

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: 035062	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2026
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)		
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 clinical record review, staff interviews, facility documentation, policies and procedures, the facility failed to protect the rights of two residents (#87, and #37) to be free from physical abuse from each other. The deficient practice could result in further abuse of residents and appropriate action not taken. Findings include: -Resident #87 (alleged victim, AV) was admitted to the facility on [DATE] with diagnoses that included Schizophrenia, social pragmatic communication disorder, anxiety disorder, autistic disorder, difficulty walking, cognitive communication deficit, generalized muscle weakness and other comorbid conditions. A behavioral care plan revised April 21, 2026 indicated that the resident #87 has a behavioral problem as evidenced by being intrusive to others, and verbally aggressive toward others. Interventions include discussing the behaviors with the resident and explaining and/or reinforce why behavior is unacceptable. Also included in the interventions is to approach calmly, divert attention and remove from the situation and take to another location to protect the rights and safety of others. A review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident has a BIMS score of 15 indicating intact cognition. The MDS also indicated that the resident wanders at the hallway for one to three days during the assessment period. An incident note dated May 16, 2026 at 6:07 pm documented that the resident #87 bit the hand of resident #37 and stated that she pulled my hair and I bit her hand. An additional situation, background, assessment and recommendation (SBAR) note on May 16, 2026 at 6:46 pm stated that the staff came to help resident #87 after she called out for help. The SBAR note also stated that at the scene, resident #37 was holding hairs on her hand and the staff separated both residents and one of the staff took resident #37 to the dining room, while other staff stayed with resident #87. Resident #87 stated during that time that I was passing by resident #37, and she pulled my hair, that is why I had to bite her on her hand. The SBAR note further stated that the nurse noticed a bore spot on the top of resident #87's head. A health status note in May 17, 2026 at 1:43 pm stated that resident #87 complained of soreness on top of her scalp, which she was given Tylenol for pain relief. -Resident #37 (alleged perpetrator, AP) was admitted to the facility on [DATE] with diagnoses that included Schizoaffective disorder bipolar type, difficulty walking, delusion related to Schizophrenia, Insomnia, and other comorbid conditions. A cognition care plan initiated on July 22, 2021 and revised on February 4, 2024 revealed that resident #37 has impaired cognitive function related to Schizophrenia, dementia with behavioral disturbances, insomnia and bipolar disorders. Some of the interventions from this cognition care plan included passive approach and stay in control when resident #37 is agitated and constantly reminding her (resident #37) that she is in a safe environment. A review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident has a BIMS score of 7 indicating severe cognitive impairment. The MDS also indicated that the resident wanders at the hallway for four to six days during the assessment period. A behavioral care plan initiated on July 22, 2021 and revised on May 4, 2026 indicated that resident #37 displays behavioral symptoms related to her diagnoses. Resident #37 exhibits care refusal, disruptive yelling, physical and verbal aggression, placing herself on the floor and wandering, delusion, and hallucination. Some of the (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
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions identified in this care plan included staff's attempts to communicate using creative refocusing to alter behavior patterns when behavioral signs such as yelling, cussing, and inappropriate behaviors arise. Based on previous behavioral notes on May 14, 2026 at 4:54 pm resident #37 was observed to be in the hallway pacing while swinging her hands, restless and was redirected to her room. On May 16, 2026 at 2:29 pm prior to the incident, the resident was also observed ambulating along the hallway and was also redirected. An additional behavioral note dated May 16, 2026 at 5:52 pm stated that staff heard other residents screamed for help, upon checking the scene, resident #37 was observed holding a bunch of hair on her hand, after pulling it from the other resident's hair. An additional behavioral Note on May 16, 2026 at 5:49 pm stated that the nurse heard someone yelling for help, the staff came to witness resident #37 holding a bunch of hairs on her hand, with resident stated I pulled resident #87's hair and she bit my hand. However, the staff intervened and took resident #37 to the dining room while the other staff stayed with resident #87. The same behavior note stated that resident #37 was assessed and a bite mark was observed on her left wrist. Resident #37 was moved to a different room, farther from resident #87. Review of the facility's final investigation (5 day) report dated May 16, 2026 indicated that resident #37 was admitted to the facility on [DATE]. Resident #37 was at baseline cognitive status, was alert and oriented with a BIMS score of 7. Resident #37 also used a walker at times but could ambulate independently and swing her arms when ambulating. On the same 5 day report, Resident #87 was admitted to the facility on [DATE] with baseline cognitive status, alert and oriented with a BIMS score of 15. Resident #87 could ambulate independently with a slow, steady gait. The facility's 5 day report noted that the incident was a reaction on both residents. Resident #37 reacted to verbal words that resident #87 had started at breakfast and possibly carried through when she was trying to get out her door. The report also stated that resident #87 biting resident #37 was a reaction to resident #37 pulling her hair. An interview with a certified nursing aide (CNA), staff #127, was conducted on June 9, 2026. Staff #127 stated that resident #37 is a little confused and wanders a lot in the hallway daily. Staff #127 also stated that resident #37 needed a lot of redirection because she is forgetful and confused on what to do next. Staff #127 stated that based on her experience resident #87 is expressive in nature and very interactive with other residents' daily routine, which was consistent with what found on the resident #7's care plan. Staff #127 reiterated that resident #37 always moving and pacing around and resident #87 constantly reminding or redirecting resident #37 which can cause friction at the behavioral unit. An additional interview with the nurse at the floor staff #82 was conducted on June 9, 2026 at 10:00 am. The staff #82 stated that they have to constantly remind resident #37 her daily routine because she easily forgets time, place and her routine. However, staff #82 stated that resident #87 is a young resident who is always interactive with other people's conversation which most of the staff always have to remind her (resident #87) not to interfere with other people's conversation. Staff #82 also reiterated that resident #87 can be verbal at times with a bold voice towards staff, residents and sometimes yelling at the nurses. Another interview with a nurse staff #49 who was at the scene on May 16, 2026 was conducted on June 9, 2026 at 12:30 p.m. Staff #49 stated that she was called to the scene on that day and saw resident #87 sitting down and a bunch of hairs was on the floor and some on resident #37's hand. Staff #49 stated that she separated the two residents with assistance from another staff member. Resident #37 had a bite mark on her left hand. Staff #49 also provided skin assessment and stated that there was no skin torn, break or wound, however, it was just a red mark. Staff #49 also provided a head to toe check on resident #87 and found part of resident #87 scalp with no hairs but there was no skin injury or wound. Staff #49 also stated that resident #87 complained that the affected scalp area was painful, and was given Tylenol that day. Staff #49 related that resident #87 told her that when she (resident #87) passed by resident #37, resident #37 pulled her hair and she (resident #87) bit her hand. Staff #49 stated that resident #87 did not elaborate more on the reason why she bit resident #37's hand. An interview with the social services staff #500 was conducted on June 9, 2026 at 1:30 p.m. Staff #500 stated that he knew about the altercation and the (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two residents are safe at this time. Staff #500 also stated that the abuse response team worked collaboratively to address further incidents by separating the two residents as further away from each other. The two residents were neighbors prior to the date of the incident. The staff #500 also reiterated that this type of incident is chronic in the behavioral units where the two residents are housed, however, the facility is providing necessary measures to mitigate abusive occurrences such as separating females and males in different units, anticipate possible hikes in resident altercations, and proper staff development skills to address and control these problems from happening. An interview with the Director of Nursing services (DON/ staff #501) was conducted on June 9, 2026 at 1:20 p.m. The staff #501 stated that their Abuse response team treated these incidents very seriously and anticipated mitigation measures especially dealing with residents diagnosed with behavioral issues. Staff #501 also stated that she reported the incident to the respective authorities within the required time frame and conducted an internal investigation and was submitted to the authorities on time. The staff #501 reiterated that her staff undergoes Abuse training on certain time i.e., upon hiring, annually, and during their annual skill fairs and monthly staff meetings. She (staff #501) reported that she has adequate staff at the behavioral units. Staff #501 defined abuse as doing something to someone with an intention to harm them however, staff #501 willingly consented that when a resident hits another resident, hitting their head, pulling their hair, biting or even slapping other residents is a form of physical abuse which echoed similar responses from all the staff that was interviewed during the survey. A review of the facility policy titled Abuse Guidelines reviewed on February 3, 2026, revealed that it is the responsibility of the employees, facility consultants, attending physicians, family members, and visitors to promptly report any incident or suspected incident of resident abuse to the facility management. The Policy also reiterated that the facility will not condone any form of resident abuse or neglect, and that all personnel are to report any signs and symptoms of abuse and neglect to their supervisor or to the director of nursing services immediately.		