Printed: 03/16/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035280	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sante of Mesa	5358 East Baseline 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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2025
NAME OF PROVIDER OR SUPPLIER Sante of Mesa		STREET ADDRESS, CITY, STATE, ZIP CODE 5358 East Baseline Road Mesa, AZ 85206	

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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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure that one resident (# 634) was properly informed by not implementing a password protocol for visitation.Based on clinical record review, interviews, and facility documentation and facility documentation and policy, the facility failed to ensure that the facility implemented a password protocol to protect one resident (# 634) from harm. The sample size was four residents. This deficient practice could result in residents being further victimized. Findings include:Resident # 634 was admitted to the facility on [DATE] with diagnoses that included dementia, respiratory failure with hypoxia, atrial fibrillation, long term use of anticoagulants, anxiety, hypertensive heart disease with heart failure, and muscle weakness. The admission Minimum Data Set (MDS) dated [DATE], revealed that the resident had a Brief Interview for Mental Status (BIMS) of 08, indicating moderately impaired cognition. The clinical record banner alert, retrieved July 2, 2025, with special instructions that the son was trespassed. A progress note dated August 15, 2023 revealed that the resident's son was trespassed from the building, and no resident information was to be shared about the resident. A progress note dated September 13, 2023 revealed a password protocol was implemented on September 11, 2023, which required a password for resident visitation. The note further revealed that assistance was required to remove parties from the resident's room that were creating a disturbance. The parties did not know there was a password needed to see the resident. The care plan did not reflect a safety plan for the resident. The clinical record did not record the password protocol for resident. A joint interview was conducted with CNA (Staff # 77) and Assistant Director of Nursing (ADON/Staff # 39) on July 2 2025 at 11:47 a.m. The parties revealed that when a guest/visitor enters the facility, that guest will sign the guest book, and ask for the room number. The parties further explained that the doors are locked from 8 p.m. to 6 a.m., and in that case, the visitors will use the intercom system and staff will escort the visitors to the room. An interview was conducted with CNA (Staff # 77) on July 2, 2025 at 11:52 a.m. The CNA revealed that abuse is any unwanted action toward someone, that can include verbal, physical, emotional, and confinement. The CNA further proceeded that if a visitor is not treating the resident with respect, she will inform the visitor to leave. In addition, she will also grab a nurse to help escort someone off the property, but fortunately, she has not had to deal with an episode like that in a long time. An interview with Licensed Practical Nurse (LPN/Staff # 43) was conducted on July 2, 2025 at 12:25 p.m. The LPN identified that abuse can be anything that would threaten a resident in their view, which can include physical, emotional, financial, and sexual in nature. During an interview conducted with the Director of Social Services (DoSS/Staff # 10), on July 2, 2025 at 1:50 p.m., revealed abuse in services is conducted approximately three to four times a year, in addition to a skills fair, to reinforce abuse training. The DoSS explained that the password protocol should have been in the resident's chart on a banner as an alert. The DoSS further explained that the password protocol is implemented on residents that require extra security from outside parties. After review of the clinical record, the DoSS revealed that facility expectations for enhanced security measures of this resident were not met. An interview conducted with the Executive Director (ED/Staff # 61) , conducted on July 2, 2025 at approximately 2 p.m., who revealed being unable to locate the password or password protocol in the chart. After review of the clinical record, the ED revealed that the password protocol should have been documented appropriately. All interviews failed to reflect what the resident's password protocol was. Involved parties were not available for interviews. The Abuse Prevention Program policy, revised December 2016, advises that the facility is to protect the residents from abuse by anyone including family members, legal representatives, friends, visitors, or any other individual. An objective of the Quality Assurance and Performance Improvement (QAPI) Plan, policy revised April 2014, reinforces and builds upon effective systems and processes related to the delivery of quality care and services. The Trauma Informed Care policy, Identification Number NS-12056, revealed the facility should implement resident-specific approaches to be developed and included in the resident's care plan. In addition, facilities must evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization.