STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035300	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mirabella at Asu	65 East University Avenue Tempe, AZ 85281

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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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 record review, staff interviews, observation and the facility policy and procedures, the facility failed to ensure that an adequate supervision and environmental safeguards were provided to prevent elopement for a resident (#105). The deficient practice placed the resident at risk for serious injury, exposure to traffic injury, abduction and death.Findings Include:Resident #105 was admitted to the facility on [DATE], and discharged on October 29, 2025 with diagnosis that included seizures, depression, anxiety, unspecified dementia without behavioral disturbance, and difficulty in walking.The progress note dated October 17, 2025 at 11:28 pm stated under Mood and Behavior that it was unknown if resident slept through the night and also stated that the resident wandered at night.Another progress note dated October 18, 2025 at 1:14 pm stated that the resident was impulsive and is wandering.A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident #105 had a Brief Interview for Mental Status (BIMS) score of 11, indicating intact cognition. Further, review of MDS revealed that Resident #105 did not exhibit any behavior.A care plan dated October 26, 2025, revealed that Resident #105 was at risk for wandering and elopement.A progress note dated October 26, 2025, revealed that around 3 a.m., resident was found exiting the facility. Per note, staff assessed the resident and returned resident to his floor by a wheelchair. Per note, no falls or injuries were noted and resident seemed very confused but pleasant. Per note, Resident #105 stated to staff that he had business to take care of when attempting to leave. Director of nursing (DON), medical director (MD), and family were notified and the resident room was changed closer to nurse station.An incident report dated October 26, 2025, revealed that Resident #105 exited the emergency exit by his room and was found wandering outside of the facility on the facility grounds. The report stated resident was alert and oriented X1, confused and looking for a store. Resident #105 was assessed and no injuries were observed.A wandering risk assessment dated [DATE], revealed that resident had a score of 10.0 and at a moderate risk for wandering.During record review, an elopement/wandering risk assessment dated [DATE] was provided by the facility. No elopement/wandering risk assessment completed prior to the incident was available for review. A facility reportable event record report submitted to the State Agency on October 26, 2025, at 9:30p.m., revealed that Resident #105 had no prior history of elopement or behavioral disturbance per medical record review and family report. The report further revealed that on October 26, 2025, at approximately 1:45 a.m., Resident #105 approached the nurse' station and stated that he wanted to go out to the store and to the bar. Staff provided redirection and assisted him back to bed. During routine care/safety rounds approximately 2:45 a.m., staff discovered that Resident #105 was not in his assigned room. A facility-wide search was initiated immediately. At approximately 3:10 a.m. Resident #105 was found outside the facility near the main entrance, walking toward a nearby convenience store. When approached, Resident #105 stated that he just wanted to go to the store to buy a couple of things and wanted to go to the bar. Two staff members safely redirected him and transported Resident #105 back to his room via a wheelchair. Resident was then assessed, placed on one-on-one observation, physician/family/administrator were notified. Resident#105 room was moved to the room closer to the nurses station. A skilled evaluation dated October 28, 2025, revealed that patient was moved to another room due to elopement risk and certified nursing assistant was assigned for 1 on 1 care.An interview was conducted on November 14, 2025, at 12:10 p.m. with a Certified Nursing Assistant (CNA, staff #15) who stated that on October 25, 2025 night shift, during her rounds, staff # 15 observed that Resident #105 was in his room during each of the following checks: - 8 p.m., 10 p.m., 12 a. m. Then at approximately 1:30 a.m., Resident #105 came to nurse station holding his wallet and stated that he was trying to find the main entrance to leave the building. Staff #15 then redirected Resident #105 to his room, assisted him to bed, and stated that he then he went back to sleep. At around 2 a.m., while conducting another round, she stated that CNA (staff#12) entered Resident #105's room and discovered that he was not there. Staff #12 then informed Staff #15 that Resident #105 was missing. Staff #15 stated that she then went to the other unit to request assistance. She stated that the Licensed Practical Nurse (LPN, staff #25) was not on the floor at that moment, so Staff #15 sought for help from CNA (Staff#40) from other unit. Since Resident #105 room was located near the stairwell, staff #15 immediately checked both flights of stairs and existed through the side door, calling out the name of Resident #105 name multiple times. Staff #15 then proceeded around to the front of facility, where Staff #15 encountered Staff #28. Staff #15 then described Resident #105 and staff #28 confirmed that he had just seen Resident #105 walking towards CVS in front of the Omni Hotel