

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Desert Terrace Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2509 North 24th Street Phoenix, AZ 85008	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47954</p> <p>Based on clinical record reviews, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure that two residents (#20) and (#40) were free from abuse from other residents (resident #75). The deficient practice could result in further incidents of resident to resident abuse.</p> <p>Findings include:</p> <p>Regarding resident #20 and resident #75</p> <p>-Resident #20 was admitted to the facility on [DATE], with diagnoses that included hemiplegia, urinary tract infection, gastroesophageal reflux disease, anxiety, and bipolar disorder.</p> <p>Review of the Discharge Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that the resident had no cognitive impairment.</p> <p>A behavioral care-plan initiated September 24, 2024 revealed that the resident was at risk for impaired cognitive function related to hemiplegia and hemiparesis following cerebral infarction, with a noted intervention of monitor, document, and report to provider any changes in cognitive function, decision making ability, difficulty understanding others, and mental status.</p> <p>-Resident #75 was admitted to the facility on [DATE], with diagnoses that included post traumatic stress disorder, anxiety, attention deficit hyperactivity disorder, substance abuse, insomnia, and depression.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had no cognitive impairment.</p> <p>A behavioral care-plan initiated September 26, 2024 revealed the resident was at risk for trauma related to history of trauma, and post-traumatic stress disorder, which a goal of no emotional, physical, or psychological problems by the review date of December 18, 2024 and noted interventions of anticipate and meet the residents needs and resident can be triggered by loud noises so provide a calm and quiet environment.</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
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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>A review of the clinical record progress notes for resident #20 dated September 30, 2024 at 12:46 a.m. revealed that the nurse knocked on resident #20's door, and upon opening resident #20 and resident #75 were raising their voices at each other. Resident #20 was out of bed moving her wheelchair and ambulating, at the same asking for her cellphone back from resident #75. Both residents continued raising their voice at each other, and resident #75 suddenly raised her voice and threatened resident #20 over the cell phone disagreement and threw the cell phone on the floor.</p> <p>An interview was conducted with a Certified Nursing Assistant (CNA/staff #55) on October 10, 2024 at 2:20 p. m. The CNA reported that resident #75 has had altercations with several residents. The CNA stated that resident #75 had psyche issues and would accuse residents of stealing her things like clothes and other belongings, even though the items were donated by the facility to resident #75. The CNA concluded that resident #75 was the instigator in the incident with resident #20.</p> <p>Regarding resident #40 and resident #75</p> <p>-Resident #40 was admitted to the facility on [DATE], with diagnoses that included acute respiratory failure, pneumonia, heart disease, congestive heart failure, insomnia, and depression.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had no cognitive impairment.</p> <p>A review of the clinical record progress notes for resident #40 dated October 3, 2024 at 10:00 a.m. revealed that resident #40 and resident #75 were engaged in a verbal exchange in the hallway. It was then observed that resident #75 raised her leg and made contact with resident #40 in the abdomen. It concludes that the residents were separated and resident #40 wished to continue to discharge as planned.</p> <p>An interview was conducted with a Certified Nursing Assistant (CNA/staff #91) on October 10, 2024 at 1:34 p. m. The CNA stated that resident #75 was alert and oriented, however she was also very behavioral. The CNA stated that she heard the resident's arguing from another room, darted out into the hallway where she witnessed resident #75 kick resident #40 in the chest. The CNA concluded that this was the first time she has seen resident #75 get physical but also stated that she had been verbally aggressive before.</p> <p>An interview was conducted with a Licensed Practical Nurse (LPN/staff #110) on October 10, 2024 at 2:50 p. m. The LPN stated that resident #75 was alert and oriented but was a textbook, druggie type of patient, and noted that she would yell out at staff and other residents. The LPN stated that resident #75 was put in a room by herself because she would cause problems any time she had a roommate. The LPN stated that resident #75 would make paranoid statements; and that, the staff would simply redirect her as best as they could.</p> <p>(continued on next page)</p>		

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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>An interview with the Director of Nursing (DON/staff #15) was conducted on September 10, 2024 at 3:16 p. m. The DON stated that resident #75 had not been at the facility long; and that, she admitted on psychiatric medications. The DON stated that the resident on arrival was asking for dosage increases on her medications that were not appropriate. The DON stated that the first incident with resident #20 raised concerns, but she thought it was an isolated incident, and that they were separated immediately. The DON then stated that the second incident involving resident #40 and resident #75 confirmed the residents were arguing in the hall, and resident #75 raised her up and made physical contact between the two. The DON concluded that after the incident they put resident #75 on 1 to 1 with staff, and eventually had her petitioned to go to a psyche facility. The DON concluded that her expectation is that residents are separated when an incident occurs and reported appropriately.</p> <p>A review of facility policy titled 'Abuse: Prevention of and prohibition against' revised October of 2024 revealed that it is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident's property, and exploitation. It further revealed that willful as used in this definition of abuse, means the individuals must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p>		