

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035175	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/13/2024
NAME OF PROVIDER OR SUPPLIER Desert Peak Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49325</p> <p>Based on clinical record review, staff interviews, and facility policy and procedures, the facility failed to ensure two residents (# 8, 12) out of five sampled remained free from abuse. The deficient practice may result in physical and/or psychosocial harm to residents as an outcome of abuse.</p> <p>Findings include:</p> <p>-Regarding Resident # 8 and Resident # 26</p> <p>Resident # 8 was admitted into the facility on [DATE] with diagnoses that included bipolar disorder, unspecified dementia with agitation, depression, and unspecified mood disorder.</p> <p>A review of the Admission MDS (minimum data set) assessment dated [DATE] for Resident # 8 revealed a BIMS (brief interview of mental status) score of 3, which indicated the resident was severely cognitively impaired.</p> <p>Resident # 26 was admitted into the facility on [DATE] with diagnoses that included schizophrenia, secondary parkinsonism, major depressive disorder, and auditory hallucinations.</p> <p>A review of the Admission MDS assessment dated [DATE] for Resident # 26 revealed a BIMS score of 14, which indicated the resident was cognitively intact.</p> <p>Review of electronic medical records (EMR) progress note dated July 10, 2024 with time of 09:49 AM, revealed Resident # 8 was intrusive with roommates' (Resident # 26) belongings; and that, was educated 3 times regarding room boundaries. Resident # 8 then became argumentative and verbally aggressive to the staff. Review of EMR revealed no other progress notes were written on that day for Resident # 8.</p> <p>Review of documentation via reportable incident revealed that on July 10, 2024 at 09:20 PM, unnamed nurse witnessed Resident # 8 out of room, and stated that he had been hit by his roommate Resident # 26.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of EMR progress note dated July 10, 2024 with time of 10:24 PM, revealed Resident # 26 had a room change to a new unit within the facility. At 10:40 PM, EMR revealed that Resident # 26 was interviewed at 10:40 PM by the local police department. However, review of EMR revealed no other progress notes were written that day for Resident # 26.</p> <p>An interview was conducted with the daughter of Resident # 8 on August 13, 2024 at 01:50 PM who stated that she had made efforts to communicate to the facility a possibility of behavior issues if Resident # 8 was placed with other residents upon admission. Moreover, the daughter confirmed that she had received a call and was notified that there was an altercation with another resident giving Resident # 8 a black eye.</p> <p>An interview was conducted with Resident # 26 on August 13, 2024 at 02:45 PM who stated that while laying in the bed, resident #26 was approached by Resident # 8; and that, he believed Resident # 8 wanted to throw him out of the bed. Resident # 26 stated this is why, I hit him in the face. Resident # 26 confirmed the name of Resident # 8 which he had swung and hit in the face. Resident # 26 stated that after the incident, an unnamed staff was, pissed at me and told the resident that it would have been best to scream. However, Resident # 26 stated screaming was not an option because, he was going to put hands on me.</p> <p>An interview was conducted with certified nursing assistant (CNA/Staff # 33) on August 13, 2024 at 02:57 PM, who stated she recalled the incident that had occurred between Residents (# 8 and # 26). Staff # 33 stated hearing a noise and Resident # 8 was bleeding above his right eye. Staff # 33 stated that she recalled being told by Resident # 8 that all he wanted was to see what Resident # 26 was doing and that's why he had approached his roommate.</p> <p>-Regarding Resident # 12 & Staff # 1</p> <p>Resident # 12 was admitted into the facility on [DATE] with diagnoses that included anoxic brain damage, major depressive disorder, anxiety disorder, and borderline personality disorder.</p> <p>A review of the Admission MDS (minimum data set) assessment dated [DATE] for Resident # 12 revealed a BIMS (brief interview of mental status) score of 15, which indicated the resident was cognitively intact.</p> <p>A care-plan initiated on June 05, 2024 revealed that the resident has a psychosocial well-being problem related to behaviors. The goal was for resident to have no indications of psychosocial well-being by/through review date. Interventions included when conflict arises, remove residents to a calm safe environment and allow to vent/share feelings. Furthermore, resident had behavior problems and interventions included approach/speak in a calm manner, divert attention, remove from situation and take to alternate location as needed.</p> <p>A behavioral treatment plan initiated on July 08, 2024 revealed de-escalation techniques suggested a calm approach, redirect, offer a choice.</p> <p>Review of EMR progress note dated July 31, 2024 with time of 01:05 PM, revealed an investigation of verbal abuse had been initiated for Resident # 12. At 01:14 PM, EMR revealed that Resident # 12 had been observed crying while in the hallway, had been assessed by psychiatry nurse practitioner, and had accepted referral for counseling services at that time.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with social work assistant (SWA/Staff # 50) on August 13, 2024 at 10:24 AM, who confirmed that licensed practical nurse (LPN/Staff # 1) had uttered towards Resident # 12, stop lying you bitch. SWA believed it was an oppositional driven response by Staff # 1 because of a recent discussion held between Staff # 1 and the Assistant Director of Nursing (aDON) concerning Resident # 12. SWA stated that while accompanying Resident # 12, observed Staff # 1 return to the nurses' station for her belongings, and walked by Resident # 12 and started calling her names. SWA stated there had been previous instances of verbal and physical aggression, from Resident # 12 towards Staff # 50, which had on one occasion prompted brief discussion by interdisciplinary team (IDT), in the morning meetings, to believe that they should not to be in the same unit. SWA could not explain why separation of unit of staff/resident was not in the care plan or progress notes, and why they were in the same unit at the time of the incident.</p> <p>An interview was conducted with assistant Director of Nursing (aDON/Staff #10) on August 13, 2024 at 11:31 AM who confirmed was a part of the morning IDT meetings. Staff # 10 stated that the purpose of the meetings was to go over anything important from the day before and recalled that on one meeting Staff # 1 had mentioned feeling trapped at the nurse's station by Resident # 12. Staff # 10 stated the police had been involved at that time. Staff # 10 reviewed electronic medical records and stated that on July 31, 2024 after the recent verbal incident, Staff # 1 was removed to a different unit. Staff # 10 reviewed notes and stated could not recall if anything else was added to the care plan because there was so much going on -- although confirmed that Staff # 1 went home that day as she was mostly upset and had made comments on her way out; and that, it was a decision made by the team. A second interview was requested later by Staff # 10 at 12:07 PM who stated wanted to provide more details regarding changes made to the plan of care since admission of Resident # 12 which included cares in pairs and being placed on 1:1 as well as switching to different units whenever Resident became physically aggressive towards other residents.</p> <p>An interview was conducted with director of human resources (dHR/Staff # 62) on August 13, 2024 at 12:59 PM, who confirmed the accuracy of documentation of resolution regarding the incident between Staff # 1 and Resident # 12 which revealed actions taken by the facility were to send Staff # 1 home. Staff # 62 confirmed that he interviewed Staff # 1 and in frustration Staff # 1 stated that the resident was acting like a brat; and that, everyone has to bow down to the princess; and that, had questioned why Resident # 12 was moved. Staff # 62 recalled that Staff # 1 was observed hyperventilating, and visibly upset and shaking who the concurred with Director of Nursing (DON/Staff # 100) that Staff # 1 should take the rest of the day off.</p> <p>An interview was conducted with Director of Nursing (DON/Staff # 100) on August 13, 2024 at 04:04 PM who stated that abuse, including physical and verbal against any resident, did not meet the facility's expectations and would not allow any of it. Staff # 100 repeated not being able to understand the question when asked to describe the risks that may result from abuse towards residents.</p> <p>An interview was conducted with administrator (Adm/Staff # 120) on August 13, 2024 at 04:08 PM who stated that the risks of abuse towards residents are that it can affect overall wellbeing of a resident whether emotional or physical. Staff # 120 confirmed that Staff # 1 had been terminated due to the witnessed verbal abuse incident that had been corroborated by witnessed interviews and observation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Policy titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program (revised April 2021) revealed, residents have the right to be free from abuse; protect from abuse by anyone including facility staff, other residents; ensure adequate oversight/support to prevent burnout, stressful working situations; establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems.</p> <p>Review of the Employee Handbook revealed, definition of abuse is the willful infliction of injury, intimidation with resulting physical harm, pain or mental anguish. Willful, means the individual must have acted deliberately.</p> <p>-Verbal abuse: abusive and demeaning language including, name calling, threatening, sarcasm, retaliation, intimidation, teasing or taunting, yelling, scolding, swearing, ridicule.</p> <p>-Physical abuse: violence or rough treatment including, scratching, pushing, hitting, pinching, shaking.</p>		