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	02/24/2023

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** 40581 Based on clinical review, staff and resident interviews, and the policy and procedures of the facility, the facility failed to ensure two residents (#3 and #8) were not abused by another resident (#12). The deficient practice could result in other residents being abused. Findings include: -Resident #3 was admitted to the facility on [DATE] with diagnoses that included Alzheimer disease with early onset, anxiety, and a traumatic brain injury. The Minimum Data Set (MDS) dated [DATE] included a staff assessment mental status score of 3 indicating the resident had a severe cognitive impairment. Review of the care plan dated January 23, 2023 revealed the resident had the potential for skin tears. On January 22, 2023, the resident had left shoulder swelling and abrasion of the left trapezium. On January 29, 2023 the resident had a one-centimeter open area on the back of his head. Interventions included that if skin tear occurs, treat per facility protocol and notify MD, family. A progress note dated January 22, 2023 revealed that the writer heard a loud noise down the hall, went to check what it was and saw resident #3 on the floor in resident #12's room near the dresser. The certified nursing assistants (CNAs) helped assist resident #3 up from the floor and redirected the resident back to his room. The resident was in bed resting. No injuries noted and neuro checks were started. (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
	035175	A. Building B. Wing	02/24/2023

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 progress note dated January 29, 2023 at 8:45 p.m. stated that resident #12 came out of his room into the hallway and pointed at his room. The writer entered the room and found resident #3 on his buttocks on the floor near the bathroom door. Resident #3 was trembling, but there were no signs of seizure noted. The residents (#12 and #21) were both seen sitting on their beds. Resident #21 appeared concerned, and resident #12 noted to be relatively relaxed with no signs of aggression or agitation. The writer and co-nurse assessed resident #3 for any injuries and none noted at the time of the report. Range Of Motion (ROM) intact, neuros within limits. Staff slowly assisted the resident to a standing position and encouraged resident #3 to sit in a chair for further examination. The resident refused to sit in the chair and proceeded to walk in the hallway. The resident was showing signs of agitation, and continued to walk with close supervision. PRN (as needed) Ativan 0.5 ml (milliliter) given for agitation/restlessness. All responsible parties notified. Neuros continuing. Staff continuing to monitor. Resident was wearing non-skid socks at time of the fall. Review of the Order Summary Report revealed an order dated January 29, 2023 to monitor abrasion to back of head for serious symptoms of infection until healed. A progress note dated January 29, 2023 at 9:15 p.m. revealed that 2-hour post fall, staff noted blood from the back of resident's head, approximately one centimeter in length. Notified the Director of Nursing (DON) with orders to monitor and assess daily. Review of the care plan dated February 15, 2023 revealed resident #3 is an elopement risk/wanderer related to the resident wanders aimlessly. Interventions included to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or a book, and to reside on a locked unit due to wandering and elopement risk. -Resident #8 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, anxiety disorder and heart failure. The Minimum Data Set (MDS) dated [DATE] included a brief interview for mental status (BIMS) score of 99, indicating the resident was not able to complete the interview. Review of the care plan dated February 9, 2023 revealed the resident is an elopement risk/wanderer related to the resident wanders aimlessly. Interventions included to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or a book, and to reside on a locked dementia unit. Progress note dated February 15, 2023 revealed that resident was ambulating and wandering in and out of other residents' rooms and when sitting in wheelchair, continues to get out of it. A progress note dated February 18, 2023 at 7:06 p.m. revealed that the writer was alerted by a CNA to resident #12's room. The writer entered the room and found resident #8 lying on the floor on his back. The resident's head was against the wall near the bathroom door. Upon inspection, a laceration was noted to the crown of his head: 4.5 x 0.5 x 0.1 centimeters. -Resident #12 was admitted to the facility on [DATE] with diagnoses that included undifferentiated schizophrenia, restlessness and agitation, and an anxiety disorder. (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	02/24/2023

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 Minimum Data Set (MDS) dated [DATE] included a BIMS score of 99 indicating the resident was not able to complete the interview. A care plan dated February 18, 2023 revealed that the resident is/has the potential to be physically aggressive, related to dementia, history of harm to others, poor impulse control. On February 18, 2023 he kicked a resident in the stomach. Interventions included the resident triggers for physical aggression when his personal space is invaded, the belief that someone is approaching him to do harm. The resident's behaviors are deescalated by the intervention of staff, providing distractions like snacks and drinks, administer medications as needed, and to place a Velcro sign across the doorway to prevent others from wandering into the room. A progress note dated January 20, 2023 at 9:46 a.m. revealed that the night shift nurse reported that resident #12 was agitated and cussing at the new roommate last night. The resident was extremely territorial, not wanting anyone to come near him or in his room. The roommate is vulnerable and appears uneasy in the room. Reported behavior to administration. A progress note dated January 20, 2023 at 10:04 p.m. revealed that staff entered the room to pick up dishes and the resident started yelling, get the cup and get the fuck out of my room. The roommate was in resting in bed at the time and quickly got up and left the room. The behavior was reported to the administrator and staff was to continue to monitor the resident. A physician progress note dated January 29, 2023 revealed that the physician spoke with guardian who was able to provided that the resident had a history of significant physical aggression at prior placements against both other residents and staff members; had a history of elopement, at one facility he eloped out the window; and, used to live at another facility, from there he was placed at several group homes which he failed. According to the documentation, the guardian was unsure of the exact reason why the recent group home will not take him back; howver, belives that it was because he was cursing at other residents. He has a history of homelessness, history of Traumatic Brain Injury, alcohol dependence, cognitive impairment, and anxiety disorder. He has in the past refused medication which has led to decompensation and increase in physical aggression. A progress note dated January 30, 2023 at 9:29 a.m., revealed that the Psych provider was on the unit. This resident's roommate (resident #21) spoke with the provider, and made the statement that he witnessed resident #12 kick a man that came into their room. The provider sent out a message to leadership thread for further investigation. The psych provider met with resident #12 at this time. Per psych provider, resident #12 confirmed that he did kick a man after being threatened. Update was sent to leadership thread, continue awaiting instructions. A progress note dated January 30, 2022 at 9:42 a.m. revealed that the message received via thread from the DON. Social Services to follow up with residents regarding accusation. A progress note dated February 18, 2023 at 6:19 p.m. revealed that the resident continues 15-minute checks following an incident at approximately 3:05 p.m. when resident reported to staff that another resident was in his room and the other resident was found lying on the floor of the resident's room with a laceration to his head. Arizona Department of Health Services (DHS) notified via website at 4:53 p.m., DHS notified via website as well. Phoenix police (PPD) notified also, unable to give estimated time of arrival. One to one placed outside of resident's door for safety pending investigation. The staff will continue to monitor and await PPD arrival. (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	02/24/2023

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 progress note dated February 18, 2023 at 7:28 p.m. revealed that at 3:00 p.m., resident #12 approached the nurse's desk asking to use the bathroom. He stated he could not use his own bathroom because there was a man in his room. The CNA entered the room to check and motioned for this writer. The writer entered the room and found resident #12 sitting cross legged on the bed and resident #8 lying on the floor. Resident #12 stated that the other resident came into his room and attacked him so he kicked him in the gut. 15-minute checks and one-to-one safety monitoring initiated. Facility documentation dated February 18, 2023 revealed a statement by a registered nurse (RN/staff #72), who stated that resident #12 stated that resident #8 attacked him and so resident #12 kicked resident #8 in the gut. Facility documentation dated February 20, 2023 revealed resident #12's statement in which he states that resident #8 wanted to fight and walked up to him while he was in bed, so he kicked him in the stomach. A physician's progress note dated February 23, 2023 at 2:37 p.m. revealed that upon exam, resident #12 is noted to be paranoid, states that another resident was trying to kill him and that he kicked him. An interview was conducted on February 23, 2023 at 2:15 p.m. with the Director of Nursing (DON/staff #1), who stated that resident #12 was transferred from the dementia unit to the behavioral unit today at 12:30 p.m. A second interview was conducted on February 23, 2023 at 3:00 p.m. with the (DON/staff #1), who stated the resident #12 originally had a roommate, resident #21, who stated on January 30, 2023 that he was afraid of resident #12 because he had seen him kick another resident, but he was not able to describe the other resident. When asked if it was possible that resident #21 was referring to resident #3, who was found on the floor in resident #12's room on January 29, 2023, she stated that it was possible. She also stated that there was supposed to be Velcro stop sign across resident #12's door to prevent other residents from entering, but it was often missing and easy to pull down. An interview was conducted on February 23, 2023 at 3:20 p.m. with a certified nursing assistant (CNA/staff #84), who stated that there is supposed to be one CNA, who monitors the hall, and is supposed to walk up and down the hall, but staff are too busy. She stated that resident #12 had prior altercations with other residents prior to resident #8 being found on the floor in resident #12's room. She stated that staff knew that resident #12 was not appropriate for the dementia unit. She stated that prior to resident #8 being found on the floor in resident #12's room, he had already stated that he had pushed resident #3. An interview was conducted February 23, 2023 at 3:31 with a licensed practical nurse (LPN/staff #156), who stated that there are residents who wander and there are residents who are aggressive on the dementia hall. She stated that they try to keep one CNA in the hallway to monitor, but they are busy and there is not a specific CNA assigned to monitor the hall. She stated that resident #12 needed supervision all the time. (CNA/staff #10) joined the interview and stated that resident #12 came to the nurse's station and asked to use the bathroom because there was another resident in his bathroom. She went with resident #12 to his room and found resident #3 on the floor. She asked resident #12 what happened and stated that he told her that resident #3 tried to attack him and he kicked him in the gut. (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	02/24/2023

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 on February 24, 2023 at 9:12 a.m. with the Social Services Director (SS/staff #2), who stated that resident #12's room change occurred yesterday on February 23, 2023 and he was moved from the dementia unit to the behavior unit. She stated that resident #12 was moved because of the incidents that occurred with other residents (#3 and #8). She stated that resident #12 is territorial and doesn't understand that the other residents mean him no harm. She also stated that the residents on the dementia unit should be monitored and should not be wandering in to other residents' rooms. She stated that when resident #3 was found in resident #12's room on the floor, she tried to interview resident #12, but he told her to get the fuck out of his room, resident #3 is nonverbal, and she talked to staff, but did not document anything. She stated that resident #12's roommate, resident #21, requested a transfer to another room because he was afraid of resident #12. On January 31, 2023, resident #21 stated that he saw resident #12 kick another male resident, but he was not able to identify the resident. She stated that when resident #8 was found on the floor in resident #12's room, resident #12 told her that he kicked him in the stomach. She stated that resident #12 had a history of being aggressive at other facilities. On February 24, 2023 at 3:12 p.m. an interview was attempted with resident #12, who stated that he wanted to be left alone. An interview was conducted on February 24, 2023 at 3:18 p.m. with resident #21, who stated that he feels a lot better know that he is no longer a roommate with resident #12. He stated that resident #12 scared him a lot because he saw him kick resident #3. The facility's policy, Abuse and Neglect Policy, revised December 2016 states residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish.