

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035071	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Mission Palms Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 6461 East Baywood Avenue Mesa, AZ 85206	

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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of facility policies and procedures, the facility failed to ensure that the facility's abuse and neglect policies are followed for one out of 145 residents (resident #145) regarding abuse reporting to appropriate agency. This deficient practice had the potential to further endanger the resident and impede a timely and thorough investigation. Findings included: Resident #176 was admitted to the facility on [DATE], with diagnoses that included fracture of an unspecified part of the neck of the femur, generalized muscle weakness, dysphagia, difficulty walking, cognitive communication deficit, protein-calorie malnutrition, epilepsy, chronic kidney disease, vascular dementia, depression, hypertension, and other comorbid conditions. The resident was discharged on October 10, 2025. Resident #176 had a care plan initiated on September 23, 2025, addressing risks for impaired cognitive function and impaired thought processes related to dementia. The goal was for the resident to maintain her level of cognitive functioning during her stay at the facility. Interventions included communicating at the resident's level of understanding, maintaining eye contact, using simple and directive sentences with appropriate cues, and stopping and returning if the resident became agitated. The resident's annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. The total mood severity score was 0, indicating no depressive or observable mood symptoms. There were no documented indicators of psychosis or behavioral symptoms. An additional MDS assessment dated [DATE], revealed a BIMS score of 9, which remained at the lower end of moderate cognitive impairment scale. This level of cognitive impairment presented a potential risk for decision-making, including the ability to assess personal safety within the facility. A nurse encounter note dated October 9, 2025, at 6:37 p.m., entered into the electronic health record by Registered Nurse (RN) Staff #116, documented that Certified Nursing Assistant (CNA) Staff #64 observed a friend of Resident #176 assisting the resident with feeding and flicking the resident's nose in an aggressive manner. CNA Staff #64 instructed the visitor not to engage in that behavior. The visitor then approached CNA Staff #64 in a confrontational manner and began yelling at her. Staff #116 documented that the resident's daughter, who was present at the facility that same day, was notified. The daughter requested that the matter be reported to the resident's case worker, and Staff #64 indicated that the incident had been reported. A review of the facility's visitor log dated October 9, 2025, revealed that the alleged perpetrator and her husband visited the resident's room on that date. However, there was no documentation of any intervention related to the visitor's behavior or any action taken in response to the allegation. Additionally, Director of Nursing (DON), Staff #22, did not describe any specific intervention implemented regarding the visitor on the date of the incident. Furthermore, a review of the electronic health record revealed no documented evidence that an allegation of abuse was reported on October 9, 2025, or thereafter. A review of the grievance log for October 2025 revealed no evidence that a grievance had been filed related</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 035071	If continuation sheet Page 1 of 6

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>to the incident. On February 10, 2026, at 10:13 a.m., an interview was conducted with Staff #64. Staff #64 stated that she reported to RN, Staff #116, that the resident's family friend flicked the resident's nose while assisting with feeding. She stated that when she attempted to stop the behavior and reassure the resident, the visitor turned and yelled at her in an aggressive manner. Staff #64 stated that this interaction was the reason she reported the encounter to Staff #116 on the same day. On February 19, 2026, at 1:45 p.m., an interview was conducted with Staff #116. Staff #116 stated that she was aware of the incident and had reported it to the DON, Staff #22. She stated that Staff #64 informed her that the visitor assisted with feeding and, during the process, grabbed the resident while instructing her to eat. When Staff #64 advised the visitor not to do so, the visitor turned and yelled at her. An interview was conducted with the DON, Staff #22, who recalled the date of the allegation. Staff #22 stated that he received a call from Staff #116 reporting that the resident's friend had become frustrated and was yelling at Staff #64 for attempting to reassure the resident. Staff #22 stated that he went to the facility immediately to assess the situation and conduct an initial evaluation. He stated that the resident reported she was okay and felt safe with both staff and visiting friends. Staff #22 further stated that, based on the outcome of his interview with the resident and discussions with the Abuse Coordinator, he determined that there were no elements of abuse or neglect and, therefore, did not report the allegation to the appropriate authorities. On February 20, 2026, at 11:59 a.m., an interview was conducted with the Abuse Coordinator, who also served as the Administrator, Staff #147. Staff #147 stated that he was aware of the allegation and had discussed it with the DON, Staff #22, regarding the nature of the incident. Staff #147 stated that the decision not to report the allegation was based on the resident interview and the resident's statement that she felt safe with both staff and the visiting friend. A review of the facility policy titled Abuse: Prevention of and Prohibition Against, revised September 9, 2025, indicated that if an allegation of abuse, neglect, misappropriation of resident property, or exploitation involved a visitor or vendor, the facility was to immediately escort the visitor from the building and report the allegation to local law enforcement, as well as to the appropriate state and federal agencies, within the required timeframes. The policy further indicated that all allegations of abuse and neglect were to be thoroughly investigated through a detailed analysis of the nature of the allegation and a determination of whether the conduct implicated resident privacy or security as protected by the Health Insurance Portability and Accountability Act (HIPAA). The policy specified that the investigation should include: (1) interviews with the individual(s) reporting the incident; (2) interviews with the resident(s); (3) interviews with any witnesses to the incident, including the alleged perpetrator; (4) review of the resident's medical record; (5) interviews with staff members who may have relevant information; and (6) review of all circumstances surrounding the incident.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 145Number of residents cited: 1TFFTE that an allegation of abuse was reported to the applicable agencies for one resident (#176)Based on clinical record review, staff interviews, and review of facility policies and procedures, the facility failed to ensure that an allegation of abuse was reported to the state agency for one out of 145 residents (resident #145). This deficient practice had the potential to further endanger the resident and impede a timely and thorough investigation.Findings included:Resident #176 was admitted to the facility on [DATE], with diagnoses that included fracture of an unspecified part of the neck of the femur, generalized muscle weakness, dysphagia, difficulty walking, cognitive communication deficit, unspecified protein-calorie malnutrition, epilepsy, chronic kidney disease, vascular dementia, depression, hypertension, and other comorbid conditions. The resident was discharged on October 10, 2025.Resident #176 had a care plan initiated on September 23, 2025, addressing risks for impaired cognitive function and impaired thought processes related to dementia. The stated goal was for the resident to maintain her level of cognitive functioning during her stay at the facility. Interventions included communicating at the resident's level of understanding, maintaining eye contact, using simple and directive sentences with appropriate cues, and stopping and returning if the resident became agitated.The resident's annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. The total mood severity score was 0, indicating no depressive or observable mood symptoms. There were no documented indicators of psychosis or behavioral symptoms. An additional MDS assessment dated [DATE], revealed a BIMS score of 9, which remained at the lower end of moderate cognitive impairment scale. This level of cognitive impairment presented a potential risk for decision-making, including the ability to assess personal safety within the facility.A nurse's encounter note dated October 9, 2025, at 6:37 p.m., entered into the electronic health record by Registered Nurse (RN) Staff #116, documented that Certified Nursing Assistant (CNA) Staff #64 observed a friend of Resident #176 assisting the resident with feeding and flicking the resident's nose in an aggressive manner. CNA Staff #64 instructed the visitor not to engage in that behavior. The visitor then approached CNA Staff #64 in a confrontational manner and began yelling at her. RN Staff #116 documented that the resident's daughter, who was present at the facility that same day, was notified. The daughter requested that the matter be reported to the resident's case worker, and CNA Staff #64 indicated that the incident had been reported.A review of the electronic health record revealed no documented evidence that an allegation of abuse was reported on October 9, 2025, or thereafter. A review of the grievance log for October 2025 revealed no evidence that a grievance had been filed related to the incident.On February 10, 2026, at 10:13 a.m., an interview was conducted with CNA Staff #64. Staff #64 stated that she reported to RN Staff #116 that the resident's family friend flicked the resident's nose while assisting with feeding. She stated that when she attempted to stop the behavior and reassure the resident, the visitor turned and yelled at her in an aggressive manner. Staff #64 stated that this interaction prompted her to report the encounter to RN Staff #116 on the same day.On February 19, 2026, at 1:45 p.m., an interview was conducted with RN Staff #116. RN Staff #116 stated that she was aware of the incident and had reported it to the Director of Nursing (DON), Staff #22. She stated that CNA Staff #64 informed her that the visitor assisted with feeding and, during the process, grabbed the resident while instructing her to eat. When CNA Staff #64 advised the visitor not to do so, the visitor turned and yelled at her.An interview was conducted with the DON, Staff #22, who recalled the date of the allegation. Staff #22 stated that he received a call from RN Staff</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>#116 reporting that the resident's friend had become frustrated and was yelling at CNA Staff #64 for attempting to reassure the resident. Staff #22 stated that he immediately went to the facility to assess the situation and complete an initial evaluation. He stated that the resident reported she was okay and felt safe with both staff and visiting friends. Staff #22 further stated that, based on his interview with the resident and discussion with the Abuse Coordinator, he determined that there were no aspects of abuse or neglect and, therefore, did not report the allegation to the appropriate authorities. On February 20, 2026, at 11:59 a.m., an interview was conducted with the Abuse Coordinator, who also served as the Administrator, Staff #147. Staff #147 stated that he was aware of the allegation and had discussed it with the DON, Staff #22, regarding the nature of the incident. Staff #147 stated that the decision not to report the allegation was based on the resident interview and the resident's statement that she felt safe with both staff and the visiting friend. A review of the facility policy titled Abuse: Prevention of and Prohibition Against, revised September 9, 2025, indicated that if an allegation of abuse, neglect, misappropriation of resident property, or exploitation involved a visitor or vendor, the facility was to immediately escort the visitor from the building and report the allegation to local law enforcement, as well as to applicable federal or state agencies, within the required timeframes.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 145Number of residents cited: 1TFFTE that an abuse investigation was conducted for one resident following an allegation of abuse (#176)Based on clinical record review, staff interviews, and review of facility policies and procedures, the facility failed to ensure that an allegation of abuse was investigated for one out of 145 residents (resident #145). This deficient practice had the potential to further endanger the resident and impede a timely and thorough investigation.Findings included:Resident #176 was admitted to the facility on [DATE], with diagnoses that included fracture of an unspecified part of the neck of the femur, generalized muscle weakness, dysphagia, difficulty walking, cognitive communication deficit, unspecified protein-calorie malnutrition, epilepsy, chronic kidney disease, vascular dementia, depression, hypertension, and other comorbid conditions. The resident was discharged on October 10, 2025.Resident #176 had a care plan initiated on September 23, 2025, addressing risks for impaired cognitive function and impaired thought processes related to dementia. The goal was for the resident to maintain her level of cognitive functioning during her stay at the facility. Interventions included communicating at the resident's level of understanding, maintaining eye contact, using simple and directive sentences with necessary cues, and pausing and returning if the resident became agitated.The resident's annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. The total mood severity score was 0, indicating no depressive or observable mood symptoms. There were no documented indicators of psychosis or behavioral symptoms. An additional MDS assessment dated [DATE], revealed a BIMS score of 9, which remained at the lower end of moderate cognitive impairment scale. This level of cognitive impairment placed the resident at potential risk for decision-making, including the ability to assess personal safety within the facility.A nurse's encounter note dated October 9, 2025, at 6:37 p.m., entered into the electronic health record by Registered Nurse (RN) Staff #116, indicated that Certified Nursing Assistant (CNA) Staff #64 observed a friend of Resident #176 assisting the resident with feeding and flicking the resident on the nose in an aggressive manner. CNA Staff #64 instructed the visitor not to engage in that behavior. The visitor then approached CNA Staff #64 in a confrontational manner and began yelling at her. RN Staff #116 documented that the resident's daughter, who was also present at the facility that day, was notified. The daughter requested that the matter be reported to the resident's case worker.A review of the electronic health record revealed no documented evidence that an allegation of abuse was reported on October 9, 2025, or thereafter. A review of the facility's grievance log for October 2025 revealed no evidence of a grievance filed related to this incident.On February 10, 2026, at 10:13 a.m., an interview was conducted with CNA Staff #64. Staff #64 stated that she informed RN Staff #116 that the resident's friend flicked the resident's nose while feeding her. She further stated that when she attempted to intervene and reassure the resident, the visitor became aggressive and yelled at her. Staff #64 reported that this behavior prompted her to report the incident to RN Staff #116 on the day it occurred.On February 19, 2026, at 1:45 p.m., an interview was conducted with RN Staff #116, who confirmed that she reported the incident to the Director of Nursing (DON), Staff #22. RN Staff #116 stated that CNA Staff #64 reported that the visitor assisted with feeding the resident and, during the process, grabbed the resident while instructing her to eat. When CNA Staff #64 advised the visitor not to do so, the visitor turned and yelled at her.An interview was conducted with the DON, Staff #22, who recalled the date of the allegation. Staff #22 stated that he received a call from RN Staff #116 reporting that the resident's friend had become frustrated and was yelling at CNA Staff #64 for attempting to reassure the resident. Staff #22 stated that he</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>immediately went to the facility to assess the situation and complete an initial evaluation. He reported that the resident stated she was okay and felt safe with both staff and visiting family friends. Staff #22 further stated that, based on his interview with the resident and discussions with the Abuse Coordinator, he determined that the incident did not meet criteria for abuse or neglect and, therefore, did not report the allegation to the state agency. On February 20, 2026, at 11:59 a.m., an interview was conducted with the Abuse Coordinator, who was also the Administrator, Staff #147. Staff #147 stated that he was aware of the allegation and had discussed it with the DON, Staff #22. Staff #147 stated that the decision not to report the allegation was based on the resident interview and the resident's statement that she felt safe with both staff and the visiting friend. A review of the facility policy titled Abuse: Prevention of and Prohibition Against, revised September 9, 2025, indicated that all allegations of abuse and neglect were to be thoroughly investigated through a detailed analysis of the nature of the allegation and a determination of whether the conduct implicated resident privacy or security as protected by the Health Insurance Portability and Accountability Act (HIPAA). The policy further indicated that the investigation should include: (1) interviews with the individual(s) reporting the incident; (2) interviews with the resident(s); (3) interviews with any witnesses to the incident, including the alleged perpetrator; (4) review of the resident's medical record; (5) interviews with staff members who may have relevant information; and (6) review of all circumstances surrounding the incident.</p>		