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	12/23/2025

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 clinical record review, staff interviews, WebMD, and review of facility documentation and policies, the facility failed to protect the rights of one resident (#1) to be free from abuse by another resident (#2). The deficient practice could result in further abuse of residents when appropriate actions are not taken.Findings Include:-Resident #1(alleged victim) was admitted to the facility on [DATE] with diagnoses of dementia, COPD (Chronic Obstructive Pulmonary Disease), and essential hypertension.The census report revealed that Resident #1 shared the same unit with Resident #2 since May 21, 2025.A comprehensive care plan dated June 5, 2025, revealed that the resident had a potential for a psychosocial well-being problem related to disease process, and the resident was at risk for impaired cognitive function. The interventions included anticipate and meet resident's needs; provide necessary cue, reorient and supervise as needed; ensure/provide a safe environment; and monitor/document/report any changes in skin status such as appearance, color, and wound healing.A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14.0, indicating that the resident was cognitively intact. The assessment also included that the resident had not exhibited behavioral symptoms.The nursing progress note dated December 3, 2025, revealed a late entry, per document, at 3:10 PM Resident #1 reported to a certified nursing assistant (CNA) that Resident #2 came into her room and hit her, and a bruise was noted to her right arm. The abuse coordinator, director of nursing (DON), resident family, and the police were notified.Another nursing progress note dated December 3, 2025, revealed per documentation, that Resident #1 approached the nursing station stating that Resident #2 went into her room and hit her. The administrator, DON, resident family, provider, and the police were notified. A skin assessment was completed and Resident #1 had redness to her face and a bruise to her right arm. Resident #2 was moved to the opposite hall. Resident #1 and Resident #2 were both placed on a 15-minute checks. On December 4, 2025, revealed another nursing progress note, per documentation, Resident #1 was on a 72-hour monitoring for a bruise on her right arm. Per documentation, the bruise was described as having a purple in the center and discoloration around the bruise.Another nursing progress note dated December 5, 2025, revealed per documentation that the resident's family informed staff that Resident #1 had bruises to her left and right upper arm. Further, per documentation, Resident #1's primary nurse assessed Resident #1 and the bruises where from the previous altercation.A Long-Term Care Evaluation progress note dated December 6, 2025, revealed per documentation, a look back detailing resident's skin change/wound acquired on December 3, 2025. Per the documentation, Resident #1 had a right outer forearm bruise, lateral right elbow bruise, and anterior neck under the chin bruise.-Resident #2 (alleged perpetrator) was admitted to the facility on [DATE], with diagnoses that included dementia, anxiety disorder, and unspecified mood disorder.The Quarterly MDS dated [DATE] revealed a BIMS score of 3.0, indicating that the resident cognition was severely impaired. The assessment also included that the resident had not exhibited behavioral symptoms.Review of care plan dated April 25, 2024, revealed an elopement risk/Resident wanders related to disorientation to place, impaired cognitive function/dementia or impaired thought processes related to dementia, and potential for behaviors related to mood disorder, dementia, and anxiety. The interventions included resident was on a secured unit; distract resident from wandering; cue, reorient and supervise as needed; 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.A review of resident's behavioral treatment plan dated October 7, 2025, revealed that the resident's current behaviors included anxious/restless/pacing, anger/frustration, impulsive behavior/not acknowledging peer's space, and physical aggression.On December 3, 2025, the behavioral treatment plan included a resident-to-resident allegation of striking another resident.The nursing progress note dated December 3, 2025 revealed per documentation, Resident #1 informed the staff that Resident #2 entered her room and she was hit by Resident #2. The administrator, DON, Resident ‘s family member, provider, and police were notified. Resident #2 was assessed with no redness or bruising. Resident #2 was placed on the opposite side of the unit and was on 15-minute checks.The census report revealed that Resident #2 was moved to another room in the same unit on December 3, 2025.An Order-Administration progress note dated December 4, 2025, revealed that Resident #2 was administered an antianxiety medication for impulsive behavior. Per documentation, Resident #2 was agitated and became verbally aggressive when staff was