STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035266	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Healthcare of Mesa	5755 East Main Street Mesa, AZ 85205

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, and record review, the facility failed to ensure that written abuse policy and procedures were followed and adhered to regulations regarding the alleged abuse of one resident (Resident #20). This deficient practice could result in allegations of abuse not being appropriately handled.Findings include:Resident #20 was admitted to the facility on [DATE], with diagnoses that included multiple fractures of the pelvis, one rib, sacrum, and vertebra, bacterial infections of unspecified site, chronic kidney disease, depression, and insomnia.An initial pool interview was conducted with Resident #20 on September 2, 2025, at 10:15 AM. During the interview, the resident stated that some of the staff are strange. The resident said that when he was first admitted to the facility, an aide was rough with him while providing care, and that she held [his] cheeks in her hands and kissed [his] forehead. Resident #20 said he didn't want to be touched or kissed in that manner and felt uncomfortable with the gesture. The resident stated that he informed the aide's boss about the incident and that the aide was then told not to be in the same room as the resident.Following the interview with Resident #20, on September 2, 2025, at 10:33 AM, an alleged abuse incident was reported to the facility Administrator (Staff #51). The Administrator stated she had not received a report of suspected abuse regarding Resident #20 before this report.On September 2, 2025, at 3:31 PM, the State Agency (SA) database of facility self-reports was reviewed online. No reports from the facility were observed.On September 3, 2025, at 11:57 AM, the SA database of facility self-reports was reviewed online. No reports from the facility were observed.An interview was conducted with the DON (Staff #76) on September 3, 2025, at 1:29 PM. The DON stated that when she receives an allegation of abuse, she first goes to see the resident who made the claim. Following a discussion with the resident, she reports the alleged abuse to the facility Administrator, the ombudsman, and the transitional nurse, Staff #122. The DON stated that she would also report the incident to Adult Protective Services (APS) if she noted bruising, a black eye, or fingerprints on the resident. She then indicated these types of abuse claims should also be reported to the State Agency (SA).The DON then said that she had received a verbal report of alleged abuse for Resident #20 from the facility Administrator on September 2, 2025. She interviewed Resident #20, who told the DON that he was fearful of explaining what had occurred, but that he did not like his current aide and wanted to talk to the DON later in the day. The DON explained that she went to speak to Resident #20 later in the day, but he was asleep. The DON stated that she had not completed an official investigation at that time, as she was waiting for instructions from the facility Administrator.An interview was conducted with the facility Administrator (Staff #51) on September 4, 2025, at 8:25 AM. The Administrator explained that when a resident makes an allegation of abuse regarding a staff member, she expects her staff to report the allegation to her and the DON immediately. She stated she would then put the alleged perpetrator on leave, complete an investigation, and then report to the SA, APS, the ombudsman, and the police if needed. The Administrator stated she always files a report if it involves alleged abuse, whether it was witnessed or reported.The Administrator stated she had not reported the alleged abuse incident regarding Resident #20, which she was made aware of on September 2, 2025, at 10:33 AM. She indicated that the reason she did not report the alleged abuse to (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the SA was that the incident occurred in July 2025 and that they were not informed of it at that time. She also indicated that following the DON interview of the resident on September 2, 2025, the Administrator struggled to say it was abuse. The Administrator continued to explain that Resident #20 had issues with female aides of color and that it appeared he didn't like that particular aide. After further discussion of the incident with Resident #20, the Administrator then decided to report the incident to the SA on September 4, 2025.On September 4, 2025, at 10:19 AM, the DON stated that she discussed the incident with Resident #20 and that he indicated the aide involved was Certified Nurse Assistant (CNA/Staff #79). The DON called the CNA, who acknowledged that an incident had been reported by Resident #20 and stated that the Registered Nurse (RN/Staff #49) working that shift was made aware of the situation.An interview was conducted with RN (Staff #49) on September 4, 2025, at 10:53 AM. The RN stated that Resident #20 had reported to him that the CNA (Staff #79) was inappropriate with him, referring to the CNA kissing him on his forehead. The RN instructed the CNA not to enter the resident's room. The RN stated he did not report the alleged incident to anybody at that time because the CNA had denied that the incident occurred. The RN reported he had received training from the facility regarding reporting alleged abuse and that he had a lack of judgment by not reporting the incident.On September 4, 2025, at 10:58 AM, an interview was conducted with a CNA (Staff #84) regarding facility abuse policy and procedures. The CNA stated she did not know if she had received training regarding abuse and neglect. She left to ask her supervisor a question. She returned to the interview and stated she had received abuse and neglect training. The CNA stated that if an incident of alleged abuse were reported to her by a resident, she would report it to her supervisor. The CNA was unable to give the name of the facility's abuse coordinator.An interview was conducted with the facility Administrator (Staff #51) on September 4, 2025, at 1:16 PM. The Administrator acknowledged that RN (Staff #49) did not report the incident he was made aware of with Resident #20 in July 2025. The administrator did not state what the risk of the nurse not reporting was, but reiterated that this particular case did not seem to fall into the abuse category. The Administrator then acknowledged the finding of deficient practice and stated she would report all alleged abuse in the future, as well as perform in-service training to the facility staff.An interview was conducted with the RN (Staff #49) on September 5, 2025, at 10:24 AM. The RN stated that the resident had made an allegation of abuse in July 2025, but the RN did not report it at that time.A policy titled Abuse Policy and Procedure, Version E1107 was reviewed. The policy revealed that all patients have the right to be free from any form of verbal, sexual, physical. abuse. The policy stated that all personnel are required to immediately report incidents of suspected mistreatment or abuse to the facility administration. The policy further stated that an incident of patient abuse must be reported to a supervisor regardless of the time lapse since the incident occurred. The policy also instructed that should the investigation reveal ?reasonable cause to believe' that abuse. had occurred, the administrator and/or director of nursing would then report findings immediately to the required SA.Appendix PP of the State Operations Manual (SOM), issued August 8, 2024, was reviewed. Code 42 CFR 483.12(b)(5) instructs that all alleged violations involving abuse are to be reported immediately, but not later than 2 hours after the allegation is made.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, and record review, the facility failed to ensure that an allegation of abuse for one resident (Resident #20) was reported to the State Agency (SA) in a timely manner. This deficient practice could result in allegations of abuse not being reported and investigated.Findings include:Resident #20 was admitted to the facility on [DATE], with diagnoses that included multiple fractures of the pelvis, one rib, sacrum, and vertebra, bacterial infections of unspecified site, chronic kidney disease, depression, and insomnia.A Minimum Data Set (MDS) dated [DATE], indicated that Resident #20 had a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment.An initial pool interview was conducted with Resident #20 on September 2, 2025, at 10:15 AM. During the interview, the resident stated that some of the staff are strange. When asked to explain the statement, the resident said that when he was first admitted to the facility, an aide was rough with him while providing care, and that she held [his] cheeks in her hands and kissed [his] forehead. Resident #20 said he didn't want to be touched or kissed in that manner and felt uncomfortable with the gesture. The resident stated that he informed the aide's boss about the incident and that the aide was then told not to be in the same room as the resident. Resident #20 stated he currently felt safe in the facility, but was fearful of the staff finding out that he reported the incident.Following the interview with Resident #20, on September 2, 2025, at 10:33 AM, the surveyor reported the alleged abuse incident to the facility Administrator (Staff #51). The Administrator indicated that the aide that Resident #20 was referring to was most likely Staff #79. The Administrator stated she had not received a report of alleged abuse regarding Resident #20 before this report. The Administrator left her office to discuss with the staff.On September 2, 2025, at 11:08 AM, the Director of Nursing (DON/Staff #76) informed the surveyor that Resident #20 had been placed on 2-hour checks and that she ensured that the psychiatric nurse practitioner was following the resident's care. The DON stated that Resident #20 had not mentioned being mistreated by staff before the current date.On September 2, 2025, at 3:31 PM, the SA database of facility self-reports was reviewed online. No reports from the facility were observed.On September 3, 2025, at 11:57 AM, the SA database of facility self-reports was reviewed online. No reports from the facility were observed.An interview was conducted with the DON (Staff #76) on September 3, 2025, at 1:29 PM. The DON stated that when she receives an allegation of abuse, she first goes to see the resident who made the claim. Following a discussion with the resident, she reports the alleged abuse to the facility Administrator, the ombudsman, and the transitional nurse, Staff #122. The DON stated that she would also report the incident to Adult Protective Services (APS) if she noted bruising, a black eye, or fingerprints on the resident. She then indicated these types of abuse claims should also be reported to the State Agency (SA).The DON then said that she had received a verbal report of alleged abuse for Resident #20 from the facility Administrator on September 2, 2025. She interviewed Resident #20, who told the DON that he was fearful of explaining what had occurred, but that he did not like his current aide and wanted to talk to the DON later in the day. The DON explained that she went to speak to Resident #20 later in the day, but he was asleep. The DON stated that she had not completed an official investigation at that time, as she was waiting for instructions from the facility Administrator.An interview was conducted with the facility Administrator (Staff #51) on September 4, 2025, at 8:25 AM. The Administrator explained that when a resident makes an allegation of abuse regarding a staff member, she expects her staff to report the allegation to her and the DON immediately. She stated she would then put the alleged perpetrator on leave, complete an investigation, and then report to the SA, APS, the ombudsman, and the police if needed. The Administrator stated she always files a report if it involves alleged abuse, whether it was witnessed or reported.When the facility Administrator was asked if she had reported the alleged abuse incident (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding Resident #20, which she was made aware of on September 2, 2025, at 10:33 AM, she stated she had not. The Administrator indicated that the reason she did not report the alleged abuse to the SA was that the incident occurred in July 2025 and that they were not informed of it at that time. She also indicated that following the DON interview of the resident on September 2, 2025, the Administrator struggled to say it was abuse. The Administrator continued to explain that Resident #20 had issues with female aides of color and that it appeared he didn't like that particular aide. After further discussion of the incident with Resident #20, the Administrator then decided to report the incident to the SA on September 4, 2025.Attempts were made to contact the alleged perpetrator (Staff #79) on September 3, 2025, at 1:46 PM, September 4, 2025, at 9:59 AM, September 4, 2025, at 12:37 PM, and September 4, 2025, at 2:16 PM. All attempts were unsuccessful.On September 4, 2025, at 10:19 AM, the DON stated that she discussed the incident with Resident #20 and that he indicated the aide involved was Certified Nurse Assistant (CNA/Staff #79). The DON called the CNA, who acknowledged that an incident had been reported by Resident #20 and stated that the Registered Nurse (RN/Staff #49) working that shift was made aware of the situation.An interview was conducted with RN (Staff #49) on September 4, 2025, at 10:53 AM. The RN stated that Resident #20 had reported to him that the CNA (Staff #79) was inappropriate with him, referring to the CNA kissing him on his forehead. The RN instructed the CNA not to enter the resident's room. The RN stated he did not report the alleged incident to anybody at that time because the CNA had denied that the incident occurred. The RN reported he had received training from the facility regarding reporting alleged abuse and that he had a lack of judgment by not reporting the incident.On September 4, 2025, at 10:58 AM, an interview was conducted with a CNA (Staff #84) regarding facility abuse policy and procedures. The CNA stated she did not know if she had received training regarding abuse and neglect. She left to ask her supervisor a question. She returned to the interview and stated she had received abuse and neglect training. When asked what she would do if a resident reported an incident to her, the CNA stated that she would report it to her supervisor. The CNA was unable to give the name of the facility's abuse coordinator.An interview was conducted with the facility Administrator (Staff #51) on September 4, 2025, at 1:16 PM. The Administrator acknowledged that RN (Staff #49) did not report the incident he was made aware of with Resident #20 in July 2025. When asked what the risk of the nurse not reporting was, the Administrator did not comment, but reiterated that this particular case did not seem to fall into the abuse category. The Administrator then acknowledged the finding of deficient practice and stated she would report all alleged abuse in the future, as well as perform in-service training to the facility staff.An interview was conducted with the RN (Staff #49) on September 5, 2025, at 10:24 AM. The RN again stated that Resident #20 did make the report of alleged abuse in July 2025, but the RN did not report it at that time.A policy titled Abuse Policy and Procedure, Version E1107 was reviewed. The policy revealed that all patients have the right to be free from any form of verbal, sexual, physical. abuse. The policy stated that all personnel are required to immediately report incidents of suspected mistreatment or abuse to the facility administration. The policy also noted that abuse should be reported by the Administrator and/or the Director of Nursing immediately to the required state agency.Appendix PP of the State Operations Manual (SOM), issued August 8, 2024, was reviewed. Code 42 CFR 483.12(b)(5) instructs that all alleged violations involving abuse are to be reported immediately, but not later than 2 hours after the allegation is made.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, review of facility documents and policy, the facility failed to provide written notice to the resident or resident representative that specifies duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility for one resident (#48). The deficient practice could result in residents not being able to exercise their right to return to the facility of choice. Number of residents sampled: 12Number of residents cited: 1 Findings include: Resident #48 was admitted to the facility on [DATE] with a diagnosis that included sepsis, anemia and hypertension.A review of Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15.0, cognitively intact.A review of care plan dated July 24, 2025 revealed resident has an alteration in respiratory function.A review of progress notes dated August 6, 2025 revealed resident was noted to be short of breath, febrile with a temperature of 101.4, has low blood pressure of 102 over 60, and a heart rate of 102 beats per minute. The staff notified the nurse practitioner and the staff received orders to start resident on intravenous push (IVP) Lasix 40 mg (milligram) every day for three days and to hold/not administer oral Lasix for four days due to resident have a large right pleural effusion. Resident was administered one gram of acetaminophen (APAP) for fever. The IVP Lasix was administered by the director of nursing (DON). Resident's laboratory blood work was pending. Resident's urine and stool samples were collected and were sent to lab for testing. The provider was updated about the Resident's condition and additional orders, CBC (complete blood count) and CMP (comprehensive metabolic panel) daily for three days, were received from the provider. The progress notes also revealed that resident and resident's family requested to be transferred to the hospital.Review of progress note dated August 6, 2025 at 8:43 PM revealed the date and time resident left facility: August 6, 2025 at 18:03 PM; Bed hold policy was given: Emergent transfer; and Family/Responsible party notified of transfer: Yes.Review of MDS discharge-Return Anticipated assessment revealed Resident #48 was discharged on August 6, 2025 to a short-term general hospital. An interview was conducted on September 4, 2025 at 9:28 AM with a Licensed Practical Nurse (LPN)/Staff #82. Staff #82 stated that when he transfers a resident out to a hospital, it could be due to an emergency such as chest pain, oxygen saturation dropping and not able to maintain even after titrating oxygen to keep the resident's oxygen saturation above 90 percent using a rebreather mask, and a resident looking diaphoretic. Before transferring a resident, Staff #82 notifies the provider and receives an order to call 911. Regarding a resident who was sent out to the hospital but end up not admitted to the hospital, the resident have within 24 hours and returns back to the facility. The hospital calls the facility that the resident is coming back and the facility arrange a transportation to pick resident up from the hospital. However, Staff #82 stated that if the resident is in the hospital for over 24 hours, the resident is offered a bed hold. The admission and or case manager calls the resident or resident's family regarding bed hold.An interview was conducted on September 4, 2025 at 10:00 AM in the case management office with case manager Registered Nurse (RN)/ Staff #106. Staff #106 stated that she does discharge planning, she assists with placement, help with home health resources, care giving, and transportation. Staff #106 stated that when a resident is discharged to a hospital, she does not do anything with residents that goes to the hospital, she does not do bed hold, and it is the nurse or business office that takes care of bed hold. And, their DON sent reports of discharges to the ombudsman. An interview was conducted on September 4, 2025 at 10:06 AM with Patient Account Coordinator/Staff #74. Staff #74 stated that she checks and verifies insurance and get authorization, checks resident's documentation for every resident in the facility so she and the case manager can plan a safe discharge for the resident. Staff #74 stated that she takes care of bed hold. She stated that if their resident is admitted in the hospital, she takes care (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of bed hold so the resident will not lose their room. She will offer the resident a bed hold either in person before going out to the hospital or she will speak or reach out to the resident's family member or Power of Attorney (POA). She stated that the cost is $600.00 per day and she will have the form ready for resident or family to sign. She sated that the Bed Hold acknowledgement form is provided each time a resident is send out. But if a resident is going home, going to an assisted living (AL), the bed hold is not offered because it is not needed. Furthermore, Staff #74 stated that if a resident was not able to consent, she would look in the resident's chart to see who the resident's POA or emergency contact. If the bed hold is not signed or was declined verbally, the resident might still be able to come back if a bed is available and that will be handled by admission and not her.On September 4, 2025 at 12:05 PM, a request was made for a bed hold document for Resident #48 and at 1:13 PM Regional Director of Clinical Resource/Staff #300 returned the form, CMS form 807, and wrote Document unavailable to provide.An interview was conducted on September 4, 2025 at 1:41 PM with DON/Staff #76. The DON stated that the process regarding bed hold, Staff #74 from the finance and the administrator handles bed hold and admission to make sure they can fill the bed. Furthermore, the DON stated that if a bed hold was not communicated to the resident, the risk is resident will not have a placed to be at and will be sent some place else.An interview was conducted on September 5, 2025 at 10:44 AM with the administrator/Staff #51 in her office. The administrator stated that their bed hold policy process is if a resident was sent out, there is a follow up with resident's family member so the resident will have the chance to hold the bed if that is what they like, and the process of bed hold starts after the resident is sent out. The administrator stated that her corporate is starting to create a packet to be given to nurses so if there is a resident who is send out, the nurses will know what to do, to always make sure that there is a bed hold when a resident is sent out, and that there is always a communication to resident and family regarding bed hold. The administrator stated that regarding Resident #48, her previous DON charted that a bed hold was given but she is not seeing the document while looking at Resident #48's electronic record. The administrator stated that during the day, the bed hold is handled by Staff #74. Despite the administrator stating that her previous DON charted that a bed hold was given, review of the progress note dated August 6, 2025 at 8:43 PM revealed a documentation Bed hold policy was given: Emergent transfer, and the documentation did not indicate whether a bed hold was given or not. Review of facility's admission packet, Section 14 Bed Holds, revealed If the Patient leaves the Facility for a temporary stay in an acute care hospital, the Patient and/or Legal Representative may request that the Facility hold a bed until the Patient returns. Determinations regarding bed hold requests will be made at the Facility's sole discretion.Review of facility's policy titled, Bed Hold, updated on April 22, 2024 revealed prior to discharge, or as soon as possible thereafter if discharge is emergent, a facility representative will provide the patient, a family member, or legal representative a written notice of the specific duration of the bed-hold and the charges included, if any.