| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035095 | A. Building<br>B. Wing | 12/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Desert Cove Nursing Center | 1750 West Frye Road<br>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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>(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 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, and review of facility documentation and policies, the facility failed to ensure that professional standards of care were followed regarding the implementation of Physician-ordered speech services for Resident #2. The deficient practice could result in speech issues not identified and treated as appropriate. Findings include: Resident #2 was admitted to the facility on [DATE] with diagnoses of Other Fracture of Upper and Lower End of Right Fibula, subsequent Encounter for Closed Fracture with Routine Healing, Progressive Supranuclear Ophthalmoplegia/Steele-Richardsonolszewski (SRO), and muscle weakness. Review of the most recent quarterly Minimum Data Set (MDS) dated [DATE] revealed the Resident #2 had a Brief Interview for Mental Status (BIMS) score of 12, indicating she was cognitively intact. Further review of the MDS revealed Resident #2 was receiving Physical Therapy (PT) and no Speech Therapy (ST) or Occupational Therapy (OT). Review of the revised Care Plan dated November 12, 2025 revealed a focus for Activities of Daily Living (ADL) assistance and therapy services needed to maintain or attain highest level of function. Interventions included to administer therapy services as ordered and assist with mobility and ADLs as needed. Review of a physician order dated November 25, 2025, revealed a speech evaluation due to a diagnosis of increased weakness in voice for one time only for 1 day verbal, with a documented completion date of November 26, 2025. A request for the completed speech evaluation was completed on December 18, 2025 at 1:27pm. When asked for the speech evaluation, the Director of Nursing (DON, Staff #103) stated she was unable to locate the speech evaluation.An interview was conducted on December 18, 2025 at 1:47 p.m. with the Director of Nursing (DON/Staff #103). Staff #103 stated she was unable to obtain the speech evaluation that was requested and stated the evaluation was not completed as documented. Staff #103 stated she provided immediate education to the Licensed Practical Nurse (LPN/Staff #18) regarding proper order entry and documentation after identifying the problem. Staff #103 stated the physician order had been entered incorrectly and included a one-day stop date, which caused the order to automatically reflect as completed regardless of whether the evaluation was performed. Staff #103 stated she was unaware of the order and further stated the order should not have been documented as completed and the appropriate staff should have been notified of the new order. Staff #103 stated that Staff #30 was aware of the family's concern because they had stopped Staff #30 in the hallway. Staff #103 further stated the risks associated by not properly entering orders or notifying appropriate staff creates risks, including residents not receiving required care, potential harm to residents, and miscommunication among staff.An interview was conducted on December 18, 2025 at 2:08 pm with the Speech Therapist (Staff #30). Staff #30 stated, the last time he saw Resident #2 was when she was admitted to the facility. Staff #30 stated, he is always checking his Point Click Care (PCC) and did not see any orders for Resident #2, specifically, for the date of November 25, 2025. Staff #30 stated that if he is unaware of new orders, he cannot provide the services that he is there for as that is his duty. Staff #30 further stated that it would be neglectful if orders are not completed because the staff are not providing the services that the resident needs. An interview was conducted on December 18, 2025 at 2:54 pm with Resident #2. Resident #2 stated she has never received any speech therapy for her voice and the only therapy she is currently receiving is Physical Therapy (PT).Review of the facility policy titled Nursing Documentation issued on August 20, 2019 and reviewed on September 5, 2024 states, This facility will ensure nursing documentation is consistent with professional standards of practice, the state nurse: practice act, and any state laws, governing the scope of nursing practice. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, and facility documentation, policies and procedures, the facility failed to ensure that adequate supervision and monitoring was provided for one resident (#76) who was left unattended in the shower room for an extended period of time. The deficient practice could result in avoidable accidents and/or decline in function.Findings include: Resident #76 was re-admitted to the facility on [DATE], with diagnoses that include Acute on Chronic Systolic (Congestive) Heart Failure, Diabetes Mellitus, chronic respiratory failure, difficulty in walking, not elsewhere classified, and muscle weakness. Upon further review, Resident #76 has a history of bilateral below-the-knee amputation (BKA). Review of the care plan dated September 12, 2025, revealed a focus indicating the Resident #76 is at risk for falls related to decreased endurance, strength, and mobility. Interventions include assisting with Activities of Daily Living (ADLs) as needed and call light within reach. Further review of the care plan revealed a focus stating Resident #76 is at risk for impaired skin integrity. Interventions include educating the resident/family/caregivers as to causes of skin breakdown, including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition, and frequent repositioning and follow facility policies/protocols for the prevention/treatment of skin breakdown. Review of the Braden Scale Skin assessment dated [DATE] revealed Resident #76 has existing pressure ulcers and is at risk for Unavoidable Pressure Injury (UPI) development or decline of skin integrity due to bowel/bladder incontinence, Chronic Obstructive Pulmonary Disease (COPD), Peripheral Vascular Disease (PVD), Chronic Heart and Renal Disease, Diabetes, Thyroid Disease, and Morbid Obesity.Review of the Fall Risk Evaluation dated September 19, 2025, revealed Resident #76 had a score of 12, indicating the resident to be at risk for falls due to medications, health conditions, and mobility. Review of the 5-Day Minimum Data Set (MDS) dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident is cognitively intact. Further review of the MDS revealed the resident needs maximal or substantial assistance with bathing and toileting. Further review of the MDS reveals the resident had a formal skin assessment and was assessed to be at risk of developing pressure ulcers/injuries. Per the MDS, the resident uses a motorized wheelchair with orthotics/prosthetics due to a history of BKA and is on continuous oxygen. Review of the Certified Nursing Assistant (CNA) Tasks for Resident #76 for September 2025 revealed that during bathing, Resident #76 requires one person to maximal assistance when bathing. A phone interview conducted on December 18, 2025, at 1:31 pm with the alleged perpetrator (CNA/Staff #23) revealed that staff must not leave residents unattended in the shower room. If a resident requests privacy, staff may close the shower curtain and instruct the resident to press the call light when assistance is needed. Staff #23 stated she pushed Resident #76, in the shower chair, up to the sink to shave once he had finished showering. Staff #23 stated she got really sick at that moment due to personal health issues and was sent home by the Director of Nursing (DON/Staff #109). Staff #23 stated that Staff #109 instructed her to notify the other staff of Resident #76 before leaving. Staff #23 stated she notified a Licensed Practical Nurse (LPN) and a CNA about Resident #76 being in the shower room. Staff #23 stated, the CNAs on the other side do not talk to each other and must not have relayed the information. An interview was conducted on December 18, 2025, at 3:10 pm with Resident #76. Resident #76 revealed there had been an incident where the staff had left him in the shower room for an hour. Resident stated the staff left him or must've forgotten about him. Resident #76 stated that he was in the shower chair pushed up against the mirror to shave and thought he must have fallen asleep or that's what they have told him. Resident #76 stated that when he woke up, he pulled himself toward the door by grabbing onto things nearby. Resident #76 further stated, when he reached the door, a staff member found him by opening the door. Resident #76 stated that there was no call light nearby. Resident #76 stated Staff #109 had seen him after he got back in bed and completed a head-to-toe assessment. An interview was conducted on December 18, 2025, at 4:04 p.m. with the Director of Nursing (DON/Staff #109). Staff #109 stated she sent Staff #23 home and instructed her to notify other staff regarding Resident #76. Staff #109 stated that when she became aware of the incident, the shower room door was open and Resident #76 was seated in a wheelchair. Staff #109 stated Resident #76 may have previously been seated in a shower chair before she observed him. Staff #109 further stated Resident #76 could be left alone while seated in a wheelchair. Staff #109 further stated that staff are expected not to leave residents unattended; however, she stated she would not be upset if they left them. Staff #109 stated |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, observation, and staff interviews, the facility failed to ensure that appropriate infection control practices were implemented and followed for one resident (#33). The deficient practice could result in a spread of preventable illness to residents and staff.Findings include:Resident #33 was admitted to the facility on [DATE], with a diagnosis that included infection and inflammatory reaction due to an indwelling urethral catheter, subsequent use, urinary tract infection, obstructive and reflux uropathy, unspecified.During an observation on December 17, 2025, at 2:50 PM, while standing directly across the hallway in line of resident #33's room, a Certified Nursing Assistant (CNA/Staff#7) observed to enter resident #33's room. Staff #7 was observed entering the resident's bathroom, returning with a canister, and proceeded to empty the catheter bag that was observed hanging from the lower bed rails belonging to resident #33. CNA (Staff #7) was then observed to be wearing gloves, but was not observed to be wearing a gown.An interview was conducted with the CNA (Staff #7) immediately following the observation. The CNA stated she was emptying the resident's catheter and should have been wearing a gown. CNA (staff#7) stated she has received infection control training and has access to personal protective equipment, but was in a hurry and forgot, and just put on her gloves. CNA (staff #7) stated that the risks of not following infection control procedures are if something is in the resident's urine, it could cause cross-contamination to other residents or staff.An interview was conducted on December 17, 2025, at 3:39 PM with Licensed Practical Nurse (LPN/Staff #9). Staff #9 stated that when providing catheter care, Enhanced Barrier Precaution (EBP) needs to be followed and would include the use of a gown, gloves, and a mask. Staff #9 stated the risks of not following EBP recommendations are outbreak of infections, which is bad for the patients, bad for the neighboring patients, and bad for the facility. Staff #9 stated the facility has provided staff training and has also provided online classes and in-services for all staff regarding EBP.An interview was conducted with the Director of Nursing (DON/Staff #1) on September 23, 2025, at 4:00 PM. The DON stated that staff are expected to follow EBP guidelines if they come in contact with any bodily fluids, and this would include when emptying a catheter. The DON stated the CNA should have worn a gown and gloves when providing catheter care and/or emptying the catheter. The DON stated that the risks of not following EBP guidelines are that germs from the catheter can potentially pass on to other residents from staff clothing. Review of the facility policy titled Indwelling Urinary Catheter (Foley) Management, last reviewed September 10, 2024, revealed that staff should wear gloves and gowns during any manipulation of the catheter or collecting system. Review of the facility policy titled Transmission-based Precautions and Isolation Procedures, most recently revised on August 19, 2025, revealed that staff should wear gloves and a gown during high-contact resident care activities that would prevent the transfer of viruses to staff hands and clothing. |