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. **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 (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	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. Resident #105 was observed attempting to cross the street. Staff #15 then called out the name of Resident #105 name and quickly approached him. Upon contact, Resident #105 appeared confused and stated that he was going out for a beer because he had just gotten a divorce. Staff #15 stated that she informed Resident #105 that he was at facility and that staff #15 and staff #28 would assist him back to his room safely. Then with the help of staff #28, staff #15 obtained a wheelchair and escorted Resident #105 back upstairs. Staff #15 then notified LPN #25 in the hallway of the incident and explained what had occurred. She stated that Resident #105 remained calm and sat with staff #15 in the second-floor living area until the end of the shift. Staff #15 then stated that residents in facility did not have access to the elevator and needed a security code (FOB) to go in and out of elevator. Staff #15 then stated that there is also an emergencyexit through stairs which had a push bar to open the door and an alarm would turn on as the door was opened. CNA (staff #15) also stated that when someone tried to open the emergency exit door then an alarm would turn on. Staff #15 then stated that maintenance also notified all staff that if emergency exit door were not latched properly then the door would not shut properly. Staff #15 stated that this may have facilitated the elopement of Resident #105. Staff #15 also stated that risk associated with resident's elopement would be falls, getting hit by car, or the resident missing.An interview was conducted on November 14, 2025, at 12:15 p.m. with a Licensed Practical Nurse (LPN, staff #25) who stated that she was an agency staff. Staff #25 then stated that she did not recall the exact date but she recalled about the incident regarding Resident #105. Per staff #25, on October 26, 2025, she was not on the floor and was on a break when she got a call from facility that she needed to return to the facility. LPN then stated that in the main lobby in first floor she encountered Resident #105 in his wheelchair with staff #28. Staff #25 then directed resident to the second floor. Resident #105 was then assessed for injury, and was put on one on one with staff #15. LPN then stated that residents in the facility did not have access to elevator and can go in and out of the building with either CNA or nurse or family member. Staff #25 also stated that she did not have idea that there was another exit (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	door down the hallway by the resident's room and how it worked. Staff #25 further stated that risk associated with resident elopement would be injury or hit by car.An interview was conducted on November 14, 2025 at 1:10 p.m., with the administrator (staff #30) who stated that interdisciplinary team (IDT) make determination which resident and when a resident can go in and out of the facility. Staff #30 then stated that the facility is skilled nursing and did not have a secured unit and if a resident wanted to go out then that's resident's right but the facility advises residents to check with nurses for their safety. Staff #30 then stated that residents did not have access to the elevator and needed a security code (FOB) to go in and out of elevator. Staff #30 further stated that facility does have emergency exit door which was not advice to use for regular access. Staff #30 also stated that there is a sign that stated Push until alarm sounds, and door will open in 15 second, Access to floors 1 and 2 only and when the emergency door opens then an alarm will sound. Staff #30 then stated that Resident #105 did not have any history of elopement in the past and after the incident happened, x-ray was done on Resident #105 for any injury, facture or dislocation of bone. Staff #30 also stated that after the elopement incident, all residents were assessed and no residents were identified at elopement risk. Staff #30 further stated that risk associated if resident elopes would be getting hurt or feeling dehydrated.An interview was conducted on November 14, 2025 at 1:43 p.m., with the director of facility services (staff #35) who stated that there are four stairway emergency exit door in building which lock from the outside and go from second floor to the loading dock on ground floor of south side of building. Staff #35 further stated that door has local alarm and alarm goes off from the moment alarm was touched and then hold the door for fifteen second before the door open. Staff #35 then stated that door alarm is pretty loud but if a staff is in resident room then it may not be heard. Staff #35 also stated that if a resident is able to come out of second floor emergency exit then there are no other alarms in either first or ground floor and resident can easily go out of the building by pushing the door bar.An observation was made on November 14, 2025 around 2pm with Staff #35 of emergency exit door(EED) located near the room where Resident #105 was initially before the elopement on October 26, 2025. During the observation, staff #35 pushed the push bar of EED and an alarm started beeping for approximately 15 seconds and then the door got unlocked without the requirement of FOB or card access. After the door opened, it was also observed that there was continuous flight of stairs which went from second floor to loading dock on ground floor of south side of building.Review of the facility's policy titled Elopement and Hazardous Wandering, reviewed on November 2025, revealed that all residents will be assessed for risk of elopement through the pre-admission and/or admission process. The facility will put measures in place to minimize the risk of elopement that are individualized to resident needs. When an elopement occurs, immediate efforts to locate the resident will be taken. All occurrences will be documented and all follow-up required by State and Federal regulations will occur.