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	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Cove Nursing Center	1750 West Frye Road Chandler, AZ 85224

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, the State Agency's (SA) complaint portal, and review of the facility's policies and procedures, the facility failed to ensure 5 out of 5 residents' (#7, #10, #40, #90, and #100) medications administration were accurately documented in the Medication Administration Record (MAR). The sample size was 5. The deficient practice could cause an unclear indication of whether medication was administered to the right resident. Findings include:-Regarding Resident #7:Resident #7 was admitted on [DATE], with diagnoses that included major depressive disorder, anemia, and sepsis. An order summary dated February 21, 2026, revealed an order for Oxycodone HCL Oral Tablet 5 MG (a Controlled Substance/ an Opioid), give 1 tablet by mouth every 8 hours as needed for pain. A comprehensive Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 8, indicating that Resident # 7 had moderate cognitive impairment. The MDS further revealed that in Section N, the resident was taking opioid medications. An Individual Resident's Controlled Substance Record initiated on February 27, 2026, for Oxycodone HCL Oral Tablet 5 MG revealed that the Alleged Perpetrator, Licensed Practical Nurse (LPN/staff #777), identified that she had administered the medication on March 04, 2026. However, the Medication Administration Record (MAR) for March 2026 for Oxycodone HCL Oral Tablet 5 MG revealed that the medication was not administered on March 04, 2026. A care plan initiated on March 02, 2026, revealed a focus area of expressing pain or discomfort as related to abdominal pain. The care plan also revealed a goal that the resident will not have an interruption in normal activities due to pain, with noted interventions including that the resident would be evaluated for the effectiveness of pain medication. -Regrading Resident #10Resident #10 was admitted on [DATE], with diagnoses that included Muscle Weakness, Cardiomyopathy, and cellulitis. A care plan initiated on February 13, 2026, revealed a focus area of expressing pain or discomfort. The care plan also revealed a goal that the resident will experience pain relief by the review date, and included an intervention noting to administer pain medication as ordered.A comprehensive (MDS) assessment dated [DATE], revealed a (BIMS) score of 13, indicating that Resident # 10 had moderate cognitive impairment. The MDS further revealed that in Section N, the resident was taking opioid medications. An order summary dated February 21, 2026, revealed an order for Oxycodone HCL Oral Tablet 5 MG (a Controlled Substance/ an Opioid), give 1 tablet by mouth every 6 hours as needed for pain. An Individual Resident's Controlled Substance Record initiated on February 19, 2026, for Oxycodone HCL Oral Tablet 5 MG revealed that Staff #777 identified that she had administered the medication on March 04, 2026.A Medication Administration Record (MAR) for March 2026 for Oxycodone HCL Oral Tablet 5 MG revealed that the medication was not administered on March 04, 2026. A witness Interview / Statement Form dated March 10, 2026, revealed that Resident #10 stated that he had not taken any narcotic pain medication since February 22, 2026. -Regarding Resident #40Resident #40 was admitted on [DATE], with diagnoses that included Chronic Kidney Disease, Anxiety disorder, and Heart Failure. A care plan initiated on February 17, 2026, revealed a focus area of expressing pain and discomfort. The care plan also revealed a goal that the resident will experience pain relief and interventions that (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included to evaluate the effectiveness of pain intervention. A comprehensive (MDS) assessment dated [DATE], revealed a (BIMS) score of 15, indicating that Resident # 14 was cognitively intact. The MDS further revealed that in Section N, that the resident was taking opioid medications. An order summary dated February 17, 2026, revealed an order for Hydromorphone (a Controlled Substance/ an Opioid), give 1Mg/ML tablet by mouth every 1 hours as needed for pain. An Individual Resident's Controlled Substance Record dated February 17, 2026, for Oxycodone HCL Oral Tablet 5 MG revealed that Staff #777 identified that she had administered the medication on March 04, 2026A MAR for March 2026 for Hydromorphone 1 MG/ML revealed that the medication was not administered on March 04, 2026. -Regarding Resident #90:Resident #90 was re-admitted on [DATE], with diagnoses that included Pneumonia, Muscle Weakness, and Hyperlipidemia. An order summary dated January 16, 2026, revealed an order for Oxycodone HCL Oral Tablet 5 MG, give 1 tablet by mouth every 4 hours as needed for pain. The order summary further revealed that this order was discontinued on January 26, 2026.An Individual Resident's Controlled Substance Record dated January 16, 2026, for Oxycodone HCL Oral Tablet 5 MG revealed that Staff #777 identified that she had administered the medication on March 4, 2026. A care plan initiated on January 21, 2026, revealed a focus area of expresses pain or discomfort related to a patella fracture. The care plan also revealed a goal that the resident will express pain relief and in intervention that included evaluating the effectiveness of pain intervention. A Nursing Home Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that the Resident was cognitively intact. The MDS further revealed that in Section N, the resident was taking opioid medications. -Regarding Resident #100Resident #100 was admitted on [DATE], with diagnoses that included Depression, Hyperlipidemia, and Muscle Falls. A comprehensive (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that Resident # 100 was cognitively intact. The MDS further revealed that in Section N, the resident was taking opioid medication. A care plan initiated on March 01, 2026, revealed a focus area which noted that the resident is on pain medication therapy related to the disease process. The care plan also revealed a goal that the resident will be free of any discomfort or adverse effects from pain medication and an intervention to administer pain medication as ordered.An order summary dated February 28, 2026, revealed an order for Oxycodone HCL ER (Extended Release) 10 mg tablet, give 1 tablet by mouth two times a day for moderate to severe pain.An Individual Resident's Controlled Substance Record initiated on February 28, 2026, for Oxycodone HCL Oral Tablet 10MG revealed that Staff #777 identified that she had wasted the medication on March 04, 2026 at 2100. A shift schedule dated March 4th, 2026, revealed that Staff # 777 was working 8:00 pm to 6:00 AM the following day with residents #7,#10,#40, #90, and #100. A complaint form submitted to the Arizona Board of Nursing dated March 11, 2026, alleged that Staff #777 was involved in theft, including suspected drug diversion. The complaint form also revealed that on March 4, 2026, Staff #777 documented to administration the discontinuation of hydromorphone for Resident #40, and administered one 5 mg tablet of oxycodone to Resident #10; however, it was not documented in the resident's chart. The complaint form further revealed that a discontinued medication for Resident #90 was administered and was not reflected in the resident's chart. This complaint also revealed that Staff #777 documented disposing of 10 mg of oxycodone for Resident #100 without a second nurse to co-sign.A facility investigation summary dated March 10, 2026, revealed that Staff #777 was suspected of drug diversion. The summary then revealed that on March 10, 2026, the Arizona Board of Nursing, local law enforcement, contacted the nursing agency, and the Medical Director (MD) were notified. The Summary also revealed that the nurse had destroyed a medication without a co-signing nurse as well as discrepancies in the documentation of medication administration. The summary conclusion revealed that the facility had substantiated the allegation of drug diversion based on documentation discrepancies, resident interview, and failure to follow controlled substance handling proceduresAn undated facility document titled Possible Diversion revealed the following : Resident #7: OxyContin 5 mg tablet every 8 hours as needed. Documented that (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication was signed out on March 4, 2026, at 9:30 PM; however, no signed documentation of medication administration in PCC (Point Click Care)Resident #10: OxyContin 5 mg tablet every 6 hours as needed. Documented that medication was signed out on March 4, 2026, at 10:00 PM; however, no signed documentation of medication administration in PCC (Point Click Care), and Resident #10 stated that he had not received the medication. Resident #40: Hydromorphone 1mg/ml tablet every hour as needed. Documented that medication was signed out on March 4, 2026, at 9:30 PM; however, no signed documentation of medication administration in PCC (Point Click Care), and the medication was discontinued. Resident #90: OxyContin 5 mg tablet every hour as needed. Documented that medication was signed out on March 4, 2026; however, the medication was discontinued on January 26, 2026. Resident #100: OxyContin 10 mg tablet every 4 hours as needed. Documented that the medication was marked as waste. An undated facility document, noted to be used for training, titled Assisting with a Narcotic Dose revealed that the two staff members will sign off on the narcotic shift-out sheet. The document then revealed that when administering narcotics, it would be documented on the MAR and Narcotic sheet. The document further revealed that the staff member had signed off on the acknowledgment that they had received education regarding the medication discontinuation procedure and narcotic documentation requirement.An interview was conducted on April 15, 2026, at 11:35 AM with a Certified Nursing Assistant (CNA/Staff #34) who stated that if there was a prescribed medication that was stolen from a resident, it would be considered misappropriation, because it involves taking the resident's property. Staff #34 stated that the facility practice is it to keep the medication cart locked. CNA also stated that she would ensure that there are no medications left unattended in the resident rooms. She then stated that Resident #90 would need pain medication for the left knee and had recently undergone surgery. She also stated that Resident #100 would ask for pain medication frequently. She then stated that medication is important for both mental health and overall well-being. An interview was conducted via phone on April 14, 2026, at 1:50 PM with the alleged perpetrator (AP/Staff #777) who stated that on March 04, 2026, she had worked for the facility through their contracted nursing agency. She then stated that during this shift, she was responsible for passing medications, assisting with resident care, and ensuring that all residents were safe and doing well. Staff #777 then stated that the process for medication administration is that staff will ensure the correct medication is given to the right resident at the right time and in the correct dose. She then stated that during that shift, she did administer the medication to the residents, but could not recall if it was documented on the MAR. She further stated that she did not think it mattered at the time to document on the MAR because there were times when she didn't. Staff #777 further stated that one resident refused their narcotic medication, so she has disposed of the medication; however, she did not obtain a second nurse's signature to ?waste' the medication because she forgot to. She also stated that when logging in to the nursing application, she was unable to return to work for the facility. Staff #777 then stated that she attempted to contact the facility to follow up, but did not receive a return call. She also stated that she had received a letter from the Board of Nursing notifying her that they were made aware of what happened. She then stated that for documentation in the narcotic log, they write down the time medication was administered, resident's name, the amount administered, the name of the staff who administered the medication, and date administered. They also documented in the electronic system MAR.An interview was conducted on April 17, 2026, at 2:36 PM with a Licensed Practical Nurse (LPN/Staff #23) who stated that during the medication pass process, staff would verify the resident, dosage, route, and time. She also stated that when administering narcotics, the nurse would document the resident, amount in hand, dosage, and the individual administering the medication on the Resident's Controlled Substance Record. She also stated that once the medication has been administered, it is documented on the MAR. She further stated that when disposing of medication, two nurses are required to sign off on the log. An interview was conducted on April 17, 2026, at 3:02 PM with the staff (LPN/staff #2) who stated that when she was administering non-narcotic medication to Resident #10, the resident had asked when the last (continued on next page)

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