

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/19/2024
NAME OF PROVIDER OR SUPPLIER  Desert Cove Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1750 West Frye Road Chandler, AZ 85224	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49399</p> <p>Based on clinical record review, facility documentation, and staff interviews, the facility failed to ensure three residents (#1, #2 and #3) were provided adequate supervision to prevent resident abuse. The deficient practice could result in residents being at risk for abuse.</p> <p>Findings include:</p> <p>-Resident #1 was admitted to the facility on [DATE] which include a diagnoses of Hypertension, Diabetes Mellitus, Aphasia, Cerebrovascular Accident (CVA), and Bipolar Disorder.</p> <p>A review of resident's care plan dated August 14, 2023 revealed resident has the potential to be physically aggressive -strikes at others related to poor impulse control, non verbal, multiple cerebrovascular accident, confusion/impaired cognition. Resident will try to interact with others by tapping/patting them on the arm which can be misconstrued as hitting especially due to his hand contractures which appear fistlike , resident enjoys music via his headphones. Interventions include to administer medication as ordered, assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, and pain, modify environment: avoid crowding, no other residents should be within arms length of resident, staff to be present with resident when out of bed.</p> <p>A review of resident's care plan dated June 13, 2024 revealed resident is involved into 1:1 activities and small group activity such as church music and social events. Resident has to be greater than arms length of other resident due to him feeling threaten so he might try to swing at a person so a staff member must be with him at all times.</p> <p>A review of record revealed a Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed severe cognitive impairment. Resident is non verbal but able to make needs known with gestures/pointing.</p> <p>A review of resident's care plan dated November 8, 2024 revealed resident #1 was struck on their left shoulder.</p> <p>A review of care plan revealed an intervention dated November 12, 2024 was initiated for resident #1 to be escorted by staff in and out of dining room.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 035095
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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 review of record dated November 16, 2024 revealed staff saw Resident #1 hitting another resident in the hall between room [ROOM NUMBER] and room [ROOM NUMBER]. Resident #1 use his fist and hit the other resident in his right arm three times. Both residents were separated and assessed for injury, police notified of altercation between resident #1 and another resident.</p> <p>-Resident #2 was admitted to the facility on [DATE] which include a diagnoses of Hypertension, Alzheimer's Disease, Dementia, and Depression.</p> <p>The Minimum Data Set (MDS) dated [DATE] revealed a BIMS score of 7.0 indicating severely impaired.</p> <p>A review of resident's care plan dated October 5, 2024 revealed resident has impaired cognitive ability related to Alzheimer's Dementia which can fluctuates quickly between pleasantly confused to aggression BIMS score of 7.0. The interventions include allow extra time for resident to respond to questions and instructions, face and speak clearly when communicating with resident, and keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion.</p> <p>A review of resident's care plan dated November 8, 2024 revealed resident is physically aggressive to staff related to diagnosis of dementia and physical aggression to peer. The goal is for resident to not harm self or others. The intervention included the resident's triggers for physical aggression are multiple people trying to provide care. The resident's behaviors is de-escalated by one staff member providing care and others leaving area.</p> <p>A review of resident's record dated November 8, 2024 revealed a Behavior Note progress note stating that patient while in the dining room area had struck a patient on the back.</p> <p>-Resident #3 was admitted to the facility on [DATE] with diagnoses of Hypertension, End-Stage Renal Disease (ESRD), and Diabetes Mellitus.</p> <p>The MDS assessment dated [DATE] revealed a BIMS score of 12.0 indicating moderately impaired.</p> <p>A review of Health Status Note progress note dated November 11, 2024 revealed the physician was made aware of the resident being hit by another resident in the right upper arm outside the dining room in the hallway after breakfast.</p> <p>A review of progress note, Alert Note, dated November 16, 2024 revealed staff observed a resident using his fist and hitting resident #3 in his right arm three times in the east wing hall between rooms [ROOM NUMBERS]. Both residents were separated and assessed for injury, and no injury noted.</p> <p>An interview was conducted on November 19, 2024 at 10:50 am with a registered nurse (RN)/staff #40. Staff #40 stated that regarding a resident to resident altercation, they have not observed any incident, but if it happens, they separate them, calm them down, they call their director of nursing (DON) and ask her for further recommendation such as calling the police and documenting it for risk management. In addition, Staff #40 stated that they heard about one resident who has dementia, had a stroke, uses one arm to punch with, and they identified the resident as resident #1 involved with an incident that happened in November with resident #3. Staff #40 stated that they heard resident #1 punched resident #3, then resident #3 was moved over to the other wing.</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>Attempted to interview resident #1 on November 19, 2024 at 12:55 PM. Resident #1 was non-verbal and smiled at the surveyor. Resident #2 and Resident #3 were not available for an interview.</p> <p>An interview was conducted on November 19, 2024 at 12:56 PM with a licensed practical nurse (LPN)/Staff #35. Staff #35 stated that resident #1 loves to listen to music and has outburst. Staff #35 stated that last Monday resident #1 tapped the upper arm of resident #3 while they were coming out of the dining area and this incident happened again on November 16.</p> <p>An interview was conducted on November 19, 2024 at 1:31 PM with the DON/Staff #25 and she stated that the residents were in the dining room and resident #1 backed up his wheelchair to resident #2. Resident #2 then hit the shoulder of resident #1. Regarding resident #1 and resident #3, the DON stated that on November 16, resident #1 and resident #3 were in the hallway and resident #1 touched resident #3's arm with his close hand.</p> <p>An interview was conducted on November 19, 2024 at 2:07 PM with the administrator/staff #20. The administrator stated that regarding Resident #1 and #2, the incident happened in the dining room in the evening, Resident #1 wears a headphone and resident #2 moved her wheelchair. Resident #1 reach over the handle of resident #2's wheelchair and resident #2 responded by hitting resident #1's back left shoulder. The administrator stated that resident #2 reached around and smacked resident #1. The administrator stated that there was a physical contact. Their plan for resident #1 is to escort the resident to and from the dining room and nowhere close to resident #2. Regarding resident #1 and resident #3, the administrator stated that on November 11 incident, both residents were leaving the dining room and when they were in the hallway, resident #3 was waiting for resident #1 to move faster, and resident #1 reacted to resident #3's gesture and that is when resident #1 hit resident #3 on his arm. The staff member that saw the incident between resident #1 and resident #3 was near the conference room door while the two residents were exiting the dining room. The administrator stated that no staff was exiting with them and nobody was escorting resident #1 at that time. In addition, regarding the incident on November 16 with resident #1 and resident #3, both residents were heading to the dining room and a staff saw resident #1 hit resident #3. No one was escorting resident #1 to the dining room.</p> <p>Review of facility's policy titled, Abuse-Prevention, issued on October 4, 2022 and reviewed in June 17, 2024 revealed the facility policy is to prevent and prohibit all types of abuse.</p> <p>Review of facility's policy titled, Resident Rights, issued June 8,2020 and revised in September 10, 2024 revealed (17) the resident has the right to be free from abuse.</p>		