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	06/29/2026

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, staff and resident interviews, facility documentation and review of facility policies and procedures, the facility failed to protect the rights of one resident (Resident #46) to be free from physical abuse from another resident (Resident #27). The deficient practice could place residents at risk for resident to resident abuse and potential physical harm.Findings include:-Regarding Resident #46:Resident #46 (Alleged Victim, AV) was initially admitted to the facility on [DATE], and was re-admitted on [DATE], with diagnoses that included acute posthemorrhagic anemia, diaphragmatic hernia, gastric ulcer with hemorrhage, hemiplegia and hemiparesis following cerebral infarction, attention and concentration deficit, anxiety disorder, and other comorbid conditions.A care plan dated May 21, 2026, indicated that the resident exhibited behavioral problems, including yelling and calling out when triggered. Interventions included anticipating and addressing the resident's needs, explaining procedures in detail, and allowing time for the resident to adjust to changes.A behavior care plan revised on May 21, 2026, revealed that Resident #46 had behaviors that included manipulation, yelling, and calling out related to anger, a history of harming others, and poor impulse control. Interventions included anticipating and meeting the resident's needs, assisting the resident in developing more appropriate coping and interaction skills, intervening as necessary to protect the rights and safety of others, and removing the resident from situations by taking him to an alternate location when indicated.The Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #46 required supervision while wheeling his manual wheelchair for 50 feet and partial assistance when wheeling 150 feet. A nursing incident note dated June 27, 2026, at 7:20 a.m., revealed that Resident #46 made his way into the hallway toward the dining room. The note further indicated that a Certified Nursing Assistant (CNA, Staff #105) transported both Resident #46 and Resident #27 down the hallway. while the residents were in close proximity to one another, Resident #27 became agitated and struck Resident #46 on the left side of the chest three times. The CNA immediately separated the residents, and nursing staff completed neurological and skin assessments following the incident.An observation of Resident #46 was conducted on June 29, 2026, at 1:45 p.m. The resident independently wheeled himself to the conference room and recalled the incident in a manner that was generally consistent with the information he reported to nursing staff on June 27, 2026. Resident #46 stated that a CNA wheeled both himself and Resident #27 to the dining room. Resident #46 further stated that Resident #27 was positioned on his left side and that the two wheelchairs were very close together when Resident #27 struck him in a backhand motion with his right fist three times to the left side of his chest. Resident #46 stated that staff separated them immediately and that he (Resident #46) subsequently reported the incident to one of the nurses on the unit.-Regarding Resident #27:Resident #27 (Alleged Perpetrator, AP) was admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left nondominant side, aphasia, bipolar disorder, contractures of both hands, and other comorbid conditions.A behavior care plan revised on July 20, 2023, revealed that Resident #27 was at risk for changes in mood and behavior related to (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

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	06/29/2026

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	medical conditions. Interventions included consulting the resident regarding customary routines and avoiding crowded areas because the resident had difficulty expressing himself when others were in close proximity. An additional behavior care plan revised on May 7, 2024, directed staff to maintain at least an arm's-length distance between Resident #27 and others whenever possible. The care plan further indicated that Resident #27 had the potential to become physically aggressive and strike others due to poor impulse control, nonverbal communication, multiple stroke episodes, confusion, and impaired cognition.The MDS assessment dated [DATE], revealed that Resident #27 had impaired communication, including difficulty making himself understood and understanding others. The MDS further indicated that the resident required supervision while wheeling both 50 feet and 150 feet with turns.A review of Resident #27's nursing notes revealed no documentation regarding the incident that occurred on June 27, 2026. However, nursing documentation dated June 26, 2026, indicated that Resident #27 exhibited physically aggressive behaviors, including biting and hitting certified nursing assistants during morning care, and was redirected by staff.An observation conducted on June 29, 2026, at 1:49 p.m., in Resident #27's room revealed that CNA Staff #75 was providing one-to-one supervision. Staff #75 stated that it was her first day serving as the resident's sitter. At the time of the observation, Resident #27 was lying calmly in bed and displayed no behavioral concerns.During a telephone interview conducted on June 29, 2026, at 1:02 p.m., CNA, Staff #105, who witnessed the altercation, stated that she transported both residents to the dining room on the morning of June 27, 2026. She stated that she maneuvered both wheelchairs simultaneously by placing one hand on each wheelchair. Staff #105 further stated that the residents acknowledged one another and, shortly thereafter, Resident #27 struck Resident #46 three times on the chest. Staff #105 stated that she immediately separated the residents.An interview with Unit Nurse Staff #88 was conducted on June 29, 2026, at 1:12 p.m. Staff #88 stated that she did not witness the incident because she was administering medications at the time. She reported that Resident #46 approached her independently in his wheelchair and stated that Resident #27 had struck him three times on the left side of his chest. Staff #88 stated that she assessed Resident #46 and observed no bruising or visible injuries, and that his vital signs were within normal limits. She further stated that nursing staff implemented measures to ensure the safety of both residents and reported the incident to the Director of Nursing (DON) and the attending physician.An interview with the Director of Nursing (DON), Staff #120, was conducted on June 29, 2026, at 2:45 p.m. Staff #120 stated that she was notified by facility staff that one resident had reported being physically struck by another resident. She stated that the facility's abuse response team immediately reported the allegation to the appropriate authorities within the required timeframes and initiated an internal investigation. Staff #120 further stated that the CNA who witnessed the incident had transported both residents simultaneously by holding one hand on each wheelchair and acknowledged that Staff #105 was a newly hired employee. Staff #120 stated that resident-to-resident physical altercations constituted physical violence and should be prevented at all times. This statement was consistent with information obtained from other nursing staff during the investigation.A review of the facility policy titled Abuse Prevention, revised April 1, 2026, revealed that the facility was committed to preventing and prohibiting all forms of abuse and neglect. The policy further stated that the facility was responsible for establishing a safe environment by identifying, correcting, and intervening in situations in which abuse was more likely to occur. The policy included staff education, maintaining sufficient staffing levels to meet resident needs, and ensuring that assigned staff were knowledgeable regarding each resident's care needs and behavioral symptoms.