STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035196	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandridge Post Acute	255 West Brown Road Mesa, AZ 85201

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** 47341 Based on resident and staff interviews, clinical record review, and facility policy, the facility failed to ensure adequate supervision was provided to prevent elopement for one resident (#37). The deficient practice resulted in resident eloping from the facility. Findings include: Resident #37 admitted [DATE] with diagnoses of dementia, diastolic congestive heart failure (CHF), adjustment disorder and anxiety disorders The elopement risk dated January 29, 2024 revealed a score of 10 indicating the resident was at risk for elopement. Another elopement risk dated April 29, 2024 revealed a score of 22 indicating the resident was at risk for elopement. The assessment included that the resident voiced attempt to elope but there was no action made. The initial facility report received on August 26, 2024 revealed that on August 25, 2024 at 7:15 p.m., a certified nurse assistant (CNA) told the on-duty nurse that the resident cannot be located during checks and changes. The documentation included that the resident was saying for the last week that he had been wanting to leave. Per the report, the facility started the elopement procedure. However, review of the clinical record revealed no documentation that resident was expressing to leave the facility; whether the resident was placed in increased monitoring; and that, the resident eloped from the facility on August 25, 2024. Despite documentation that the resident was at risk for risk for elopement, there was no evidence found that a care plan was developed with interventions implemented to address the resident's risk for elopement until August 26, 2024. The care plan dated August 26, 2024 included that the resident was an elopement risk/wandered related to impaired safety awareness. Interventions included providing structured activities such as toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes; and, assessing for fall risk. (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	The elopement and wandering risk observation/assessment dated [DATE] revealed the resident expressed plan to leave but had not attempted to leave the facility. It also included that the resident ambulated independently with or without the use of an assistive device; and, the resident was in the locked memory care unit. Another elopement and wandering risk observation/assessment dated [DATE] revealed a score of 22 indicating the resident was at risk for elopement. Per the assessment, the resident had verbalized a desire to leave the facility, packed their belongings, stood by exit doors, or attempted to open an exit do; had exhibited unsafe wandering or has made one or more attempts to elope prior to admission or in the last year; and exhibited unsafe wandering or elopement attempts and was difficult to redirect. The documentation also included that based on the elopement and wandering risk observation/assessment findings, a wander guard alarm was indicated. The logbook documentation on check operation of door monitors and patient wandering system revealed the following findings: -August 2, 2024 - the back door, chi patio and front door had a pass remark; and, -August 16, 21 and 29, 2024- the front door had a pass remark. The CNA documentation from August 1 through August 30, 2024 revealed that resident had wandering behavior documented on August 8, 9, 20, 21, 23 and 29, 2024. The facility 5-day report submitted on August 30,2024 included that on August 25, 2024 at around 7:00 p.m., the NOC (night) shift nurse was doing rounds for their medication pass when the nurse noticed that the resident was not in his room. Per the documentation, the resident was not found on the unit and the patio; and, an elopement was called and local police department was notified. The documentation also included that the nurse and CNA drove on areas around the facility but was not able to find the resident. On August 26, 2024, Monday, the facility management team and other staff from sister facilities searched different parts of the city following all leads from all sources but still was not able to find the resident. On August 27, 2024 Tuesday, the administrator received a call from a case manager from a hospital who reported that the resident was at the emergency department (ED) of hospital since Monday August 26, 2024. The facility concluded that the resident eloped from the facility on the evening of August 25, 2024; and, the facility executed elopement protocol per facility policy. Plan of action included updating the care plan, staff in-service training on elopement, and all door alarms were serviced on unit that the resident resides. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the nurse manager (staff #77) was conducted on August 30, 2024 at approximately 1:20 p. m. The nurse manager stated she was very familiar with resident #37 and his plan of care. She stated that the resident on the long-term care unit, but approximately 8 months to a year ago, he was moved to the locked unit due to his wandering behavior and decrease in BIMS score. She stated that the facility remained unsure on how the resident eloped from the facility; but, she recalled that she got a call Sunday night from the nurse (LPN/staff #45) who reported that the resident was not in his room, the cafeteria, or anywhere on the unit. The nurse manager said that staff searched the whole building and called police; and, several staff members drove around the neighborhood and were unable to locate the resident. The nurse manager stated that the hospital notified the facility on Tuesday, August 27, 2024 that they had found the resident who was in the hospital. She stated that the resident to the facility on Wednesday, August 28, 2024; and that, since the resident's return, he was placed on every 15-minute checks and the facility had increased Activities engagement so the resident was not isolated. In an interview with resident #37 conducted on August 30, 2024 at 1:26 p.m., the resident stated that he did not recall the incident of his elopement. However, he said that he will figure out how to escape from the facility eventually. An observation of the secured unit was conducted with a CNA (staff #12) on August 30, 2024 at 2:22 p.m. The door to the smoking area was blocked by a wheeled medication cart. When the medication cart was wheeled out of the way, the door was unlocked, opened and the alarm did not sound off. The CNA proceeded going outside to the patio and smoking area and checked the gate which was locked. The CNA stated that the gate was low the gate; and that, some residents who were tall and could get over it easily. In an interview with a licensed practical nurse (LPN/staff #45) conducted on September 3, 2024 at 11:25 a.m. , the LPN stated that she was working the day resident #37 went missing. The LPN stated that the resident had a low BIMS score, had no previous elopement, was admitted in the secured unit for 8 months and had been wandering and asking to leave. The LPN said that when she started her rounds, a family member/visitor came up to her saying they had brought a coffee for Resident #37 who was not in his room. She said that she thought the resident stepped outside to smoke; but, when she went outside she did not find the resident. The LPN said that she then went to double check in the resident's room, but the resident was not in there; and, the roommate reported that resident #37 was gone and had left earlier that day at around 4pm. She stated the facility shut down the building, began the search, and informed the local police and supervisor (staff #77). The LPN said that she was not sure how the resident was able to leave since the door to the smoking area required a staff to open it and the alarm would sound off immediately if the door was opened and startle the residents when they open the door. Further, the LPN stated that there had been a flood on the unit in August, and this may be the reason why the door to the smoking area can be opened without the alarm sounding off or why the alarm no longer works. In an interview with the Director of Nursing (DON) conducted on August 30, 2024 at 2:57 p.m., he stated that the facility 5-day investigation report had not found anything of significance; and that, the facility was not able to figure out how the resident had eloped on August 25, 2024. He stated there were no cameras on the secure unit. The DON also stated that the expectation was for staff to do checks and changes to keep resident safe, offer the resident the ability to go outside in the day; and that, staff will do risk assessment on every resident that is admitted and quarterly thereafter. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy on Wandering and Elopements with revision date of March 2019 included that the facility will identify residents who are at risk for unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.