

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 01/24/2025
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** 40581</p> <p>Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that one resident (#44) was not abused by another resident (#55). The deficient practice could result in residents being physically and emotionally harmed.</p> <p>Findings include:</p> <p>Resident #44 was admitted on [DATE] with diagnoses that included bipolar disorder, generalized anxiety, unspecified mood disorder, and end stage renal disease.</p> <p>The care plan dated March 10, 2023 revealed that the resident has a potential for injury while smoking. The interventions included to observe the resident smoking, while in the designated area.</p> <p>The Minimum Data Set, dated dated [DATE] included a brief interview for mental status score of 15 indicating the resident was cognitively intact.</p> <p>An alert note dated April 24, 2023 at 6:56 p.m. revealed that resident #44 was assaulted by another resident on the patio at 5:30 p.m. The resident reported having a disagreement with the other resident and he began to hit him in the back of his head on the right side. The resident refused to go to the hospital.</p> <p>A progress note dated April 24, 2023 at 7:50 p.m. revealed that at approximately 5:30 p.m. the resident was sitting on the smoking patio, when another resident stood up and approached him unprovoked and punched him behind his right ear. The certified nursing assistant immediately separated both residents. The area behind the right ear was noted to have redness. Resident #44 denied any pain and stated did not need to go and be checked out. The resident was placed on a change of condition for monitoring. The provider assessed the resident with no new orders at this time.</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>An Interdisciplinary Team (IDT) meeting note dated April 25, 2023 revealed that on April 24, 2023, the resident was sitting on the smoking patio with the other residents when another resident quickly stood up from his wheelchair and approached this resident, unprovoked, and punched him behind his right ear. A certified nursing assistant (CNA) witnessed the interaction and immediately stepped between the residents separating them. This resident chose to stay on the smoking patio. Resident #44 stated to the CNA that he didn't say anything to the other resident and that resident (#55) just got up and started hitting him. Resident #44 refused a skin assessment, but does have a small reddened area noted behind the right ear. The provider was in the facility and checked the resident.</p> <p>A care plan dated April 25, 2023 revealed that the resident has the potential for a mood problem, behavior problems related to depression, anxiety, bipolar disorder, mood disorder, irritability, and anger. On April 24, 2023, an incident was witnessed with another male resident. Interventions included to monitor/observe in mood/behaviors, fear of other residents and /or staff and notify provider if present.</p> <p>-Resident #55 was admitted on [DATE] with diagnoses that included unspecified mood affective disorder, psychoactive substance abuse, nicotine dependence, and dysphagia.</p> <p>The care plan dated March 10, 2023 revealed that the resident has a potential for injury while smoking. The interventions included to observe the resident while in the designated area.</p> <p>Review of the care plan dated March 14, 2023 revealed that resident #55 took anxiety medication related to anxiety as evidenced by restlessness. Interventions included to monitor/record occurrence of target behavior symptoms (restlessness) and document per facility protocol.</p> <p>Review of the care plan dated March 14, 2023 revealed that resident #55 was prescribed psychotropic medications related to a traumatic brain injury that induces psychosis as evidenced by paranoid delusions. Interventions included to monitor/record occurrence of target behavior symptoms (paranoid delusions) and document per facility protocol.</p> <p>The Minimum Data Set, dated dated [DATE] included a brief interview for mental status score of 14 indicating the resident was cognitively intact.</p> <p>A nurse progress note dated April 24, 2024 at 7:25 a.m. revealed that the resident was noted to have a significant change in mental status. The medical doctor was notified and received new orders for UA (Urinalysis)/ CMP (Compressive Metabolic Panel).</p> <p>The nursing note dated April 24, 2023 at 8:28 a.m. stated that the nurse received additional orders for a psych consult and additional labs as well.</p> <p>A physician note dated April 24, 2023 at 1:52 pm (late entry) included a history of present illness, which revealed that the resident had previously exhibited aggressive/violent behavior while in another skilled nursing facility.</p> <p>The nurse note dated April 24, 2023 at 3:41 p.m. revealed that the resident continues to have episodes of increased agitation in which the resident refuses to take medications and continue to not be able to redirect the resident.</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>A nurse note dated April 24, 2023 at 6:35 p.m. revealed that the resident was transported to the hospital via 911 related to increased agitation.</p> <p>An interview was conducted on January 24, 2025 with a certified nursing assistant (CNA/staff #13), who stated that there is supposed to be at least one staff present when the residents are smoking to ensure the safety of the residents, which includes supervising the residents to ensure that they are not harming each other. She stated that if a resident was agitated and heading toward another resident, she would redirect the resident and if the resident hits another resident, it is abuse.</p> <p>An interview was conducted on January 24, 2025 at 3:11 p.m. with a licensed practical nurse (LPN/staff #21), who stated that staff should be able to recognize if there is a change in a resident's body language and know if a resident is becoming agitated. He stated that he and other staff have been trained on deescalating techniques and if a resident hits another resident, it is abuse.</p> <p>An interview was conducted with the Director of Nursing (DON/staff #1) on January 24, 2025 at 3:44 p.m. Staff #1 stated that it is her expectation that staff read cues when supervising the residents and if a resident has a diagnosis, the staff should be monitoring the behaviors. She also stated that all of the staff have received training on abuse and when a resident hits another resident, she considers it abuse.</p> <p>The facility policy, Abuse: Prevention of and Prohibition Against states that it is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.</p>