

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 02/12/2025
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** 49399</p> <p>Based on clinical record review, residents and staff interviews, facility documentation and policies and procedures, the facility failed to ensure two residents (#1 and #3) were free from abuse. The deficient practice could result in continued abuse to residents.</p> <p>Findings included:</p> <p>Regarding Resident #1:</p> <p>-Resident #1 was admitted to the facility on [DATE] with diagnoses of Schizoaffective disorder, bipolar type, dementia and dysphagia.</p> <p>Review of resident's baseline care plan dated January 23, 2025 revealed skin is intact.</p> <p>Review of care plan dated January 25, 2025 revealed resident is at risk for behaviors related to Schizophrenia. The interventions included assist the resident to develop more appropriate methods of coping and interacting, encourage the resident to express feelings appropriately, explain all procedures to the resident before starting, allow the resident time to adjust to changes, and intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, and remove from situation and take to alternate location as needed.</p> <p>Review of clinical record titled, Weekly Skin check Licensed nurse, dated January 26, 2025 at 10:33 revealed a skin observation finding that states no skin issues noted and skin is clean dry and intact (CDI).</p> <p>Review of clinical record dated January 26, 2025 at 22:24 revealed an alert progress note stating resident complaint about roommate yelling at her and getting upset that there was water left on the toilet. Resident states that roommate came over slapped her on the left side of the face and grabbed her hands making her right index finger bleed. The director of nursing (DON) and assistant director of nursing (ADON) were notified. A one on one staff at the room, and a 15-minutes checks started.</p> <p>Review of clinical record titled, Behavior Charting-DPCC Nurse Assessment, dated January 26, 2025 at 22:38 revealed behaviors displayed included yelling/screaming/cursing/abrasive tone, yelling at roommate. The intervention included redirection, verbally de-escalated, one on one, and visual checks/15-minute safety checks.</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
---	-------	-----------

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 02/12/2025
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>Review of clinical record titled, Weekly Skin check Licensed nurse, dated January 26, 2025 at 23:05 revealed a skin observation finding that states cut to right index finger, no other skin issues noted.</p> <p>Review of clinical record dated January 27, 2025 at 00:12 revealed a nurse progress note stating certified nursing assistants (CNAs) called the nurse to the residents' room because they were yelling back and forth, and that resident was bleeding from the finger. The nurse entered the room and the residents continued yelling blaming each other. Resident claims to have been slapped in the face by roommate and that roommate grabbed her hands and cut her finger. Resident's finger was cleaned and a band aid applied. Skin check completed. The DON and ADON were notified. The residents were separated and a 15-minute checks started.</p> <p>Review of admission Minimum Data Set (MDS) assessment dated [DATE] at 10:22 am revealed a Brief Interview for Mental Status score of 15.0, indicating cognitively intact, without behaviors of acute onset mental status change, disorganized thinking, altered level of consciousness, and inattention.</p> <p>A review of clinical record titled, Brief Interview For Mental Status (3.0 BIMS) dated January 27, 2025 at 15:27 revealed a BIMS score of 6.0 indicating severe impairment.</p> <p>Review of clinical record titled, Weekly Skin check Licensed nurse, dated January 27, 2025 at 21:58 revealed a skin observation finding that states laceration to right index finger.</p> <p>In addition, review of admission MDS assessment revealed on January 31, 2025 at 9:19 am, the behavior assessment section revealed no hallucinations, no delusions, and no presence of behavioral symptoms exhibited. Regarding resident's functional abilities, resident has no upper and lower extremity impairment, uses a walker, requires mostly supervision or touching assistance, is independent with walking at least 10 feet to 50 feet, and regarding medications, use antipsychotic, antianxiety, and anticonvulsant medications.</p> <p>Review of care plan dated February 4, 2025 revealed resident is independent for meeting emotional, intellectual, physical, and social needs. The intervention included to introduce the resident to residents with similar background, interests and encourage/facilitate interaction.</p> <p>Regarding Resident #3:</p> <p>-Resident #3 has a recent admission to the facility on [DATE] with a diagnosis that included paranoid schizophrenia, dementia, post -traumatic stress disorder (PTSD), anxiety disorder, and bipolar disorder.</p> <p>Review of quarterly MDS assessment dated [DATE] revealed a BIMS score of 14.0 indicating cognitively intact, without behaviors of acute onset mental status change, inattention, nor altered level of consciousness, has little interest or pleasure in doing things, has social isolation, no hallucinations, has delusions, and exhibits physical and verbal behavioral symptoms.</p> <p>Review of clinical record revealed a resident had a room change on January 26, 2025.</p> <p>(continued on next page)</p>		

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 02/12/2025
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>Review of clinical record dated January 27, 2025 revealed a nurse progress note stating the CNAs called the nurse to the residents' room due to yelling back and forth, and a resident was bleeding from her finger. When the nurse arrived in the residents' room, the residents continued yelling and blaming each other. Resident states that she is mad because roommate left water on the toilet seat. Resident claims that roommate cut her own finger. The nurse performed a skin check and notified the DON and ADO. The residents were separated and a 15-minute checks was started for monitoring.</p> <p>Review of clinical record dated January 27, 2025 revealed a social service progress note stating that social service met with resident regarding incident. The resident stated she was in her room fixing her sheets when her roommate started yelling at her for no apparent reason. Resident stated she did not go over to her roommate while she was yelling at her. Resident stated her roommate scratched herself and that the roommate blamed the resident for scratching her nose. Writer asked resident if she felt safe at the facility. Resident stated she felt safe and she wanted to stay in her current room and her belongings were brought over to the new unit.</p> <p>Review of care plan revised on May 20, 2024 revealed resident has a behavior problems related to Paranoid Schizophrenia. The interventions included to administer medications as ordered, monitor/document for side effects and effectiveness, allow her to pace, and ensure needs are met.</p> <p>During the survey on February 11, 2025 at 1:08 pm, the administrator/Staff #20 stated that one of their locked unit had an emergency plumbing issue last week, Monday, so they moved residents from that unit to their open rooms throughout the facility and for the other remaining residents, they moved them in the dining room/activity room, day care room and medical record room.</p> <p>An interview was conducted on February 11, 2025 at 3:48 pm with CNA/staff #116. Staff stated that she works the evening shift and regarding resident #3, she stated that resident is new in their unit, only been there for a week. Resident is independent, she dresses herself, and comes out from her room for meals. Staff stated that her abuse training included reporting to the administrator of allegation of abuse within 2 hours. Regarding a resident to resident altercation, she separates residents, deescalate, and then she will speak to resident on why they did it.</p> <p>An interview was conducted on February 11, 2025 at 3:55 pm with resident #3 in her room. Resident #3 stated that everything is fine, she has been in the facility for several months, she was in the first floor and now to this part of the facility. Resident stated that she is being treated okay, and receiving medication shots. While speaking to the resident, she started crying and walked outside her room towards the nurses' station by a white board and sat down in a chair.</p> <p>An interview was conducted on February 11, 2025 at 4:02 pm with CNA/Staff #175. Staff #175 stated that regarding resident #3, he stated that resident was transferred in the unit for a week now, resident is very independent, but very particular about food she eats. Staff stated that he heard that resident #3 and her roommate had a little argument, and resident was moved since Monday from her previous unit due to a redoing pipes in the unit.</p> <p>(continued on next page)</p>		

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 02/12/2025
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>An interview was conducted on February 11, 2025 at 4:06 pm with licensed practical nurse (LPN)/Staff #184. Staff #184 stated that resident #3 refuses a lot of care, resident has been on few places, resident can answer small recent details such as questions about snacks, and resident has delusions. Regarding resident to resident altercations, her training is to immediately separate them, interview them separately, notify the administrator and DON, their family, doctor, guardian or case manager and do a skin assessment.</p> <p>An interview was conducted on February 11, 2025 at 4:13 pm with ADON/Staff #234. The ADON stated that resident #1 calls her family, using the facility cordless phone, and resident has been involved with an altercation with resident #3. ADON stated that she was not the nurse on duty when it the incident happened, Staff #186 was the nurse on duty at that time.</p> <p>An interview was conducted on February 11, 2025 at 4:42 pm with CNA/Staff #148. Staff stated that he was working in that unit in January this year, but did not see everything that happened. He stated that he was on his way to answer the call light and saw resident #1 has a bleeding finger. Staff stated that resident #1 was sleeping and was hit by roommate resident #3. He separated them, they relocated resident #3, and made sure the resident that remained in the room felt secured.</p> <p>An interview was conducted on February 12, 2025 at 11:16 am with the interim DON/Clinical resource/Staff #32. The DON stated that regarding the resident #1 and resident #3 incident, resident #1 made allegations about resident #3 grabbing her hand, no one had seen it, they saw resident #1's left finger had skin tear left and looks like an abrasion to her finger. The DON stated that for any trype of incident, staff separates residents immediately, they notify the abuse coordinator immediately, they start their investigation process, and because of their behavior resident population, the first thing to do is separate and report. The DON added that regarding resident #1, resident #1 had not been in the facility that long, only been for few weeks. Regarding their new admitted residents, their social service and nurses assess them, they alert charting for new admits, and they do angel rounds twice a week. In addition, regarding resident #3, resident had past incident of not getting along with roommates, has auditory and visual hallucinations. The DON stated that to prevent incidents, they have care and pairs, hall monitoring rounding were they check and laying eyes to their resident hourly, they have orders for monitoring behaviors, and they have increase activities assigned to each units.</p> <p>Review of facility's policies titled, Abuse Policy revised December 2016 and Resident Rights policy revised February 2021 revealed residents have the right to be free from abuse.</p>		

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 02/12/2025
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 0920</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399</p> <p>Based on observations, clinical record reviews, interviews and policy review, the facility failed to provide a designated room to accommodate residents dining and activities while undergoing construction. The deficient practice could result in resident's individual needs and preferences not accommodated.</p> <p>Findings included:</p> <p>During a complaint survey on February 11, 2025 at 1:08 pm, the administrator/Staff #20 stated that one of their locked unit, had an emergency plumbing issue last week, Monday, so they moved residents from that unit to their open rooms throughout the facility and for the other remaining residents, they were moved in the dining room/activity room, day care room and medical record room.</p> <p>On February 11, 2025 at 1:18 pm the administrator ushered the surveyor to the dining room/activity room which is currently being use for ten resident beds and another room across the hallway from the dining room is the medical record room and day care room which is currently being use to place seven resident beds.</p> <p>An interview was conducted on February 11, 2025 at 1:40 pm with a lead certified nursing assistant (CNA)/Staff #102. Staff #102 stated that her responsibility is to oversee the CNAs. She also stated that the residents placed in the day care room are resident #9, resident #2, resident #10, and resident #6, and in the adjacent room separated by a dutch door are resident #11, resident #1 and resident #12. Present during the interview is assistant director of nursing (ADON)/Staff #234. The ADON stated that the residents were relocated since last Monday, February 3rd, due to a plumbing issue in their unit. During the interview, Staff #26 was present and stated that the setup of the beds included call bells at bedside for each resident and privacy curtains. In addition, during the interview, two CNAs arrived in the room, Staff #120 and staff #179, and then Staff #102 left the room once the two CNAs came in. Furthermore, the ADON stated that the room where they have four residents is called the day care room and the other room connected to the day care room is the medical records room for the other three residents.</p> <p>The medical record room has access to a restroom.</p> <p>An interview was conducted on February 11, 2025 at 2:32 pm with CNA/Staff #141. Staff #141 stated that the room were ten residents are in is used for dining and activity. But if there is no resident beds in the dining room, it is used for dining and for activities such karaoke. Staff stated that currently the residents' unit is being fixed and she does not know how long the residents had been staying in the dining room because this is not her usual unit, her unit is called the [NAME] lane. Staff stated that when a resident needs to be changed while is currently sleeping in the dining room, they use a privacy curtain, and she stated that there is only two residents that is incontinent and the rest of the residents are using the bathroom in the other room. Regarding staffing, she stated that she is the only CNA working at the dining room and there is a floater CNA in case they need assistant with anyone, and one nurse. The floater aid /CNA comes and peek in through the door to see if they need assistance but the floater aid/CNA does not stay.</p> <p>(continued on next page)</p>		

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 02/12/2025
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 0920</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On February 11, 2025 at 3:27 pm , surveyor observed each resident has their own call bell at their bedside table, and a nurse with the medication cart between resident #4 and resident #5 beds.</p> <p>An interview was conducted on February 11, 2025 at 3:28 pm with resident #6. Resident #6 stated was moved in the room since Thursday because they were doing plumbing and tiling, and she was informed of the move couple days before. Resident stated that meal tray are placed at the bedside over the bed table. Resident wear briefs and takes bedbath.</p> <p>On February 11, 2025 at 3:32 pm, the ADON identified resident #1 who was talking on a cell phone on speaker, who is sitting in the middle of the day care room, speaking loud on the phone. Staff #233 stated that resident #1 likes to sit with them.</p> <p>An interview was conducted on February 11, 2025 at 4:17 pm with CNA/staff #3. Staff stated that work is being done in the locked unit so there is ten residents in the dining room. Staff #3 identified the residents as resident #8, resident #13, resident #14, resident #15, resident #7, resident #16, resident #17, resident #18, resident #5, and resident #4. Staff stated that each resident has a beside table and a call bell to ring.</p> <p>An interview was conducted on February 12, 2025 at 08:36 am with resident #4. Resident #4 is in the dining room sitting in his bed. Resident #4 stated that they are remodeling his room, he has been in the dining room for a week, they bring his food at the bedside table, the room has a bathroom located in the back of the dining room, they take him outside the dining room for shower, and he has a call bell at the bedside table. Review of clinical record revealed resident #4 has a Brief Interview for Mental Status (BIMS) score of 15.0 indicating cognitively intact.</p> <p>An interview was conducted on February 12, 2025 at 08:40 am with resident #8. Resident is lying in bed in the dining room. Resident stated that he had been there for 5 years. Review of resident clinical record revealed a BIMS score of 15.0 indicating cognitively intact.</p> <p>An interview was conducted on February 12, 2025 at 08:41 am with resident #7. Resident is sitting in bed in the dining room. Resident stated that he has been in the dining area for 3 weeks due to plumbing issues. Resident stated that he eats on his bedside table, uses the bathroom located in the other room and they take him out of the dining room for showers. Resident has a call bell at bedside. Review of clinical record revealed a BIMS score of 14.0 indicating cognitively intact.</p> <p>An interview was conducted on February 12, 2025 at 8:46 am with speech therapist/Staff #259. She stated that she is here for resident #5. She stated that resident was in the unit but due to construction , resident was moved to the activityroom/dining room. Staff stated that she usually finds a quiet room in the resident's room to do by mouth trials, practice swallow strategies, aspiration precaution, , and for today she will be doing speech therapy at resident's bedside in the dining room.</p> <p>An interview was conducted on February 12, 2025 at 8:52 am with CNA/staff #148. Staff stated his unit is one of the locked unit which is under construction. He stated that he has been working for two days in the [NAME] dining room where the residents are placed. He stated that the [NAME] dining room is use to be the dining room for residents to eat. He stated that his unit has been closed for about a week.</p> <p>(continued on next page)</p>		

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 02/12/2025
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 0920</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on February 12, 2025 at 9:00 am with registered nurse (RN)/Staff #225. Staff #225 stated that they are doing work in the unit, tearing up plumbing, and the construction has been going on for one week and a half. She stated that she came to work on Wednesday, February 5, and the residents were already moved in the dining room.</p> <p>An interview was conducted on February 12, 2025 at 9:14 am with Maintenance director/Staff #41. Staff stated that his responsibility is to keep the building well maintained and make sure is within regulation. Staff stated that one of the unit's mainland plumbing failed and it has been an ongoing issue for a while. Then, on Monday, February 3, they finished prepping the two rooms, one room used to be a day care room and the medical record room, and the other room prepped was the [NAME] dining room. He stated that they cleared and cleaned the entire rooms, and made sure there is access to restroom. Staff stated that they moved twenty-six residents, some went to other units, and he does not know how many residents were moved in the [NAME] dining room, day care room and medical record room. Staff stated that they finished the plumbing on Friday, February 7, the concrete started on Saturday, February 8, and the flooring started on February 10, because the concrete needs to cure. At 9:24 am, Staff #41 and surveyor headed to the dining room. At 9:25 am, staff measured the square footage of the dining room. The measurement is 43 feet (ft) by 24.5 ft which equals to 1053.5 square feet. At 9:30 am, there are 4 residents in the day care room. Staff #41 measured the day care room square footage. The measurement is 24.5 ft by 17.5 ft which is 428.75 square feet. At 9:38 am, staff #41 is in the medical record room which has three residents. The medical record room measurement is 16.5 ft by 12.25 ft which equals to 200.95 plus a nook 5.5 ft by 6.0 ft which equals to 33 sq ft. The total square footage of the medical record room is 233.95 sq ft. At 9:47 am, staff remeasured dining room. The dining room measured 41.0 ft by 24.5 ft which equals to 1004.5 sq ft.</p> <p>An interview was conducted on February 12, 2025 at 10:43 am with CNA/Staff #120. Staff #120 stated that the residents in the day care room has been there since last Monday. Staff stated that all four residents eat in the room, the meal trays are placed at their bedside table, and they are offered activities if resident wants to go. During the interview, surveyor observed snacks such as yogurt, bananas, and jello, were on top of a table, and staff stated that the snacks were brought in at 10:00 am, and there is no refrigerator in the day care room. When asked about where they keep resident's clothes/belongings, staff #120 stated that residents' clothes were stored in the maintenance area and the residents important belongings such as lap tap, cellphone, and chargers are with them. At 10:50 am, staff #120 showed surveyor the maintenance area which is next room to the dining area and a door leading to the kitchen.</p> <p>The maintenance area was observed to have maintenance tools and housekeeping carts. At 10:54 am, Housekeeping/Staff #280 and housekeeping manager/Staff #24 identified the room as housekeeping and maintenance room for storage. Staff stated that the room has tools for maintenance, they keep the wet and dry pick up machine to clear all water/suck water if they do strip and wax floor, a machine for wet and dry for auto scrub for the floor, and two vacuums to vacuum the carpet. Staff #24 stated that they temporary put the residents clothes there in the maintenance area/storage.</p> <p>An interview was conducted on February 12, 2025 at 11:16 am with the interim director of nursing/clinical resource (RN/Staff #32). She stated that the unit is a plumbing nightmare, nothing would flush and go down, the back two rooms kept having flush problem. She stated that about 23 to 27 residents were moved on February 3. She stated that they started jack hammering by noon. The plumbing stuff is done tentatively today, February 12, and they will tile the floor, and then start moving resident back to the unit by tomorrow.</p> <p>(continued on next page)</p>		

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 02/12/2025
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 0920</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility's policy titled, Shelter In Place and Procedure, no effective or revision date revealed Three potential types of sheltering in place have been identified: (2) Physical Plant related-This would typically be in response to an issue that has rendered a Zone uninhabitable. This situation might cause an evacuation from one zone to another. It also could be for a longer period of time. See Evacuation-Partial.</p> <p>Review of facility's policy titled, Facility Evacuation-Partial, no effective or revision date revealed it is everyone's responsibility to protect our residents, guests, and staff from injuries and fatalities in the event of a disaster. This procedure outlines steps that must be taken to safely evacuate residents to a safe area within the facility. Safe Area: Resident gathering areas: dining rooms, day rooms, activity rooms, therapy rooms.</p> <p>Review of facility's policy titled, Resident Rights, revised February 2021 revealed Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to : a. a dignified existence; b. be treated with respect, kindness, and dignity.</p>		

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 02/12/2025
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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49399</p> <p>Based on observations, record reviews, interviews and policy review, the facility failed to ensure safe and comfortable environment for residents. The deficient practice could impact the residents' safe, sanitary, and homelike environment.</p> <p>Findings included:</p> <p>During a complaint survey on February 11, 2025 at 1:08 pm, the administrator/Staff #20 stated that one of their locked unit, had an emergency plumbing issue last week, Monday, so they moved residents from that unit to their open rooms throughout the facility and for the other remaining residents, they were moved in the dining room/activity room, day care room and medical record room.</p> <p>On February 11, 2025 at 1:18 pm the administrator ushered the surveyor to the dining room/activity room which is being use for ten beds for ten residents and another room across the hallway from the dining room is the medical record room and day care room which is being use to place seven beds for seven residents.</p> <p>An interview was conducted on February 11, 2025 at 1:40 pm with a lead certified nursing assistant (CNA)/Staff #102. Staff #102 stated that her responsibility is to oversee the CNAs. She also stated that the residents placed in the day care room are resident #9, resident #2, resident #10, and resident #6, and in the adjacent room separated by a dutch door are resident #11, resident #1 and resident #12. Present during the interview is assistant director of nursing (ADON)/Staff #234. The ADON stated that the residents were relocated since last Monday, February 3rd, due to a plumbing issue in their unit. During the interview, Staff #26 was present and stated that the setup of the beds included call bells at bedside for each resident and privacy curtains. In addition, during the interview, two CNAs arrived in the day care room, Staff #120 and staff #179, and then Staff #102 left the room once the two CNAs came in. Furthermore, the ADON stated that the room where they have four residents is called the day care room and the other room connected to the day care room is the medical records room for the other three residents.</p> <p>The medical record room has access to a restroom.</p> <p>An interview was conducted on February 11, 2025 at 2:32 pm with CNA/Staff #141. Staff #141 stated that the room were ten residents are placed is used for dining and activity before moving the residents in there. But if there is no resident beds in the dining room, it is used for dining and for activities such karaoke. Staff stated that currently the residents' unit is being fixed and she does not know how long the residents had been staying in the dining room because this is not her usual unit, her unit is called the [NAME] lane. Staff stated that when a resident needs to be changed while is currently sleeping in the dining room, they use a privacy curtain, and she stated that there is only two residents that is incontinent and the rest of the residents are using the bathroom in the other room. Regarding staffing, she stated that she is the only CNA working at the dining room and there is a floater CNA in case they need assistance with anyone, and one nurse.</p> <p>(continued on next page)</p>		

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 02/12/2025
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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On February 11, 2025 at 3:27 pm , surveyor observed each resident has their own call bell at their bedside table, and a nurse with the medication cart between resident #4 and resident #5 beds.</p> <p>An interview was conducted on February 11, 2025 at 3:28 pm with resident #6. Resident #6 stated was moved in the room since Thursday because they were doing plumbing and tiling, and she was informed of the move couple days before moving. Resident stated that the meal tray are placed at the bedside over the bed table. Resident wear briefs and takes bedbath and do not need a restroom.</p> <p>On February 11, 2025 at 3:32 pm, the ADON identified resident #1 who was talking on a cell phone on speaker, sitting in the middle of the day care room, and speaking loud on the phone. Staff #233 stated that resident #1 likes to sit with them.</p> <p>An interview was conducted on February 11, 2025 at 4:17 pm with CNA/staff #3. Staff stated that work is being done in the locked unit so there is ten residents in the dining room. Staff #3 identified the residents as resident #8, resident #13, resident #14, resident #15, resident #7, resident #16, resident #17, resident #18, resident #5, and resident #4. Staff stated that each resident has a bedside table and a call bell to ring.</p> <p>An interview was conducted on February 12, 2025 at 08:36 am with resident #4. Resident #4 is in the dining room sitting in his bed. Resident #4 stated that they are remodeling his room, he has been in the dining room for a week, they bring his food at the bedside table, the room has a bathroom located in the back of the dining room, they take him outside the dining room for shower, and he has a call bell at the bedside table. Review of clinical record revealed resident #4 has a Brief Interview for Mental Status (BIMS) score of 15.0 indicating cognitively intact.</p> <p>An interview was conducted on February 12, 2025 at 08:40 am with resident #8. Resident is lying in bed in the dining room. Resident stated that he had been there for 5 years. Review of resident clinical record revealed a BIMS score of 15.0 indicating cognitively intact.</p> <p>An interview was conducted on February 12, 2025 at 08:41 am with resident #7. Resident is sitting in bed in the dining room. Resident stated that he has been in the dining area for 3 weeks due to plumbing issues. Resident stated that he eats on his bedside table, uses the bathroom located in the other room and they take him out of the dining room for showers. Resident has a call bell at bedside. Review of clinical record revealed a BIMS score of 14.0 indicating cognitively intact.</p> <p>An interview was conducted on February 12, 2025 at 8:46 am with speech therapist/Staff #259. She stated that she is here for resident #5. She stated that resident was in the unit but due to construction , resident was moved to the activityroom/dining room. Staff stated that she usually finds a quiet room in the resident's room to do by mouth trials, practice swallow strategies, aspiration precaution, , and for today she will be doing speech therapy at resident's bedside in the dining room.</p> <p>An interview was conducted on February 12, 2025 at 8:52 am with CNA/staff #148. Staff stated his unit is one of the locked unit which is under construction. He stated that he has been working for two days in the [NAME] dining room where the residents are placed. He stated that the [NAME] dining room is use to be the dining room for residents to eat.</p> <p>He stated that his unit has been closed for about a week.</p> <p>(continued on next page)</p>		

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 02/12/2025
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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on February 12, 2025 at 9:00 am with registered nurse (RN)/Staff #225. Staff #225 stated that they are doing work in the unit, tearing up plumbing, and the construction has been going on for one week and a half. She stated that she came to work on Wednesday, February 5, and the residents were already moved in the dining room.</p> <p>An interview was conducted on February 12, 2025 at 9:14 am with Maintenance director/Staff #41. Staff stated that his responsibility is to keep the building well maintained and make sure is within regulation. Staff stated that one of the unit's mainland plumbing failed and it has been an ongoing issue for a while. Then, on Monday , February 3, they finished prepping the two rooms, one room used to be a day care room and the medical record room, and the other room prepped was the [NAME] dining room. He stated that they cleared and cleaned the entire rooms, and made sure there is access to restroom. Staff stated that they moved twenty-six residents, some went to other units, and he does not know how many residents were moved in the [NAME] dining room, day care room and medical record room. Staff stated that they finished the plumbing on Friday, February 7, the concrete started on Saturday, February 8, and the flooring started on February 10, because the concrete needs to cure. At 9:24 am, Staff #41 and surveyor headed to the ding room. At 9:25 am, staff measured the square footage of the dining room. The measurement is 43 feet (ft) by 24.5 ft which equals to 1053.5 square feet. At 9:30 am, there are 4 residents in the day care room. Staff #41 measured the day care room square footage. The measurement is 24.5 ft by 17.5 ft which is 428.75 square feet. At 9:38 am, staff #41 is in the medical record room which has three residents. The medical record room measurement is 16.5 ft by 12.25 ft which equals to 200.95 plus a nook 5.5 ft by 6.0 ft which equals to 33 sq ft. The total square footage of the medical record room is 233.95 sq ft. At 9:47 am, staff remeasured dining room. The dining room measured 41.0 ft by 24.5 ft which equals to 1004.5 sq ft.</p> <p>An interview was conducted on February 12, 2025 at 10:43 am with CNA/Staff #120. Staff #120 stated that the residents in the day care room has been there since last Monday. Staff stated that all four residents eat in the room, the meal trays are placed at their bedside table, and they are offered activities if resident wants to go. During the interview, surveyor observed snacks such as yogurt, bananas, and jello, were on top of a table, and staff stated that the snacks were brought in at 10:00 am, and there is no refrigerator in the day care room. When asked about where they keep resident's clothes/belongings, staff #120 stated that residents' clothes were stored in the maintenance area and the residents important belongings such as lap tap, cellphone, and chargers are with them. At 10:50 am, staff #120 showed surveyor the maintenance area which is next room to the dining area and a door leading to the kitchen.</p> <p>The maintenance area was observed to have maintenance tools and housekeeping carts. At 10:54 am, Housekeeping/Staff #280 and housekeeping manager/Staff #24 identified the room as housekeeping and maintenance room for storage. Staff stated that the room has tools for maintenance, they keep the wet and dry pick up machine to clear all water/suck water if they do strip and wax floor, a machine for wet and dry for auto scrub for the floor, and two vacuums to vacuum the carpet. Staff #24 stated that they temporary put the residents clothes there in the maintenance area/storage.</p> <p>An interview was conducted on February 12, 2025 at 11:16 am with the interim director of nursing/clinical resource RN/Staff #32. She stated that the unit is a plumbing nightmare, nothing would flush and go down, the back two rooms kept having flush problem. She stated that about 23 to 27 residents were moved on February 3. She stated that they started jack hammering by noon. The plumbing stuff is done tentatively today, February 12, and they will tile the floor, and then start moving resident back to the unit by tomorrow.</p> <p>(continued on next page)</p>		

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 02/12/2025
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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of facility's policy titled, Shelter In Place and Procedure, no effective or revision date revealed Three potential types of sheltering in place have been identified: (2) Physical Plant related-This would typically be in response to an issue that has rendered a Zone uninhabitable. This situation might cause an evacuation from one zone to another. It also could be for a longer period of time. See Evacuation-Partial.</p> <p>Review of facility's policy titled, Facility Evacuation-Partial, no effective or revision date revealed it is everyone's responsibility to protect our residents, guests, and staff from injuries and fatalities in the event of a disaster. This procedure outlines steps that must be taken to safely evacuate residents to a safe area within the facility. Safe Area: Resident gathering areas: dining rooms, day rooms, activity rooms, therapy rooms.</p> <p>Review of facility's policy titled, Resident Rights, revised February 2021 revealed Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to : a. a dignified existence; b. be treated with respect, kindness, and dignity.</p>		