STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035225	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun City Post Acute	9940 West Union Hills Drive Sun City, AZ 85373

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 observation, interview, and record review, the facility failed to ensure adequate monitoring and supervision to prevent avoidable accident for one Resident (#1). The deficient practice could result in an inadequate supervision of residents and further accidents.Findings include:Resident #1 was admitted to the facility on August, 24, 2025 with diagnoses that included other symptoms and signs involving cognitive functions and awareness, Wernicke's Encephalopathy, other abnormalities of gait and mobility, and unsteadiness on feet.A quarterly minimum data set (MDS) assessment dated [DATE] revealed that the resident had a brief interview for mental status (BIMS) score of 8, which indicated moderate cognitive impairment.A care plan focus initiated on November 28, 2025 revealed that Resident #1 exhibited behavior problems that include, but are not limited to wandering, exit-seeking, rummaging through other's belongings, throwing and pushing items, agitation, restlessness, hallucinations, delusions and displays poor safety awareness.Review of the facility's 5-day incident report investigation revealed that on December 7, 2025 at 5:55pm, Licensed Practical Nurse (LPN / Staff #14) had heard the door alarm from the unit (dementia) entrance inside the facility. Staff #14 assessed and began to sweep the unit to account for all residents, where she found that at approximately 7:37 pm Resident #1 was unaccounted for and began a search for him. An additional alarm was heard; and that, the sound came from the facility's main entry door. Staff #14 called Certified Nursing Assistant (CNA / Staff #27) to aide in the search. Staff #27 later found Resident #1 quickly wheeling himself away at approximately less than 500 feet from the facility driveway entrance. The facility 5-day report revealed that the resident attempted to get away from the staff member, tipped his wheelchair, and scrapped his knee in the process. The resident was then sent to the hospital for evaluation.A change of condition (CoC) progress note dated December 7, 2025 at 9:00 p.m. revealed that the resident was sent to the hospital for increased behaviors, altered mental status (AMS), visual hallucinations, psychosis, aggressive behaviors, exit seeking behaviors, yelling out at nursing staff, and redirection difficulty.An observation conducted on December 30, 2025 at 11:00 a.m. from within the dementia unit revealed that an emergency unit exit had a sign on the door, ‘Emergency Exit Only. Push until alarm sounds. Door can be opened in 15 seconds'. Additionally, the same message was on the facility's main exit door sign.An interview was conducted with Licensed Practical Nurse (LPN / Staff #30) on December 30, 2025 at 11:18 am which confirmed that Resident #1 was in the locked dementia unit. Staff #30 stated that residents should not go out; and that, there is always someone with the residents. Staff #30 stated that she had heard that Resident #1 had eloped and accomplished that by going out the unit door.An additional observation conducted on December 30, 2025 at 11:20 am revealed Staff #30 demonstrated how the door operates, with the indicated sign was pressed for a few seconds and triggered the door alarm to beep. After a few more seconds a steady alarm began to sound which allowed the door to be opened.An interview with certified nursing assistant (CNA / Staff #47) was conducted on December 30, 2025 at 11:33am. Staff #47 revealed that she was aware that Resident #1 had a recent elopement. Staff #47 revealed that the doors to the unit are equipped with an alarm and that, they usually have staff in the hallway and dining room nearby.An interview with Director of Nursing (DON / Staff #5) was conducted on December 30, 2025 at 12:3 9am who revealed that the facility's front doors are locked and prevent access from the outside, but people can get out from the inside due to fire safety and that an alarm will sound. Staff #5 stated that staff should act if there is a fire or resident leaving. Staff #5 revealed that receptionist hours are from 7:00 am to 7:00 pm; and that, the lobby was monitored after-hours by - staff going back and forth near nurse's station, and rounding. Additionally, Staff #5 revealed that a risk to elopement was that a resident could hurt themselves.An observation was conducted, in conjunction with Staff #5, on December 30, 2025 at 12:39 am who revealed that the location where Resident #1 was found was at the end of the facility driveway -- next to the city sidewalk and near the street.Review of the facility provided policy titled Wandering and Elopements, revised March, 2019, revealed that the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.