

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Citadel Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 5121 East Broadway Road 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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation, policy review, and the State's Agency (SA) complaint tracking system, the facility failed to protect two residents (#3 and #9) right to be free from sexual abuse by other residents (#4 and #10). The deficient practice could result in residents being at risk for further abuse. Based on clinical record review, staff interviews, facility documentation, policy review, and the State's Agency (SA) complaint tracking system, the facility failed to protect two residents (#3 and #9) right to be free from sexual abuse by other residents (#4 and #10). The deficient practice could result in residents being at risk for further abuse. Findings include:-Regarding Resident #9 (Alleged Victim):Review of Resident #9's care plan initiated on October 25, 2018 revealed resident has impaired cognitive function related to dementia and memory loss. Resident #9 was admitted to the facility on [DATE] with a diagnosis that included Hypertension, Diabetes mellitus (DM), Arthritis, Non-Alzheimer's Dementia, Depression, and Schizophrenia. Review of Minimum Data Set (MDS) annual assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 8.0, moderately impaired and rejection of care, wandering and behavioral symptoms were not exhibited. Review of the Interdisciplinary Team (IDT) progress notes dated July 20, 2023 revealed resident was interviewed regarding a resident to resident contact. Resident reported that she felt safe in the facility, that no one touched her and that she would report it if something did happen. Resident was being monitored for her psychosocial well-being. Review of another MDS for significant change dated August 1, 2023 revealed a BIMS score of 5.0, severe impairment and behavioral symptoms not exhibited. -Regarding Resident #10 (Alleged Perpetrator):Resident #10 was admitted on [DATE] with a diagnosis that included diabetes mellitus (DM), hypertension and cerebrovascular accident (CVA). Review of admission MDS assessment dated [DATE] revealed a BIMS score of 7.0, severe impairment, and resident exhibited physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually). Review of care plan initiated on June 23, 2023 revealed a potential for a behavior problem related to cognitive decline. The interventions included to anticipate and meet needs, approach in a calm manner, and document behaviors and resident response to interventions. Review of nursing progress notes dated July 20, 2023 revealed the resident was seen touching another resident around the waistband. The residents were immediately separated, assessed, questioned, and educated. The provider and representative were notified. Resident #10 was placed on a one on one supervision, psych referral sent, and resident placed on change of condition monitoring. Review of another care plan initiated on July 20, 2023 revealed a potential to demonstrate inappropriate behaviors. The interventions dated July 20, 2023 included one on one staff observation, psych to evaluate and treat, and educating resident regarding being appropriate with others. Review of progress note dated July 21, 2023 revealed resident is on change of condition monitoring for inappropriate behaviors. On July 21, 2023, review of record revealed that Resident #10 was discharged to another facility. Review of facility's 5-day investigation report revealed that an interview was conducted with a certified nursing assistant (CNA/Staff #901). Staff #901 reported that she walked into the dining room where Resident #9 and Resident #10 were sitting in their wheelchair directly in front of each other. Staff stated that she thought she saw Resident #10's hands on Resident #9's lap and around her waistband. Staff #901 reported that while she was walking in, she observed Resident #9 pushed Resident #10's hand away and began to propel herself towards her lunch table. Staff #901 ensured the residents were safe and separated and she went to get help. The facility investigation concluded that abuse did not occur. -Regarding Resident #3 (Alleged Victim):Resident #3 was admitted to the facility on [DATE] with a diagnosis that included Hypertension, Urinary tract infection (UTI), Diabetes mellitus (DM), Non-Alzheimer's Dementia, Seizure disorder, and Depression. Review of significant change in status MDS assessment dated [DATE] revealed a BIMS score of 8.0, moderately impaired. Review of care plan initiated on April 30, 2024 revealed resident has an alteration in neurological status related to history of subarachnoid hemorrhage. The interventions included cueing and reorientation as needed. Another care plan initiated on April 24, 2024 revealed resident was at risk for impaired cognitive function/dementia or impaired thought processes related to unspecified dementia, and at risk for communication problem related to expressive aphasia. Review of nursing progress notes dated June 14, 2024 at 18:32 PM revealed Resident #3 was observed in a male resident's room. Resident was taken out of the room and brought back to her own room. Resident #3 was placed on a 15-minute checks. A skin check was completed and found no bruising</p>		