

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2026
NAME OF PROVIDER OR SUPPLIER Villa Maria Post Acute and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4310 East Grant Road Tucson, AZ 85712	
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 review, staff interviews, facility documentation, and policy review, the facility failed to ensure adequate supervision to prevent one of one sampled resident (Resident #1) from eloping the facility while a Peripherally Inserted Central Catheter (PICC) line remained in place. The deficient practice could place the resident at risk for interruption of prescribed intravenous therapy, catheter-related infection, misuse of the PICC line, overdose, and death. Findings Include: Resident #1 was admitted on [DATE], and discharged on May 18, 2026, with a diagnosis that included cellulitis of the left lower limb, muscle weakness, abnormalities of gait and mobility, assistance with personal care, hypokalemia, opioid abuse, and depressive disorders. An elopement and wandering evaluation completed on April 25, 2026, indicated a score of 5.0, indicating Resident #1 is at low risk for elopement and wandering and has no history of eloping in the last 6 months. A care plan initiated on April 28, 2026, had a focused area for Resident #1 having ineffective coping related to alcohol abuse and substance abuse. Interventions included: encouraging contact with support system (for example: family member, group sponsor). Encourage the resident to make choices and participate in planning of care and scheduled activities. An admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #1 was cognitively intact. A discharge summary and post-discharge plan of care were completed on May 18, 2026, at 06:15 AM, which indicated that Resident #1 left the facility without notifying the staff, and the discharge location description indicated that Resident #1 left Against Medical Advice. A nursing note dated May 18, 2026, at 06:47 AM revealed that at 0600, Resident #1 was observed entering another resident's room. At 06:20 AM, a Certified Nursing Assistant (CNA) in the hall wanted to check Resident #1's vitals, but was unable to find Resident #1. All areas were searched for Resident #1, and Resident #1 was not located. An open window was discovered in the room Resident #1 had entered. Assistant Director of Nursing (ADON), the provider, and the police were notified. A nurse note dated May 18, 2026, at 06:30 AM revealed that Police Department was notified that Resident #1 had left the facility while a PICC line remained in place. Another nursing note dated May 18, 2026, at 4:18 PM revealed that Adult Protective Services (APS) was notified of Resident #1 leaving with a PICC line. Documentation indicated Resident #1 was alert and oriented X 4. Further review of the medical record failed to identify documentation that Resident #1 notified staff of a intent to leave prior to exiting the facility or that staff had the opportunity to initiate the facility's AMA process before the resident left the facility. Multiple call attempts were made to Resident #1 on June 18, 2026, at 11:06 AM and 12:31 PM, but she was unreachable due to the phone no longer being in service. A call attempt was made to the Resident #1 on June 19, 2026, at 08:14 AM, but was unreachable because the phone was no longer in service. Multiple call attempts were made to contact the Licensed Practical Nurse (LPN/Staff #3), who was on the shift when Resident #1 eloped. The LPN did not answer her phone. An interview was conducted on June 18, 2026, at 1:07 PM with CNA (Staff #11), who stated that elopement occurs when a resident leaves the facility without staff knowledge. She stated facility staff initiate a Code Yellow, search resident rooms, bathrooms, the facility, and the surrounding grounds, and notify ADON (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 035147
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She stated if resident not found after searching everywhere, police are notified of the missing resident. Staff #4 stated that if the resident with a PICC line goes out of the window, it is considered to be elopement. CNA further stated that she was not aware that Resident #1 tried to leave the facility nor that Resident #1 mentioned leaving the facility; Staff #4 stated she was unaware of leaving out of the window. An interview was conducted on June 18, 2026, at 1:45 PM with Licensed Practical Nurse (LPN/staff #6), who stated that elopement is when someone is at risk of leaving. She states that elopement would be considered if the resident takes off and leaves the facility premises and is not found. She stated that the facility process for elopement is to search the entire property for the resident and surrounding areas, and call around hospitals. If the resident is not alert and has dementia, police will be called and the administrator. Then stated that if they are alert and oriented, police, the administrator, and the provider are notified. She stated the staff document the description of the incident in the resident's chart, what was done to find the resident, and who was notified. She stated that the resident going out of the window is considered to be elopement or AMA. She stated that when a resident wants to leave AMA, they are supposed to sign the form, and some residents do not sign the paperwork. The LPN stated that an AMA resident is educated about the risks of leaving the facility without medical advice and the benefits for them to stay. She stated that if the staff are not aware of the resident leaving, no AMA work would be completed because they would not be aware of them leaving. She stated that the risk of the resident leaving the facility with a PICC line who has a substance abuse history would be infection control and them having access to insert things. LPN stated that she received report on May 18, 2026, from the previous nurse (Staff #3) that Resident #1 went out of the window in another resident's room with a PICC line and that she left AMA. She stated that Staff #3 notified her that management and police were notified. An interview was conducted on June 18, 2026, at 2:16 PM with the Social Services Manager (SSM/staff #7), who stated that her role as social services manager is to take care of residents' discharge planning, ordering services, take care of grievances, and work with residents' insurance. She stated that discharge planning starts as soon as a resident is admitted to the facility, and she meets with the resident 24-48 hours before discharge planning to review the care plan, ask about their needs, and ensure the services needed are in place. She stated that the AMA process is that staff try to educate the resident about the risks and benefits of leaving without medical advice, and if they do leave with AMA, it should be documented. She stated that if the resident does leave, then we try to ensure they are ok for the first three days. Then she stated that elopement is when a resident either wanders or leaves the facility premises, and they are confused or not mentally or physically safe. Staff #7 stated that Resident #1 did not have a discharge date because she did not finish her antibiotics. Staff #7 further stated that she left AMA by going out of the window with a PICC line in place. She stated that she reported to APS about this and did not have to report to the Department of Health Services (DHS) because she was alert and oriented times four and not confused, and that was her decision. She further stated that in Resident #1's case, it would not be considered elopement because she was physically and mentally independent. She stated that Resident #1 leaving with a PICC line would pose a risk because she can use the PICC line for anything and not receive the medication that she needs. A call attempt was made on June 18, 2026, at 2:53 PM to ADON (Staff #9), she did not answer the phone. An interview was conducted on June 18, (continued on next page)		

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She stated that her expectation of the staff member when a resident elopes is to search the whole facility, attempt to contact the resident if they can, contact the family or person listed on their records, search the surrounding areas of the facility, notify the provider, notify police, APS, DHS, and notify DON or the administrator in between. She stated that residents can leave the facility with a PICC line, and they have, and when that happens, police and APS are notified. She stated that the AMA discharge process is initiated when the resident either intends to leave without medical advice. She stated that when this happens, the staff try to educate the resident about the benefits of staying and the risk of leaving the facility; the AMA form is signed then. She stated that if the resident is present, they will sign the AMA form. She stated that if they know how the resident left, it would be considered AMA, not elopement, and it would be documented in the resident's chart if risks and benefits are explained to the resident when leaving AMA. DON further stated that Resident #1 had eloped on May 18, 2026, then changed her answer to AMA. DON explained that morning, Resident #1 was in another resident's room, Resident #2's room, and was not found when the CNA wanted to take her vitals, but the window was observed to be open in another resident's room, so that's where she had gone out of the facility. She stated that the police were called; Resident #1 had left through the window with a PICC line, which would be considered AMA, not elopement. DON further stated that the resident came back and was advised to go to the hospital and came on May 23rd to pick up her clothing, and stated nothing was documented in the resident's chart, which should have been. DON stated that there was no AMA form filled out for her; if they knew before she wanted to leave, it would have been filled out. She stated that Resident #1 leaving with a PICC line out of the window could pose risks such as death, increased infection control, and taking drugs with the PICC line access. An interview was conducted on June 19, 2026, at 08:21 AM with the LPN (staff #3), who stated that elopement is when a resident leaves the facility without letting staff know or runs away from the facility. She stated that elopement is considered when a resident is completely out of the facility and nowhere to be found in the facility. She stated that the facility process for elopement is to let the staff know the resident is missing, check the area, and check the parking lot; if not found, let the supervisor know; the supervisor will notify the provider, family, and police. She stated that if the resident leaves out of the window, then that would be considered elopement. She stated the process for AMA is to explain to the resident why they are here, the risk of leaving, the benefits of staying, and if they still refuse, then they will sign the AMA form, the provider will be notified, and the supervisor. LPN stated that if the resident did notify the staff that they want to leave, then it would be considered AMA. She stated that there are many risks if the resident elopes with a PICC line and has a history of substance abuse; there will be a risk of inserting drugs into their PICC line. LPN stated that she recalls the incident with Resident #1, it was morning when LPN was finishing her meds. A CNA was trying to look for Resident #1 to do her vitals, and she saw her going into another resident's room, and went there, and she was not found, but that room's window was open. Then they started to look for Resident #1, looked from room to room, looked in the whole building, outside, and she was not found; then the supervisor, doctor, and police were notified. LPN further stated that she did try to call Resident #1, but her number was not working, but did not document that in the medical records. She further stated that Resident #1 did elope from the facility; it was not AMA. Staff #3 stated that Resident #1 did come back to the facility at midnight that day with a male and wanted her to remove the PICC line; however, Staff #3 advised Resident #1 to go to the hospital to remove the PICC line and left the facility with the male she came with. She stated that this was not documented in the Resident #1 chart since she was no longer a (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patient and was discharged ; she notified her supervisor. She stated that the risk for Resident #1 in her case would be may overdose on the drugs. Reviewed the policy Elopement/Unsafe Wandering Revised date January 2026, revealed that elopement occurs when a resident leaves the facility premises or safe area without authorization (example: an order for discharge, appointment, or leave of absence), and/or any necessary supervision to do so. Also, it is the policy of the facility to provide a safe environment for all residents through appropriate assessment and interventions to prevent accidents related to unsafe wandering or elopement.		