

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/25/2026
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)		
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and review of facility policy and procedure, the facility failed to protect a resident's (#2) right to be free from physical abuse from another resident (#1), for one of three sampled residents. The deficient practice could lead to physical or psychosocial harm of a resident. Findings include: -Regarding Resident #2: Resident #2 was admitted to the facility on [DATE], with diagnoses that included bipolar disorder, major depressive disorder, anxiety disorder, acute ischemia of the large intestine, stage 4 pressure ulcer of sacral region, and paraplegia. A care plan focus initiated April 20, 2026, revealed Resident #2 had the potential to demonstrate verbally abusive behaviors due to mental/emotional illness and poor impulse control. Interventions included to analyze and document key times, places, circumstances, triggers, and what de-escalates behavior, to document observed behavior and attempted interventions, for psychiatric consult as indicated, and to assess the resident's understanding of the situation and allow time for the resident to express self and feelings towards the situation. Another care plan focus initiated April 20, 2026, revealed Resident #2 was at risk for impaired cognitive function or impaired thought process due to bipolar disorder, depression, cognitive deficits, history of traumatic brain injury, urinary tract infection, and post-traumatic stress disorder. Interventions included to engage in simple, structured activities that avoid overly demanding tasks, for social services to provide psychosocial support as needed, and resident centered behavioral interventions: (please specify) which was left blank and did not specify any resident centered behavioral interventions. A physician's order dated April 20, 2026, included for Divalproex Sodium oral tablet delayed release 250 mg, to give 1 tablet by mouth two times a day for bipolar disorder as evidenced by mood lability, and to include non-pharmacological interventions and outcome observed. A physician's order dated April 21, 2026, included for a nicotine transdermal patch for 21 mg / 24 hours. The order was discontinued on April 24, 2026. Additionally, a care plan focus initiated April 22, 2026, revealed Resident #2 had a potential for injury due to smoking, and had a behavior of asking other residents for cigarettes. Interventions included to explain smoking policy, to observe smoking while in designated area, and to monitor to assess compliance with facility smoking policy/individual plan. An admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #2 had a Brief Interview for Mental Status (BIMS) assessment score of 15, indicating intact cognition. A Psychiatric Note dated June 9, 2026, revealed a follow-up psychiatric consultation due to the resident's history of bipolar disorder, anxiety disorder, borderline personality disorder, and depression. Recommendations included that Resident #2 had continued behaviors since last visit, therefore the plan was to continue the psychotropic medications. A Nursing note dated June 16, 2026, revealed Resident #2 was observed going from room to room attempting to steal cigarettes, and that the nurse spoke with the resident regarding his behavior. The note revealed the resident became aggressive and belligerent with staff and threatened to pull the nurse's hair braids out. The note included the resident was educated on his behaviors with staff, wandering into other resident rooms, smoking hours, and sharing cigarettes. A Social Services note dated June 17, 2026, revealed Social Services and the Administrator spoke with Resident #2, who then agreed to transfer to another (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 035014
		If continuation sheet Page 1 of 5

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents to smoke, that she was on the patio and assisting residents with getting water, and she overheard a resident yell look they're arguing, and when Staff #5 looked up she saw Resident #1 come out of the hallway through the glass sliding doors, into the outdoor patio area. Staff #5 stated that Resident #1 stated that he had just hit Resident #2, and Staff #5 stated that she replied for Resident #1 not to do that. Staff #5 stated that another resident (Resident #8) stated that she saw Resident #1 hit Resident #2. Staff #5 also stated that after the incident, Resident #1 told her that he had hit Resident #2 because he had overheard Resident #2 speaking disrespectfully to Staff #5 earlier. Staff #5 stated that later that day, Resident #2 approached her and apologized for speaking disrespectfully to her. An interview was conducted with Resident #8 on June 25, 2026, at 10:56 a.m. who stated that on Saturday, June 20, 2025, between 9:00 and 10:00 a.m., she was on the smoking patio and witnessed the incident between Resident #1 and Resident #2. Resident #8 stated that she saw what looked like Resident #1 yelling at Resident #2 in the hallway just inside the glass door from the smoking patio. Resident #2 stated she observed Resident #1 hit Resident #2 in the face with his fist. An interview was conducted with a CNA (Staff #10) on June 25, 2026, at 11:59 a.m., who stated that CNAs monitor for residents' behaviors to determine if anything is new or changed, and that would be reported to the nurse. The CNA stated that an example of physical abuse would be one resident hitting another resident. Regarding Resident #2, the CNA stated that she had heard through verbal report from other staff that he could be mean and aggressive. Regarding Resident #1, the CNA stated that he was behavioral and often called staff names. The CNA stated that she had heard that there was a physical altercation incident between the two residents recently. An interview was conducted with a CNA (Staff #31) on June 25, 2026, at 12:05 p.m., who stated that abuse could be verbal, mental, financial, or physical, and some examples of abuse would be residents using foul language toward each other or hitting each other. The CNA stated that she received verbal report at shift change when she worked on June 21, 2026, that on the previous day, Resident #1 and Resident #2 had a physical altercation incident. An interview was conducted on June 25, 2026, at 12:14 p.m., with a Registered Nurse (RN / Staff #76) who stated that there were different types of abuse, including physical or verbal, and that she would consider one resident hitting another resident a form of abuse. The RN stated that she arrived to work on Sunday, June 21, 2026, and noticed that Resident #1 had a one to one staff member placed with him. The RN stated that she then asked Resident #1 why he had a sitter, and Resident #1 stated that he had hit Resident #2 in the face. An interview was conducted on June 25, 2026, at 1:46 p.m. with the Director of Nursing (DON / Staff #22) on June 25, 2026, at 1:45 p.m., who stated that her understanding of abuse was that it could include mental, physical, emotional, or financial abuse, and was an instance where a resident suffered physical harm or psychosocial harm. The DON stated an example of physical abuse would be any unwanted physical contact, including hitting, spitting, and shoving. The DON stated that the process for preventing abuse was for staff to monitor residents constantly, to notice any indication of changes in behavior, and to put into place any necessary interventions. The DON stated that behavior monitoring was documented primarily on the MAR/TAR, including any NPI that were put into place for residents. Additionally, the DON stated that if a resident had repeated behaviors, then the care plan would be updated to address the behavior. The DON stated that if there was a situation where physical abuse of a resident occurred in the facility, the risk to the resident would be injury or psychosocial harm. Regarding Resident #1, the DON stated that the resident had bipolar disorder, schizophrenia, and insomnia, and had behaviors of being rude to staff members. Regarding Resident #2, the DON stated that he had bipolar disorder, major depressive disorder, and anxiety, and had a history of behaviors including refusing cares, and being verbally disrespectful toward staff. Regarding the incident, the DON stated that she was out of the facility on vacation at the time, and had received a message on June 20, 2026, that Resident #2 was being placed with a one to one staff member. The DON stated she subsequently learned that Resident #2 reported to the charge nurse (Staff #45) that Resident #1 had made physical contact with him, and that she was informed that Resident #2 did not have any skin issues or injuries (continued on next page)		

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