

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035062	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER Desert Haven Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2645 East Thomas Road Phoenix, AZ 85016	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910</p> <p>Based on observation, staff interviews, and review of facility documentation, the facility failed to ensure call light was within reach for one resident (#27). The deficient practice could result in a preventable accident and resident not able to meet the resident's needs.</p> <p>Findings include:</p> <p>Resident #27 was admitted to the facility May 17, 2024 with two discharges to the hospital on July 22, 2024 and October 21, 24. Resident was readmitted to the facility on [DATE] with diagnoses of atherosclerotic heart disease of native coronary artery without angina pectoris, encephalopathy, unspecified, and bipolar disorder.</p> <p>Review of the quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (brief interview of mental status) score of 06 indicating severe cognitive impairment. Further review of the MDS revealed the resident has both upper and lower impairment on both sides.</p> <p>A care plan dated May 29, 2024 revealed resident had activities of daily living (ADL) self-care deficit and needed assistance with bed mobility, transfer, locomotion, eating, toilet use, personal hygiene, bathing related to spinal stenosis, impaired mobility and behavioral episodes. The care plan also revealed interventions which included positioning rail(s) as an enabler: 1/4 rails; Assist and/or guard position rails and soft touch call light.</p> <p>The physician order report revealed an order dated October 31, 2023 for opiod medication monitoring for nausea, vomiting, sedation, slowed reaction, respiratory depression.</p> <p>An observation was conducted on November 06, 2024 at 9:20 A.M. The soft touch call light was in the resident's top dresser drawer, approximately two feet out of reach from the resident.</p> <p>A follow up observation on November 06, 2024 at 12:36 P.M. revealed the resident's soft touch call light pinned on the resident's lap at her hip -- out of reach for the resident. The resident was screaming for help. This surveyor entered the resident's room and the resident immediately asked if this surveyor could have the call light placed where she is able to reach it.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the providers progress note dated August 27, 2024 revealed resident was seen for follow-up due to altered mental status. The note stated, Since last week her delirium and screaming is nearly constant. She is up all night and then naps during the day. Recently did a GDR on Seroquel and she is somewhat worse with behaviors, continues to see things on wall but this is no different that prior to her hospitalization . This morning she was napping but opened her eyes. Says the oxygen does not stay on, this provider adjusted the NC. She requires 1:1 assist with eating, bed positioning, hygiene and other ADL's.</p> <p>An interview was conducted on November 06, 2024 at 12:53 P.M with certified nursing assistant (CNA#12/Staff) CNA #12 stated that resident #27 was dependent for total care and dependent for eating. Stated the resident requires a pad call light due to limited movement. She stated the resident had limited movement with her right arm; and that, she did not recall whether she had placed the call light within reach for the resident after her rounds at 6:30am. CNA #12 stated she assisted the resident with her breakfast at approximately 7:40 a.m. and following breakfast at approximately 9:15 a.m. had placed the call light on the resident's gown. She stated no one else had entered the resident's room, since she was the one assigned to the resident for the day. CNA #12 stated when the resident needs assistance she will use her call light or start yelling.</p> <p>In an interview with the Director of Nursing (DON/Staff#12) November 06, 2024 at 1:07 P.M. she stated resident #27 uses a touch call light and it should be placed on her upper chest. The DON stated the resident does not have the ability to reach her call light at her hip and had noticed this when in the resident's room. The DON stated she had to reposition the resident's call light to where it was within reach; and that, the risk of not having the call light within reach is the resident would be unable to call for help if needed and could fall.</p> <p>A request was made for the facility Call Light Policy. DON/Staff#12 stated the facility does not have a Call Light Policy and signed a statement indicating the facility does not have a Call Light policy.</p>		