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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035175	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER Desert Peak Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - 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, resident and staff interviews, and policy review, the facility failed to ensure that 2 of 34 sampled residents (#84 and #75) were free from physical or verbal abuse from other residents (#39 and #37). The deficient practice could result in residents being physically and emotionally harmed. Findings Include: -Regarding Resident #84: Resident #84 (alleged victim) was admitted to the facility on [DATE], with diagnoses of borderline personality disorder, other schizophrenia, major depressive disorder, generalized anxiety disorder, personal history of traumatic brain injury, and chronic pain syndrome. The clinical record revealed documentations that decisions and consent were made by the resident's legal guardian/Brother. A quarterly minimum data set (MDS) dated [DATE] revealed that Resident #84 had a BIMS (brief interview of mental status) score of 15, indicating intact cognition. A behavior assessment was completed on April 15, 2026, which revealed that Resident #84 displayed behaviors that included agitation/aggression, yelling/screaming/cursing/ abrasive tone, and threatening others. A care plan dated April 15, 2026 revealed Resident #84 received physical aggression from another resident. Interventions included residents were separated immediately, Resident #84 was sent to acute care hospital for evaluation, 15-minute checks upon return from acute care setting, monitor for emotional upset and encouragement to continue with normal routine, a referral was to be sent for counseling services with a tentative start date the week of April 20, 2026 and skin checks immediately and for 3 days with a report of abnormal findings to the MD (medical doctor). An incident note dated April 15, 2026 revealed that an incident occurred in the dining room while the residents were eating dinner. The incident note indicated that Resident #84 was verbally insulting another resident, Resident #39, who then told Resident #84 not to talk to him. Resident #84 asked Resident #39 what he was going to do about it, approaching him, and then Resident #39 hit Resident #84 in his left eye. It was documented that Resident #84 stated that Resident #39 told him not to talk to him, then stood up and pushed the table and hit him. The incident note stated that Resident #84 went to his room, vitals were initiated, skin assessment completed and PERRL (Pupils are Equal, (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 0600 Level of Harm - Actual harm Residents Affected - Few	Round, and Reactive to Light). It was documented that the resident complained of pain at the site where he was struck. An incident note dated April 15, 2026 revealed that Phoenix PD (Police Department) was notified at 5:40PM. An officer responded to the complaint. The medical provider and psychiatric provider were notified at approximately 6:00PM. An online APS report was completed at 7:03PM. The case manager was notified via email at 7:27PM. The Ombudsman notified via email at 7:29PM. Review of Resident #84's order summary revealed that an order was placed on April 15, 2026 for transfer to Banner University for a 1-day follow-up care from incident. A nurse's note dated April 15, 2026 revealed that Resident #84 was picked up via AMR (American Medical Response) non-emergent transport and transferred to Banner University Medical Center on a stretcher. Transfer was initiated due to a physical altercation in which the resident sustained an assault to the left eye. It was documented that the resident complained of nausea with no episodes of vomiting observed. PRN (pro re nata – as needed) Zofran was administered, along with all scheduled medications, prior to departure to the hospital. Resident #84 was documented as stable at time of transfer. POA (Power of Attorney) and facility management were notified of transfer. A behavior note dated April 15, 2026 revealed that Resident #84 exhibited argumentative and verbally aggressive behavior toward CNA (Certified Nursing Assistant) staff during care. It was documented that Resident #84 was heard yelling at staff and making insulting remarks, stating they are the worst CNAs he has ever had. The resident was also noted to be condescending, frequently instructing CNAs on how to perform their assigned tasks. Additionally, it was noted that the resident was observed yelling out loudly instead of utilizing the call light appropriately. The note further revealed that when the call light was used, the resident repeatedly pressed it despite needs already being addressed. It was documented that staff attempted redirection and provided reassurance; however, the behavior was noted to have persisted throughout the shift until resident was picked up by AMR for transport to the hospital. A nurse's note dated April 16, 2026 revealed that the facility was informed that a scan showed a hemorrhage and fracture to the left socket and that Resident #84 was still awaiting labs and would be admitted . A nurse's note dated April 16, 2026 revealed that the facility was informed that the resident was clear to return. No new medications were ordered. Findings were a fracture in the orbital wall with a bulbar hemorrhage. A nurse's note dated April 16, 2026 revealed that Resident #84 had returned from the ER (Emergency Room) visit at 05:57AM with findings of retrobulbar hemorrhage and fracture of the inferior orbital wall. The note revealed that the provider, facility management, and Resident #84's brother were notified and that vital signs were obtained upon return. The note further documented that no new orders were received at this time and that Resident #84 was to follow up with the specialist as recommended. The note revealed that the Plan of care was ongoing. A review of the hospital discharge instructions from the emergency department dated April 15, 2026, revealed that Resident #84 received a CT (Computed Tomography) Orbits without Intravenous contrast exam. It was documented that the impression of the exam revealed that Resident #84 had an acute left inferior orbital wall mildly displaced fracture and trace left retrobulbar hemorrhage (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A nurse's note dated April 16, 2026 revealed that Resident #84 did not want to eat in the unit dining room due to the incident on the previous day. Facility staff offered alternative dining options and Resident #84 was in agreement, but stated I am fasting, that's the only cure for sickness. A nurse's note dated April 16, 2026 revealed that Resident #84 remained in bed throughout the day and was offered the option to dine in an alternative dining area for both breakfast and lunch. The resident declined to get out of bed for both meals. He did consume his breakfast in his room. The resident reported having no appetite for lunch and requested that Ensure supplements be provided as a meal replacement until his appetite improves. Additionally, the resident requested that psychiatry be consulted regarding the possibility of initiating antidepressant therapy . A referral has also been placed with Behavioral Health Services (BHS) for counseling support. A care plan dated April 17, 2026 revealed Resident #84 has potential for impaired vision, pain, infection r/t left orbital fracture. Interventions included to encourage Resident #84 to avoid nose blowing and sneezing with mouth closed to prevent straining, monitor for edema, bleeding, pain, S/S infection, signs of vision loss and report abnormal findings to MD/NP, monitor for pain and administer analgesics as ordered, monitor for sudden pain or increase in vision loss which may indicate orbital compartment syndrome and notify MD/NP (Nurse Practitioner) of findings, schedule optometry visits per orders, and treat anxiety r/t orbital fracture as needed. Review of Resident #84's order summary revealed that an order was placed on April 17, 2026 for Hydrocodone-Acetaminophen Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen). Give 1 tablet by mouth every 4 hours as needed for pain 6-10. A skin assessment dated [DATE] revealed that the resident has bruising to his left eye. -Regarding Resident #39 Resident #39 (alleged perpetrator) was initially admitted to the facility on [DATE], and re-admitted on [DATE] with diagnoses that include intermittent explosive disorder, schizoaffective disorder bipolar type, and personality change due to known physiological condition. The clinical record revealed documentations that decisions and consent were made by the resident's responsible party/Father. A care plan entry dated September 30, 2022 with a revision of March 18, 2024 revealed a Focus area indicating that Resident #39 uses psychotropic medications r/t (related to) Behavior management, Disease process schizoaffective disorder; bipolar type with interventions including Administer psychotropic medications as ordered by physician and to monitor for side effects and effectiveness every shift . A care plan entry dated March 17, 2023 with a revision on March 18, 2024 revealed a Focus area indicating that Resident #39 has behavior problems with interventions including administration of medications as ordered and to monitor/document for side effects and effectiveness, anticipate and meet the resident's needs, and assist the resident to develop more appropriate methods of coping and interacting and to encourage the resident to express feelings appropriately. A care plan entry dated March 18, 2024 with a revision on November 26, 2024 revealed a Focus area indicating that Resident #39 uses a non-psychotropic medication for Intermittent explosive disorder (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A nurse's note dated April 16, 2026 revealed that Resident #39 was observed being picked up by two law enforcement officers at 6:42PM. Resident remained calm, cooperative, and compliant with all instructions given by officers, with no noted behavioral issues or resistance. Prior to departure, Resident #39 took all scheduled medications as prescribed without difficulty. No acute distress observed at time of transfer. An investigative interview provided by the facility on April 17, 2026 revealed that Staff #76 was sitting at the nurse's station when she heard a scream coming from the dining area. It was documented that when Staff #76 arrived in the dining area, she witnessed Resident #84 leaving the dining area and was on the phone, saying that he was calling the police. Staff #76 further stated, as documented, that Resident #39 was standing in a fighting stance, was easily redirected, and sat down to finish his dinner. Staff #76 notified the Assistant Director of Nursing (ADON), a skin assessment was performed, PERRL Staff #76 reported that Resident #84 only complained of pain on his left eye at the time and later complained of nausea/vomiting (N/V). It was documented that Staff #76 later notified family, psych, NP, and set up a non-emergent transfer to Banner University. An investigative interview provided by the facility on April 17, 2026 revealed that Staff #3/CNA (Certified Nursing Assistant) was a witness to the altercation on April, 15, 2026. It was documented that staff #3 reported that to his knowledge, Resident #84 was talking about his nightly routine before he goes to bed, when Resident #39 told him to shut up and he doesn't want to hear him speak. It was documented that staff #3 then reported that all of a sudden, Resident #39 jumped up, shoved the table out of the way, and 'socks' Resident #84 in the eye. It was further noted that staff #3 then reported that he wheeled Resident #84 from the dining room to Resident #84's room. An investigative interview provided by the facility on April 17, 2026 revealed that Staff #242/CNA had witnessed the event. It was documented that Staff #242 reported that Resident #39 asked Resident #84 not to talk to him. It was further documented that staff #242 further reported that Resident #84 continued to talk to Resident #39, and that's when Resident #39 got up from his table and went over to Resident #84's dinner table, shoved the table at him, then Resident #39 punched Resident #84 in the left eye. It was documented that Staff #242 then was reported to have gotten up to try and get Resident #39 to focus on her while the other staff member (Staff #3) took Resident #84 out of the dining room. An investigative interview of Resident #39 was provided by the facility on April 17, 2026, where it was revealed that Resident #39 told Resident #84 not to talk to him, Resident #39 said that Resident #84 would not stop talking, Resident #39 then said that he stood up and pushed the table and hit Resident #84. An investigative interview of Resident #84 was provided by the facility on April 17, 2026, where it was revealed that Resident #39 told Resident #84 don't talk to me, Resident #84 states that he was not talking, and Resident #39 stood up, pushed the table, and hit Resident #84. A phone interview was conducted with Staff #76 on April 17, 2026 at approximately 11:00AM . During the interview, Staff #76 reported that she was not in the dining area when the incident occurred and that she entered the area after the incident. She stated that she had been at the nurse's station. She stated that she heard a loud yell coming from the dining room. She stated that she observed Resident #84 wheeling himself out and that she saw Resident #39 facing another resident. Staff #76 further stated that after Resident #39 sat down, she found out Resident # 39 had struck Resident #84. She stated that she did a full assessment. Staff #76 stated that resident #39 declined to go to the hospital (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	initially, but changed his mind. Staff #76 was able to redirect Resident #39. Staff #76 further stated that there had been no issues between the two residents prior to the event, and was not aware of any inappropriate behaviors from Resident #39 prior to the event. Additionally, Staff #76 stated that she reported the event and that the police were notified. Staff #76 was asked if anyone had witnessed the event happen and she reported that two staff members, Staff #3 and Staff #242 had witnessed the event . A phone interview was conducted with Staff #242 on April 17, 2026 at approximately 1:48 PM. During the interview, Staff #242 reported that during dinner time, Resident #39 had asked Resident #84 not to speak to him. She stated that Resident #84 asked what did he do, and Resident #39 shoved the table. Staff #242 reported that Resident #39 told Resident #84 not to talk to him again. Staff #242 then stated that Resident #84 responded with something and that was when Resident #39 hit Resident #84. Staff #242 stated that she was helping feed a resident and got up and told Resident #39 to focus on the staff. Staff #242 reported that it happened so quick and the other staff member (Staff #3) removed Resident #84 from the dining room. Staff #242 then revealed that she had witnessed Resident #39 strike Resident #84 once on the left side of his face with a closed, right fist. Staff #242 additionally revealed that there was a red mark and that you could obviously tell he had been hit. Staff #242 stated that Resident #39 was eating his dinner and was calm and that two other residents were talking about something sexual. She stated that she told the two other residents to stop because it could offend other people. She stated that after some time went by, she was helping a resident and that she witnessed resident #39 telling resident #84 not to talk to him again. She stated that that Resident #84 said something and then Resident #39 shoved the table. Resident #84 answered back something else and that's when Resident #39 struck him. Staff #242 then stated that Resident #39 did not exhibit any inappropriate behaviors toward resident #84 or other residents prior to the event, she reported the event to the nurse on shift, and had stayed with Resident #39 while he ate. A phone interview was conducted with the Responsible Party/Father (RP) of Resident #39 on April 17, 2026 at 8:53AM. RP reported that he understands that Resident #39 had an altercation with another resident and that the facility had informed him of the altercation. RP had reported that the facility said that Resident #39 punched another guy. RP reported that Resident #39 said that there was another guy tickling him and other people . RP then stated that he started in on Resident #39 and Resident #39 told him to quit and he wouldn't, so Resident #39 punched him. RP went on to say that the guy (Resident #84) wouldn't let up from what he understood. RP then continued to say that he's not saying he deserved it, and that he was pretty sure this is the first time Resident #39 hit someone. RP went on to say that Resident #39 is no longer at the facility and he was taken somewhere to get a closer observation called UPC, and when he talked to Resident #39, he was not upset at all and stated that he was obedient. An interview was conducted with Resident #84 on April 17, 2026 at 9:17 AM in the resident's room. Resident #84 reported that he was telling Resident #39 about a video game and that if he has $15, then he can play it. Resident #84 stated that Resident #39 said don't talk to me, then pushed the table and punched him right in the eyeball. Resident #84 further stated that he got punched like a truck and that Staff #242 witnessed the whole thing. He stated that it happened in the dining room. Resident #84 stated that Resident #39 was eating his food and he snapped and then hit him. Resident #84 then reported that staff brought him to his room, he felt nauseous, and went to the hospital. Resident #84 then identified Resident #39's first name as the resident who struck him. Resident #84 then reported that he called 911 and that he got skeletal damage and blood in the back of his eye from the attack. Resident #84 continued to state that he never had a problem with Resident #39. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON/Staff #151) on April 17, 2026 at 11:17 AM. Staff #151 defined resident to resident abuse as directed verbal altercation or directed physical altercation and any altercation directed towards another resident. Staff #151 then stated that there had been a resident to resident abuse in the facility about two days prior. Staff #151 stated that she was notified that Resident #39 and Resident #84 were in the dining room, Resident #39 got up and struck Resident #84, that the event was witnessed, and that contact was confirmed by both residents. Staff #151 continued that the residents were separated, Resident #84 went to his room. Resident #39 went to his room. She stated that a 1:1 was placed with Resident #39 and the residents were kept separated. She stated that Resident #84 was placed on 15-minute checks and Resident #39 was placed on 1 to 1 supervision. Staff #151 further stated that Resident #84 agreed transfer to the hospital and returned back to the facility. She stated after the resident was back from the hospital the resident didn't want to go back to the dining room. Staff #151 further stated that he was offered to go to another dining room. She stated that an emergent petition was filed on Resident #39, it was accepted and resident #39 was transferred to get him evaluated. Staff #151 stated that there was bruising on the left eye, and an orbital fracture for resident #84. Staff #151 stated regarding their internal investigation, that there is no denying this one. She stated that she had a staff member in the dining room helping another resident eat, but it happened so fast . An interview was conducted with the Administrator (Staff #241) on April 17, 2026 at 11:42 AM. Staff #241 defined abuse, as physical contact between two residents or potentially a staff member and a resident. Staff #241 stated that resident to resident abuse, would be if one of the facility's residents abused another one of the residents. Staff #241 stated that the most recent abuse that had occurred was on Wednesday, April 15, 2026. Staff #241 stated that as a result of what he learned from the investigation Resident #39 hit Resident #84 while they were on the unit, more specifically the dining room. Staff #241 stated that there was a resulting injury to the left side of Resident #84's face. Staff #241 stated that the result of his investigation was, sending Resident #84 out, to get him checked out. He further stated that there was an injury to the orbital, but they said he could be treated at the facility. He stated that he had been told that it was a fracture. He further stated that he talked to Resident #39 a couple of times. He stated that there is no doubt that Resident #39 hit Resident #84. Staff #241 stated, there were witnesses. He further stated that iIt will be verified by the facility when the 5-day investigation is submitted. -Regarding Resident #75 Resident #75 was admitted to the facility on [DATE], with diagnoses that included schizophrenia, fracture of the lower leg, bipolar disorder, chronic obstructive pulmonary disease, anxiety disorder, type 2 diabetes, asthma, hypertension, intellectual disabilities, nicotine dependence, and obesity. A behavioral care plan dated March 23, 2026, revealed that the resident had verbal aggression towards others, and that she exhibited demanding behaviors with interventions to not provide requests when made in a demanding, rude, threatening, or aggressive manner. The behavioral care plan interventions further revealed that if the resident remained rude, threatening, or demanding, staff were to ensure safety and explain that they would return once she had calmed down. A Medicare 5-Day Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 09, which indicated moderately impaired cognition. A physician's order dated April 3, 2026, revealed safety checks every 15 minutes from April 4, 2026, until April 10, 2026. (continued on next page)

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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 - Actual harm Residents Affected - Few	A physician's order dated April 3, 2026, revealed safety checks every 15 minutes from April 4, 2025, until April 10, 2026. A behavior progress note dated April 3, 2026, at 10:22 p.m. revealed that the resident was at the nurses' station asking for a shower when another resident came and gave staff sodas. The note further revealed that another resident asked for a soda, and Resident #37 told her no. The note also revealed that the other resident called Resident #37 a fat b**** and to mind her own business. The note revealed that Resident #37 told the other resident to stop before she slapped her, and the other resident kept name-calling until Resident #37 jumped up and swung at the other resident. An incident progress note dated April 4, 2026, at 7:20 a.m. revealed that a police officer arrived at the unit at 6:46 a.m. Review of a facility investigation dated April 8, 2026, revealed that on April 3, 2026, at approximately 5:35 p.m., it was reported that Resident #37 and Resident #75 were at the nurses' station engaged in a verbal argument over a soda when both residents stood up from their wheelchairs and approached each other. The Facility investigation further revealed that Resident #37 swung her arm at Resident #75, and staff intervened and separated the residents. The facility investigation also revealed that a skin assessment was completed for Resident #75 at the time of the incident, and there was no injury, redness, trauma, or swelling noted. The facility investigation revealed that a female peer, Resident #38, was in the area during the time of the incident and stated that she saw Resident #37 swing her arm, but did not witness any physical contact between the two residents. The facility investigation further revealed that statements were taken from staff who were present at the time of the incident, and that they reported they did not witness any physical contact, however, there was a verbal argument between the residents. The facility investigation also revealed that Resident #37 was interviewed after the incident and stated that there was a verbal interaction between the two residents over a soda, and that she stood up from her chair, but that was it. The facility investigation revealed that Resident #75 was interviewed after the incident and stated that there was a verbal interaction between the two of them, and that Resident #37 swung at her. The facility investigation revealed that the facility was unable to determine if physical contact was made between the residents. The self-report further revealed that Resident #75 complained of pain to her chin after the incident occurred, with a skin assessment noting no injuries, trauma, or swelling. The facility investigation revealed a typed statement from Resident #75, dated April 7th, 2026, that revealed she asked for a soda, and Resident #37 told her no. The typed statement from Resident #75 further revealed that they continued to argue, Resident #37 stood up from her chair, and swung her arm at Resident #75 before staff separated them from each other. The facility investigation revealed a typed statement from Resident #37, dated April 7th, 2026, that revealed that they got into a verbal argument because Resident #75 wanted Resident #37's soda, and that Resident #37 told her that she was not going to spend her money on a soda for Resident #75. The typed statement further revealed that Resident #75 said some things that were not very nice before Resident #37 stood up out of her