STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035095	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Cove Nursing Center	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and review of facility policy, the facility failed to ensure an allegation of abuse was reported to mandated entities within 2 hours for one resident (#2). The deficient practice could lead to an allegation of abuse not being investigated by all mandated entities timely, resulting in possible ongoing abuse to a resident.-Findings include: Resident #2 was admitted to the facility July 7, 2025, with diagnoses that included encounter for surgical aftercare following surgery on the circulatory system, peripheral vascular disease, type 2 diabetes mellitus, and major depressive disorder.A brief interview for mental status (BIMS) assessment dated [DATE], revealed the resident had a score of 14, indicating intact cognition.A Weekly Skin Integrity Data Collection dated July 19, 2025, revealed the resident's groin had a surgical incision, no redness, no bruising, no swelling to peri-area.An email receipt dated July 19, 2025, revealed that an Adult Protective Services report was submitted at 5:59 p.m.A facility self-report dated July 19, 2025, submitted to the State Agency at 6:13 p.m., revealed that Resident #2 reported to staff that a male Certified Nursing Assistant (CNA) entered her room the morning of July 18, 2025, twice, once with the nurse and once alone. The male CNA asked if she used the bathroom, or needed to be changed, patting the top of her incontinent brief. Resident #2 then stated that she used the bathroom, and the CNA left her room. Resident #2 stated that, at first, she did not think anything of it, but then later decided she should say something. The resident was unable to say who the male CNA was, but that he had a grey beard and was wearing green scrubs. The nurse that worked on July 18, 2025, was interviewed and stated that she was in and out of the resident's room multiple times during her shift and she was not accompanied by any CNA, and that the resident never said anything about the incident. At approximately 4:00 p.m. on July 19, 2025, the resident called the local police department and filed a complaint. A police officer responded and interviewed both the resident and the male CNA that worked yesterday. Per the documentation, after interviewing both parties, the officer had the Assistant Director of Nursing (ADON) take the CNA into the resident's room and asked the resident if she knew the CNA. The resident responded that she did not know the CNA, and had never seen him before.An interview written statement dated June 19, 2025, at 7:00 a.m., signed by the ADON (Staff #26), revealed an interview with a CNA (Staff #60). The statement revealed the ADON spoke with Staff #60 regarding stated allegations by Resident #2. Staff #60 stated he did not go in the resident's room at all on July 18 2025. The ADON informed Staff #60 that he was being sent home pending the investigation, and Staff #60 left the building. At approximately 8:30 a.m., the ADON called and requested that Staff #60 come back to the facility to work. At approximately 9:30 a.m., Staff #60 returned to work and went to the East unit.A time punch detail report revealed that Staff #60 had time punches as follows:-July 18, 2025: Punched in from 6:55 a.m. to 2:10 p.m. and from 2:15 p.m. to 5:42 p.m.-July 19, 2025: Punched in from 6:50 a.m. to 7:28 a.m. and from 9:04 a.m. to 5:35 p.m.A telephonic interview was conducted with a CNA (Staff #19) on July 22, 2025, at 9:44 a.m. Staff #19 stated that she believed she was the first staff that Resident #2 reported the allegation to. Staff #19 stated that sometime between midnight and the early morning hours of July 19, 2025, that she entered Resident #2's room and Resident #2 stated that I feel like I've been molested. Staff #19 stated that Resident #2 said that she sleeps with her nightgown up, and that a male staff entered the room and asked if she got up to use the restroom or if she used an incontinence brief. Staff #19 stated that Resident #2 said that the male staff said he had to check to see if she had urinary incontinence, and then patted the front of her brief over the genital area three times and then left the room. Staff #19 stated that Resident #2 gave a description and a name of the alleged perpetrator, and that Staff #19 reported to the nurse right away. A telephonic interview was conducted on July 22, 2025, at 10:11 a.m., with a Licensed Practical Nurse (LPN / Staff #31), who stated that she was the night nurse that worked the shift between July 18 and July 19, 2025. Staff #31 stated that she was notified of the allegation by a CNA (Staff #19) late in the night shift of July 18-19, 2025. Staff #19 stated that she then spoke to Resident #2 who said that at approximately 8:00 - 10:00 a.m. on July 18, 2025, that Resident #2 was in her room and a male staff entered and asked her if she used the bathroom, and then the male staff reached down and patted the front of her brief three times to see if she was incontinent, and then the male staff left the room. Staff #31 stated that Resident #2 reported a name of the male staff, which was the same first name as Staff #60, and provided a description. Staff #31 stated that she notified the Director of Nursing (DON) right away, and that later the DON responded that she was going to notify the Administrator An interview was conducted with the