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	01/22/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the clinical record review, resident interview, resident representative interview, facility documentation, and policy review, the facility failed to ensure the resident received adequate assistance devices to prevent falls for one of the three sampled Residents (#1). The deficient practice could lead to further accidents.Findings Include: Resident #1 was admitted on [DATE], with a diagnosis of bipolar disorder, chronic obstructive pulmonary disease, hypo-osmolality, anxiety disorder, extrapyramidal and movement disorder, hyponatremia, and age-related osteoporosis. The care plan dated October 15, 2025, had a focused care area for Resident #1, who is at risk for falls related to high-risk medication use, incontinence, poor mobility, hand contractures, and involuntary movements. Interventions included anticipating and meeting the resident's needs, ensuring the resident's call light is within reach, and encouraging the resident to use it for assistance as needed. Interventions further noted the resident needs a prompt response to all requests for assistance, educate the resident/family/caregivers about safety reminders and what to do if a fall occurs, encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improving mobility, ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in a wheelchair, follow facility fall protocol, and evaluate and treat as ordered or as needed, and the resident needs a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night if applicable; handrails on walls and personal items within reach. The care plan dated October 15, 2025, had an additional focused care area for Activity Daily Living (ADL) self-care performance deficit related to the need for staff assistance with ADL's due to pain, contractures. Interventions included functional abilities may fluctuate related to behaviors/stamina and mood, see tasks for current levels, hoyer lift transfers and monitor for safety, bathing/showering: Avoid scrubbing & pat dry sensitive skin, bathing/showering: Check nail length and trim and clean on bath day and as necessary. Interventions further included to report any changes to the nurse, encourage the resident to discuss feelings about self-care deficit, encourage the resident to participate to the fullest extent possible with each interaction, encourage the resident to use bell to call for assistance., monitor/document/report as needed any changes, any potential for improvement, reasons or self-care deficit, expected course, declines in function and physical therapy (PT) and occupational therapy (OT) evaluation and treatment as per Medical Doctors (MD) orders. An alert notes dated November 22, 2025, at 11:18 AM revealed that Resident #1 reported to the Certified Nursing Assistant (CNA) that he fell at 5:30 am. It was noted that the nurse assessed the resident post-fall with another staff member. Resident #1 stated that he was being helped with a hoyer lift by a CNA, and that the CNA forgot to take the sling off. It was documented that the resident reported that he slid down to the floor. The registered nurse (RN) assessed the resident #1's range of motion which was within normal limits (WNL) and at baseline. Resident (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

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	01/22/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 had contractures to his legs where he is unable to extend them out; his hands were also contracted and unable to open. The Skin of resident was intact, no bruising, redness, abrasions, swelling, or skin tears noted. The resident reported that he has pain in his knees and left hip mild-moderate. He was medicated with as-needed Tylenol. The note stated that a call was placed to the resident's power of attorney (POA), Nurse practitioner (NP), and Assistant Director of Nursing (DON). The orders were received for an X-ray of the resident #1 left hip and left knee. Also, the Neuro-check were WNL, the resident#1 was alert and able to make needs known. The note stated the resident denied hitting his head. The care plan dated November 22, 2025, had a focused care area for an actual fall with: (no injury, minor injury, serious injury). Interventions included x-rays to left hip and knee. A fall risk evaluation was completed on November 22, 2026, where the resident scored 14.0 and is at risk for falls. The evaluation indicated that the resident had 1 to 2 falls in the last three months and is chair-bound. The resident was alert and oriented times three with adequate vision, gait/balance, and muscular coordination required to use assistive devices. It was documented that the resident had 3 predisposing diagnosis. Review of the X-ray results dated November 20, 2025, at 12:59 pm revealed no acute fracture or dislocation. The osseous structure appeared intact. A modest joint space narrowing. Review of the employee file of the CNA (Staff #1) who transferred Resident #1 by himself from his bed to the wheelchair, had a disciplinary action dated November 25, 2025, of termination because the staff member failed to report the resident incident and failure to use the equipment per policies and guidelines. It has also stated that the employee assisted a resident #1 into his wheelchair using Hoyer lift. When the employee #1 were transferring employee #1 did not have a second employee to assist him during the use of the hoyer lift, which caused the resident #1 to slip out of his wheelchair onto the floor. The employee #1 did not report the Resident #1 sliding off his chair onto the floor to the nurse, and got the resident up before he was able to be assessed for injuries. The Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating that the resident was moderately cognitively impaired. An interview was conducted on January 22, 2026, at 08:49 AM, with Resident #1's Representative, who stated that her brother had a fall, which was caused by a staff #1 member who tried to get him up with a mechanical lift in the dark. She stated that her brother told him to turn on the light, but he still proceeded to transfer him with the mechanical lift and caused the fall. She stated that after this incident, he was terminated. An interview was conducted on January 22, 2026, at 12:14 PM with Resident #1, who stated that the staff #1 was not listening to him, and came to assist him with a mechanical lift (hoyer) at 5:30 am by himself and hooked the sling strap on the hoyer, he stated felt the tugging and that the strap was stuck, but he kept pulling it, in spite of being told that the strap was stuck. He stated that all of a sudden he fell on his bottom. He stated that after the incident, he couldn't use the leg; it got worse and worse every day. He stated he already had trouble with his left knee, and that due to staff member #1 it got worse. An interview was conducted on January 22, 2026, at 11:46 AM with CNA(Staff #4), who stated that the facility's process for Hoyer lift is to two have two people present when transferring the residents. She stated all four loops are hooked into the machine correctly, and double checked to ensure they are all connected to ensure resident safety. She stated that you should not proceed with the transfer until it is ensured that the hooked up to the machine, as it would be wrong. The CNA also stated that this is why the second person is there with you to ensure the 4 hooks are attached and advice if the hoyer lift transfer is safe to proceed. She stated that she has not witnessed any residents sliding off the sling. An interview was conducted on January 22, 2026, at 12:26 PM with a Licensed Practical Nurse (LPN/Staff #2), who stated that the (continued on next page)

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	01/22/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's process for using the Hoyer lift is to have two employees use it. She stated that you would need to put the sling underneath the resident, and then on the top, you will hook the sling to the four points on the hoyer and then one of the staff members usually lifts the resident in the sling by using the remote control. Also, stated that one of the staff members will guide the resident's body to have support. She stated that the hoyer sling should be hooked up and secured; if it is not properly hooked up, the risk would be that the resident can slip off the sling. She stated that she was not there when Resident #1 had the fall, and she was not aware of the incident. An interview was conducted on January 22, 2026, at 12:42 AM with a CNA (Staff #3), who stated that the facility process for hoyer lift transfers is to have two have staff members assist, always ensure that you have correct collars attached to hook and hoyer at all times and ensure they are all secured. When the transfer is completed, they should be unhook. An interview was conducted on January 22, 2026, at 3:35 PM with a Registered Nurse (RN/ Staff #5), who stated that the facility's process for Hoyer lift is to have two staff members, who can be any combination of nursing staff members. She stated that first, the staff members will bring supplies such as the Hoyer lift, and ensure the Hoyer battery discharged , enter the patient room, and inform the resident that you will be getting them out of bed, raise the bed in the appropriate height, slide the sling underneath the resident, once it is placed, then use the ring connect sling to the Hoyer, they are color-coded and match those colors hoyer and sling, . She stated that once everything is secured, instruct the resident to cross their arms over their chest. This helps prevent grabbing onto the lift bar and reduces the risk of injury during movement. If the resident is able, have them keep their arms crossed throughout the transfer. Before lifting, ensure the wheelchair, shower chair, or geri chair (whichever is being used for the transfer) is locked and stable. Once the resident is safely lifted into the air, carefully rotate the Hoyer lift toward the receiving chair. When positioning the resident into the chair, open and position the lift legs as needed for stability. Guide the resident gently into place, cupping and supporting them as needed to ensure proper alignment. Lower the resident slowly and make sure they are properly seated with hips positioned toward the back of the chair. If the resident appears uncomfortable after lowering, pause and readjust as necessary to ensure safe and proper positioning. She stated that the risk of having one person do the Hoyer lift, can pose a risk for falls, serious injury, or even death. An interview was conducted on January 22, 2026, at 3:57 PM with the Director of Nursing (DON/Staff #6), who stated that the facility's process for hoyer lift is to have two staff members perform a Hoyer transfer. She stated that you would first put the sling under the resident and attach the color-coded loops to the Hoyer, and lift up to transfer surface and be as close to it as possible. The transfer can be a chair or a bed. The DON stated you would lift them up, place them on the surface, and remove the sling. She stated she expects to have two staff members to do the transfer; if not, this can pose a risk of injury to the resident. She stated that for Resident #1, the staff member #1 did not use the second person to conduct the hoyer lift transfer for Resident #1. She stated staff member #1 forgot to unhook the sling, which made Resident #1 slide off the chair and lower him to the ground. She stated that they performed an xray for Resident #1. She stated that having one staff member to do the Hoyer transfer does not meet her expectations, nor the facility's expectations, and that's why Staff #1 is no longer here in the facility and has been terminated. A Policy titled Lifting Machine, Using A Mechanical was revised in October 2017, revealing that at least two nursing assistants are needed to safely move a resident with a mechanical lift.