Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

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	07/01/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47341 Based on clinical record review, resident and staff interviews, and facility documentation and policy, the facility failed to ensure care and treatment according to professional standards of practice was provided to one resident (#1). The deficient practice resulted in the hospitalization of the resident and amputation of his leg. Findings include: Resident #1 was admitted on [DATE] with diagnoses of borderline personality disorder, obsessive-compulsive disorder, epilepsy, and an anxiety disorder. Review of the clinical record revealed documentation that the resident was in a car accident, had metal pieces in his left foot; and that, in October and November of 2019, he was again noted to be limping and complaining of pain to right lower leg. The care plan initiated on 11/11/2022 revealed the resident had a goal related to his potential for impairment to skin integrity related to his potential for poor safety awareness. Interventions included following facility protocols for treatment of injury and identifying and documenting potential causative factors and eliminate and resolve where possible. The care plan dated 03/08/2023 included that the resident had diabetes mellitus and had the potential for pressure ulcer development. The goals were that the resident will not have complications related to diabetes and the resident will have intact skin, free of redness, blisters or discoloration. Interventions included to check all body for breaks in skin and treat promptly as ordered by the doctor; and, to follow facility policies/protocols for the prevention/treatment of skin breakdown. The follow-up encounter notes dated 04/04/2024 included that the resident had red/open areas to the right upper shoulder; and that, there was no edema noted on the extremities. The skin observation dated 04/09/2024 revealed a red area; however, the documentation did not identify the location of the red areas observed. The shower sheet dated 04/10/2024 included that the resident had swelling to his right leg. (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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The clinical record revealed no documentation whether the swelling to the resident's right leg was reported to the nurse or the provider; and that, it was assessed and interventions were put in place to address this. The nursing weekly skin check dated 04/12/2024 revealed the resident had wound to the right bicep which was healing, scabbed and without drainage or swelling. However, there was no documentation of any redness or swelling to the resident's right leg. Per the documentation, the skin was expected color for ethnicity without lesions or rashes, was warm, dry with no edema, and had normal turgor with no tenting. The follow-up NP (nurse practitioner) note dated 04/16/2024 included the resident had red and open areas to the right upper shoulder; and, had no edema on the extremities. The nursing weekly skin check dated 04/18/2024 included the resident had a scab on the right shoulder and the rest of the skin was clean, dry and intact. It also included that the skin color was normal to ethnicity and skin turgor was good. The documentation did not include any redness or swelling to the resident's right leg. The wound progress note dated 04/18/2024 revealed there was no edema or tenderness to the right and left lower extremities. A progress note dated 04/25/2024 at 07:23am documented that a certified nursing assistant (CNA) alerted the nurse that the resident had redness to his right leg. The nurse completed an assessment and took the vitals: -Temperature of100.4 degrees Fahrenheit; -Pulse of 92 bpm (beats per minute); -Respiration-breaths per minutes; -Blood pressure-140/100; and, Oxygen saturation-90%. Per the documentation, these vital were reported to the NP who ordered a stat CBC (complete blood count), CMP (comprehensive metabolic panel), CRP (C-reactive proteins) labs and a chest -X-Ray. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The NP progress note dated on 04/25/2024 revealed that a leakage to the right lower extremity sweat pants at groin/leg/thigh was noted; and that, the resident's leg appeared red and swollen from ankle to calf with some open/yellow slough dime-sized areas noted to distal shin on right lower extremity. Per the documentation, when the resident's pants were removed, a variety of items including snacks, straws, and toys fell out; and, these hoarded items were next to the skin which might be a component of the irritation. The documentation included that the NP requested the wound nurse consult promptly for evaluation and treatment and expressed concern for the sudden onset of symptoms. Physical exam included had 2+ edema on the extremities, red/open areas to the right lower extremity from the ankle to the knee, and swelling but no redness to the left lower extremity. Diagnoses included edema bilateral lower extremities and cellulitis on the right lower extremity. Plan was to start Doxycycline (antibiotic) for 7 days and Lasix (diuretic) twice daily for 3 days. Further, the documentation included that the stat labs (CBC, CMP and CRP) and ultrasound were pending: and, an oral antibiotic was to be started for seven days and Lasix (diuretic) for edema to be given twice a day for three days. The physician order dated 4/25/2024 included the following orders: -two STAT (immediate) orders for ultrasounds to his bilateral lower extremities to evaluate for deep vein thrombosis (DVT) related to redness on his leg and cellulitis; -Another STAT order for CBC, CMP and CRP labs; and, -Doxycycline 100 milligrams (mg) tablet by mouth twice a day until 05/02/2024. The Medication Administration Record (MAR) for April 2024 revealed documentation that Doxycycline was administered to the resident as ordered. The clinical record revealed that the orders for physician-ordered laboratory tests were completed on 4/25/2024 at 3:14 p.m. The following results from the STAT labs on 04/25/24 were flagged as high: -White blood cell count (WBC) was 22.9 thousand per cubic millimeter (Normal range was 4.0 to 11.0); -Absolute Neutrophil was 14.6 thousand per microliter (Normal range was 1.5 to 7.8); -Absolute Monocyte 4.3 thousand per microliter (Normal range was 0.2 to 1.0); -Absolute Immature Granulocytes 2.2 thousand per microliter (Normal range was 0.0 to 0.1); -CRP was 173.6 milligrams per liter (mg/L) (Normal range was less than or equal to 4.9 mg/L). The clinical record revealed no evidence that the provider was notified and had reviewed these lab results. The shower sheet dated 4/28/2024 included the resident had swelling and reddened right leg. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A nursing progress note from 04/29/2024 revealed that the ultrasound was completed and results were pending. A wound note from 04/30/2024 included that the wound care team was consulted due to the worsening cellulitis of unknown origin in his right leg; and that, the resident was started on Doxycycline by attending NP with no improvement. Wound assessment included an unhealed full thickness cellulitis on the right lower leg measuring 34 cm (centimeters) length x 34 cm width x 0.2 cm depth; had moderate amount of yellow drainage noted; wound bed had 1-25% pink granulation, 51-75% epithelialization; and, periwound skin was warm, had edema and erythema and presented with signs and symptoms of infection. Active problems included cellulitis of the right lower limb. Plan included wound treatment. recommendation was for a wound culture and possible intravenous (IV) antibiotics for severe worsening cellulitis. The NP progress note dated 04/30/2024 revealed that the resident's right lower extremity appeared more swollen, red, and inflamed than previous exam. It also included that the ultrasound was negative and the stat labs were reviewed with concern for sepsis or osteomyelitis. Per the documentation, the NP discussed these concerns with the director of nursing (DON) and wound care provider and recommended sending the resident to the emergency room for prompt IV antibiotics and wound culture as a delay may compromise the patient. The nursing progress note dated 04/30/2024 included that the resident was sent out non-emergent per the wound provider and the NP. Per the documentation, the resident's dressings to the right leg were wet with exudate; there were large red areas and swelling on the right leg below the knee; and, toward the ankle there were blister like areas there was and open areas on the upper leg. The hospital history and physical dated 05/01/2024 included that the facility reported that the resident had been walking around the facility with no change in ADLs (activities of daily living) or mentation from baseline. Per the documentation, the facility noticed possible cellulitis of the right lower extremities initiated Doxycycline 100 mg BID since 04/26/2024; and that, the resident hoarding things and stuff things up his pan leg may have caused the infection. Physical examination included that the right lower extremity had erythema, edema and several areas of purulence extending from the ankle to the mid-upper thigh. Assessment included that the resident presented with a purulent right leg SSTI (skin and soft tissue infection); and, the facility began Doxycycline 100 mg twice daily on 04/26/2024 but the resident had worsening of infection and was transferred to the hospital. Per the documentation, the resident was afebrile, hypertensive, tachypneic (rapid and shallow breathing) and had a WBC of 21.2. Further, the documentation also included that CT scan showed that the resident had a tibial rod on the right lower leg. Active problems included severe purulent cellulitis and sepsis; and that, the right leg was marked to monitor extension of the infection. The hospital progress note dated 05/06/2024 included that the resident presented with chronic osteomyelitis in the setting of longstanding tibial nail that had spread the cellulitis proximally; and that, the resident's family would like to proceed with above the knee amputation. the infectious disease assessment included right lower extremity wounds/ulcerations with SSTI with extensive Pseudomonas. The nursing progress note dated 05/12/2024 included that the resident returned at the facility and that, the resident had an above the knee amputation to the right leg. Per the documentation, the area had multiple stitches with no signs and symptoms of infection noted. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The skin evaluation dated 05/19/2024 revealed above the knee amputation to the right leg. The care plan was revised on 05/24/2024 to include a goal for wound care related to the above the knee amputation due to infection. The undated online reportable event record/report submitted by the facility included that a complaint was filed with the State Board of Nursing against the DON (Director of Nursing) alleging negligence on behalf of all the nurses; and that, a resident who was admitted to the behavior unit had severe infection on the right lower extremity that went unnoticed and untreated. It also included that when treatment was initiated, it was by oral antibiotics instead of IV (intravenous) antibiotics. The facility 5-day investigative report revealed an interview with the registered nurse (RN/staff #18) conducted by the facility on 6/24/2024. Per the documentation, The RN reported that he knew the resident had cellulitis and his leg got worse as far as redness, weeping, swelling, and hardness; and that, two providers were present and they originally wanted to treat the resident at the facility before ultimately sending Resident #1 out to the hospital. In an interview with a licensed practical nurse (LPN/staff #9) conducted by the facility included that the nurse recalled when the resident had an infection in his right leg, and that was when she was told the computers were down. She brought it to the DON's attention and was told there was an order for dressing and antibiotics. Continued review of the facility report revealed that based on their investigation, interviews and chart review, the facility cannot conclude that there was negligence on behalf of the nurses, management or practitioners. In an interview with a Licensed Practical Nurse (LPN/staff #45) conducted on 07/01/2024 at 2:42 p.m., the LPN stated that the turn-around time on stat labs can depend on the laboratory provider; and, it was usually sooner but can be up to 24 hours. During the interview, a review of the clinical record was conducted with the LPN who stated that it was not appropriate for labs completed and had results in on 04/25/2024 be reported/reviewed by the provider only on 04/30/2024 which was 5 days after. The LPN said that she would have been concerned and reported the lab result to the provider immediately because of the result on the WBC count of Resident #1. During an interview with a certified nursing assistant (CNA/Staff #23) conducted on 07/01/2024 at 2:49 p.m., the CNA stated that CNAs complete skin checks during showers; and, the CNAs were required to check the full body for redness, breakdown, or bruises. She stated she provided care for Resident #1; but, she does not recall noticing any redness on his leg from April 18- to April 25, 2024. Further, the CNA said that she was unsure if she gave resident #1 a shower during that time. (continued on next page)

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