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	02/23/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, and facility policy review, the facility failed to ensure that the care plan was reviewed and updated for one out of three sample Residents (#1). The deficient practice could lead residents to not receive proper care.Findings Include: Resident #1 was initially admitted on [DATE], and re-admitted on [DATE], with a diagnosis that included vascular dementia, mood disorder, constipation, venous thrombosis and embolism, hypotension, dysphagia, anxiety disorder, and post-traumatic stress disorder. The Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed no Brief Interview for Mental Status (BIMS) assessment. It also revealed that cognitive skills for daily decision-making are severely impaired. The care plan dated June 09, 2025, had a focused care area for Resident #1 being at risk for elopement related to a history of elopement before admission and during stay. Interventions included assessing for fall risk, monitoring for fatigue and weight loss, and residing on a secure unit. The Behavioral treatment care plan dated November 24, 2025, revealed that Resident #1 behaviors being Sundowners. Interventions included that when Resident #1 starts showing signs of sundowning, like increased confusion, agitation, restlessness, repetitive motions, emotional distress, anxiety and restlessness, or pacing in late afternoon or evening, staff should calmly reassure the resident and provide a structured, soothing environment. Also, staff should reduce the stimulation before sundown by dimming lights gradually, minimizing noise, and avoiding large group activities. Use a consistent evening routine to help Resident #1 feel secure, and provide familiar, calming activities such as music, folding laundry, or looking through photos. Speak in a soft, clear tone and avoid correcting or arguing if he becomesconfused or disoriented. If he appears anxious, redirect him gently and offer reassurance that he is safe. Monitor for possible physical needs such as hunger, toileting, or pain that may be contributing to the behavior An incident report dated December 04, 2025, revealed that the resident #1 was pacing in the hallway and appeared to be restless, then the resident ambulated towards the north exit door and exited the facility into the smoking area, where staff followed him immediately, resident was observed climbing the wall; verbal redirection was attempted by staff, but it was not effective and facility code was initiated. One nurse is positioned outside the wall; additional staff remain inside with the resident. The Resident #1 jumped over the wall to the outside of the wall to the outside area and began running off the facility grounds. Staff continued to redirect the Resident back to safety, but were unsuccessful. The resident's sister and provider were notified. Provider gave orders for Resident #1 to be sent to the hospital. With the help of 911, Resident #1 was taken to the facility and assessed, and no injuries were noted. Immediate action was taken, which included verbal redirection; the resident refused, the provider notified, and sent to the hospital for further evaluation, resident's sister was notified regarding the current status, 911 was called for assistance, and staff followed the resident while maintaining visual contact and redirection, and (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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-emergent medical transport to the hospital. Review of care plan revealed no updated care plan or any new interventions for the focused area for the risk of elopement related to a history of elopement before admission and during stay after the incident occurred on December 04, 2025, with Resident #1. Review of the Behavioral Care Plan revealed no evidence of an updated care plan after the incident occurred December 04, 2025. An Incident report dated December 07, 2025, revealed that the Resident #1 was observed to be restless and agitated, with continuing pacing in the hallway. The resident refused all medication, treatments, and vitals. The resident was entering the resident's rooms, entering the nurses' station, and going through the drawers. Resident #1 called 911 multiple times at the nurses' station. Redirection and distraction was unsuccessful, the guardian was notified, and the police arrived. At 08:22 am, resident exited the unit and exited the facility. The staff called 911, and Assistant Director of Nursing (ADON), Resident #1 had a large rock posturing and attempting to throw at the staff. The guardian was on the call during the event. Resident #1 is climbing the brick wall with a rock in his hand. The nurse and another staff present at all times when he proceeded to walk to the street. ADON and the police arrived, and police helped him to get back to the facility. The Resident was noted to have a scrape on the left wrist after climbing the brick wall. Per the Psych provider, an order was placed to receive psychiatric evaluation and stabilization at the medical center. The guardian agreed to this and was transferred. The immediate action taken section of the incident report was the same as the nursing descriptions. Review of care plan revealed no updated care plan or any new interventions for the focused area for the risk of elopement related to a history of elopement before admission and during stay after the incident occurred on December 07, 2025, with Resident #1. Review of the Behavioral Care Plan revealed no evidence of an updated care plan after the incident occurred December 04, 2025. Review of the elopement care plan revealed no new interventions to prevent resident elopement after the incident happened on December 07, 2025, for Resident #1. A Discharge summary dated [DATE], at 12:58 AM revealed that at Resident #1 made his way outside by holding the exit door onto the patio. Resident #1 was able to climb over the fence and jump. It was unknown if the patient hit his head. Staff went outside and called 911 for assistance. The resident did return back inside the facility, and then later he exited the patio. American Medical Response (AMR) was called as directed by the Director of Nursing (DON) to send the resident out for assessment. Resident #1 was made aware of the issue. An interview was conducted on February 23, 2026, at 2:05 PM with a Certified Nursing Assistant (CNA/staff #6), who stated that they know if the resident wanders or is at risk of elopement by their attitude and behaviors, such as wandering up and down the halls. Staff #6 stated that they ensure residents' safety when they are an elopement risk by keeping an eye on them at all times. The CNA stated that some of the interventions that are used to ensure safety would include redirecting the resident, keeping a close eye on them, monitoring their movements, and staff will document. The CNA further stated that most of the residents are strong, and they push the exit door. She stated she does not handle care plans and would not know new interventions would be placed after the resident leaves the facility. She stated that if current interventions are not effective, the care plan should be changed and updated. Staff #6 stated that Resident #1 tried to elope, but the staff member was present with Resident #1 when she tried to leave. The staff member #6 stated she does not remember a date for when he tried to leave. She stated they do not hold residents because they can not restrain them; they just redirect the resident to return to the facility if they see them leaving. An interview was conducted on February 23, 2025, at 2:21 PM with a Licensed Practical Nurse (LPN/staff #9), who stated that as nurses do not create the care plans; the ADON and DON are the ones who update the care plans and put interventions. She stated that other (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	departments participate in care plans and they review the care plan with behaviors, and ensure the care plan is followed at all times. Further stated that she can suggest interventions for the resident if one intervention is not effective to the DON or ADON. The LPN stated she knows if the resident is an elopement by looking over the care plan. She stated that residents with behavior are already at elopement risk, and are treated as an elopement risk. Staff #9 stated that she always checks on the residents, each employee is parked around the building in case the resident tries to leave, so they can easily notify, and do continuous rounding. An interview was conducted on February 23, 2025, at 2:40 PM with the DON (Staff #5), who stated that elopement is when the facility does not know where a resident is, or we lose sight of the resident. She stated that when elopement happens in the facility, staff start to search for the resident inside and on the grounds of the facility, and expand as they need to, notify the police department, provider, and Power of Attorney (POA), or their emergency contact. She stated that when a resident is found and returned to the facility, they assess the resident for the injuries. She stated that all the Residents get screened for elopement upon admission, quarterly, or as needed. She stated Resident #1 has climbed the fence three times. To ensure the safety of Resident #1, they sent him to the hospital after the first incident on December 04, 2025, and stated that it is not reflected on the care plan as one of the interventions. She also stated that when resident #1 came back, there were no other interventions placed and no change in medication. Staff #5 stated that the same event occurred on December 07, 2024, where Resident #1 was sent to the hospital and was seen by a psych provider. She stated that these interventions were not reflected in the care plan either. On December 26, 2025 the resident climbed the fence with the supervision of staff and was sent to the hospital, but did not return to the facility. She stated the interventions should have been implemented in the care plan, and she stated someone should have looked into and put them in there, but it was not there. She stated that care plan not being updated can risk a resident not getting proper care. The facility policy titled Care Plans, Comprehensive Person-Centered, last revised March 2022, revealed a comprehensive, person-centered care plan should include measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs, is developed and implemented for each resident. Care plan interventions are chosen only after data gathering, proper sequencing of the events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision-making. The interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident's conditions and the desired outcome is not met.