STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035164	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Blossom Health & Rehab Center	60 South 58th Street Mesa, AZ 85206

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	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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(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- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility records, staff interviews, and facility policy, the facility failed to ensure that that an allegation of abuse was reported as required. Findings include:-Resident #100 was admitted on [DATE] with diagnoses of Major Depressive Disorder, difficulty walking, and type 2 Diabetes Mellitus.An annual Minimum Data Set (MDS) dated [DATE] included that this resident was cognitively intact. This document included that this resident required supervision for all activities of daily living.-Resident #12 was admitted on [DATE] with diagnoses of Major Depressive Disorder, hemiparesis and hemiplegia.A quarterly Minimum Data Set (MDS) dated [DATE] included that this resident was cognitively severely impaired with fluctuating inattention and required extensive assistance for bed mobility, dressing, toilet use and personal hygiene.An intake for a facility reported incident received September 16, 2022 included that resident #12 was the resident involved and that previous complaints states male resident touched resident in the vagina. This intake included that a call was received from the Administrator and when APS worker notified him of the allegation on Friday, all parties were notified. The alleged perpetrator (Resident #100) who is alert and oriented, was immediately placed with a 1:1 sitter around the clock and will remained so until the resident is transferred out to another facility which may happen today.A 5-day report with a fax date of September 23, 2022 included that the date of this incident was on September 16, 2022.However, a nursing progress note dated September 9, 2022 included that around 1830 a Certified Nursing Assistant (CNA) informed the nurse that a resident complained that resident #100 touched her inappropriately. This note included that the charge nurse was notified and that she informed the Director of Nursing (DON).An interview was conducted on July 18, 2025 at 9:08 AM with a CNA (staff #14) who said that it is my job is to prevent abuse, and to protect the residents. This staff said that first she would come to see what is the scenario and make sure the residents are safe, and if it is a resident to resident abuse, she would remove one of the residents and inform her nurse. This CNA said the nurse would take over because it is abuse.An interview was conducted on July 17, 2025 at 10:16 AM with a Licensed Practical Nurse (LPN/staff #110) who said that abuse can be financial, emotional or physical. She said that if she witnessed abuse, that she would try to deescalate the situation then she would try to separate the residents and immediately call her administrator, notify the provider, and the supervisor or administrator usually reach out to the resident's family.An interview was conducted on July 18, 2025 at 10:40 AM with a LPN (staff #107) who said that she was provided abuse training and that she would report it to the Nurse Manager or the DON and that they report it to the Department of Health and other authorities.An interview was conducted on July 18, 2025 at 10:50 AM with an Assistant Director of Nursing (ADON/staff #82) who said that staff should immediately call the Abuse Coordinator/Executive Director or the DON.An interview was conducted on July 18, 2025 at 11:06 AM with the DON (staff #82) included that her expectation for her staff would be to immediately report it. This DON included that the Abuse Coordinator/Executive Director is involved and that usually he calls her and they investigate. This DON included that they report sexual abuse within 2 hours and that they try to get an initial investigation so they know a little better what to report. This DON reviewed the clinical record and said that the progress note dated September 9, 2022 looked like the incident reported on September 16, 2022. A follow up interview was conducted on July 18, 2025 at 11:45 AM with the DON (staff #82) who verified that the incident reported on September 16, 2022 was the incident that was recorded on September 9, 2022 progress note. This DON said that it was probably because that nurse was agency and did not report it correctly and that she was not working in the facility during that time. A policy titled Abuse: Prevention of and Prohibition Against reviewed September 2024 included that allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to ensure one of three residents (#62) received services that met professional standards in regards to his medications being administered per provider order. This deficient practice could lead to medical complications.Findings include:Resident #62 was admitted on [DATE], with diagnoses that included bacteremia, urinary tract infection, sepsis and sacral decubitus.A provider order was written on April 7, 2025, for Ceftaroline Fosamil (an antibiotic), 400 milligrams intravenously (IV) every 8 hours for sepsis for 29 days. The first dose of the medication was scheduled to be administered the night of the resident's admission on [DATE].Review of Resident #62's Medication Administration Record (MAR), dated April 2025, revealed a code of 7 for the following scheduled IV doses: April 7, 2025 at 8:00 PM, April 8, 2025 at 8:00 AM and 2:00 PM, April 9, 2025 at 2:00 PM and April 10, 2025 at 8:00 AM. A code of 7 was defined in the MAR as meaning the medication was not administered, and to see the progress notes.Progress notes for Resident #62 were reviewed. A note on April 7, 2025, at 11:52 PM, stated, waiting on pharmacy. On April 8, 2025, at 6:59 PM, it stated, on order. On April 9, 2025, at 1:40 PM, the note stated, pending arrival. On April 10, 2025, at 10:54 AM, it stated night shift charting. Unknown if hanged.There was no indication in the progress notes that the provider was notified that the IV antibiotics were not administered per order.Two infectious disease doctor visit summaries, dated April 8, 2025 and April 10, 2025, revealed the reason for the consultation was for antibiotic management. The provider indicated that the plan was for the resident to take Ceftaroline until May 7, 2025. The note indicated that the provider discussed with nursing on duty. There was no indication in the note that the provider was aware that the resident had missed some scheduled doses of the IV antibiotic.An interview was conducted with a Licensed Practical Nurse (LPN/staff #41) on July 16, 2025, at 9:35 AM. The LPN stated that if she were missing a medication from the medication cart, she would check the facility for the medication, re-order it through the system, call the pharmacy and notify the director of nursing or the manager on duty.An interview was conducted with a Registered Nurse (RN/staff #45) on July 17, 2025, at 11:25 AM. The RN stated if he were missing an IV medication, he would notify the IV company. If it was unavailable, he would notify the provider and the director of nursing and document in the progress notes.An interview was conducted with the Director of Nursing (DON/staff #125) on July 17, 2025, at 12:45 PM, who stated that if an IV antibiotic was missing, she would expect staff to look for it, call the pharmacy and notify the provider. She stated those actions should be documented in a progress note.The DON then reviewed Resident #62's medical record. She located several progress notes stating that the medication was not administered per the provider's order. She stated she was unsure as to the reason the antibiotics were not administered according to the order. She could not locate any progress notes stating a provider had been notified.A follow-up interview was conducted with the DON on July 18, 2025, at 11:10 AM. The DON acknowledged that the IV antibiotics should have been administered per the provider's order and that the documentation showed that the resident missed several doses, without proper documentation of the provider being notified. The risk of the deficient practice was that the resident's infection could be prolonged and could possibly worsen.A review of the facility's medication policy revealed that staff are to notify the provider if there are irregularities in the administration of medications.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility policy, the facility failed to ensure that 1 out of 10 sampled residents (# 41) received pain medication as ordered by the physician. The deficient practice could result in the potential for the resident to be in unnecessary pain.Findings include: Resident #41 was admitted on [DATE], with diagnoses that included fracture of the pelvis without disruption of the pelvic ring, fall from a roof, pain in the right shoulder, and muscle weakness.Review of the Resident's care plan revealed that Resident # 41 is currently prescribed an opioid for pain, effective September 11, 2023, with an intervention task that included to administer opioid medication as prescribed. Review of Resident's # 41 Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS revealed that Resident # 41 was on Opioids for pain, which he received occasionally, and rated his pain level an 8 out of 10 over the last 5 days. Review of the Resident's orders revealed the following orders,Dated September 12, 2023, at 1:25 p.m. Oxycodone HCL Oral Tablet 5 MG 1 tablet by mouth every 4 hours as needed for pain 1-3. Discontinued September 19, 2023, at 2:58 p.m. Dated September 12, 2023, at 1:25 p.m. Oxycodone HCL Oral Tablet 5 MG 2 tablets by mouth every 4 hours as needed for pain 4-10. Discontinued September 19, 2023, at 2:58 p.m.Dated September 19, 2023, at 2:59 p.m. Oxycodone HCL Oral Tablet 5 MG 1 tablet by mouth every 4 hours as needed for pain 1-3. Discontinued September 22, 2023, at 7:56 a.m.Dated September 19, 2023, at 2:59 p.m. Oxycodone HCL Oral Tablet 5 MG 2 tablets by mouth every 4 hours as needed for pain 4-10. Discontinued September 22, 2023, at 7:56 a.m. Review of September 2023 Medical Administration Record (MAR) revealed on September 15, 2023, administration of Oxycodone HCL Oral 5 MG Tablets at 8:47 a.m., one tablet was administered for a pain level of 6 out of 10.Further review of the Controlled Drug Receipt/Record/Disposition Form revealed that on September 15, 2023, only one tablet was pulled from the cart at 8:00 a.m.Review of September 2023 MAR revealed on September 17, 2023, administration of Oxycodone HCL Oral 5 MG Tablets at 2:05 p.m., one tablet was administered for pain level 5 out of 10, and at 11:35 p.m., only one tablet was administered for a pain level of 8 out of 10.Further review of the Controlled Drug Receipt/Record/Disposition Form revealed that on September 17, 2023, only one tablet was pulled from the cart at 2:10 p.m., and one tablet was pulled from the cart at 11:40 p.m.Review of September 2023 MAR revealed on September 18, 2023, administration of Oxycodone HCL Oral 5 MG Tablets at 4:40 a.m., one tablet administered for pain level 8 out of 10. At 12:50 p.m., one tablet was administered for a pain level of 6 out of 10, and at 4:55 p.m. and one tablet was administered for a pain level of 7 out of 10. Further review of the Controlled Drug Receipt/Record/Disposition Form revealed that on September 18, 2023, only one tablet was pulled from the cart at 4:00 a.m., and 12:51 p.m. Two tablets were pulled at 5:00 p.m., even though only one tablet was marked administered at that time. Review of September 2023 MAR revealed on September 19, 2023, administration of Oxycodone HCL Oral 5 MG Tablets at 4:15 a.m. one tablet administered for a pain level of 5 out of 10, and at 12:37 p.m., one tablet was administered for a pain level of 7 out of 10.Further review of the Controlled Drug Receipt/Record/Disposition Form revealed that on September 19, 2023, only one tablet was pulled from the cart at 4:15 a.m. and 12:40 p.m.Review of September 2023 MAR revealed on September 20, 2023, administration of Oxycodone HCL Oral 5 MG Tablets at 5:21 a.m., one tablet for a pain level of 6 out of 10, and at 1:37 p.m., one tablet was administered for a pain level of 7 out of 10.Further review of the Controlled Drug Receipt/Record/Disposition Form revealed that on September 20, 2023, only one tablet was pulled from the cart at 5:23 a.m. and 1:35 p.m.Review of September 2023 MAR revealed on September 21, 2023, administration of Oxycodone HCL Oral 5 MG Tablets at 1:30 a.m., one tablet for a pain level of 6 out of 10, and at 7:19 p.m., one tablet was administered for a pain level of 7 out of 10.Further review of the Controlled Drug Receipt/Record/Disposition Form revealed that on September 21,2023 only one tablet was pulled from the cart at 1:31 a.m. and 6:48 a.m.An interview was conducted on July 18, 2025, at 10:12 a.m. with Registered Nurse (RN/Staff # 108), who stated that if a narcotic needed to be administered, we would look at the orders and usually we need to try a non-pharmaceutical intervention first but if that does not work then we would dispense the narcotic based on the parameters of the orders. Once the medication is pulled from the cart, she would document the date, time. and the amount of the narcotic on the narcotic count sheets. Once it is recorded, we then administer the narcotic to the resident, and then we document the administration into the MAR. RN #108 revealed that after some time, she would then follow up

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility policy, the facility failed to ensure drug records were in order and that an account of all controlled drugs was maintained for 1 out of 10 sampled residents (# 41). The deficient practice could result in the potential for the resident to not being properly medicated. Findings include: Resident # 41 was admitted on [DATE] with diagnoses that included fracture of the pelvis without disruption of the pelvic ring, fall from a roof, pain in the right shoulder, and muscle weakness.Review of the Resident's care plan revealed that Resident # 41 is currently prescribed an opioid for pain, effective September 11, 2023, with an intervention task that included to administer opioid as prescribed. Review of Resident's # 41 Minimum Data Set (MDS) dated [DATE] revealed a BIMS of 15, which indicates the resident is cognitively intact. The MDS revealed that Resident # 41 was on opioids for pain, which he received occasionally and rated the pain an 8 out of 10 over the last 5 days. Review of the Resident's orders revealed the following orders,Dated September 12, 2023, at 1:25 p.m. Oxycodone HCL Oral Tablet 5 MG 1 tablet by mouth every 4 hours as needed for pain 1-3. Discontinued September 19, 2023, at 2:58 p.m.Dated September 12, 2023, at 1:25 p.m. Oxycodone HCL Oral Tablet 5 MG 2 tablets by mouth every 4 hours as needed for pain 4-10. Discontinued September 19, 2023, at 2:58 p.m.Dated September 16, 2023, at 3:12 p. m. Oxycodone HCL Tablet 5 MG 2 tablets by mouth two times a day for pain. Discontinued September 19, 2023, at 2:44 p.m. Dated September 19, 2023, at 2:59 p.m. Oxycodone HCL Oral Tablet 5 MG 1 tablet by mouth every 4 hours as needed for pain 1-3. Discontinued September 22, 2023, at 7:56 a.m.Dated September 19, 2023, at 2:59 p.m. Oxycodone HCL Oral Tablet 5 MG 2 tablets by mouth every 4 hours as needed for pain 4-10. Discontinued September 22, 2023, at 7:56 a.m.Dated September 19, 2023 at 2:44 p. m. Oxycodone HCL Tablet 5 MG 2 tablets by mouth two times a day for pain management. Discontinued September 22, 2023, at 7:56 a.m. Review of the Controlled Drug Receipt/Record/Disposition forms for September 13, 2023, revealed that Oxycodone HCL 5 MG tablets were taken from the cart at, 8:20 a.m. 2 tablets marked. This entry was crossed out with a note of dropped/wasted along with two staff initials.8:45 a. m. 2 tablets marked12:55 p.m. 2 tablets marked4:50 p.m. 1 tablet marked8:40 p.m. 2 tablets marked Review of September 2023, Medical Administration Record (MAR) revealed on September 13, 2023, administration of Oxycodone HCL Oral 5 MG Tablets was at the following times,8:45 a.m. 2 tablets as needed for pain of 8. 12:55 p.m. 2 tablets as needed for a pain of 7.4:40 p.m. 1 tablet as needed for a pain of 3. Review of the Controlled Drug Receipt/Record/Disposition forms for September 16, 2023, revealed that Oxycodone HCL 5 MG tablets were taken from the cart at, 8:00 a.m. 2 tablets marked.5:24 p.m. 2 tablets marked.8:00 p.m. 2 tablets marked.Review of September 2023, Medical Administration Record (MAR) revealed on September 16, 2023, administration of Oxycodone HCL Oral 5 MG Tablets was at the following times,8:00 p.m. 2 tablets scheduled for a pain of 5.Review of the Controlled Drug Receipt/Record/Disposition forms for September 21, 2023, revealed that Oxycodone HCL 5 MG tablets were taken from the cart at, 1:31 a.m. 1 tablet marked6:59 a.m. 1 tablet marked No Time marked, there is a note indicating the rest of the medication was sent home with the patient on September 21, 2023, with two staff initials.Review of September 2023, Medical Administration Record (MAR) revealed on September 21, 2023, administration of Oxycodone HCL Oral 5 MG Tablets was at the following times,1:30 a.m. 1 tablet as needed for pain of 6.7:19 a.m. 1 tablet as needed for pain of 7. 8:00 a.m. 2 tablets scheduled for pain of 6.An interview was conducted on July 18, 2025, at 10:12 a.m. with Registered Nurse (RN/Staff # 108), who stated that if a narcotic needed to be administered, once the medication is pulled from the cart, she would document the date, time, and the amount of the narcotic on the narcotic count sheets. Once it is recorded, we then administer the narcotic to the resident, and then we document the administration into the MAR. If the resident refuses or the narcotic gets dropped, we then waste the medication and document on the narcotic sheet that the medication was wasted, and have two nurses sign off on the narcotic sheet. RN # 108 also stated that at the end of the shift, the narcotic cards and each individual pill are counted with the oncoming nurse. If count is off, then they would try and recount it. If it continued to be off, we would contact the Director of Nursing for further instructions. An interview with the Director of Nursing (DON/Staff # 125) was conducted on July 18, 2025, at 11:46 a.m. revealed that at the end of every shift, the outgoing and incoming nurses will reconcile the count of the narcotic cards to the actual count of narcotics on hand. The facility has an independent pharmacy that conducts reconciliation between narcotic count sheets and the MAR. DON # 125 acknowledged that the