STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035151	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sabino Canyon Rehabilitation & Care Center	5830 East Pima Street 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. (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- 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. Findings include: -Resident #100 was admitted to the facility on [DATE] with diagnoses that include diabetes mellitus type 2, lupus, vascular dementia, chronic kidney disease, depression, and hypertension. An admission Minimum Data Set (MDS) assessment dated [DATE] indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 11, indicating mild cognitive impairment. A care-plan initiated April 29, 2025 revealed the resident is at risk for falls related to multiple diagnoses, including a history of 7 falls from May 6, 2025, to August 22, 2025. There are noted interventions of 1:1 as staffing allows, continue wander guard, and resident in room with high traffic area near nurse's station. This indicating the resident is high risk for falls. A care-plan initiated August 22, 2025 revealed the resident had an elopement episode and was an elopement risk / wanderer, with a goal of safety will be maintained and noted interventions of document wandering behavior, attempt diversional interventions, and one to one as staffing allows. This indicates the resident is high risk for elopement. An elopement assessment risk evaluation dated April 29, 2025 revealed the resident was assessed with a score of 3, indicating very low risk for elopement. An elopement assessment risk evaluation dated August 18, 2025 revealed the resident had dementia, and was given an elopement score of 11, indicating high elopement risk. A progress note dated July 30, 2025 at 6:30 a.m. revealed that a CNA heard a noise from resident #100's room and rushed to the room, found resident #100 on the floor, got patient up with 2-assist (two staff members required), started neuro checks (an assessment to check the mentation of the resident), and that resident #100's vital signs were within normal range. A progress notes date August 22, at 6:00 p.m. revealed the fire department arrived at the facility and notified a licensed nurse that resident #100 was found outside of the facility and as being transported to the local hospital as a precaution. The note further states that the son was made aware, and that the local police department called related to the incident, as well as the provider was made aware. A progress note dated August 22, 2025 at 10:30 p.m. revealed staff received report from nurse the local hospital, and assessments were largely negative except that the resident had a left knee skin tear. An IDT progress note dated August 25, 2025 at 10:07 a.m. revealed review of incident on August 22, 2025 that resident #100 was found outside of the facility, had a reported fall and was transferred to the emergency room. It further states the resident was returned to the facility with a negative CT scan to head, and negative x-rays to neck and face, and also noted the resident had some edema to arms, with a pending x-ray. It also noted that a new wander guard was in place as a precaution. A progress note dated august 25, 2025 at 6:05 p.m. revealed resident #100 left the facility for a right arm fracture via wheelchair with transport and accompanied by staff. A progress note dated August 25, 2025 at 7:00 p.m. revealed that transportation was set up for the resident to see an orthopedic surgeon, and that the son was at the appointment with resident #100. A progress note dated August 25, 2025 at 9:15 p.m. revealed that resident #100 returned to the facility accompanied by staff/CNA. A provider progress note, signed August 29, 2025 at 10:10 a.m. revealed staff reported to provider recent incident of patient elopement. Resident #100 left the facility through the front door, and states she sneaked out and walked off property believing a casino was right there. It states resident #100 asked a passerby for directions and continued walking. Resident #100 was found by paramedics near a different nursing facility. It further states the resident fell and sustained an upper extremity injury, and that the initial evaluation at the local hospital missed the fracture, and increasing pain and swelling prompted transfer to different local hospital where x-rays confirmed the fracture. It further stated that orthopedic surgery is scheduled for repair and rotator cuff. The note concludes that resident #100 continues to have delusional behavior, and that the delusions contributed to resident #100's elopement and subsequent injury. A review of therapy notes dated September 26, 2025 revealed the resident was on precautions for falls, non-weight bearing for right upper extremity, right shoulder periprosthetic fracture, a sling for comfort, and a history of dementia. A review of hospital records for resident #100 dated August 22, 2025 at 5:43 p.m. revealed resident #100, with an unknown medical history, dementia, and on blood thinners, was found down. It further stated the resident was a memory care patient, found on the street. The note continues that resident #100 has pain in her face, blood around her nose, and denies other recent illness or injury. It states resident #100 highly endorses some pain, and that she does not recall why she fell