STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035014	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Terrace Healthcare Center	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035014	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Terrace Healthcare Center	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of facility documentation and policies, the facility failed to protect the rights of one resident (#1) to be free from abuse by another resident (#2). The deficient practice could result in further abuse of residents when appropriate actions are not taken.Findings Include:-Resident #1(alleged victim) was readmitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis of the left non-dominant side, major depressive disorder, and age-related bilateral cataract.The census report revealed that Resident #1 shared the same room with Resident #2 since September 26, 2025. A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13.0, indicating that the resident was cognitively intact. The assessment also included that the resident had not exhibited behavioral symptoms.Review of the comprehensive care plan dated September 14, 2023, revealed the resident had a potential for a psychosocial well-being problem related to the disease process, and the resident was at risk for impaired cognitive function. The interventions included to provide necessary cues, stop and return if agitated, and ensure/provide a safe environment.The nursing progress note dated October 5, 2025, revealed that at approximately 4:15 PM, the certified nursing assistant (CNA/Staff #6) reported that Resident #1 had a bloody face and that Resident #2 was walking away from Resident #1. According to the document, the nurse found Resident #1 in the restroom with blood on his face, had superficial wounds to the right forehead, bridge of nose, tip of nose, upper lip, and chin. The documentation included that Resident #2 used his hand to hit the face of Resident #1. Further, the documentation included that Resident #1 wanted to press charges, and the police were called.The care plan was revised on October 5, 2025, to include a resident-to-resident incident report. The intervention included to monitor for psychosocial changes and changes in mood/behavior patterns.The Weekly/PRN Skin Evaluation dated October 5, 2025, revealed lacerations to the right forehead measuring 2.0 by 0.2; bridge of nose measuring 1.4 by 1.5; top of nose measuring 0.8 by 0.1; top of lip measuring 0.4 by 0.1; and chin measuring 0.8 by 0.1.There was no evidence found that Resident #1 was transferred to the hospital.-Resident #2 (alleged perpetrator) was admitted on [DATE], with diagnoses that included cellulitis of the right lower limb and Type 2 Diabetes Mellitus.The IDT (Interdisciplinary Team)-BIMS assessment dated [DATE], revealed Resident#2 had a BIMS score of 15.0, indicating that the resident was cognitively intact.A review of the Nursing progress note dated October 5, 2025, revealed that at approximately 4:15 PM, the CNA (Staff #6) noted Resident #2 was walking away from Resident #1 who had blood on his face. Per the progress note, Resident #2 initially denied hitting Resident #1, but later admitted to hitting Resident #1 due to his use of a racial slur.Another nursing progress note dated October 5, 2025, revealed Resident #2 was discharged from the facility after signing AMA.The undated facility investigation report revealed a Resident-to-Resident incident between Resident #1 and Resident #2 on October 5, 2025. The Licensed Practical Nurse (LPN/Staff #9) reported to the Director of Nursing (DON/Staff #23) and the administrator (Staff #20) that the CNA (Staff #6) who was in the room of Resident #1 and Resident #2 found Resident #1 with a bloody face while Resident #2 was walking away from Resident #1. Per the report, the LPN found Resident #1 in the restroom with blood on his face, and that Resident #1 insisted that Resident #2 used his hand and making contact on his face. The report also revealed that Resident #1 would like to press charges. Continued review of the facility investigation report revealed that Resident #1 had superficial wounds to the right forehead, bridge of nose, top of nose, upper lip, and chin, and that Resident #2 left the facility against medical advice on October 5, 2025. Further, the facility investigation report concluded that, based on their record review and staff interviews, the incident was an unanticipated and isolated incident that happened in an area with adequate staff supervision.On October 22, 2025, at 10:42 AM, an interview was conducted with Resident #1, who stated that last week or a couple of weeks ago, while he was sitting in his wheelchair, he was hit on his left forehead, had a cut, and was bleeding. Resident #1 stated that he had pain for a couple of hours after he got hit.A phone interview was conducted on October 22, 2025, at 10:56 AM with a CNA (Staff #6), who stated that regarding the incident between Resident #1 and Resident #2, the CNA stated that the day before the incident, Resident #2 was yelling at another resident. The incident between Resident #1 and Resident #2 happened a couple of Sundays ago, and she was working that weekend. She stated that Resident #2 was only in the facility for a short time, and Resident #2 was the aggressor during the incident with Resident #1. She said that she was at the nurses' station when she heard a resident yelling, stop hitting him. The CNA