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	11/19/2025

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 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, facility documents, staff interviews and facility policy, the facility failed to ensure that 2 residents (#6, 66) were not abused. Findings include:--Regarding the incident between resident #100 and resident #66 -Resident #100 was admitted on [DATE], with diagnoses of Major Depressive Disorder, and Hemiplegia and Hemiparesis following cerebral infarction affecting the right dominant side. A quarterly Minimum Data Set (MDS) dated [DATE], included that this resident had moderately impaired cognition and that the resident used a wheelchair. A care plan dated January 4, 2024, included that resident #100 has impaired cognitive ability with impaired insight and poor recall. Interventions included to cue, reorient, and supervise. A Health Status Note dated March 19, 2024, included that resident #100 was witnessed by a CNA to be pulling on another resident's shirt as the other resident was propelling herself in her wheelchair by this resident. This note included that the other resident yelled, and the Licensed Practical Nurse (LPN) intervened, and this resident let go of the other resident's shirt. A Health Status Note dated April 1, 2024, included that resident #100 was in the dining room and was witnessed propelling herself towards another resident in an aggressive manner staff stopped her and redirected her back to where her lunch was. A Health Status Note dated April 10, 2024, included that at 1210pm, resident #100 was being pushed in her wheelchair by a kitchen aide, and she stated that resident #100 reached to her left and grabbed the left upper arm of another resident in the middle of the 100 hallway and pinched the other resident's arm. This note included that the Kitchen staff member said it was completely unprovoked and that the other resident was not even looking in this resident's direction prior to this occurring. The Kitchen aide stated that resident #100 quickly pinched her arm and let go, and the other resident touched her own upper arm discoloration with scratch marks noted immediately after the incident. This note included that the Kitchen aide asked in Spanish why she grabbed the other resident's arm, and resident #100 said because she is telling lies and saying they are a couple. Resident #100 took herself to her room, and resident #66 went into the dayroom. This note included that a complete body assessment was done for both residents and that family, staff, the physician, and the police were notified. -Resident #66 was admitted on [DATE], with diagnoses of Major Depressive Disorder and dementia. A quarterly MDS dated [DATE], included that this resident was severely cognitively impaired and had episodes of inattention and wandering. This document included that this resident used a wheelchair. A care plan dated June 17, 2023, included that this resident has impaired cognitive ability and/or impaired thought processes related to Alzheimer's dementia. This document included an intervention to cue, reorient, and supervise as needed. An event note dated April 10, 2024 included that at approximately 12:10 PM a dietary aide reported to the nurse that as she was pushing resident #100 in her wheelchair in the hallway toward the nurse's station, when resident #66 was propelling herself the opposite way, and the resident she was pushing reached out and grabbed the left upper arm of resident #66 but immediately let go. This note included that resident #66's left upper arm was checked by the nurse and that she is noted to have 3 discolored purple and red areas on her left upper arm. This note included that resident #66's family and physician were called. A skin check dated April 10, 2024, (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	included that an area of impairment was found after an altercation with another resident that had purple/red discoloration on the left upper arm in 3 areas, which included the left hand, thumb side, and right forearm. An interview was conducted on September 23, 2025, at 1:36 PM with an LPN (staff #5) who said that resident #100 was not aggressive but that she did not like one of the residents who used to be in a room next to hers and that she said it was because she did not have friends like that. This nurse said that resident #100's son talked to her and told her it was because she believed the other resident wanted to be more than friends. This nurse confirmed that the resident was #66 and that the kitchen aide had come to her and said that she had seen resident #100 pinching resident #66. This nurse said that she did not remember who the kitchen aide was. --Regarding the incident between resident #120 and #6:-Resident #120 was admitted on [DATE], with diagnoses of Bipolar disorder, other sequelae of cerebral infarction, and chronic pain syndrome.A quarterly MDS dated [DATE], included that this resident had a memory problem with short- and long-term memory and that this resident was severely impaired in making decisions regarding the tasks of daily life. This document included that this resident had impairment in all extremities. This document included that this resident used a wheelchair and that he required supervision for wheeling 50 feet with 2 turns and to wheel 150 feet.A health status note dated May 1, 2024, included that it was reported to the nurse that resident #120 was sitting outside his room in the hallway facing east, and struck the other resident on her right upper arm with an action figure, and that the victim's sister witnessed from the front desk. This nurse included that a 15-minute patient check was initiated.A psychosocial note dated May 3, 2024, included that resident #120's family was contacted to discuss care plan interventions related to resident #120's impulse control and discussed moving the resident's room. This note included that resident #120 continues to be monitored by staff and is with staff members when out of the room, dining, or in an activity. This note also included that when around other residents in his wheelchair, this resident should remain at least an arm's length away related to poor impulse control.-Resident #6 was admitted [DATE], with diagnoses of aphasia following cerebral infarction, muscle weakness, and hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side.A quarterly MDS dated [DATE], included that the resident was severely cognitively impaired and that this resident was impaired on one side of the upper and lower extremities. This document included that this resident used a wheelchair and that she required supervision for wheeling 50 feet with 2 turns and partial/moderate assistance to wheel 150 feet.An event note dated August 14, 2023, included that resident #120 was sitting in the lobby in her wheelchair next to resident #6. This note included that a sales representative was exiting the building and did knuckles with resident #120, and that resident #120 then reached over and hit resident #6 in her left arm 2-3 times and on her left neck area. This note included that the receptionist and admission director saw the incident and were able to separate the residents, and both were returned to their rooms. This note included that no injuries were found, that a new placement was being sought for resident #120, and that resident #120 will have staff present whenever he is out of bed.However, a health status note dated April 30, 2024, included that resident #6 was wheeling west down the hallway and got struck by another resident who was sitting outside his room in the hallway facing east. This note included that resident #6 got hit on her right upper arm with an action figure. This note included that the resident's sister witnessed from the front desk, heard her saying Ow, that hurt and that she looked and saw the other resident hit her. This note included that the other resident continued to wheel down the hall and that no other staff or residents observed the incident.An interview was conducted on September 23, 2025, at 10:53 with the family member who had witnessed the April 30, 2024, altercation. This family member said that resident #6 was sitting in the hallway in and resident #120 came by and he had this doll and he was hitting her, and I had told him to stop hitting, and he kept doing it. This family member said that resident #120 was hitting her on the arm and that there were no injuries except a red mark that went away. This family member said that the staff moved resident #120 further back into the nursing home and that resident #120 would always (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shake his fist at resident #6.An interview was conducted on September 23, 2025, at 1:08 with an LPN (staff #38) who said that resident #6 was forgetful and that she was not aggressive. This nurse said that resident #120 is still in the facility and that he does not speak, but that when he's excited, he will swing his fist that which means that he's happy about you, and that some people take it as aggression. This nurse said that she was told about the altercation and that she believes that resident #120 tried to use his toy to show he was excited and not in a bad way. This nurse said that she asked resident #66 about this incident the next day, and that she did not remember. An interview was conducted on September 23, 2025, at 3:36 PM with the Director of Nursing (DON/staff #1), who said that her expectation is that abuse does not happen. This DON said that she was not in the facility at the time of the incident, as she started work at the facility in May to June of 2024. This DON reviewed the incident between resident #120 and resident #6, and said that it is abuse because a resident is touching someone, and that he should not be touching someone. This DON said that if resident #120 had hit someone with the toy, then it would be abuse. This DON then reviewed the incident between resident #100 and resident #66 and said that pinching is abuse and that this incident sounded like abuse. A policy reviewed May 6, 2025, titled Abuse - Prevention included that it is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation.