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	03/31/2023

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 - Actual harm Residents Affected - Few	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** 43863 Based on clinical record reviews, staff interviews, facility documentation, policy and procedures, the facility failed to ensure adequate supervision was provided for 1 of 3 sampled residents (#12) to prevent elopement; and, failed to ensure safety while providing care resulting to a fall for 1 of 3 sampled residents (#11). The deficient practice could result in avoidable accidents. Findings include: -Regarding Resident #11 Resident #11 was admitted on [DATE] with diagnoses of muscle weakness, history of falling, abnormal posture, anxiety disorder and mood disorder. A care plan initiated on April 10, 2017, revealed resident had self-care deficit. Interventions included limited to extensive assist with activity of daily living (ADL) and incontinent care as needed. A physician order dated April 20, 2020 included to admit resident to hospice for diagnosis of senile degeneration of the brain. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE]. 2020 revealed that the resident scored 99 on a Brief Interview of Mental Status (BIMS), which indicated that the interview could not be completed. The MDS included the resident had short-term and long-term memory problems, with rejection of care being exhibited on 1-3 days during the assessment dates, and required extensive assistance for toilet and personal hygiene, with one-person physical assist. The nursing note dated August 13, 2020 included resident was awake but was not responding to verbal stimuli like he used to, was not eating or drinking at this time. It also included that resident was responding to physical stimuli when repositioned or during hygiene care. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A psychiatric evaluation note dated August 13, 2020 included that according to staff, the resident had an overall decline with little to no oral intake, had decrease responsiveness and was being followed by hospice for end of life care. Mental status exam included the resident was lethargic, disoriented, non-cooperative, confused and unfocused. The documentation also included the resident had a longstanding psychiatric history but was presenting with significant decline. Diagnosis was dementia with behavioral disturbance and undifferentiated schizophrenia. Plan was to discontinue psychotropic medications and to continue to monitor mood and behavior. The hospice physician order dated August 14, 2020 at 11:45 a.m. revealed that all routine and psychotropic medications were discontinued. This order also included orders for morphine (narcotic opioid) and Ativan (anti-anxiety). Review of nursing progress notes dated August 14, 2020 at 12:53 p.m. revealed the resident remained in bed with continued comfort cares due to expected death. Per the documentation, resident was sedated and occasionally responded to tactile stimuli. The documentation included that at approximately 10:00 a.m. a certified nursing assistant (CNA) was changing the resident who was lying on his left side while the CNA was providing care. It also included that the resident became agitated, rolled towards the wall; and when the resident rolled, the bed moved and the resident fell between the wall and the bed. Per the documentation, the resident sustained laceration to the left temporal area and a skin tear to the right elbow; and that, hospice, POA (power of attorney) and the provider were notified. The nursing progress note dated August 14, 2020 at 02:40 p.m., revealed that resident's comfort level was continued to be monitored; and that, respirations continued to be shallow and was decreasing rate steadily with no apnea. Per the documentation, at 2:27 p.m., resident was noted to be without respiration or apical pulse and with eyes fixed; and that, hospice and provider were notified. Review of a Facility Reportable Event Record/Report dated August 17, 2020 revealed that the resident was being changed by the CNA; and, the resident was lying on his side while the CNA was providing care, the resident became slightly agitated and rolled toward the wall. It also included that the bed moved from the wall when the resident rolled and the resident fell between the wall and the bed. Per the documentation, the resident sustained a temporal laceration measuring 3.8 x 3.8 cm and a J-shaped skin tear to the right elbow measuring 3.8 x 1.8 and was cleansed with saline, edges approximated and covered with tegaderm. Continued review of the facility report revealed that the wheels on the bed were unlocked at the time of the incident because the CNA was walking around the bed to provide care; and that, maintenance was contacted to ensure the bed was functioning properly. The facility report included a written statement from the involved CNA (staff #172) dated August 14, 2020. The documentation included that the CNA (staff #172) provided care at the time of the fall, wrote the resident started to resist during patient care and as the CNA continued patient care the resident rolled from a side position onto the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on March 28, 2023 at 2:24 p.m. with a CNA (staff #97) who stated there would be no reason to move a resident's bed if there was one person providing incontinence care. She also stated that if the wheels of a bed were unlocked to move, the expectation was to re-lock the wheels once the bed had been moved and prior to starting incontinence care. The CNA said the expectation was that once the resident becomes agitated or becomes combative during continence care, staff was to stop care immediately, lower the bed, and ask a nurse to come in and talk to the resident. The CNA stated that if the resident does not agree to continue the care, then staff are to approach the resident later. Further, the CNA stated that if a resident becomes agitated or combative it was the resident's way of communicating to staff that they do not want to continue with the care. In an interview with a licensed practical nurse (LPN/staff #36) conducted on March 28, 2023 at 2:35 p.m., the LPN stated she would not move the bed away from the wall prior to providing incontinent care. She said that if she would move the bed away from the wall, she would re-lock the brakes prior to starting care to ensure the safety of the resident. The LPN further stated that it was the facility's expectation to step away if a resident becomes agitated/combative during incontinent care. An interview was conducted on March 28, 2023 at 3:23 p.m. with the Interim Director of Nursing (interim DON/staff #109) who stated that the expectation was for staff to relock the brakes on the bed after it was moved and prior to starting patient care. She further stated the only reason to move a bed from it being against a wall, would be if two staff were providing care. The interim DON stated that if a resident becomes agitated during care, staff should stop immediately, and call for assistance. During the interview, a review of the facility reportable event record/report was conducted with the interim DON who stated that per the CNA's interview, the care was not provided according to professional standards because the CNA did not stop the care when the resident resisted. The interim DON stated that the risk of continuing care when a resident was agitated and leaving the bed wheels unlocked during resident care could result in resident injury; and that, this did not meet the facility expectations. Review of a facility policy titled, Safety and Supervision of Residents, included that the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. Environmental hazards include bed safety, safe lifting and movement of residents, and unsafe wandering. Review of a facility policy titled, Dignity, revealed that each resident shall be cared for in a manner that promotes and enhances his/her sense of well-being. Staff are expected to treat cognitively impaired residents with dignity and sensitivity. Residents are treated with dignity and respect at all times. When assisting with care, residents are supported in exercising their rights. -Regarding Resident #12 Resident #12 was admitted on [DATE] with diagnoses of hallucinations, encephalopathy, convulsions, cerebral aneurysm and mental disorder to known physiological condition. The elopement/wandering risk data set dated [DATE] revealed no history of elopement in the past 6 months and that the resident was able to transport self independently by ambulation. Per the assessment, the resident had predisposing diagnosis for elopement, had poor safety/environmental awareness and was at risk for elopement. Plan was to follow prevention of elopement protocols. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The clinical record revealed no other elopement/wandering risk data set completed after March 6, 2019. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 06, which indicated severe cognitive impact. The MDS also included that the resident had no behaviors or wandering behaviors exhibited within the look back period. The quarterly MDS assessment dated [DATE] revealed the resident had short and long-term memory problems, had modified independence for daily decision making and was not coded for the presence of wandering during the look back period. A psychiatric evaluation note dated August 11, 2020 included that the resident had a recent increase in agitation and was verbally aggressive with nursing staff; and that, this was an unusual behavior for the resident. Diagnoses included vascular dementia with behavior disturbance and alcohol-induced persisting dementia. Per the documentation recent aggression and threatening behavior occurred just prior to his diagnosis of COVID and likely represents a psychiatric manifestation of the illness. Further, the documentation included that the resident does not need further psychiatric medication at this time. A social service note dated September 3, 2020 at 6:11 p.m. revealed that social service director (SSD) called the police at 5:30 p.m. due to the resident missing from his doctor's appointment. Despite documentation that the resident was at risk for elopement, there was no evidence found in the clinical record that a care plan was developed with interventions to address the risk for elopement until September 3, 2020. The care plan dated September 3, 2020 included the resident had been successful with elopement. Goal was that the resident will not elope and choose to remain at the facility. Interventions included resident will have an escort for all appointments and to have psychotherapy consult for coping mechanisms. A nursing note dated September 4, 2020 at 9:31 a.m. revealed that at approximately 4:30 p.m., the director of nursing (DON) was notified that the resident did not return from his appointment at the cardiologist. Per the note, the resident's ride did not show up at the scheduled pick-up time; and that, the unit clerk (at approximately 12:10 p.m.) that a second pick up was called and was scheduled to be at the clinic in an hour. Further, the note included that cardiology clinic staff reported seeing the resident getting into a vehicle but did not give specific time. The clinical record revealed that the family and provider was notified of the resident's elopement. A review of the nursing progress note dated September 5, 2020 included the resident arrived at 9:00 p.m. and was placed on precautionary isolation and 15-minute monitoring. Per the documentation the resident appeared to be weak, unsteady when he stood up, was not able to walk and sat back down on the bed. It also included that the resident was alert and oriented x 3, had sunburn on his shoulders and back, both legs from above the knee down to his feet. According to the documentation, the resident reported that he went to another city, to the casino and to a friend's house and was walking to the park when he fell . The note included that the resident said he could not stand up so he crawled to a tree and sat under it all day. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a hospital note dated September 5, 2020 revealed the resident was brought into the emergency room for intoxication after he was found outside of a liquor store with altered level of consciousness. The documentation revealed the resident reported he was living in a nursing home facility up to 2 days ago when he escaped. Physical examination included a first-degree sunburn on bilateral anterior lower legs. The report also included that the resident was alert and oriented x 1 and could only reveal his name. Diagnoses were abdominal pain, dehydration, diabetic ketoacidosis, electrolyte imbalance, and confusion. The toxicology reports revealed ethanol, plasma 196, which indicated depression of the central nervous system. A nursing note dated September 6, 2020 included that the resident took the bus, got in the light rail to another city where he went to his friend's house, went to buy vodka bottle. The documentation also included that the resident slept next to the liquor store the first night and his friend made him a bed in the back for him to sleep on the second night. Review of a Facility Reportable Event Record/Report dated September 8, 2020 revealed that resident #12 went to a cardiologist appointment on September 3, 2020, unescorted. The report revealed that the staff member scheduled to escort the resident did not come in and the Director of Nursing and the other members of the management team decided the resident could go unaccompanied. Later in the day at 3:55 p.m., facility management was made aware the resident had not returned to the facility. Staff were dispatched to the physician office and surrounding areas to search on Friday and Saturday in an effort to locate the resident. The report included that the police, family, and state agency were made aware and a silver alert was activated on Friday; and that, the police located the resident at 1:00 p.m. on Saturday (September 5, 2020) and was transferred to the hospital for evaluation. An interview was conducted on March 24, 2023 at 11:51 a.m. with a Social Services Director (SSD/staff #56) who stated that all residents are transported to appointments with an escort, including those that have high risk for elopement. She said that if there was no escort available, the appointment would be rescheduled; and that, the facility expectation was to send all residents to appointments with an escort. The Social Services Director further stated that she could think of any reason that a resident who was an elopement risk would be sent to an appointment alone; and that, this could result in the resident being lost and vulnerable for injury. In an interview with a CNA (staff #103) conducted on March 24, 2023 at 12:22 p.m., the CNA stated that the facility process was to have an escort for all resident scheduled for an appointment; and that, at the time of the incident in September 2020, none of their residents are sent out to an appointment unescorted. The CNA stated this had been that way since she started working in the facility for the past [AGE] years. Regarding resident #12, the CNA stated she was familiar with the resident and that the resident was an elopement risk. The CNA also said she was in the building on the day the resident went to the appointment; and that, the resident's escort was on the way; but, transportation got in early. The CNA said that they called and informed the DON who made the decision to go send resident #12 by himself. She stated that evaluations for elopement risk are completed on admission and quarterly. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on March 24, 2023 at 12:06 p.m. with an LPN (staff #93) who stated that the facility process was to send an escort with the resident to all appointments outside of the facility. She stated the admitting nurse would complete an elopement risk upon resident admission; and that, residents assessed to be at risk for elopement would have an escort to medical appointments. Regarding resident #12, the LPN stated she was familiar with the resident; and that, the resident went out to an appointment and went with a friend to a casino. The LPN stated resident #12 told her he went off drinking and to the casino. The LPN further stated that if resident #12 was assessed as an elopement risk prior to the appointment at the time of the incident, resident #12 he should have had an escort to the appointment. During an interview with the administrator (staff #45) conducted on March 24, 2023 at 1:55 p.m., the administrator stated resident #12 was found to be an elopement risk and the DON at that time decided to send the resident to the appointment without an escort. A review of the clinical record was conducted with the administrator during the interview. The administrator stated there was no evidence that the provider or other administration had been consulted prior to the DON making the decision to send the resident to the appointment unescorted. She stated that she found no effort in the medical record that the DON followed up on the resident to see that he made it to the appointment and there was no evidence that they asked transport to stay. She stated that this did not follow the facility policy enacted on 2015. She stated that resident #12 was transported out of the facility unsafely, and could result in a severe detriment to the resident. She stated that her expectation was that all residents have an escort when transported to appointments In an interview with the Director of Nursing (DON/staff #95) conducted on March 24, 2023 at 2:39 p.m., the DON stated that all residents receive wandering/elopement assessments on admission and quarterly. She stated that if the resident was assessed to be at risk for wandering/elopement, this should be on the care plan. The DON stated that every resident whether high risk or low risk for elopement at the facility has an escort to all appointments. She stated that sending a resident out to an appointment without an escort does not meet the facility process. She stated that she would expect the facility policy for elopement to be followed; and that the risk for not following protocol could result in resident eloping from the appointment and be lost, resulting in possible resident injury. During the interview, the DON reviewed the care plan for resident #12 and stated that the resident was not care planned for an elopement risk. Further, the DON stated there was no evidence of quarterly elopement risk assessment; and that, this did not meet the facility expectations. Review of the facility policy titled, Transportation Dental Services, revealed that a member of nursing staff or social services will accompany the resident to the office when resident's family is not available. Review of the facility policy titled, Diagnostic Services Transportation, revealed that a member of the nursing staff, or social services, will accompany the resident to the diagnostic center when the resident's family is not available. Review of the facility policy titled, Behavioral Unit Policy for Residents and Staff, revealed that residents may go off the unit only when directly supervised. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy titled, Resident Outside Appointment Process, revealed that the Unit Coordinator will arrange appointments for residents that will include requesting an escort from the resident's insurance company or internal staffing. Lead CNAs on each unit will be responsible for making sure the resident has an appropriate escort with them prior to departure. Review of the facility policy titled, Wandering and Elopements, revealed that the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm. If identified as a risk for wandering, elopement, the resident's care plan will include strategies and interventions to maintain the resident's safety. Review of a facility policy titled, Safety and Supervision of Residents, included the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs. Environmental hazards include bed safety, safe lifting and movement of residents, and unsafe wandering. Review of a facility policy titled, Elopement Protocol, revealed that the facility maintains a process to assess all residents for risk and elopement, implement prevention strategies of those identified as an elopement risk, institute measures for resident identification and conduct a missing resident procedure. All residents will be assessed on admission, quarterly and with changes of condition for risk factors that would place the resident at risk for elopement such as wandering or elopement. All residents who are identified at risk for elopement will have their picture taken and be placed in the elopement book and the care plan will be updated. If a resident is identified at risk for elopement an id bracelet containing the facility address and phone number will be placed on the resident.