STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Peak Care Center	8825 South 7th Street Phoenix, AZ 85042

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 - 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** 42306 Based on review of clinical records, staff interviews, facility investigations, and facility policy and procedures, the facility failed to ensure one resident (#5) did not physically abuse another resident (#6). The deficient practice could result in other residents being abused. Findings include: -Resident #6 was admitted on [DATE] with diagnoses of schizoaffective disorder, bipolar disorder, adrenocortical insufficiency, conversion disorder with seizures or convulsions, violent behavior, and personal history of other mental and behavioral disorders. -Resident #5 was admitted on [DATE] with diagnoses that included Schizoaffective disorder, major depressive disorder, nicotine dependence, and essential hypertension; and was the identified alleged perpetrator. The interim care plan dated November 4, 2022 revealed the resident had no cognitive impairment and was taking antipsychotic/psychotropic medications. However, the interim care plan did identify behaviors and did not include interventions to direct staff on how to deal with aggressive behaviors of resident #5. The admission summary dated November 4, 2022 included resident #5 was a smoker, was a little irritated that he did not have cigarettes. The physician order summary report revealed the resident was prescribed with the following antipsychotic medications: -Haloperidol 5 mg (milligrams) by mouth three times a day for psychosis (start date of November 4, 2022); and, -Latuda 40 mg two times a day for psychosis (start date of November 5, 2022) These medications were transcribed onto the MAR (medication administration record) for November 2022. However, the MAR revealed that on November 5, 2022, Haloperidol was not marked as administered on the night shift; and, Latuda was not marked as administered on the 8:00 a.m. and 2:00 p.m. shift. Both medications had a code of 9 that indicated to see progress notes. (continued on next page)

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
	035175	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Peak Care Center	8825 South 7th Street Phoenix, AZ 85042

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 - Actual harm Residents Affected - Few	The administration note dated November 5, 2022 included that Latuda was pending delivery from pharmacy. Another administration note dated November 5, 2022 revealed Latuda was not available pending insurance approval; and that, the NP (nurse practitioner) was notified. Review of another administration note dated November 5, 2022 included that Haloperidol was not available; and that, delivery from pharmacy was pending. There was no evidence found in the clinical record that Haloperidol and Latuda was administered as ordered on November 5, 2022. A behavior report dated November 5, 2022 revealed that resident #5 attempted to reach and grab another resident; and that, staff had to get in-between the two residents. The documentation also included that resident #5 said he was trying to get the other resident's hat; and that, a staff asked the resident to keep his hands to his self. The report did include that the physician/provider was notified. A nursing note dated November 5, 2022 included that at approximately 7:25 a.m., the CNA (certified nurse assistant) reported that resident attempted to reach out to grab another resident while in the hall way. Per the documentation, the CNA got in between and resident #5 stated that he was trying to get the other resident's hat. It also included that the CNA attempted to redirect the resident who chose to wait for breakfast by the dining room door. The documentation did not indicate that the physician/provider was notified of the resident #5's behavior. A nursing note dated November 5, 2022 included that at approximately 2:00 p.m. resident #5 demanded to go outside during the smoke break was very agitated for not having cigarettes and was yelling/cursing at staff. Per the documentation, resident #5 stated fuck you I'm getting the hell out of here! You want me to jump the fence to get some 'cigs' I can do it if you want me to. Further, the note included the resident threw the ashtray bucket over the patio fence, went back inside the unit, punched the trash can, went to his bedroom and slammed his door shut. According to the documentation the provider and the psych NP were notified. A nursing note dated November 6, 2022 included that all medications were administered without difficulty and staff will continue to monitor. However, the MAR documentation on November 6, 2022 revealed the MAR coded 1 indicating absent from home without meds for Haloperidol on three shifts and for Latuda on two shifts. A care plan was initiated on November 6, 2022 for behavior problems related to aggressive behavior with a history of resident to resident incidents. The goal was that the resident would have fewer episodes of aggressive behavior. Interventions included to administer medications as ordered, monitor/document for side effects and effectiveness, intervene as necessary to protect the rights and safety of others, divert attention, remove from situation and take to an alternate location as needed, and to intervene before agitation escalates. A behavior report dated November 6, 2022 included that resident #5 told staff that the next time staff say huh to him, he was going to get aggressive with her. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Peak Care Center	8825 South 7th Street Phoenix, AZ 85042

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 - Actual harm Residents Affected - Few	Another behavior note dated November 6, 2022 revealed the resident threatened to get physical with staff due to staff inability to understand him. The documentation did not include that the provider was notified. In another behavior note dated November 6, 2022 it included the resident was in the room throwing a trash can and a chair; and was yelling and screaming at staff. Per the note, the resident continued to yell out at staff, redirection was given but was not effective. The documentation did not include that the provider was notified of the resident's aggressive behavior. A nursing note dated November 6, 2022 included that on November 5, 2022 at approximately 5:30 pm, resident #5 was by nurses' station yelling and was demanding for cigarettes. The note included that resident #5 threw a spoon at the door; and, another resident (#8) yelled at resident #5 from the hall telling resident #5 to shut up and behave! The documentation included that resident #5 yelled back don't tell me to shut up!; and, ran towards resident #8 to try to strike at her. The note included that staff was able to get the female resident out of the way and resident #5 went to his bedroom, was laughing talking to self; and that, the staff continued to monitor resident #5 closely. Despite documentations that smoking triggered the resident's aggressive behaviors, smoking was not addressed in the care plan. A nursing note dated November 6, 2022 revealed that at approximately 6:10 a.m. resident #5 was sitting on a chair in the hallway yelling and cursing at staff; and was cursing another resident who was pacing in the hallway. The note also included that resident #5 yelled I will fuck all you pussies up! There's no fucking men down here. According to the documentation, staff attempted to deescalate resident #5; but was not effective. Despite the resident #5's escalating aggressive behavior towards staff and other residents, there was no evidence found in the clinical record that the provider was notified after each these episodes. Another nursing note dated November 6, 2022 included that resident #5 was in the hallway yelling/cursing at staff; and, at approximately 6:25 a.m. another resident (#6) yelled from his bed and told resident #5 .shut the fuck up. According to the documentation, resident #5 quickly went into resident #6's bedroom and got on top of him, punched the resident (#6) in the face multiple times. The note included that 911 was called immediately and extra staff was called to the unit to assist in de-escalation. It also included that resident #5 sat in wheelchair by unit exit door for a few minutes and then went to his bedroom willingly. According to the documentation, the administrator, DON (Director of Nursing), Psych NP (Nurse Practitioner), and medical provider were all notified; and, at 7:05 am resident #5 was escorted by police out of the facility. A review of another nurse progress note dated November 6, 2022 at 12:57 p.m. (approximately 6 hours after the incident) included that resident #6 had complained of chest pain and pain/blurriness to right eye, the physician was notified and an order was received to send resident #6 to the ER (emergency room) via non-emergency transport for a CT (Computed tomography Scan) and CXR (chest x-ray). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Peak Care Center	8825 South 7th Street Phoenix, AZ 85042

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 - Actual harm Residents Affected - Few	A psychiatric evaluation dated November 6, 2022 revealed staff reported resident #5 became angry in the morning of November 6, 2022 and had entered the room and hit resident (#6) in the face. The evaluation included that the NP recommended against accepting the resident back to the facility given his high level of physical aggression despite multiple psychiatric medications. A facility investigation dated November 11, 2022 included that resident #5 had a behavior problem related to aggressive behavior with a history of resident to resident incidents. The investigation included that resident #6 was assessed, had abrasions to the bridge of nose, right cheek, left and right forehead; and was given medication for reported discomfort and pain. The investigation included that due to the diagnoses and behaviors of both residents (#5 and #6) in the high acuity unit, the quick escalation of behaviors can occur and was expected. It also included that both residents had a history of verbal and physical aggression towards staff and residents. Interventions in place to de-escalate did not help. The investigation also included an interview with a CNA (certified nursing assistant) who reported that the doors to the resident rooms should have been shut to protect them while resident #5 was agitated. Further review of the facility investigation revealed that due to the diagnosis and behaviors of residents in high acuity unit, quick escalation of behaviors can occur and was expected; and that, interventions in place to de-escalate did not help resident #5 as he became aggressive towards staff as well. The report included that the facility determined that interventions placed will protect resident #6 and other residents from incidents to occur; and, was unable to substantiate abuse or neglect. An interview was conducted on January 5, 2023 at 1:05 p.m. with a CNA (staff #16) who stated she tries to read the admission paperwork to identify behaviors and triggers of residents being admitted on the high acuity behavioral unit; and that, the triggers and behaviors are communicated to the staff so they know how to approach them. Staff #16 also stated that rounding on the unit is completed every 10-15 minutes. Regarding resident #5, the CNA stated she was present when resident #5 was admitted ; and that, resident #5 was unkempt and looked wild; however, resident #5 was happy to be home because he had been at the facility before. Staff #16 stated resident #5 had been very aggressive; and trigger points for resident #5 included not being able to smoke, being told no, and other residents yelling at him. Staff #16 stated that based on the reviewing of resident's behavior from admission to the morning of November 6, 2022, resident #5 had been escalating. Staff #16 stated there was one regular staff and two agency staff working the unit the morning of November 6, 2022; and, they did not see the triggers. During an interview with a psychiatry NP (staff #22) conducted on January 5, 2023 at 2:26 p.m. the NP stated she was part of the admission process for resident #5; and her acceptance of a resident is based on medication compliance and recent physical aggression. Staff #22 stated that when resident #5 was admitted not all of his notes were beautiful; but, there was room with his medications to make adjustment if needed. Staff #22 stated the resident sort of laughed and his behaviors were sandwiched around good nights so she felt the resident was doing well; and, she knew he had a history of being verbally aggressive. The NP stated that prior to the resident hitting resident #6 in the face she was notified on November 6, 2022 about the behaviors of resident #5. The NP also said that cigarettes were a trigger for the resident in the past; and that, missed doses of medications were not good for him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Peak Care Center	8825 South 7th Street Phoenix, AZ 85042

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 - Actual harm Residents Affected - Few	An interview was conducted with a registered nurse (RN/staff #28) on January 5, 2023 at 3:14 p.m. The RN stated that she was completing a medication administration in the hallway and noted the female resident yelling to herself. Staff #28 stated that she did not know what triggered resident #5 the evening of November 5, 2022 but she just saw him going after the female resident who was removed from the area and was monitored until resident #5 de-escalated. Regarding the incident on November 6, 2022, the RN said she was getting report when she noticed resident #5 yelling in the hallway and she tried to get resident #5 away from other resident's doorways but resident #5 would not budge. The RN stated that was when resident #6 yelled out from his room because resident #5 woke him up; and then resident #5 ran into the room and jumped onto resident #6. During an interview conducted with the Director of Nursing via phone (DON/staff #33), the Assistant Director of Nursing (ADON/staff #40), and the Administrator (staff #37) on January 6, 2023 at 11:35 a.m., the DON stated the expectation was when admitting a resident to the behavior unit, staff had to review the medical record; and that, the staff on the unit have the experience to handle aggressive behavior and use de-escalation. The DON stated the expectation was that staff would call for assistance or the police when a resident continues to have aggression towards the staff and other residents and when de-escalation techniques were not working. The DON also stated that when the staff get the resident to calm down and keep other residents safe, staff will call the provider and document the notification of the behaviors. The DON stated she did not recall seeing much aggression from resident #5 in the hospital records but she knew the staff were concerned about his physical aggression. She stated that after the first aggression towards residents on November 5, 2022 the provider should have been notified. The Administrator who was present during the interview stated there were text messages to the provider but nothing documented in the electronic record that included details of what was discussed. The DON stated she thinks the doors to other resident rooms should have been closed when resident #5 was yelling up and down the hallway. The DON stated that the staff did get an order for Haldol PRN (as needed) after the incident for running in the hallway but it was not documented in the chart. The DON stated that there were communications with the nurse practitioner and the staff were instructed to keep monitoring and de-escalating the situation; and that, there was a huge delay in medications. A facility policy titled Behavioral Assessment, Intervention, and Monitoring (revised March 2019) included that the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individuals' mental status, behavior, and cognition, including onset, duration, intensity and frequency of behavioral symptoms. New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. Continued review of the policy included that interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environmental reasons for the behavior. The care plan will include, at a minimum: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Peak Care Center	8825 South 7th Street Phoenix, AZ 85042

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 - Actual harm Residents Affected - Few	-Description of the behavioral symptoms; -Targeted and individualized interventions for the behavioral and/or psychosocial symptoms; -The rationale for the interventions and approaches; -Specific and measurable goals for targeted behaviors; and, -How the staff will monitor for effectiveness of the interventions. A facility policy titled Abuse Policy (reviewed/revised September 2022) included that the residents have the right to be free from abuse and includes but not limited to freedom from verbal, mental or physical abuse. Abuse is the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain or mental anguish. The administration will protect residents from abuse by anyone including other residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Peak Care Center	8825 South 7th Street Phoenix, AZ 85042

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42306 Based on clinical record reviews, staff interviews, and policy and procedures, the facility failed to ensure that comprehensive care plans were developed for one resident (#1) regarding wandering behaviors. The deficient practice could result in residents needs based on the comprehensive assessment not being met. Findings include: Resident #1 was admitted on [DATE] with diagnoses of Alzheimer's disease, lymphedema, and disorders of bone density and structure. A quarterly Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 0 indicating the resident had severe cognitive impairment. According to the assessment, the resident had wandering behaviors that occurred 4 to 6 days prior to the assessment; and that, the resident required supervision for bed mobility, transfers, walking in room and corridor, locomotion on and off unit, dressing, eating, and toilet use. A nursing note dated November 25, 2022 included the resident was alert with confusion, was pacing hallways with short periods of rest room, was showing signs of anxiety, intrusive with neighbors and exit seeking. A nursing note dated November 26, 2022 revealed the resident slept part of the night and woke up ambulating thru the hallway. The documentation included that the resident was alert with confusion with no behavior noted this shift and monitoring will continue. A nursing note dated December 10, 2022 included the resident was alert to self, pacing up and down the hall constantly; and that, an antianxiety medication was given which helped for a little while. The note included that the resident started trying to push on doors and redirection was not easy but she was doing better. A nursing note dated December 16, 2022 included that the resident was alert with baseline confusion and paces on unit with supervision. Despite documentation that the resident had wandering and exit-seeking behaviors, the clinical record revealed no evidence that a care plan was developed with interventions to address the resident's wandering or exit seeking behaviors. During a phone interview with the Director of Nursing (DON/staff #33) conducted on January 6, 2023 at 11:35 a.m., the DON stated that when a resident has exit seeking or wandering behaviors, staff are expected to develop a care plan with the appropriate interventions. The DON stated that interventions for wandering residents include keeping the secured doors closed on the unit, providing supervision, and alarms on the doors that talk to resident to encourage them to turn around. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Peak Care Center	8825 South 7th Street Phoenix, AZ 85042

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Wandering and Elopements (revised March 2019) included the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Peak Care Center	8825 South 7th Street Phoenix, AZ 85042

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42306 Based on clinical record review, staff interviews, and review of policies and procedures, the facility failed to ensure the comprehensive care plan was revised to include new fall interventions for one resident (#7). The deficient practice could result in the care plan not reflecting the interventions required to meet the resident needs. Findings include: Resident #7 was admitted on [DATE] with diagnoses of metabolic encephalopathy, sepsis, acute respiratory failure with hypoxia, and Parkinson's disease. A care plan initiated on October 28, 2022 included resident was at risk from falls related to injuries, confusion, Parkinson's, and Alzheimer's. The goal was that the resident would be free of falls. Interventions included to anticipate needs and follow facility fall protocol. A nursing note dated October 28, 2022 revealed that at 9:55 p.m. staff went to assess the back side of resident who had an unwitnessed fall. The nursing note dated October 28, 2022 included the resident had an unsteady gait, had attempted to walk without assistance and had to be redirected consistently to prevent falls. An alert note dated October 28, 2022 included the resident had a witnessed fall. According to the documentation, the resident attempted to ambulate without staff assistance and fell on his buttocks. An administration note dated October 29, 2022 revealed the resident was trying to get up from bed and wheel chair on his own and was redirected and repositioned several times. The incident note dated October 31, 2022 included the resident was found on the floor sitting on his buttock next to the bed. Per the documentation, the resident had bruising on the right hip; and that, the resident reported that his hip was hurting and pain medication was given. Further, the note included that the physician ordered to send the resident to nearest emergency room . Review of the clinical record revealed the fall care plan was revised on October 31 and November 8, 2022 to include new interventions of a floor mat at the bedside, bed in a low position and providing non-skid socks or shoes on at all times. However, the care plan did not include interventions to address the resident's behavior of attempting to get out of his wheelchair or standing up without assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Peak Care Center	8825 South 7th Street Phoenix, AZ 85042

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing via phone (DON/staff #33) conducted on January 6, 2023 at 11:35 a.m., the DON stated when a resident has a fall/s the staff will review and revise the care plan with appropriate interventions to prevent further falls. The DON stated that interventions for falls include the fall protocols, bed locked in a low position, and non-slip socks. Further, the DON said resident #7 would attempt to walk on his own and stand up from his wheelchair; and that, prior to November 11, 2022 all interventions were in place so they were not reevaluated. The facility policy on Falls and Fall Risk, Managing revised on March 2018 included that based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e. , to try one or a few at a time, rather than many at once). If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Peak Care Center	8825 South 7th Street Phoenix, AZ 85042

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42306 Based on review of clinical records, staff interviews, and policy and procedures, the facility failed to ensure adequate supervision and assistance was provided for two residents (#1 and #7). The deficient practice could result in avoidable accidents for residents. Findings include: -Resident #1 was admitted on [DATE] with diagnoses that included Alzheimer's disease, lymphedema, and disorders of bone density and structure. A quarterly Minimum Data Set (MDS) assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 0 indicating the resident had severe cognitive impairment. According to the assessment, the resident had wandering behaviors that occurred 4 to 6 days prior to the assessment; and that, the resident required supervision for bed mobility, transfers, walking in room and corridor, locomotion on and off unit, dressing, eating, and toilet use. A nursing note dated November 25, 2022 included the resident was alert with confusion, was pacing hallways with short periods of rest room, was showing signs of anxiety, intrusive with neighbors and exit seeking. A nursing note dated November 26, 2022 revealed the resident slept part of the night and woke up ambulating thru the hallway. The documentation included that the resident was alert with confusion with no behavior noted this shift and monitoring will continue. A nursing note dated December 10, 2022 included the resident was alert to self, pacing up and down the hall constantly; and that, an antianxiety medication was given which helped for a little while. The note included that the resident started trying to push on doors and redirection was not easy but she was doing better. A nursing note dated December 16, 2022 included that the resident was alert with baseline confusion and paces on unit with supervision. Despite documentation that the resident had wandering and exit-seeking behaviors, the clinical record revealed no evidence that interventions were put in place to address the resident's wandering or exit seeking behaviors. An interview was conducted on January 5, 2023 at 1:57 p.m. with a CNA (staff #11) who stated that resident #1 would pace a little more in the evening setting off alarms with her exit seeking behavior; and that, the resident was easily distracted. During an interview conducted with a registered nurse (RN/staff #47) on January 5, 2023 at 3:44 p.m., staff #47 stated that resident #1 had wandering/exit seeking behavior and often pack up belongings to leave. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Peak Care Center	8825 South 7th Street Phoenix, AZ 85042

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy titled Wandering and Elopements (revised March 2019) included the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. -Resident #7 was admitted on [DATE] with diagnoses that included metabolic encephalopathy, sepsis, acute respiratory failure with hypoxia, dysphagia, gastrostomy status, and Parkinson ' s disease. A care plan dated October 28, 2022 revealed the resident was at risk from falls related to injuries, confusion, Parkinson's, and Alzheimer's. The goal was that the resident would be free of falls. Interventions included to anticipate needs and follow facility fall protocol. A nursing note dated October 28, 2022 included the resident arrived October 27, 2022 at 9:08 pm via gurney; and, the resident was alert and oriented to self and had a new peg tube in place with binder covering site. Per the documentation, the resident only allowed assessment in front half of body. At 9:55 p.m., staff went to assess the back side of resident who had an unwitnessed fall and there were no injuries noted and neurological checks were started. A nursing note dated October 28, 2022 revealed the resident continued to be monitored status post fall with no injuries and neuros (neurological checks) were in place; and that, the resident refused to have his blood pressure taken all shift after multiple attempts. The note included the resident had peg tube in place with stitches attached; and that, the peg tube was patent with no signs or symptoms of infection to site. The note included resident had existing skin tear to left arm, scabs to lateral left arm, redness to mid back, sacral area, bruising to left arm/hand and to the right hand and discoloration to lower extremities bilaterally. The note included that the resident had been confused, was pulling on feeding tube multiple times, attempted to walk without assistance, was not steady and was redirected consistently to prevent falls. An Alert note dated October 28, 2022 included the resident had a witnessed fall when the resident attempted to ambulate without assistance from staff and fell on his buttocks. The note included that the resident was able to perform PROM (passive range of motion) without discomfort and the nursing staff assisted resident up into recliner chair. An Administration note dated October 29, 2022 included the resident was trying to get from bed and wheel chair on his own and was redirected and repositioned several times. The note also included that staff would continue to monitor the resident. An incident note dated October 31, 2022 included the resident was found on the floor in bedroom next to bed and was sitting on his buttock next to bed. Per the documentation, the resident Had bruising on the right hip, reported that his hip was hurting and pain medication was given. Further, the note included that the provider ordered to send the resident to nearest emergency room . The fall care plan was revised on October 31, 2022 to included interventions for a floor mat at the bedside and the bed in a low position. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Peak Care Center	8825 South 7th Street Phoenix, AZ 85042

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A post fall investigation dated October 31, 2022 revealed the resident was found on the floor on his buttocks, was not able to tell what happened before the fall and had bruising to the right hip. Per the investigation, the resident was last observed 10 minutes prior to the fall, used a cane or walker and was barefoot at the time of the fall. The hospital admission note dated November 1, 2022 included the resident presented to the emergency department after falling out of bed and had a right lower extremity pain. The documentation also included that x-rays revealed a right intratrochanteric fracture (hip fracture). The clinical record revealed that resident #7 was readmitted at the facility on November 4, 2022. An admission summary dated November 4, 2022 included that resident's gait was not assessed, communication was not clear/not able to answer questions posed clearly, had only allowed staff to do skin evaluation; but, refused a head to toe evaluation. Per the documentation, the resident had a surgical wound to the right hip with a dry dressing that was clean and intact. A nursing note dated November 10, 2022 revealed that at 6:18 pm a CNA reported that the resident was found on the floor on his left side with feet facing the door. Per the documentation, the wheelchair was positioned next to bed and the resident was pleasantly confused and stated I need to go over there. Further, the note included the resident was able to move all limbs; but the resident was unable to provide numerical pain value. The documentation also included there was no visual indications of pain or discomfort at the time and the resident was assisted from floor onto his wheelchair. The clinical record revealed no evidence that fall interventions were reviewed/revised and new interventions were put in place after the fall on November 10, 2022. A nursing note dated November 18, 2022 included the resident was sitting in his wheelchair at the nurses' station, was frequently scooting self forward in his wheelchair and was encouraged multiple times to sit back for safety and not to attempt self-transfers. It also included the resident leaned forward and fell to the ground before the nurse could reach him. Per the documentation, the resident hit his head on the floor face down with his forehead receiving impact and resulted in two quarter sized hematomas with a very scant abrasion to lower hematoma. Despite documentation of recurrent falls, the clinical record revealed no evidence that interventions were reviewed/revised to include new fall interventions implemented after October 31, 2022. An interview was conducted on January 5, 2023 at 1:57 pm with a CNA (staff #11) who stated the resident was always a fall risk and the staff needed to keep eyes on him at all times. Further, the CNA said that the resident was always trying to crawl out of bed and he didn't like wearing socks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. Building B. Wing	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Peak Care Center	8825 South 7th Street Phoenix, AZ 85042

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview with the Director of Nursing (DON/staff #33) conducted on January 6, 2023 at 11:35 a.m., the DON stated the expectation was for staff to do a head to toe assessment when a resident is found on the floor to ensure there are no injuries. The DON stated with the neurological checks the staff would assess if the resident could move with commands, if they had equal grips with their hands, and if they had equal leg strength. The DON also said residents with dementia are assessed for pain post fall by asking questions for a verbal response and also looking for facial expressions or grimacing. Regarding resident #7, the DON stated that the facility had fall interventions in place; but, the facility did not reevaluate these interventions after the falls on October 31, 2022. A facility policy titled Falls and Fall Risk, managing (revised March 2018) included that based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e. , to try one or a few at a time, rather than many at once). If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. Position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified.