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	11/19/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, and staff interviews, the facility failed to ensure that residents are free from abuse from another resident (Residents #3 and #5). The universe was 144, and the sample size was 3. The deficient practice could lead to further instances of resident-to-resident altercations, thereby promoting an unsafe environment.Findings include:-Regarding Resident #3:Resident #3 was admitted on [DATE], with diagnosis that included bipolar disorder, current episode mixed, moderate; depression, unspecified; post-traumatic stress disorder, unspecified; unspecified convulsions; borderline personality disorder; and antiphospholipid syndrome.An MDS (Minimum Data Set) assessment dated [DATE], revealed a BIMS (Brief Interview for Mental Status) score of 15, indicating intact cognition at the time of the assessment.A skin assessment conducted on September 18, 2025, revealed no evidence of skin issues or injuries.A review of a progress note dated September 19, 2025, revealed that at 9:49 AM, an Assistant Director of Nursing (ADON/Staff #23) was notified of a resident-to-resident altercation. The progress note revealed that there were no alterations to Resident #3's skin, and the resident remained alert and oriented times 4, indicating they are alert and can accurately state their person (name), place (current location), time (date and time), and situation (reason for being there). The progress note also indicated that Resident #3 felt safe with no further concerns at that time. The progress note revealed that Resident #3 had followed up with the psychiatric provider, and the Nurse Practitioner (NP) was notified. A subsequent progress note dated September 19, 2025, revealed that at 10:15 AM, Resident #3 met with their psychiatric provider. Resident #3 denied any psychological or psychosocial disturbances from the alleged altercation, and the provider determined that there were no recommendations to change Resident #3's care.A review of another progress note, dated September 22, 2025, revealed that at 3:02 PM, an ADON (Staff #34) documented an incident investigation was conducted between Residents #3 and #5 on September 18, 2025. The progress note revealed that Resident #3 returned to the unit from the business office with a Certified Nursing Assistant (CNA) escort. The CNA escort returned with three pieces of candy for Resident #5 and then proceeded to chat with them. Resident #3 interrupted the conversation, and Resident #5 threw the three pieces of candy at Resident #3. Resident #3 had positioned herself in front of Resident #5, which led Resident #5 to slap Resident #3; Resident #3 then returned the slap to Resident #5. The progress note also revealed that Residents #3 and #5 were separated immediately. Resident #3 had been provided education regarding confrontations when met with aggression from other residents, and a skin assessment had been completed following the incident, with no evidence of injuries. -Regarding Resident #5:Resident #5 was admitted on [DATE], with the diagnosis that included type 2 diabetes with mellitus with unspecific complications; personality disorder, unspecific; cerebrovascular disease, unspecific; anxiety disorder due to known physiological condition; and chronic kidney disease.An MDS (Minimum Data Set) assessment on August 5, 2025, revealed a BIMS score of 6, indicating that the resident had severe cognitive impairment, further noting that Resident #5 had significant problems with thinking and memory.A review of a progress note dated September 18, 2025, revealed that Resident #5 transferred to a new unit. A review of a room change form dated (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	September 18, 2025, revealed that Resident #5 had signed it.A progress note dated September 19, 2025, revealed that at 9:54 AM, an ADON (Staff #23) was notified of a resident-to-resident altercation. The progress note revealed that there were no alterations to Resident #5's skin, and the resident remained alert and oriented. The progress note revealed that Resident #5 had followed up with the psychiatric provider.A review of another progress note dated September 19, 2025, revealed that at 10:30 AM, Resident #5 met with their psychiatric provider. Resident #5 reported the incident involving Resident #3 to the psychiatric provider and stated that she had thrown her candy at Resident #3 because Resident #3 was not respecting her personal space. Resident #5 denied any psychological or psychosocial disturbances from the alleged altercation.An interview was conducted on October 7, 2025, at 1:01 PM, with Resident #3. The resident stated that they could recall the incident. Resident #3 stated that Resident #5 made racial slurs to the CNA escort and did not like what Resident #5 was saying. Resident #3 stated that she responded to Resident #5, and Resident #5 responded by throwing candy pieces at her. Resident #3 stated that she postured herself to Resident #5, Resident #5 slapped her first, and that she hit Resident #5 back. Resident #3 also stated that the CNA immediately separated the two of them and ensured that both she and Resident #5 were safe. Resident #3 also stated that the facility ensured both she and Resident #5 were placed in separate units, and that they felt safe at the facility following the incident. An interview was conducted on October 7, 2025, at 1:39 PM, with a CNA (Staff #21). The CNA stated that the facility provides training and education regarding what abuse is, how to identify abuse, and what to do if abuse or neglect is identified. The CNA also stated that allegations of abuse and neglect are to be reported to the Administrator and the DON immediately but no longer than 2 hours. Regarding the resident-to-resident altercation between Residents #3 and #5, the CNA stated that he was a witness to the altercation. The CNA stated that he recalled assisting Resident #3 to the business office to get candy to bring back for the other residents. He further stated that Resident #5 started stating racial slurs, and Resident #3 proceeded to posture herself in front of Resident #5; however, Staff #21 further stated that Resident #5 was the individual who made contact first with a slap to the arm of Resident #3. Resident #3 immediately slapped Resident #5 on her arm, and the CNA stated that he separated the two residents. The CNA further stated that due to the nature of the resident-to-resident altercation involving physical contact, the incident needed to be reported immediately for alleged abuse. An interview was conducted on October 7, 2025, at 1:42 PM, with Resident #5. Resident #5 exhibited a disorganized thought process and required prompts and cues to return to the topic of discussion. However, Resident #5 stated that she recalled an incident in which they threw candy at another resident because the resident was not respecting their personal space. Resident #5 also stated that she was moved to a new unit and was able to make new friends in the new unit. Resident #5 was unable to recall any other details.An interview was conducted on October 7, 2025, at 3:12 PM, with an ADON (Staff #34). Staff #34 stated that the facility provides training and education regarding what abuse is, how to identify abuse, and what to do if abuse or neglect is identified. Staff #34 also stated that allegations of abuse and neglect are to be reported to the Administrator and the DON immediately, but no longer than 2 hours for an adequate report and investigation. Regarding the incident between Residents #3 and #5, Staff #34 reviewed the investigation report. Staff #34 stated that Resident #3 returned to the unit with a CNA, who then proceeded to have a conversation with Resident #5. Resident #3 interrupted the conversation, and Resident #5 responded by throwing pieces of candy at Resident #3 and ultimately swatted at Resident #3 with an open hand. Resident #3 swatted back at Resident #5 with an open hand; however, a CNA separated Residents #3 and #5 before the altercation could escalate. Staff #34 stated that they assisted another ADON (Staff #23) with the investigation, during which both residents were assessed for injuries, and complete skin checks were conducted, revealing no evidence of injuries or skin concerns. Staff #34 stated that following the incident, Resident #5 was moved to another unit. Interviews with both Resident #3 and #5 had been conducted, as well as interviews with other residents and the staff in the unit. Staff #34 stated that their conclusion of the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation is that a resident-to-resident altercation did occur, which began when Resident #5 threw candy at Resident #3.An interview was conducted on October 7, 2025, at 3:59 PM, with the Administrator (Staff #30), the Director of Nursing (Staff #20), and an Administrator in Training (Staff #28). The Administrator stated that the facility provides training and education regarding what abuse is, how to identify abuse, and what to do if abuse or neglect is identified. The Administrator also stated that abuse and neglect training also included an overview of the Elder Justice Act and the facility process as a witness to alleged abuse or neglect. Regarding the incident between Residents #3 and #5, Staff #34 stated that the allegation of resident-to-resident abuse was substantiated following a review of the collected evidence, which was compiled by Staff #23 (ADON) and Staff #34 (ADON).A review of a facility policy titled Abuse Policy revealed that the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy also defined abuse as the willful infliction of injury, unreasonable confinement, or punishment that can have the result of physical harm, pain, or mental anguish or deprivation. The policy also revealed that incidents of abuse or allegations of abuse, including but not limited to resident-to-resident altercations, are to be reported within two hours from the time the facility is made aware of the incident.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, facility documentation, and a policy review, the facility failed to implement its abuse policy by not reporting an allegation of abuse involving two residents (#5 and #10) to the State Agency. The deficient practice could result in further incidents of abuse.Findings include:Regarding resident #5Resident #5 was admitted to the facility on [DATE], with diagnoses of bipolar disorder, current episode mixed, moderate, depression, unspecified, post-traumatic stress disorder, unspecified, borderline personality disorder, anxiety disorder, unspecified, nicotine dependence, cigarettes, uncomplicated, panic disorder [episodic paroxysmal anxiety].Review of the care plan, date-initiated August 20, 2024, revealed a focus for PTSD and behavior problems related to bipolar disorder, depression, PTSD and borderline personality disorder. Interventions included administration of medication as ordered, care in pairs, and intervene as necessary to protect the rights and safety of others. Review of Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident's cognition is intact. Further review of the MDS revealed no indicators for mood or behaviors. Review of the behavior charting dated October 13, 2025, for detailed behaviors revealed the following documentation: Patient is getting increasingly annoyed with another patient's vulgar language. The patient states she is nearing the point of 'doing something.'Review of the progress note documentation dated October 24, 2025, states, Patient switched rooms and unit. Patient was on Sunset, but moved to [NAME]. Patient was comfortable with the switch and is looking forward to making new friends and having a fresh start on the new unit. Patient is alert and oriented x4, received her 1400 medications, and medications were sent over to the nurse on [NAME]. Narcotic sheets were given to [NAME] nurse.Regarding resident #10Resident #10 was admitted to the facility on [DATE], with a diagnosis including bipolar disorder, unspecified, anxiety disorder, unspecified, other chronic osteomyelitis, unspecified site.A review of the MDS dated [DATE], revealed a BIMS score of 13, indicating that the resident's cognition is intact. Further review of the MDS revealed no indicators for mood, verbal behavioral symptoms directed towards others, e.g., threatening others, screaming at others, cursing at others, and rejection of care. Review of the care plan, date-initiated September 27, 2025, revealed a focus on behavior problems related to bipolar disorder with aggressive behaviors. Interventions include care in pairs, intervening as necessary to protect the rights and safety of others. Review of the behavior care plan dated September 30, 2025, revealed past behaviors for physical aggression, threatening, leaving facilities against medical advice (AMA), mood swings, and false accusations. Current behaviors include anxiety, agitation, intrusiveness, cursing, and abrasive tone.An interview was conducted on October 28, 2025, at 9:34 am with resident #5. The resident was interviewed alone and in private in her room. Resident #5 stated she has resided at the facility for over a year. Resident #5 stated she had previously resided in another unit for approximately 5-6 months and that they have a smoking patio on the unit. Resident #5 stated she had been harassed by resident #10 numerous times. Resident #5 stated on October 15, 2025, he got into it with me during smoke break; he called me a w**** and that I have two p****** one in my mouth and one in my private parts and I should have pe***** put in them to shut me up. Resident #5 stated Licensed Practical Nurse (LPN/staff #16) and a certified nursing assistant (CNA/staff # 20) were both on the patio. Resident #5 stated that staff #16 called the assistant director of nursing Assistant Director of Nursing (ADON/staff #34) to the unit to get the situation under control and then spoke to resident #10 about it. Resident #10 stated that Resident #5 sexually harasses the female staff. Resident #5 stated that was the only time he called me those nasty names, but that he does call her a psych patient and makes fun of her blindness. Resident #5 stated, They did not take me seriously until I filed a report with the police for sexual harassment for them to move me. I spoke to the police, and they said it did not meet the criteria for an injunction for harassment, but I was granted an order for protection. Resident #5 stated she asked the staff to move her out of the (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unit multiple times, and the facility would not until she called the police. Resident #5 stated she could not recall who she asked to be moved. Resident #5 stated she was moved because the order of protection states that she and resident #10 are unable to be in the same residence, so they moved her to a different unit. Resident #5 stated that she does feel safe in the new unit, but is concerned that she may run into resident#10 within the facility.An interview was conducted on October 28, 2025, at 9:48 am with Licensed Practical Nurse (LPN/Staff #14). Staff # stated she has worked for the [NAME] behavior unit for approximately one month, but before that had worked for the Sunset behavior unit and was familiar with residents #5 and #10. Staff # 14 stated that resident #5 will have pseudo seizures when attention-seeking and can be verbally aggressive towards both staff and residents. Staff #14 stated that while she only provided care for resident #10 for two days, she stated that he can be a little mean towards other residents, but had not observed any vulgarity from resident #10, nor did she receive a report from the other unit as to what happened between resident #10 and resident #5. Staff #14 stated resident #5 had wanted to move off the unit for approximately one month before her move due to it being a step-up to being able to move to a group home.An interview was conducted on October 28, 2025, at 10:00 a.m. with (LPN/Staff#16). Staff #16 stated she has worked on the unit since July 2025- works every Wednesday 6a-6p. Staff #16 stated the behavior unit is a high-level behavior unit. Staff #16 stated the residents who reside on the unit are residents who are easily agitated, attention and exit seeking, and are both very physically and verbally aggressive towards staff and other residents. Staff #16 stated that when we see a resident who has become physically aggressive, we will back up and try to redirect, offer a distraction. We do contact the physician, managers, and additional staff, and have recently started a Crisis Response Protocol. Staff #16 stated that when there is a resident-to-resident incident, we will take away their privileges for activities and/or smoking, which will sometimes stop the behaviors. Staff #16 stated that resident #10 is always complaining, is very disrespectful, refuses care, and then will call the state and complain that he did not receive care. Staff # stated resident #10 is verbally aggressive and will make vulgar statements with no boundaries, but the aggressions are always directed towards staff. Staff #16 stated the incident involving residents #5 and #10 started when resident #10 became upset when the unit manager went to resident #10's room and informed him that he could not order food outside of the facility, except on designated days. Staff #16 stated resident #5 was wheeling herself towards the smoking patio when resident #10 commented, She can order at any time. Staff #16 stated that resident #5 did not reply. Staff #16 stated resident #10, then went out to the patio and was talking about it nonstop and how certain people can order from Amazon. Staff #16 stated that CNA/Staff #20 was also on the patio supervising the smoking patients and had reported that resident #10 did not make any inappropriate statements directed at resident #5; she stated, His mind was set on his inability to order food. Staff # 16 stated there was never any inappropriate language from resident #10 because I would need to report it to my manager. Staff #16 further stated that any inappropriate language between males and females would be considered harassment. Staff stated she was unaware if police had spoken to resident #5, and that she had not received any report that they had. An interview was conducted on October 28, 2025, at 10:27 a.m. with (CNA/Staff # 18). Staff #18 stated that they have worked on the behavior unit for eight months and is familiar with residents #5 and #10. Staff #18 stated resident 10 can be rude to some people, mostly staff, as far as not getting his way, you become the villain in his world. Staff #18 stated resident #10 is cares-in-pairs due to refusing care and will complain that it was not provided. Staff #18 stated that resident #10's interaction with other residents is never good. Staff #18 stated, he is very short with them and not very nice. Staff #18 stated that resident #10 will call other residents' names, is rude in his response towards other residents. Staff #18 reported that resident #5 is easy going. In regards to the alleged incident involving residents #5 and #10, Staff #18 stated they had heard about some type of confrontation between them, but that it was not on their shift. Staff #18 stated that when there is any type of incident with the resident's it is their responsibility to de-escalate the situation.An (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation was made on October 28, 2025, at 10:40 a.m. of resident #10 on the behavior unit- observed resident agitated due to wanting his cigarette break. The resident was cursing while other residents seated near the nursing station could hear him. The staff tried informing him that he would be allowed to go out once social services provided his cigarettes. This information appeared to agitate him even further, and he proceeded to curse at the staff. The resident was eventually escorted to the smoking patio with staff. Resident #10 returned much calmer, waiting for the next cigarette break. A telephonic interview was conducted on October 28, 2025, at 11:01 a.m. with (CNA/Staff#20). Staff #20 stated that they have worked for the facility for over a year and have been working in the behavior unit since March 2025. They provided details regarding their job responsibilities, which include: responding to call lights, watching for all types of behaviors, making sure there are no resident-on-resident altercations, and looking out for resident safety. Staff #20 stated they were working on the evening shift on the date of the alleged altercation between residents #5 and #10. Staff #20 stated resident #20 has good moods and moods that can be off- and easily agitated with noises and screaming, she can get bothered, but has never had any issues with her. Staff #20 stated that resident #10 has been on the behavior unit for approximately one month. Staff #20 stated resident #10 can be boisterous, very demanding, strong with his words, and a little scary with his words that have me a little afraid. he [resident #10] likes to put fear into the CNAs with threats of calling the state on them; he speaks very aggressively. Regarding the alleged incident, Staff #20 stated residents #5 and #10 were passing words back and forth. Staff #20 stated resident #10 was using curse words directed at resident #5about the other receiving deliveries of food and from Amazon. Staff #20 stated they kept arguing about packages. Staff #20 stated she asked them to stop, but they kept accusing each other about resident #10 having food delivered and resident #10 accusing resident #5 of having Amazon deliveries. Staff #20 stated that resident #10 was using the curse words m^^^^^f*****, a**h***, and words used regarding resident #5 vagina, but did not hear any threats of sexual abuse or insertion of male genitalia. Staff #20 stated once they came back in from the patio, both residents #5 and #10 were sent to their rooms, but they continued to argue with each other, refusing to go into their rooms and separate from out in the hallway. Staff #2 stated that resident #5 finally agreed to go into her room. Staff #20 stated later that evening, there were no further disagreements. Resident #5 stayed in her room until the smoke break at 7:00p. Nothing was reported during that smoke break between them.An interview was conducted on October 28, 2025, at 11:30 a.m. with a social services assistant (Staff #22). Staff #22 stated they have worked for the facility since December 2023 and are responsible for two behavior units. Staff #22 stated their job responsibilities include: shopping for the residents, applying for ALTCS, attending care conferences, and assisting with any resources that the residents may need. Staff #22 stated that resident #10 is young, likes to order a lot of things, has made accusations about other residents, has pseudo seizures, and exhibits attention-seeking behaviors. Staff #22 stated that resident #10 has been with the facility for approximately 2 months. Staff #22 stated his behaviors include accusing staff of not caring for him, and will pick and choose who he wants to pick on, will call the state agency and make accusations, and requires a lot of redirection. Staff #22 stated his behavior towards other residents can be aggressive, by yelling at them in a high tone, speaking to them very aggressively. Staff #22 stated his use of inappropriate language is directed towards staff, but has not been observed, nor has it been reported that he has used any inappropriate language towards other residents. Staff #22 stated she was informed that there was an incident between residents #5 and #10 during the smoke break, and the inability to place orders. Staff #22 further stated that resident #5 made an accusation regarding resident #10 and was moved to another unit after she had filed a protective order for resident #10. Staff #22 stated there were no prior concerns and that they appeared to be friendly with one another. An interview was conducted on October 28, 2025, at 11:53 a.m. with the Social Services Director (Staff #24). Staff #24 stated he has been with the facility for one year and that his job responsibilities include advocating for the resident, handling grievances, speaking to the residents (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily, and investigating reports if needed. Staff #24 stated resident #5 was moved to another unit due to another resident saying something to her, because it happened on another shift, and to protect the resident. Staff #24 stated, We became aware of the incident on Friday the October 24, 2025. I was informed by the Assistant Director of Nursing (AND/Staff #34) that resident #5 had made accusations that resident #10 had made verbal threats towards her and had used inappropriate language. Staff #24 stated they were unaware of what the language consisted of. Staff #24 stated that resident #10 can be verbally aggressive towards staff regularly. Staff #24 stated they have not received any reports of verbal aggression towards residents, only directed towards staff. Staff #24 stated that resident #10's behaviors are addressed by talking to him off the unit and getting to the root of the problem. Staff #24 stated that resident #10 can be verbally abusive towards staff with the use of F words. Staff #24 stated that any allegations of abuse are immediately reported to the abuse coordinator. Review of the facility's internal investigation dated October 27, 2025, revealed that on October 23, 2025, resident #5 reported to staff that she had placed a call to APS regarding resident #10 and not feeling safe with him on the same unit. Resident #5 reported to staff that resident #10 had told her that she had two p******, one in her mouth and one down below and that she should get raped. The report further documents that resident #5 contacted the police on October 24, 2025, and filed a report against resident #10. While the facility conducted an internal investigation, the facility failed to report allegations of abuse to the state agency.An interview was conducted on October 28, 2025, at 12:18 p.m. with Administrator/ Staff #30. The administrator stated he is also the abuse coordinator for the facility. Staff #30 stated staff are trained to report allegations of abuse, and part of that process is notifying the DON, separating the resident to ensure their safety, and implementing an internal investigation. Staff #30 stated he became aware of the alleged incident involving residents #5 and #10 on October 24, 2025. Staff #30 stated he was informed by (DON/Staff #32), who was informed by the Assistant Director of Nursing (ADON/Staff #34). Staff #30 stated the state agency encourages facilities to report all allegations of abuse, even when the facility determines from its internal investigation that it is unfounded. Staff #30 stated he would consider allegations of rape to be reported to the state agency. Staff #30 stated, I messed up; it should have been reported. An interview was conducted on October 28, 2025, at 12:18 p.m. with the Director of Nursing/Staff #32. Staff #32 stated that, due to the Order of Protection, residents #5 and #10 will not be able to interact with one another. The concern for joint activities will be addressed by offering activities in the units, and will work closely with the activity department to ensure the residents' safety. Staff #32 stated that all allegations of abuse should be reported to the state agency within two hours. Staff #32 stated that allegations of rape would be considered a verbal threat and should be reported, and the risk of not reporting can cause more harm to the resident.Review of the facility policy titled Abuse Policy states, Our residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, neglect, deprivation of goods or services, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and policy and procedures, the facility failed to ensure that an allegation of verbal abuse, for one resident (#5), was reported to the State Survey Agency within the required timeframe.Findings include:Regarding resident #5Resident #5 was admitted to the facility on [DATE], with diagnoses of bipolar disorder, current episode mixed, moderate, depression, unspecified, post-traumatic stress disorder, unspecified, borderline personality disorder, anxiety disorder, unspecified, nicotine dependence, cigarettes, uncomplicated, panic disorder [episodic paroxysmal anxiety].Review of the care plan, date-initiated August 20, 2024, revealed a focus for PTSD and behavior problems related to bipolar disorder, depression, PTSD and borderline personality disorder. Interventions included administration of medication as ordered, care in pairs, and intervene as necessary to protect the rights and safety of others. Review of Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident's cognition is intact. Further review of the MDS revealed no indicators for mood or behaviors. Review of the behavior charting dated October 13, 2025, for detailed behaviors revealed the following documentation: Patient is getting increasingly annoyed with another patient's vulgar language. The patient states she is nearing the point of 'doing something.'Review of the progress note documentation dated October 24, 2025, states, Patient switched rooms and unit. Patient was on Sunset, but moved to [NAME]. Patient was comfortable with the switch and is looking forward to making new friends and having a fresh start on the new unit. Patient is alert and oriented x4, received her 1400 medications, and medications were sent over to the nurse on [NAME]. Narcotic sheets were given to [NAME] nurse.Regarding resident #10Resident #10 was admitted to the facility on [DATE], with a diagnosis including bipolar disorder, unspecified, anxiety disorder, unspecified, other chronic osteomyelitis, unspecified site.A review of the MDS dated [DATE], revealed a BIMS score of 13, indicating that the resident's cognition is intact. Further review of the MDS revealed no indicators for mood, verbal behavioral symptoms directed towards others, e.g., threatening others, screaming at others, cursing at others, and rejection of care. Review of the care plan, date-initiated September 27, 2025, revealed a focus on behavior problems related to bipolar disorder with aggressive behaviors. Interventions include care in pairs, intervening as necessary to protect the rights and safety of others. Review of the behavior care plan dated September 30, 2025, revealed past behaviors for physical aggression, threatening, leaving facilities against medical advice (AMA), mood swings, and false accusations. Current behaviors include anxiety, agitation, intrusiveness, cursing, and abrasive tone.An interview was conducted on October 28, 2025, at 9:34 am with resident #5. The resident was interviewed alone and in private in her room. Resident #5 stated she has resided at the facility for over a year. Resident #5 stated she had previously resided in another unit for approximately 5-6 months and that they have a smoking patio on the unit. Resident #5 stated she had been harassed by resident #10 numerous times. Resident #5 stated on October 15, 2025, he got into it with me during smoke break; he called me a w**** and that I have two p****** one in my mouth and one in my private parts and I should have pe***** put in them to shut me up. Resident #5 stated Licensed Practical Nurse (LPN/staff #16) and a certified nursing assistant (CNA/staff # 20) were both on the patio. Resident #5 stated that staff #16 called the assistant director of nursing Assistant Director of Nursing (ADON/staff #34) to the unit to get the situation under control and then spoke to resident #10 about it. Resident #10 stated that Resident #5 sexually harasses the female staff. Resident #5 stated that was the only time he called me those nasty names, but that he does call her a psych patient and makes fun of her blindness. Resident #5 stated, They did not take me seriously until I filed a report with the police for sexual harassment for them to move me. I spoke to the police, and they said it did not meet the criteria for an injunction for harassment, but I was granted an order for protection. (continued on next page)

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	035175	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Peak Care Center	8825 South 7th Street Phoenix, AZ 85042

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5 stated she asked the staff to move her out of the unit multiple times, and the facility would not until she called the police. Resident #5 stated she could not recall who she asked to be moved. Resident #5 stated she was moved because the order of protection states that she and resident #10 are unable to be in the same residence, so they moved her to a different unit. Resident #5 stated that she does feel safe in the new unit, but is concerned that she may run into resident#10 within the facility.An interview was conducted on October 28, 2025, at 9:48 am with Licensed Practical Nurse (LPN/Staff #14). Staff # stated she has worked for the [NAME] behavior unit for approximately one month, but before that had worked for the Sunset behavior unit and was familiar with residents #5 and #10. Staff # 14 stated that resident #5 will have pseudo seizures when attention-seeking and can be verbally aggressive towards both staff and residents. Staff #14 stated that while she only provided care for resident #10 for two days, she stated that he can be a little mean towards other residents, but had not observed any vulgarity from resident #10, nor did she receive a report from the other unit as to what happened between resident #10 and resident #5. Staff #14 stated resident #5 had wanted to move off the unit for approximately one month before her move due to it being a step-up to being able to move to a group home.An interview was conducted on October 28, 2025, at 10:00 a.m. with (LPN/Staff#16). Staff #16 stated she has worked on the unit since July 2025- works every Wednesday 6a-6p. Staff #16 stated the behavior unit is a high-level behavior unit. Staff #16 stated the residents who reside on the unit are residents who are easily agitated, attention and exit seeking, and are both very physically and verbally aggressive towards staff and other residents. Staff #16 stated that when we see a resident who has become physically aggressive, we will back up and try to redirect, offer a distraction. We do contact the physician, managers, and additional staff, and have recently started a Crisis Response Protocol. Staff #16 stated that when there is a resident-to-resident incident, we will take away their privileges for activities and/or smoking, which will sometimes stop the behaviors. Staff #16 stated that resident #10 is always complaining, is very disrespectful, refuses care, and then will call the state and complain that he did not receive care. Staff #16 stated resident #10 is verbally aggressive and will make vulgar statements with no boundaries, but the aggressions are always directed towards staff. Staff # stated the incident involving residents #5 and #10 started when resident #10 became upset when the unit manager went to resident #10's room and informed him that he could not order food outside of the facility, except on designated days. Staff #16 stated resident #5 was wheeling herself towards the smoking patio when resident #10 commented, She can order at any time. Staff #16 stated that resident #5 did not reply. Staff #16 stated resident #10, then went out to the patio and was talking about it nonstop and how certain people can order from Amazon. Staff #16 stated that CNA/Staff #20 was also on the patio supervising the smoker and had reported that resident #10 did not make any inappropriate statements directed at resident #5; she stated, His mind was set on his inability to order food. Staff # 16 stated there was never any inappropriate language from resident #10 because I would need to report it to my manager. Staff #16 further stated that any inappropriate language between males and females would be considered harassment. Staff stated she was unaware if police had spoken to resident #5, and that she had not received any report that they had. An interview was conducted on October 28, 2025, at 10:27 a.m. with (CNA/Staff # 18). Staff #18 stated that they have worked on the behavior unit for eight months and is familiar with residents #5 and #10. Staff #18 stated resident 10 can be rude to some people, mostly staff, as far as not getting his way, you become the villain in his world. Staff #18 stated resident #10 is cares-in-pairs due to refusing care and will complain that it was not provided. Staff #18 stated that resident #10's interaction with other residents is never good. Staff #18 stated, he is very short with them and not very nice. Staff #18 stated that resident #10 will call other residents' names, is rude in his response towards other residents. Staff #18 reported that resident #5 is easy going. In regards to the alleged incident involving residents #5 and #10, Staff #18 stated they had heard about some type of confrontation between them, but that it was not on their shift. Staff #18 stated that when there is any type of (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident with the resident's it is their responsibility to de-escalate the situation.An observation was made on October 28, 2025, at 10:40 a.m. of resident #10 on the behavior unit- observed resident agitated due to wanting his cigarette break. The resident was cursing while other residents seated near the nursing station could hear him. The staff tried informing him that he would be allowed to go out once social services provided his cigarettes. This information appeared to agitate him even further, and he proceeded to curse at the staff. The resident was eventually escorted to the smoking patio with staff. Resident #10 returned much calmer, waiting for the next cigarette break. A telephonic interview was conducted on October 28, 2025, at 11:01 a.m. with (CNA/Staff#20). Staff #20 stated that they have worked for the facility for over a year and have been working in the behavior unit since March 2025. They provided details regarding their job responsibilities, which include: responding to call lights, watching for all types of behaviors, making sure there are no resident-on-resident altercations, and looking out for resident safety. Staff #20 stated they were working on the evening shift on the date of the alleged altercation between residents #5 and #10. Staff #20 stated resident #20 has good moods and moods that can be off- and easily agitated with noises and screaming, she can get bothered, but has never had any issues with her. Staff #20 stated that resident #10 has been on the behavior unit for approximately one month. Staff #20 stated resident #10 can be boisterous, very demanding, strong with his words, and a little scary with his words that have me a little afraid. he [resident #10] likes to put fear into the CNAs with threats of calling the state on them; he speaks very aggressively. Regarding the alleged incident, Staff #20 stated residents #5 and #10 were passing words back and forth. Staff #20 stated resident #10 was using curse words directed at resident #5about the other receiving deliveries of food and from Amazon. Staff #20 stated they kept arguing about packages. Staff #20 stated she asked them to stop, but they kept accusing each other about resident #10 having food delivered and resident #10 accusing resident #5 of having Amazon deliveries. Staff #20 stated that resident #10 was using the curse words m^^^^^f*****, a**h***, and words used regarding resident #5 vagina, but did not hear any threats of sexual abuse or insertion of male genitalia. Staff #20 stated once they came back in from the patio, both residents #5 and #10 were sent to their rooms, but they continued to argue with each other, refusing to go into their rooms and separate from out in the hallway. Staff #2 stated that resident #5 finally agreed to go into her room. Staff #20 stated later that evening, there were no further disagreements. Resident #5 stayed in her room until the smoke break at 7:00p. Nothing was reported during that smoke break between them.An interview was conducted on October 28, 2025, at 11:30 a.m. with a social services assistant (Staff #22). Staff #22 stated they have worked for the facility since December 2023 and are responsible for two behavior units. Staff #22 stated their job responsibilities include: shopping for the residents, applying for ALTCS, attending care conferences, and assisting with any resources that the residents may need. Staff #22 stated that resident #10 is young, likes to order a lot of things, has made accusations about other residents, has pseudo seizures, and exhibits attention-seeking behaviors. Staff #22 stated that resident #10 has been with the facility for approximately 2 months. Staff #22 stated his behaviors include accusing staff of not caring for him, and will pick and choose who he wants to pick on, will call the state agency and make accusations, and requires a lot of redirection. Staff #22 stated his behavior towards other residents can be aggressive, by yelling at them in a high tone, speaking to them very aggressively. Staff #22 stated his use of inappropriate language is directed towards staff, but has not been observed, nor has it been reported that he has used any inappropriate language towards other residents. Staff #22 stated she was informed that there was an incident between residents #5 and #10 during the smoke break, and the inability to place orders. Staff #22 further stated that resident #5 made an accusation regarding resident #10 and was moved to another unit after she had filed a protective order for resident #10. Staff #22 stated there were no prior concerns and that they appeared to be friendly with one another. An interview was conducted on October 28, 2025, at 11:53 a.m. with the Social Services Director (Staff #24). Staff #24 stated he has been with the facility for one year and that his job responsibilities include advocating for the resident, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	handling grievances, speaking to the residents daily, and investigating reports if needed. Staff #24 stated resident #5 was moved to another unit due to another resident saying something to her, because it happened on another shift, and to protect the resident. Staff #24 stated, We became aware of the incident on Friday the October 24, 2025. I was informed by the Assistant Director of Nursing (AND/Staff #34) that resident #5 had made accusations that resident #10 had made verbal threats towards her and had used inappropriate language. Staff #24 stated they were unaware of what the language consisted of. Staff #24 stated that resident #10 can be verbally aggressive towards staff regularly. Staff #24 stated they have not received any reports of verbal aggression towards residents, only directed towards staff. Staff #24 stated that resident #10's behaviors are addressed by talking to him off the unit and getting to the root of the problem. Staff #24 stated that resident #10 can be verbally abusive towards staff with the use of F words. Staff #24 stated that any allegations of abuse are immediately reported to the abuse coordinator. Review of the facility's internal investigation dated October 27, 2025, revealed that on October 23, 2025, resident #5 reported to staff that she had placed a call to APS regarding resident #10 and not feeling safe with him on the same unit. Resident #5 reported to staff that resident #10 had told her that she had two p******, one in her mouth and one down below and that she should get raped. The report further documents that resident #5 contacted the police on October 24, 2025, and filed a report against resident #10. While the facility conducted an internal investigation, the facility failed to report allegations of abuse to the state agency.An interview was conducted on October 28, 2025, at 12:18 p.m. with Administrator/ Staff #30. The administrator stated he is also the abuse coordinator for the facility. Staff #30 stated staff are trained to report allegations of abuse, and part of that process is notifying the DON, separating the resident to ensure their safety, and implementing an internal investigation. Staff #30 stated he became aware of the alleged incident involving residents #5 and #10 on October 24, 2025. Staff #30 stated he was informed by (DON/Staff #32), who was informed by the Assistant Director of Nursing (ADON/Staff #34). Staff #30 stated the state agency encourages facilities to report all allegations of abuse, even when the facility determines from its internal investigation that it is unfounded. Staff #30 stated he would consider allegations of rape to be reported to the state agency. Staff #30 stated, I messed up; it should have been reported. An interview was conducted on October 28, 2025, at 12:18 p.m. with the Director of Nursing/Staff #32. Staff #32 stated that, due to the Order of Protection, residents #5 and #10 will not be able to interact with one another. The concern for joint activities will be addressed by offering activities in the units, and will work closely with the activity department to ensure the residents' safety. Staff #32 stated that all allegations of abuse should be reported to the state agency within two hours. Staff #32 stated that allegations of rape would be considered a verbal threat and should be reported, and the risk of not reporting can cause more harm to the resident.Review of the facility policy titled Abuse Policy states, Our residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, neglect, deprivation of goods or services, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.6. Identify and assess all possible incidents of abuse or allegations of abuse, including but not limited to are to be reported within 2 hours from the time the facility is made aware.