

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035286	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2025
NAME OF PROVIDER OR SUPPLIER Sante of North Scottsdale		STREET ADDRESS, CITY, STATE, ZIP CODE 17490 North 93rd Street Scottsdale, AZ 85255	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, and staff interviews, the facility failed to ensure that adequate supervision and interventions were provided to one resident (#2) to prevent elopement from the facility. The deficient practice resulted in one resident leaving the building without notice, and could result in other residents going missing and/or getting injured.</p> <p>Findings include:</p> <p>Resident #2 was admitted to the facility on [DATE] with diagnoses including nontraumatic acute subdural hemorrhage, type two diabetes mellitus, and vascular dementia.</p> <p>Review of Resident #2's care plan revealed a focus, initiated on April 1, 2025, that the resident was at risk for wandering behavior and at risk for elopement. Interventions in place on April 1, 2025 included the following: to clearly identify the resident's room and bathroom, to follow facility protocols for patients with wandering tendencies, to keep the patient's photo at nursing stations and the front entrance, to identify triggers and patterns for wandering or eloping, to move the resident to the second floor, for staff to be aware of patient's whereabouts, to provide care in a calm and reassuring manner, to provide clear and simple instructions, and to reorient to surroundings.</p> <p>Review of the Nurse Practitioner (NP) note dated April 2, 2025 revealed that the resident was observed ambulating in the hallway. The resident displayed disorganized thinking and speech, and he displayed a fixation on contacting his brother. The resident was provided orientation to his environment and situation.</p> <p>Review of an additional NP note dated April 3, 2025 revealed that the resident was alert and oriented to self only. The NP revealed that the resident had been confused and was seen ambulating in the hallway without clothing.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nurse's note dated April 5, 2025 revealed that Resident #2 was not found in his room, and a code pink was initiated on April 5, 2025 at 09:20AM. At this time, the NP and facility management were notified, and a search for the resident was started. Upon searching the perimeter of the building, staff were notified by a pedestrian that a possible resident was in the soccer field near the facility. Staff went to the soccer field, and observed Resident #2 sitting in a golf cart with an Emergency Medical Technician (EMT) at 09:55AM. A skin assessment and vital signs were completed, and no signs of injury or distress were noted. The resident was then assisted back to the facility at 10:15AM, and appropriate parties were contacted. Upon return, frequent checks were initiated and the resident's care plan was updated to reflect elopement risk. Additionally, pictures were placed of the resident at all nurses' stations and the front desk.</p> <p>Review of the facility investigative report for Resident #2's elopement on April 5, 2025 revealed that staff working during the event had provided statements. These statements revealed that the resident had last been seen by staff between 08:30AM to 09:00AM.</p> <p>Interview was conducted on April 8, 2025 at 12:00PM with a Certified Nursing Assistant (CNA/Staff #16), who stated that if a resident is known to have wandering tendencies, he makes sure to check on that resident often to see their needs. He further explained that if he sees these residents wandering in the halls, he would ask where they are going or if they needed help. The CNA explained the process for a missing resident would be to go to the front desk and attempt to find the resident. If the resident is not found, then a code pink is initiated. When this happens, he explained that all staff are alerted. Staff search all the rooms, halls, therapy areas, and outside areas.</p> <p>Interview was conducted on April 8, 2025 at 11:51AM with a Registered Nurse (RN/Staff #7), who stated that residents with wandering tendencies are typically distracted to prevent elopement. She gave examples of distractions used to be television, games, and activities with staff. The RN reported that she was unaware of any residents who had recently eloped, but described that if a resident was not able to be located, she would alert the charge nurse and Director of Nursing, and all staff would look for the resident.</p> <p>Interview was conducted on April 8, 2025 at 1:56PM with a Licensed Practical Nurse (LPN/Staff #42), who confirmed that she was the nurse assigned to Resident #2 on the date that he had eloped from the facility. The LPN stated that Resident #2 had approached her on April 5, 2025 between 06:30 and 07:00AM, stating that he had plans and had people to see. The LPN told the resident that he did not have plans to go to Physical Therapy that day, and the resident walked down the hall at that time. The LPN explained that the resident continued to linger in the hallway. The LPN stated that she went into Resident #2's room around 09:20AM to administer medications and could not locate the resident in his room or in the halls. She reported that upon discovering the resident was not accounted for, she notified her supervisor. When asked when the last time anyone saw the resident was, the LPN reported that she had seen the resident near the nurses' station around 09:15AM. The LPN further explained that no one else, including the front desk staff, had seen the resident exit the building, but that he was found in the soccer field near the facility. Upon return, the resident's family decided to take the resident home, as he was set to discharge the next day. The LPN described the resident as a fast walker and that he would often wander into the doorways of other residents. She reported that Resident #2 had a history of eloping, as he had previously eloped from the prior facility he resided at. The LPN reported that this history partially contributed to him being moved from a downstairs room to an upstairs room at this facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview was attempted with the staff who had worked the front desk on the date of Resident #2's elopement, but the staff member was unable to be reached for interview.</p> <p>Interview was conducted on April 8, 2025 at 2:46PM with the Director of Nursing (DON/Staff #34), who stated that the facility is not set up for patients with wandering tendencies, so staff attempt to assess if the facility is a safe environment for them prior to admission. The DON explained that if the person is cleared to admit to the facility but has dementia or is prone to wandering behaviors, then interventions are put into place for that resident. These interventions included placing them close to the nurses' station, updating the care plan to include elopement risk, and posting the resident's picture at nurses' stations and the front desk. When asked what factors would categorize a resident as an elopement risk, the DON gave the examples of having an elopement history and having confused mentation or wandering habits. The DON also stated that residents are allowed to come and go from the building but are asked to sign in and out when doing so. She also stated that residents have the right to leave AMA. When asked if residents who are not cognitively intact can leave the building unattended, the DON stated that the facility does not send staff to accompany residents out of the building, so family would be contacted to see if the family could come in or bring whatever the resident desired. The DON identified the risks associated with not knowing where a resident is to be safety and liability concerns. When asked about Resident #2's elopement, the DON confirmed that the resident had been seen on April 5, 2025 at about 06:30AM for shift-change and vital signs. She stated that Resident #2 continued to pace up and down the hallway and talk to staff around 08:30AM. The DON then described the steps taken once the nurse realized he was missing, including searching and finding the resident at the soccer field with an off-duty EMT. When asked if the front desk staff had seen Resident #2 leave, the DON replied that the front-desk staff was interviewed and did not see the resident go. He had assumed that the resident had left when the staff stepped away to go to the printer. The DON stated that the resident was not noted as an elopement risk prior to the elopement occurring, as the resident had not shown behaviors during his stay that would make him be an elopement risk. She elaborated that the resident had been noted to be pacing up and down the hallways, and this was why the resident's room was moved from the first floor to the second floor and his photos were placed at the front desk and nurses' stations. The DON stated that the resident did not appear to be exit-seeking or pushing on any doors.</p> <p>Review of the facility policy titled, Behavioral Assessment, Intervention and Monitoring, dated December 2016, revealed that the interdisciplinary team evaluates behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident, and develops a plan of care accordingly. Additionally, this policy specified that the DON or designee will evaluate whether the staffing needs have changed based on the acuity of residents and their plan of care.</p>		