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	12/16/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure one resident (#103)'s medication was not left at bedside and resident was assessed for self-administration of medication. The deficient practice could place resident's safety at risk.Findings include:Resident #103 was admitted to the facility on [DATE] with diagnoses that included dementia, Obstructive Sleep Apnea (OSA), depression, heart failure, and chronic kidney disease.A review of the admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14.0, indicating cognitively intact.The care plan dated November 13, 2025, revealed resident was at risk for impaired cognitive function/dementia or impaired thought processes related to new admission. The interventions included keep routine consistent to decrease confusion, monitor/document/report to provider and to the nurse any changes in cognitive function specifically changes in decision making ability, memory, recall and general awareness, sleepiness/lethargy, and confusion.Another care plan initiated on November 26, 2025 revealed that resident had the potential for psychosocial well-being problem related to disease process, and takes psychotropic medication. The interventions included observe for side effects of anti-depressant medication such as confusion, mood change, hallucinations/delusions, drowsiness, sedation, social isolation, suicidal ideations, withdrawal, decline in ability to help with/do activities of daily living, dizziness/vertigo, and fatigue.However, the comprehensive care plan did not include a self-administration of medication care plan.A review of physician order revealed an order for Diphenhydramine Hydrochloride (HCl) oral tablet 25 milligram (MG), give one tablet by mouth every 24 hours as needed for itching for 14 Days at bedtime with a start date of December 14, 2025 and a start time of 10:00 AM.There was no order for self-administration of medication found in the resident's clinical record.According to [NAME] Nursing Drug Handbook, Diphenhydramine is used for short-term management for insomnia (difficulty falling asleep or staying asleep) in adults. The brand name is Benadryl, and it is available over-the-counter. The tablet comes in different dosages, 25 MG and 50 MG.On December 14, 2025, approximately 8:00 AM, Resident #103 was observed in her room lying in bed and next to her bed was her bedside table. On top of her bedside table there was a medication cup, and inside of the medication cup was a small rectangular pink pill.An interview was conducted on December 14, 2025, at 8:07 AM with a Licensed Practical Nurse (LPN/Staff #12) in Resident #103's room. Staff #12 described the pill found at the resident's bedside table as half a tablet that looks like Benadryl. Staff #12 asked the resident if she had asked for a Benadryl and the resident responded by saying do not to take my Benadryl. Staff #12 took away the medication cup with the pill inside the cup from the resident's bedside table. At 8:11 AM, Staff #12 opened her work laptop computer parked outside the room in the hallway to look at resident #103's electronic clinical record. Staff #12 said that she does not see an order for the Benadryl in the resident's electronic clinical record. Staff #12 walked towards a Registered Nurse (RN/Staff #89) who was the nurse for Resident #103. Staff #12 informed Staff #89 that Resident #103 said that the Benadryl was left at her bedside last night. Staff (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#89 stated that it was not him that left it and that he was not made aware about any Benadryl for the resident. Staff #89 wasted the pill by throwing it in the sharp container located at the side of the medication cart. Staff #89 stated that he will notify the resident's provider about the Benadryl.A review of the Medication Administration Record (MAR) for December 2025 revealed a transcribe order for Diphenhydramine HCl oral Tablet 25 MG give 1 tablet by mouth every 24 hours as needed for itching for 14 Days at bedtime dated December 14, 2025, at 9:48 AM with a discontinue date of December 14, 2025, at 1:21 PM. And, another transcribed order for Diphenhydramine HCl oral Tablet 25 MG give 0.5 tablet by mouth every 24 hours as needed for itching for 14 Days at bedtime dated December 14, 2025, at 1:21 PM.An interview was conducted on December 15, 2025 at 9:50 AM with another LPN (Staff #108). The LPN stated that the process for medication administration included verifying the resident's name, right resident, right time, and right medication. She stated that before administration of medication to a resident, she would make sure that an order or a prescription for the medication was received from the doctor. She said that after receiving an order, she would place the order in the resident's electronic clinical record, and then she can administer the medication to the resident. Further, she stated that she would not give a medication without an order because a resident's medication needs an order from the resident's provider. She said that if one of her residents asked for a Benadryl, she will first get an order from the provider, transcribed the order in the MAR, then give the medication to the resident, and then document in the MAR that the medication was administered. She said that she would not administer Benadryl without an order, and it is not within her nursing scope of practice to give a medication without an order. She also stated that she will not leave a medication at bedside because anybody who wanders can walk in the resident's room and take the resident's medication, the resident could get double dose, and leaving a medication at bedside is against the facility's policy.Another interview was conducted with an LPN on December 15, 2025 at 12:39 PM. The LPN (Staff #1) stated that during medication administration, he will make sure that the medication matches the medication order to keep the resident safe and prevent medication error. He said that a medication order from the provider was needed before he can administer a medication. He said that he cannot administer Benadryl without an order even if his residents tell him that they take Benadryl at home. Further, he will reach out to the provider using a secured work cellphone to communicate the resident's medication request. He stated that once he had received an order for Benadryl, he will verify the medication to the order, prepare the medication for the resident, administer the medication to the resident, and stay with the resident to make sure the resident can swallow the pill without any issue. He will not leave a medication at bedside for resident's safety, because his resident might not take the medication. Further, he said that there is a process called self-administer when medications are left at bedside. He said that self-administration of medication requires a provider order, and the assessment of the mental capacity of the resident because he would not leave a medication at bedside to a resident who is confuse or with dementia due to lack of judgement and cognitive impairment. He reinstated that everything he provides to his residents for their needs requires an order from the provider.On December 15, 2025, at 1:00 PM, the Director of Nursing (DON/Staff #46) was interviewed. The DON stated that the process and expectation for medication administration was to have orders and administer the medications according to the orders given by the provider, and she expects her staff to stay and observe the resident taking the medication during administration. The DON stated that she would not give a medication without an order. She said that there should be an order from the provider, and if the staff gave a medication without an order, she would initiate an investigation. The DON stated that she was made aware of the Benadryl medication issue for Resident #103. She stated that a self- administration of medication process would include an assessment to check a resident's competency. She said that for a resident to self-administer medication, the resident needs to be alert and oriented; understands the medication and how to administer it; what the effects of the medication; and requires an order from the provider to self-administer the medication. Regarding the Benadryl for Resident #103, the DON stated that (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was an order obtained from the provider to give Benadryl. She said that the order was in the staff/provider work cellphone text message. She said that the Benadryl order was received on Saturday evening, the nurse administered the medication, the night nurse watched the resident take her Benadryl, the nurse left the resident's room after the resident placed the medication in her mouth, the resident bite the medication in half and the resident requested to save the other half of the Benadryl. The DON stated that the Benadryl medication was not self-administered and not given without an order. The DON stated that she will provide the documentation of Benadryl order received on Saturday from the staff work cellphone text message.Review of the facility document from a staff work cellphone text message regarding Benadryl order revealed on top of the message was Saturday 8:49 PM, and the text messages were Resident #103 would like a Benadryl to sleep. Can I have an order for that, and Yeah prn.Upon further review of the Benadryl text message, the Benadryl order did not have a date stamped on the message, the Benadryl text did not include the dose and frequency of administration, time of administration, and route of administration. Regarding the text messages of Benadryl, the resident's electronic clinical record did not reveal a documentation that an order for Benadryl to sleep prn was received on Saturday at 8:49 PM, the December 2025 MAR did not reveal a transcribed order for Benadryl to sleep prn received on Saturday at 8:49 PM, and there was no documentation on the December 2025 MAR that the resident was administered a Benadryl to sleep prn after an order was received on Saturday at 8:49 PM.A follow up interview was conducted with the DON on December 16, 2025 at 12:58 PM. The DON stated that regarding physician orders, she expects the staff to get an order from a physician, and place the order in the electronic clinical record in a timely manner. She said that a timely manner was dependent on the situation. She said she expects the staff to place the order in the electronic clinical record by the time the dose is due. Regarding the Benadryl order, the DON said that when her staff received an order, the expectation was to give the medication. The DON read the order of Benadryl from the staff/provider cellphone text message. From the staff/provider cellphone text message, the DON said, order Benadryl as needed, and did not provide a dose. Further, the DON stated that her expectation of the Benadryl order was that if the order was different from a normal over-the-counter dose, then she expects a specific order. The DON stated that the provider was notified of the order clarification on the morning of December 14, 2025, and the half-dose order clarification was entered at 1:30 PM on December 14, 2025.However, according to [NAME] Nursing Drug Handbook, Benadryl is available over-the-counter, and the tablet form comes in different dosages, 25 MG and 50 MG. Since Benadryl, an over-the-counter medication comes in different dosage, the Benadryl text message order received on Saturday at 8:49 PM did not include a specific order for dosage for the nurse to administer to the resident.Review of facility policy titled Medication Administration-Oral revised on September 2025, revealed that it is the facility policy to accurately prepare, administer and document oral medications. The procedure included to identify resident eMAR (electronic Medication Administration Record) orders, administer the drug to resident, document administration of medication. The policy's Essential Points revealed no medication is to be administered without a physician's written order, the nurse preparing the drug administers it, the person administering medication must remain with the resident until all medication has been swallowed, fractional dosage: whole tablets not marked in one-half by means of well-defined line may not begiven by breaking the dry tablet in what seems to be half, and if there is any question in regard to dosage, the person in doubt should not give the drug until she has obtained information which clarifies drug dosage.Review of another facility policy titled Physician Orders revised on September 2025, revealed that drugs shall be administered, and the facility to accurately implement orders in addition to medication orders (treatment, procedures) only upon the order of a person duly licensed and authorized to prescribe such drugs. The procedures included that all drugs and biological orders shall be written, dated, and signed by the person lawfully authorized to give such as order; verbal orders will be recorded timely in the resident's chart by the person receiving the order and must include the date and the time of the order; drug orders must be recorded in the resident's medical (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record under orders; medication, treatment or related procedure orders are transcribed in the eMAR, accordingly; and orders of the medication must include:A. Name and strength of the drug;B. Quantity or specific duration of therapy;C. Dosage and frequency of administration;D. Route of administration if other than oral; andE. Reason or problem for which given.