STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035299	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northpark Health and Rehabilitation of Cascadia	2020 North 95th Avenue Phoenix, AZ 85037

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the clinical record review, staff interviews, facility documentation, and policy review, the facility failed to ensure that it maintained medical records that were accurately documented and complete for one of the three sample Residents (#111) for wandering/elopement risk. The deficient practice may result in a medical record that is inconsistent with person-centered plan of care and goals. Findings include: Resident #111 was admitted on [DATE], with a diagnosis of dementia, encephalopathy, hypertension, and osteoarthritis. The admission Minimum Data Set (MDS) assessment completed January 22, 2026, revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated that Resident #111 was severely cognitively impaired. MDS Section E: Behavior, revealed Resident #111 had not exhibited wandering behavior. MDS assessment revealed no wandering behavior exhibited - despite Resident #111 care planned for wandering. A care plan dated January 23, 2026, had a focused care area for Resident #111 for elopement risk/wander related to decreased cognition and decreased safety awareness. Interventions included: addressing wandering behavior by walking with or attempting to redirect from the inappropriate area; engaging in diversional activity, assessing for fall risk, completing elopement risk assessment upon admission, quarterly, and with significant change in status, providing structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. An Evaluation Summary dated January 23, 2026 at 23:44, revealed a note had been struck-out: wandering/elopement risk evaluation completed. See evaluation for details. A Wandering/Elopement Risk Evaluation dated January 23, 2026 at 23:44, revealed section status had not been signed and locked until date February 11, 2026 at 08:46. The evaluation summary and recommendations section, revealed keep door closed on her unit and when receptionist off she will close doors up front and only staff can unlock it. A Health Status Note dated January 29, 2026 at 22:00, revealed patient was found outside the facility this evening around 9:30 pm by another patient's family member. The patient was found lying on her stomach and complained of back pain. The patient was unable to move or roll over at this time, 911 was called and DON notified. Messages left for her husband to call back, doctor aware and patient was sent to hospital. An interview was conducted on February 11, 2026, at 11:57 AM with an Licensed Practical Nurse (LPN/ Staff #1), who stated that during an elopement staff initiate the pink code, they radio for staff to look for the resident, if the resident is not found then police and family members are called. Staff #1 stated that Resident #111 was not at risk for wandering before the event that took place on January 29, 2026, however that Resident #111 had been feeling anxious; and, had shared with her wanting to go home. Staff #1 stated did report this information with the incoming nurse about Resident #111 feeling anxious. An interview was conducted on February 11, 2026, at 2:26 PM with a Certified Nursing Assistant (CNA/ Staff #2), who stated that if she sees any resident walking around and wandering, she will redirect. She stated that if the residents are not alert or oriented, she will approach (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them in a very calm manner and redirect them back into their room. Staff #2 stated that Resident #111 did not exhibit any wandering behavior when she worked with her. An interview was conducted on February 11, 2026, at 3:07 PM with the Director of Nursing (DON/ Staff #4), who confirmed that the struck-out wandering/elopement risk evaluation dated January 23, 2026, was incorrect because the resident was not considered an elopement risk; and that, the facility had later completed the elopement assessment after the incident on January 29, 2026. A Policy titled, Documentation of Resident Health Status Needs and Services, (revised in October 12, 2022), revealed medical record must contain an accurate representation of the of the actual experiences of the resident and include enough information to provide a picture of the resident's progress which can include the change in his/or her condition, plan of care goals, objectives and or interventions.