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	06/25/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of records, and review of facility policy and procedure, the facility failed to ensure a resident (#5) was not abused by another resident (#10). The deficient practice could lead to psychosocial or physical harm of a resident. -Regarding Resident #5 (alleged victim):Resident #5 was admitted to the facility November 30, 2023, with diagnoses that included schizoaffective disorder, bipolar type, post-traumatic stress disorder, unspecified, schizoaffective disorder, unspecified, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, borderline personality disorder.Review of the quarterly minimum data set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating cognition is intact. Further review revealed no indicators for mood or behaviors.Review of the Care Plan revealed a focus for behavior problem which includes cares in pairs. Interventions included praise any indication of the resident's progress/improvement in behavior.Review of the Behavioral Care Plan effective June 5, 2025 revealed current behavior for verbal aggression towards staff and peers. Interventions included redirection to a quiet area or preferred activity to de-escalate, space if needed, while ensuring the safety of others. A Nurses Note dated June 19, 2025, revealed writer notified by staff of alleged altercation with res. roommate. Res. stated roommate walked behind him and hit him with an open hand in the back of the head. Writer observed res. no open areas, redness, swelling noted to area of alleged hit. Writer notified administrator, DON, APS, DHS and phoenix police department (Police report number: 2025-901621). -Regarding Resident #10 (alleged perpetrator):Resident #10 was admitted to the facility June 19, 2025 and discharged [DATE], with diagnoses that included unspecified dementia, moderate, with other behavioral disturbance, anxiety disorder, unspecified.An admission MDS assessment dated [DATE], revealed the resident had a brief interview for mental status (BIMS) score of 3, indicating severe cognitive impairment.A baseline care plan dated June 19, 2025, revealed Resident #10 revealed no behavioral concerns.Review of behavior charting nurse assessment dated [DATE] revealed agitation/aggression (verbal/physical towards others - Hitting, Kicking, grabbing, throwing objects, etc.) displayed. Detailed observed behaviors documented as resident expressed his frustrations by hitting another resident. Outcome documented as resident Sent out to hospital for a psych evaluation.A Daily Skilled assessment dated [DATE], revealed Resident #15 was alert with confusion to place, time, and situation. The assessment indicated No behavior issues noted. No change of condition was noted today, and there was no evidence of additional notes or follow-up regarding the interaction with Resident #10.An interview was conducted on June 25, 2025, at 2:07 PM, with Resident #5, who stated I was sitting in my wheelchair in my room and he (my new roommate) came up behind me and hit me in the back of my head, he was calling me names. The nurse tried to stop him, but he hit her or pushed her too. I had a headache for about five days. He hit me with his fist, I asked for Tylenol afterwards and they moved him out of my room. Resident stated he no longer had any contact with the resident asked to file charges and spoke to the police following the incident. Resident reported feeling safe in the facility and would report any further incidents to his family and to his nurseAn interview was conducted with Registered Nurse (RN / Staff #15) on June 25, 2025, at 2:27 PM. Staff #15 stated that he observed certified nursing assistant (CNA/Staff #20) standing next to resident #10 who was standing behind resident #5 who was sitting in his wheelchair and asked resident #10 to go back to his side of the room and finish his meal. Staff #15 stated Staff #20 reported to him that resident #10 got up and hit resident #5 in the back of the head. RN / Staff #15 stated neuro checks, skin assessment and vital signs were completed with no noted redness to the back of the head and no injuries noted for resident #10. RN / Staff #15 stated he administered Tylenol for resident #5 following the incident, who had no complaints of pain, but did state when resident #10 hit him, it hurt. RN / Staff #15. RN / Staff #15 stated residents #5 and #10 were new roommates, therefore no prior incidents. Stating resident #10 came to the unit five hours prior, as a new admit. RN / Staff #15 stated some of the behaviors received in report were sexual, physical and verbal and staff monitored the behaviors by keeping an eye on the resident who was wandering the unit, so it made it difficult. RN / Staff #15 stated resident #10 became aggressive after an hour and was placed on 1:1 for trying to exit.An interview was conducted with (CNA/Staff #20) on June 25, 2025, at 2:27 PM who observed the alleged altercation. Staff #20 stated the incident happened at dinner time, in their room and they were roommates. Staff #20 stated she was doing one on one with resident #10 due to elopement concerns. Staff #20 state she had served resident #10 his meal