

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 01/03/2025
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553</p> <p>Based on clinical record review, staff interviews, and facility policy review, the facility failed to ensure one resident (#26) was free from sexual abuse. The deficient practice resulted in a resident being inappropriately touched by another resident.</p> <p>Findings include:</p> <p>Resident #26 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, psychotic disturbance, mood disturbance, and anxiety.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating the resident had moderate cognitive impairment.</p> <p>Review of the care plan and nursing progress notes revealed no evidence of sexual abuse occurring. Additionally, there were no psychiatric notes or evaluations created following the abuse.</p> <p>Review of physician orders revealed no evidence of new orders following the abuse, including no new orders for psychiatric evaluation.</p> <p>Resident #13 was admitted to the facility initially on August 9, 2024. He was later readmitted to the facility on [DATE] following a short hospital stay. His admitting diagnoses included memory deficit following cerebral infarction, major depressive disorder, and other sexual dysfunction not due to a substance or known physiological condition.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident had moderate cognitive impairment.</p> <p>Review of physician orders revealed an order dated October 17, 2024, which instructed nursing staff to monitor and chart on inappropriate sexual comments. Additionally, the resident was ordered Fluoxetine HCl Capsule 40mg one time a day on October 17, 2024 for depression as evidenced by inappropriate sexual comments.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the care plan initiated on August 9, 2024 revealed a focus that Resident #13 had a behavior problem of grabbing female staff inappropriately and making sexual statements toward female staff. The entry, revised on December 20, 2024, included that Resident #13 touched a female peer. New interventions added on December 20, 2024 included that the resident be placed on 15-minute checks, and that the resident would be supervised by staff when in common areas.</p> <p>Review of the progress notes revealed that Resident #13 had multiple documented instances of inappropriate behavior towards others. A health status note dated August 11, 2024 described that during a shower, Resident #13 was grabbing the female staff in appropriate areas. The psychosocial note on August 14, 2024 revealed that the resident had been making inappropriate statements to staff and grabbed staff on the buttocks and breasts.</p> <p>An interview was conducted on January 3, 2025 at 12:33PM with Resident #13, who initially could not recall the incident with Resident #26. When asked if he recalled touching a resident at the Christmas party, Resident #13 stated that he remembered seeing a woman crying, so he kissed her. He denied that anything else occurred. He could not recall who the woman was.</p> <p>An interview was attempted with Resident #26 on January 3, 2025 at 12:48PM, but the resident was too confused to interview and was unable to be directed.</p> <p>An interview was conducted on January 3, 2025 at 11:08AM with a certified nursing assistant (CNA/Staff #2) who stated that he would define touching as sexual abuse. He recalls that he had heard about a sexual incident between Resident #13 and another resident but did not witness it. He stated that Resident #13 had previously shown sexual behaviors towards staff but only knew about one incident with another resident. He stated that Resident #13 now has to be supervised when in common areas, and that he has to watch television in his room now.</p> <p>An interview was conducted on January 3, 2025 at 11:16AM with a Licensed Practical Nurse (LPN/Staff #5) who stated she would consider sexual abuse to include verbally obscene things and touching inappropriately. When asked if any residents had shown sexually inappropriate behavior, the LPN named Resident #13, stating that she has not personally seen anything but has heard rumors that he had shown sexual behaviors toward staff. She further stated that she had heard of a sexual interaction between Resident #13 and another resident on Christmas. She explained that since this incident, Resident #13 cannot be in the dayroom alone with other female residents.</p> <p>An interview was conducted on January 3, 2025 at 11:35AM with the Admissions Assistant (Admin/Staff #11) who stated that during the facility Christmas party on December 20, 2024, she had been moving residents around to take pictures when she noticed that Resident #13 and Resident #26 were sat together in their wheelchairs, facing each other. She stated that she then saw that Resident #13 had his hand down Resident #26's pants. She elaborated that Resident #26 was wearing sweat pants with an elastic waistband, and that Resident #13 had his right hand down the top of the pants of Resident #26, almost to his elbow. Staff #11 further explained that she thought Resident #26 seemed to be okay with it, as she was moving her hand back and forth slowly on his arm. She was unsure how long the two residents had been in this situation, and there were no staff or family in the area to witness it. She stated that there were two residents who may have seen something, but that they were nonverbal and unable to provide a statement. Staff #11 explains that she immediately separated the residents, bringing Resident #26 into the common area, and notified her supervisors.</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>An interview was conducted on January 3, 2025 at 12:14PM with the Director of Nursing (DON/Staff #17) who stated that she would consider unwanted touching from one resident to another to be sexual abuse. She also stated that a resident with a diagnosis of dementia would not have the capacity to consent to an intimate or sexual relationship. The DON also explained that she was informed of the incident between Resident #13 and Resident #26 by the Administrator. She explained that following the incident, both Resident #26 and Resident #13 denied that anything had occurred. She also stated that both residents are cognitively impaired and lack the capacity to consent. Additionally, the DON explained that new interventions were implemented to supervise Resident #13. When asked if Resident #13 had previously shown any sexually inappropriate behaviors, the DON responded that he had inappropriately grabbed a staff member one time only, and that the interventions described in the care plan had been effective at managing this resident's behaviors. The DON further explained that Resident #26 did not appear to be in distress following the incident, so no psychiatric evaluation or care plan revision was conducted for this resident.</p> <p>Review of the facility policy titled, Intimacy Between Residents / Sexual Consent, revealed that the facility will ensure residents have the capacity to consent to sexual activity, and if not, will prohibit the engagement of sexual activity with others.</p> <p>Review of the facility policy titled, Abuse - Prevention, revealed that it is the policy of the facility to prevent and prohibit all types of abuse.</p> <p>Review of the facility policy titled, Abuse - Identification of Types, revealed that it is the policy of the facility to identify abuse. This policy also defines sexual abuse as non-consensual sexual contact of any type with a resident, and gives an example of sexual abuse to be unwanted intimate touching of any kind especially of breasts or perineal area. The policy further explains that sexual contact is nonconsensual if the resident appears to want the contact to occur, but lacks the cognitive ability to consent.</p>		