2026, revealed that Resident #11 may go out on pass with medications and responsible party.A physician order dated April 13, 2026, was written for levetiracetam oral tablet 100 mg/ml (milligram/milliliter) to give 5ml by mouth two times a day for seizure disorder.An elopement evaluation dated April 13, 2026, revealed that Resident #11 did not have a history of elopement or an attempted while at home, or while at the facility.A care plan dated April 14, 2026, revealed that Resident #11 was at risk for a communication problem related to expressive aphasia, stroke.A progress note dated April 14, 2026, at 3:07 p.m. revealed that the Resident had a communication board, tablet, and smart phone to utilize to communicate with staff and resident is able to understand when staff is talking to her. The progress note then revealed that resident was educated on when she is required to sign out when leaving building and notifying nurse if she leaves building. The progress note revealed that the resident is long term care and is educated on the risks of being outside during hot season and risk of dehydration and heat stroke and resident nodded to confirm understanding.An admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 08, indicating moderate cognitive impairment. Further review of MDS assessment revealed no behaviors had been exhibited during the assessment period.A progress note dated May 9, 2026, at 4:11 p.m. revealed that the Resident #11 was last administered the medication diphenhydramine HCl Capsule 25 mg, to give 1 tablet by mouth, every 6 hours as needed for itching.A nursing progress note dated May 10, 2026, at 1:11 a.m. revealed that the resident was identified as being absent from the facility during bedside medication pass. The progress note indicated that staff believed the resident was out with family and called family to confirm. The progress note relayed that the resident's family communicated that the resident was not with them, but was taken to the hospital for evaluation of heat exposure. The progress notes further relayed that an investigation was initiated immediately and the medical director was notified of the situation. A hospital report dated May 9, 2026, at 8:32 p.m. revealed that the resident was found on the curb by Emergency Medical Services (EMS) next to her motorized scooter, agitated and confused. The report further revealed that the resident was brought to the emergency room (ER) and found to be encephalopathic, agitated, and hyper thermic to greater than 40C (degree Celsius), presumed heat stroke. The report revealed that the resident was intubated and started on cooling therapy.A review of medication administration record (MAR) dated May 2026 at 8 p.m., revealed that no medication was administered as Resident #11 was absent from the facility.A facility Reportable Event Report submitted to the State Agency on May 10, 2026, revealed that on May 9, 2026, at approximately 7:30 PM- Certified Medication Assistant (CMA, staff #143) was starting her medication pass and noticed that Resident #11 was not available or in her room. CMA reported to a (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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Licensed Practical Nurse (LPN, staff # 139), that the resident was not in her room. CMA then called daughter several times to ask about resident being out on pass with family. CMA and other staff started looking in rooms in the facility and the outside patio to try to locate the resident. CMA stated that she got a response from family at 10:00 p.m. and family told CMA that the resident was not with them and that she was in hospital. Per report, the Administrator (staff #131) was immediately notified and an investigation was initiated and incident was notified to the police, ombudsman, Department of Health Services (DHS), Adult Protective Services (APS) and interviewed staffs and residents were conducted. The investigation conclusion revealed that the incident was an isolated unanticipated event due to Resident #11 did not having any previous behaviors of attempting to leave the facility.A review of a Residents Signed Out form from February 13, 2026, to May 11, 2026, revealed no evidence that Resident #11 signed out before leaving the facility.An interview was conducted on May 12, 2026, at approximately 9 a.m., with a receptionist (staff # 169) who stated that she works at the facility from Monday to Friday from 8 a.m. to 4:30 p.m. and another receptionist (Staff #180) works from Monday to Friday from 4:30 p.m. to 9 p.m. The receptionist stated that residents/visitors use the front lobby from 8 a.m. to 5 p.m. to go in and out of the building and then after 5 p.m. the front lobby door closes. The receptionist stated that the front lobby is locked by the receptionist after 5 p.m. and then the receptionist turns on the alarm at the nurse station. The receptionist also stated that the alarm at the nurse's station will sound if the door is not locked at the front lobby. The receptionist further stated that after 5:00 p.m., residents/visitors use the west side back entrance of the facility to enter the building and sign a log-in form at the nurse's station. The receptionist also stated that when resident's leave the facility, the resident had to notify the nurse and fill out the Resident Sign Out Form at the nurse's station and then the nurse would notify the receptionist at front lobby. The receptionist further stated that she was not aware that the resident eloped, as it happened on weekend when she was not working and not sure if anyone follow-up on that. The receptionist further stated that the risk of resident's leaving the building without notifying staff could result in heat stroke due to staying too long outside. An interview was conducted on May 12, 2026, at 10:35 a.m., with a Licensed Practical Nurse (LPN, staff # 139), who stated that she worked Wednesday through Thursday and every other weekend. The LPN stated that the facility process when residents leave the facility, included notifying the nurse and signing out on the Resident Sign Out form. The LPN stated that Resident #11 was alert, oriented, non-verbal, had a tracheostomy, and did not have any valve for speech and would communicate through hand gestures. The LPN stated that she was in the facility on May 9, 2026 and had cared for the resident on the date of the incident. The LPN stated that a Certified Medical Assistant (CMA, staff # 143) told her that she was looking for Resident #11 and the LPN assisted in searching rooms and the outside patio, and that the CMA had attempted several times to reach the resident's daughter. The LPN also stated that at 10:00 p.m. the resident's family informed her that the resident was in the hospital, and the Administrator (Staff #131) was notified immediately. The LPN further stated that risk resident elopement from the facility could result in heat stroke or accident An interview was conducted on May 12, 2026, at 11:32 a.m. with a CMA (staff # 143), who stated that she works night shift Wednesday, Thursday, and every other weekend from 6 p.m. to 6 a.m. Staff #143 The CMA stated that residents are expected to notify the nurse and sign-out on the sign-out form whenever they are leaving the facility. The CMA stated that the facility does not encourage residents to go out around 10 a.m. or 5 p.m. because its hot outside. The CMA further stated that she was familiar with Resident #11 and the resident did not have a wandering behavior. The CMA stated that on May 9, 2026, around 7:30 p.m., she was starting her medication pass and did not see Resident #11 and started looking in rooms and the outside patio. The CMA stated that she then called Resident #11's daughter who told the CMA that her mom was not with her but was in the hospital, and that the Administrator (staff #143) was notified. The LPN then stated that risk if a resident eloped from the facility it could result in dehydration or accidents. An interview was conducted on May 12, 2026, at 12:05 p.m. with an LPN (staff # 89) who state that she is dayshift (continued on next page)

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LPN further stated that at 12:15 to 12:30 p.m., she gave Resident #11 her diphenhydramine HCl, 1 capsule, 25 milligram(mg) for itching then checked resident around 4 p.m. regarding any concern with the itching and charted in her clinical record. LPN stated that Resident #11 did not communicate that she was leaving the building. Staff #89 stated that risk if residents with low BIMS score eloped then they would be at risk for injury, heat stroke, and dehydration. An interview was conducted on May 12, 2026, at 12:35 p.m. with the Administrator (Staff #131), who stated that facility process when residents go in and out of building depends on whether the resident is in skilled or long-term care (LTC). The Administrator stated that resident's in the skilled unit require, an order to go out for appointments or medical necessity. The Administrator further stated that resident's resident in the LTC unit require a standing order to go in and out of the facility. The Administrator also stated that LTC residents need to notify the nurse and fill out the sign-out form before going out of the building. The Administrator also stated that there are no cameras in the building and there is only exit door for residents to go in and out of facility. The Administrator stated that on May 6, 2026, around 10:45 p.m. to 11 p.m., CMA (staff #143) notified him that Resident #11 was not found in the building. The Administrator further stated that around 2:30 p.m. on May 9, 2026, Resident #11 went to receptionist (staff #142) and asking for her daughter's address to send flowers for Mother's Day. The Administrator then stated that around 7:30 p.m., CMA (staff #143) went to administer medications to Resident #11 and she could not find the resident. The Administrator stated that the CMA called the resident's daughter who informed the CMA stated that Resident #11 was in the hospital. The Administrator stated that he assumed that Resident #11 left the building before 5 p.m. through the front door on May 9, 2026. The Administrator stated that the investigation was started, notified the police, ombudsman, Department of Health Services (DHS), Adult Protective Services (APS) and interviewed staffs and residents. The Administrator and the Director of nursing (DON, staff #158) stated that all staff were provided wandering and elopement training on Sunday, May 10, 2026. An interview was conducted on May 12, 2026, at 1:15 p.m. with the Resident's daughter who stated that her mother got her address from the facility to send her flowers for Mother's Day. The Daughter further stated that, Resident #11 left the faciity on May 9, 2026, around 10 a.m. and that she received a call from the ER around 5 p.m. The resident's daughter stated that the ER staff told her that Resident #11's scooter was dead, and that the resident appeared to have had a heat stroke, was dehydrated, and had been sent to the Intensive Care Unit (ICU). The resident's daughter further stated that the facility called her around 10:55 p.m. to inform her that the facility could not find the resident. The resident's daughter stated that , she got upset with the CMA (staff #143) because facility staff were looking for the resident all day and could not find her until 10 p.m. on Saturday, May 9, 2026. The resident's daughter stated that Resident #11 did not have any behavior or history of wandering or elopement. A follow-up interview was conducted on May 12, 2026, at 3:21 p.m. with the Director of Nursing (DON (staff # 158), who that the facility process to ensure residents with low BIMS score are safe by providing the care they need and then residents care plan would reflect if they have exit seeking behavior like trying to leave the building and interventions included wonder guard, close to nurse station, and frequent monitoring and Resident #11 did not meet those qualifications. The DON then stated that she is not sure what was the Resident #11 BIMS score when she elopes the building but using her nursing assessment and judgement, Resident #11 wanted to have flowers for her daughter and knew Mother's Day was coming. DON then stated that risk if resident with low BIMS score elope then resident would be confused, not able to come back to the (continued on next page)

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