

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  04/14/2025
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124</b></p> <p>Based on observation, interviews, review of the clinical record, and review of facility policy and procedure, the facility failed to ensure one resident (#6) was prevented from an accident during a hoyer transfer with major injury, and from sustaining an avoidable fall from a wheelchair with major injury. The deficient practice could lead to residents being physically harmed, with major injuries or death.</p> <p>Findings Include:</p> <p>-Regarding Resident #6's accident during a hoyer transfer:</p> <p>Resident #6 was initially admitted to the facility June 21, 2024, with diagnoses that included unspecified dementia with other behavioral disturbance, depression, type 2 diabetes mellitus, hypotension, chronic obstructive pulmonary disease, and chronic kidney disease.</p> <p>Review of a care plan dated July 6, 2024, revealed the resident has an activity of daily living (ADL) deficit and requires a hoyer lift for transfers.</p> <p>An additional care plan dated July 5, 2024, revealed Resident #6 is at risk for behaviors due to dementia, with interventions to anticipate and meet the resident's needs, caregivers to provide opportunity for positive interaction and attention, stop and talk to the resident as passing by, explain all procedures to the resident before starting and allow the resident time to adjust, and intervene as necessary to protect the rights and safety of others.</p> <p>There was no evidence of a care plan to specifically address behaviors demonstrated during hoyer transfers.</p> <p>A physician Encounter Note dated January 3, 2025, revealed the physician was called to see the resident for a fall from hoyer. The resident was reportedly moving around in the hoyer, when a loop came unhooked from the hoyer, causing the resident to slip out and land face down. The resident sustained a head strike with two lacerations on the forehead, and a contusion/abrasion to the right elbow and right knee. The resident has right knee pain and possible right distal femur deformity, with concerns for femur/knee fracture. EMS arrived.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A Nurses Note dated January 3, 2025, revealed the resident had fallen while being transferred using a hoier lift. The resident was laying on the floor on her back, and was bleeding from two lacerations to her head, and on her right knee. The provider was called and entered the facility shortly, and 911 was called and came for the resident at 11:02 AM. Before the fall, the resident was wiggling and yelling out to everyone that passed by her room to get her up and the resident was told she would be up by lunch time, but continued yelling.</p> <p>The resident was readmitted to the facility from the hospital on January 7, 2025, with additional diagnoses of nondisplaced transverse fracture of right patella, and displaced articular fracture of head of right femur.</p> <p>A Nurses Note dated January 7, 2025, revealed the resident has an immobilizer brace to the right lower extremity, and to continue non-weightbearing.</p> <p>A physician Encounter Note dated January 8, 2025, revealed Resident #6 had a fall out of a hoier lift on January 2, 2025, and sent out to the hospital for evaluation. Imaging found a right distal femur fracture and a right patellar fracture, to be treated conservatively with a leg immobilizer brace.</p> <p>On April 14, 2025, at 11:53 AM, a formal request was made to the facility for the incident report and risk management report for Resident #6 for the fall from hoier incident in January 2025. The administrator signed a statement that incident reports are internal use only and would not be available to be reviewed.</p> <p>An observation was conducted of the hoier lift on the resident's unit on April 14, 2025, at approximately 1:15 PM. The hoier lift had hooks that pointed upward by approximately 3-4 inches so that the loop of a hoier sling could not come off the hook unless it was unweighted and lifted off, or if the loop was not fully hooked or seated correctly on the hook.</p> <p>An interview was conducted with a Certified Nursing Assistant (CNA / Staff #36) on April 14, 2025, at 12:26 PM. Staff #36 stated that the facility requires two staff to operate a hoier lift for safety during transfers. Staff #36 stated that she was not present at the time of Resident #6's fall from the hoier, however Staff #36 stated she heard that there were two staff present and questioned, how did that happen?, however was never informed how the incident happened. Staff #36 stated that the resident returned from the hospital with a bruise on her head and a fracture from the fall.</p> <p>An interview was conducted with a Registered Nurse (RN / Staff #80) on April 14, 2025, at 12:49 PM. Staff #80 stated that in January 2025, Resident #6 had a fall from a hoier lift transfer, and that she was not sure how it happened, whether the sling strap tore or that the hoier strap loop came off the hook. Staff #80 stated that the resident moves in the hoier sometimes. Staff #80 stated that the two CNAs who were assisting the resident during the hoier lift incident were Staff #45 and Staff #62.</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>An interview was conducted with the Director of Rehab and Occupational Therapy Assistant (DOR / Staff #16) on April 14, 2025, at 1:07 PM. The DOR stated that she was familiar with Resident #6 and that she was aware the resident had a fall from the hoier lift in January 2025. The DOR stated it was discussed in an IDT meeting the following day that Resident #6 was being transferred in a hoier lift and was displaying behaviors and somehow wiggled herself out of the hoier sling. The DOR stated that she could see how if someone was flailing in a hoier sling, then they could possibly work themselves out of the hoier sling. The DOR also stated that Resident #6 has moderately to severely contracted knees, which significantly limits her movement, and the resident cannot stand or walk.</p> <p>A telephonic interview was conducted with a CNA (Staff #62) on April 14, 2025, at 1:38 PM. Staff #62 stated that she was assisting with the hoier transfer at the time of the incident. Staff #62 stated that Staff #45 had the resident on the hoier lift and that Resident #6 was shaking and jiggling the straps of the hoier sling with her hands. Staff #62 stated that the resident was up in the lift, and Staff #62 then turned around to get the wheelchair and position it. Staff #62 stated by the time she turned around again, one of the sling loops came off the hoier lift hooks and the resident fell to the ground and hit her leg on the ground, and her head was injured. She stated that the position of the other CNA, Staff #45, at the time of the fall, was standing behind the main upright beam of the hoier lift, so that the beam was between Staff #45 and the resident in the sling. After the resident's fall, the staff got the nurse right away.</p> <p>A phone call was placed to a CNA (Staff #45), for an interview on April 14, 2025, at 1:39 PM, and a voicemail was left for a return call. The staff did not return the call.</p> <p>An interview was conducted with an Assistant Director of Nursing (ADON / Staff #71) on April 14, 2025, at 2:31 PM. Staff #71 stated that she was aware that Resident #6 had a fall from a hoier lift in January 2025. Staff #71 stated that she heard of the incident the following morning in the clinical meeting. Staff #71 stated that she did not know what happened during the incident, or how the fall occurred.</p> <p>An additional interview was conducted with an Assistant Director of Nursing (ADON / Staff #29) on April 14, 2025, at 2:41 PM. Staff #29 stated that Resident #6's fall from the hoier in January 2025, happened before she started her employment with the facility. Staff #29 stated that the resident tends to move around and reach for things during hoier transfers. Staff #29 stated she was not aware of how Resident #6's fall from the hoier occurred.</p> <p>A telephonic interview was conducted with Resident #6's responsible party and power of attorney (POA) on April 14, 2025, at 2:57 PM. The POA stated that the facility called him in January, 2025, to inform him of the resident's fall. He stated that he was told by facility staff that the resident fell while reaching and that the staff did not witness it. He stated as an outcome, the resident had lacerations on her forehead and a fracture.</p> <p>An interview was conducted with the Director of Maintenance (Staff #8) on April 14, 2025, at 3:12 PM. Staff #8 stated that if there is an issue with a hoier lift, that staff will report it, and he will look at the hoier. He stated that no staff reported an issue with the hoier lift on Resident #6's unit.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Director of Nursing (DON / Staff #86) on April 14, 2025, at 3:37 PM. The DON stated that she has been employed by the facility since February 17, 2025, and prior to that date, the DON position was held by Staff #90, who was no longer employed by the facility. The DON stated that residents and/or staff could be injured if staff does not follow established procedure when using equipment. She stated that she was aware that Resident #6 had a fall from a hooyer lift in January that resulted in a fracture, however she stated that she did not know any further details, and that it was not discussed by the facility. The DON stated that she was not aware of any corrective action that took place.</p> <p>A call was placed on April 14, 2025, at 3:51 PM, to the former DON (Staff #90) for an interview. A voicemail was left for a return call. The staff member did not return the phone call.</p> <p>-Regarding Resident #6's fall from a wheelchair:</p> <p>A quarterly minimum data set (MDS) assessment dated [DATE], revealed Resident #6 had a brief interview for mental status (BIMS) score of 00, indicating the resident had severe cognitive impairment. Additionally, the assessment revealed the resident had a fall within the recent 2-6 months.</p> <p>A care plan dated July 6, 2024, revealed the resident is at risk for falls due to dementia, with interventions to be sure the residents call light is within reach, ensure appropriate footwear when mobilizing in wheelchair, anticipate and meet the resident's needs, and that the resident needs a safe environment on a secured dementia unit.</p> <p>An additional intervention to the fall risk care plan, initiated April 9, 2025, indicated to adjust Roho cushion to wheelchair to minimize falls.</p> <p>An additional care plan, dated July 2, 2024, revealed the resident is an elopement risk / wanderer due to dementia, with interventions to assess for fall risk, identify pattern of wandering, and to provide structured activities: toileting, walking inside and outside, and reorientation strategies.</p> <p>There was no evidence of a care plan specifying the quantity or times that the resident required supervision from staff.</p> <p>A Behavior Note dated March 2, 2025, revealed the resident was going into other resident's rooms and taking their belongings.</p> <p>A Psychotherapy Note dated March 3, 2025, revealed the resident tends to take items from around the unit and store them in her drawers.</p> <p>A Nurses Note dated April 8, 2025, revealed staff heard shouting coming from a room and observed Resident #6 lying on the floor in the fetal position in another resident's room. The extra wheelchair cushion provided had slid off of the wheelchair with the resident at the time of the fall. The resident sustained a skin tear and bruising to left hand, bruising to left elbow, and a bump to left forehead. Notifications were made to the POA and physician.</p> <p>A Radiology Report dated April 9, 2025, revealed an x-ray of the left ankle with findings: comminuted, displaced and angulated distal fractures of the tibia and fibula.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A physician Encounter Note dated April 9, 2025, revealed the resident was being seen to follow up on a fall from wheelchair. The resident had acute tibia and fibula fractures with a recommendation to send out to the emergency department to evaluate and treat the fractures.</p> <p>A Therapy Screen Note dated April 9, 2025, revealed the screen was being completed status post fall. No changes noted at this time as the resident continues to require supervision for wheelchair mobility via manual wheelchair. Dycem (non-slip sheet material) is noted under the Roho cushion to reduce movement, as the Roho is needed to maintain skin integrity. Therapy not warranted at this time.</p> <p>A physician order dated April 9, 2025, indicated to send the resident out to the hospital for evaluation of acute pain and swelling post fall.</p> <p>On April 14, 2025, at 11:53 AM, a formal request was made to the facility for the incident report and risk management report for Resident #6 for the fall from wheelchair in April 2025. The facility administrator signed a statement that incident reports are internal use only and would not be available to be reviewed.</p> <p>An interview was conducted with a Certified Nursing Assistant (CNA / Staff #36) on April 14, 2025, at 12:26 PM. Staff #36 stated that staff supervise residents who require it, and that it is relayed in report between shifts which residents need supervision. Staff #36 stated that if they see a resident somewhere they should not be, then staff remove them from the location. Staff #36 stated that all the residents on Resident #6's unit require supervision because it is a dementia unit. Staff #36 stated that Resident #6 wanders around the unit and takes things from other residents' rooms. Additionally, Staff #36 stated she was aware that Resident #6 had fallen from her wheelchair on April 8, 2025, and that the resident was sent to the hospital. Staff #36 stated she did not know any further details.</p> <p>An interview was conducted with a Registered Nurse (RN / Staff #80) on April 14, 2025, at 12:49 PM. Staff #80 stated that Resident #6 normally wanders into other resident' rooms, she steals things, and starts giggling. Staff #80 stated that Resident #6 was alone in another resident's room, when Staff #80 heard a yell, and three staff members ran to the room. Staff #80 stated that the resident had a new wheelchair cushion from therapy, and recently just before this fall incident, the resident had a near fall from the cushion. Staff #80 stated that she observed the resident on the floor on her side and the cushion was on the floor with the resident, as if the resident had slid out. Further, Staff #80 stated that there was only one piece of dycem under the first wheelchair cushion, and that there were two wheelchair cushions present. Additionally, Staff #80 stated that there should have been a second piece of dycem between the first and second wheelchair cushions prevent it from sliding out.</p> <p>An interview was conducted with the Director of Rehab and Occupational Therapy Assistant (DOR / Staff #16) on April 14, 2025, at 1:07 PM. The DOR stated that she had issued Resident #6 a Roho cushion, and there was concern that the cushion was sliding, and then after the resident fell , staff removed the cushion. The DOR stated that she looked at the wheelchair the following morning after the fall, and there was only one wheelchair cushion at that time. The DOR stated that no staff had reported to her that there had been two wheelchair cushions in the wheelchair, and if there were, then it would be a safety concern. The DOR further stated that when there are two cushions in the wheelchair, it brings the resident up higher in the chair in relation to the armrests, and increases the likelihood for a fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with an Assistant Director of Nursing (ADON / Staff #71) on April 14, 2025, at 2:31 PM. Staff #71 stated that Resident #6 is very busy, in and out of other resident's rooms, getting into other residents' belongings. Staff #71 stated Resident #6 requires lots of supervision and redirection, as well as frequent checks. Additionally, Staff #71 stated that last week, the resident fell from her wheelchair, and that staff said that there was a cushion in her wheelchair that contributed to her fall, so the wheelchair cushion was removed from the chair.</p> <p>An interview was conducted with an Assistant Director of Nursing (ADON / Staff #29) on April 14, 2025, at 2:41 PM. Staff #29 stated that Resident #6 does wander into other residents' rooms and takes their belongings. In regard to the resident's fall on April 8, 2025, Staff #29 stated that the nurse was in another room when the resident fell in another resident's room. The ADON stated that the clinical team discussed the fall, and it was determined that the Roho cushion may have been the reason why the resident fell. Staff #29 stated that Roho cushions are much thicker and position the resident higher than other wheelchair cushions, and the Roho cushion had just been put in Resident #6's wheelchair recently. Staff #29 stated that once the clinical team reviewed the fall, it was decided to not have the resident use the Roho cushion, and it was removed. After the fall, the resident went to the hospital, and Staff #29 stated that the nurse called the hospital and received report that Resident #6 did have tibia and fibula fractures. Also, Staff #29 stated that there were no staff in-services done after the resident's fall.</p> <p>An interview was conducted with the Director of Nursing (DON / Staff #86) on April 14, 2025, at 3:37 PM. The DON stated that the facility protects residents from accidents by trying to keep them out of rooms as much as possible, and to check on residents as frequently as staff can. The DON also stated that staff supervise residents with known behaviors, and that it should be specified in the resident's care plan how much supervision that the resident requires. The DON stated that Resident #6 has dementia and wanders in her wheelchair. Regarding the resident's fall on April 8, 2025, the DON stated that the resident fell due to her cushion in her wheelchair and that the resident slid out. The DON stated that we added dycem so the resident would not slip. As an outcome, the DON stated that the resident went out to the hospital and was treated for tibia and fibula fractures. The DON stated that there were not any staff trainings or in-services after the fall incident.</p> <p>Review of the facility's manufacturer's instructions for the hoier lift on Resident #6's unit, titled EZ Way Smart Lift, 500, 600, and 1,000 lb Capacities, Operator's Instructions, revised August 10, 2018, revealed that all washable EZ Way Slings are capable of bearing a 1,000 lb. weight load. EZ Way slings are made specifically for EZ Way Smart Lifts, for the safety of patients, only EZ Way slings should be used with EZ Way lifts. A pre-operation check should be completed before operating the unit. Ensure the sling is not ripped, frayed, or showing signs of wear. When attaching the sling to the lift, make a final check of all four loop attachment points to ensure each loop is sufficiently attached to the respective hook of the hanger bars. When lifting the patient, push the UP button, continue the upward motion until there is tension on the sling legs, making sure all the loops on the sling are securely hooked on the hanger bars.</p> <p>Review of the facility's policy titled Behavioral Assessment, Intervention and Monitoring, revised March 2019, revealed the IDT will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Accidents and Incidents - Investigating and Reporting, revised July 2017, revealed all accidents and incidents involving residents shall be investigated and reported to the administrator. The Incident/Accident Report shall include, as applicable: the date and time the incident took place, the nature of injury, the circumstances surrounding the accident or incident, any corrective action taken, follow-up information, and other pertinent data as necessary.</p> <p>Review of the facility policy titled Fall Risk Assessment, revised March 2018, revealed the nursing staff, physician, and therapy staff will establish a resident-centered falls prevention plan based on relevant assessment information. The staff will evaluate functional, psychological, and environmental factors that may increase fall risk. The staff and physician will collaborate to identify and address modifiable risk factors, and interventions to try to minimize the consequences of risk factors that are not modifiable.</p>		