STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035135	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montecito Post Acute Care and Rehabilitation	51 South 48th Street Mesa, AZ 85206

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 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. (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 Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate assessment, monitoring, and supervision to prevent elopement for 2 (residents #22 and #19) of 5 sampled residents. The deficient practice could result in injury to residents.-Regarding Resident #22Resident #22 was readmitted to the facility on [DATE] with diagnoses including: Metabolic encephalopathy, cognitive communication deficit, restlessness and agitation, chronic kidney disease, , muscle weakness, difficulty in walking, protein-calorie malnutrition, altered mental status, seizures, type 2 diabetes mellitus with hyperglycemia, unspecified mood affective disorder, anxiety disorder, tobacco use, major depressive disorder, dementia, severe, without behavioral disturbance, psychotic disturbance, and mood disturbance.An admission minimum data set (MDS) assessment dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 8, indicating moderate cognitive impairment.A care plan focus initiated on August 1, 2025 revealed that resident #22 was an elopement risk and wanderer and that a wander guard device was initiated on July 31, 2025.Nursing progress note August 17, 2025 at 10:05 a.m. revealed that at 7:20 a.m. that resident #22 was speaking with staff while medications were being delivered to other residents and resident #22 was waiting for breakfast to be served. At 8:10 a.m. staff noted that resident #22 could not be located and the wander guard device was removed and left on resident #22's bed.The progress note further stated that at the same time that resident #22 was discovered missing, the facility received a call from an emergency room nurse that resident #22 was seen wandering, 911 was called and he was taken to the emergency room.A nursing progress note, on August 17, 2025 at 3:07 p.m. revealed that resident #22 had returned from the hospital. At 4:26 p.m., resident's wander guard device hand been placed on resident #22's ankle. -Regarding Resident #19 Resident #19 was admitted to the facility on [DATE] with diagnoses including: toxic encephalopathy, acute and chronic respiratory failure with hypoxia, tracheostomy status, dysphagia, aphasia, dysarthria and anarthria, cognitive communication deficit, difficulty in walking, type 2 diabetes mellitus with diabetic neuropathy, anxiety disorder, insomnia, tobacco use, unspecified asthma, and schizophrenia. An elopement/wandering assessment dated [DATE] revealed a low risk for elopement. No mental illness was selected under predisposing conditions. An admission MDS assessment dated [DATE] revealed the resident had a BIMS score of 13, indicating resident was cognitively intact.A nursing progress note from August 18, 2025 at 2:16 a.m. revealed that resident #19 had refused vitals to be taken during the evening of August 17th and seen moving around the hallways. At 10:45 p.m., licensed practical nurse, (LPN/staff #274) entered the room of resident #19 to obtain vitals and discovered that resident #19 was not there. The progress note also indicated that all personal belonging were also missing. Code 10 was declared and police were notified.On August 19, 2025, at 7:23 a.m. a nursing progress note revealed that resident #19 returned to the facility, returned to his room and assessed by staff.An interview with LPN #86 on September 4, 2025 at 1:15 p.m. revealed that she was alerted that resident #19 was missing at around 11:00 p.m. on August 17, 2025. LPN #86 stated that she was unsure how resident #19 was able to leave the building because doors are supposed to be alarmed and she believed that the door alarms were working.An interview with LPN #274 on September 4, 2025 at 2:13 p.m. revealed that before eloping the facility, resident #19 was observed walking around the facility's floors looking for snacks. LPN #274 stated that she left her shift at 6:30 a.m. on August 18, 2025. She observed resident #19 returning to the facility with the facility administrator. An interview with the director on nursing (DON/staff #338) on September 4, 2025 at 2:25 p.m. revealed that according to video surveillance, residents #22 and resident #19 both left the facility using the same south door in the main lobby. DON #338 stated that this door is open every day, without alarm from 5:00 a.m. to 10:00 p.m. and that the receptionist working the front desk has pictures of each resident that is at risk for elopement. The receptionists are scheduled daily from 8:00 a.m. to 7:00 p.m. and the entrance is not monitored 6 hours per day. Review of the facility's 5 day investigation reports for both resident #22, dated August 22, 2025, and resident #19, dated August 25, 2025, reveal that both elopements were deemed isolated incidents. Review of the facility policy titled Elopement, revised January 26, 2022 reveals that the facility is to provide a safe and secure atmosphere for all residents of the facility. Among the purposes of the policy is to ensure that residents at risk of elopement are properly monitored.