

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
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 07/14/2026
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 - 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, staff interviews, facility documentation, policies and procedures, the facility failed to protect the rights of two residents (#63 and #69) to be free from abuse from each other. The deficient practice could result in further abuse of residents. Findings include--Regarding Resident #63 Resident #63 was admitted to the facility on [DATE], with diagnoses of bipolar disorder, major depressive disorder, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, dementia with other behavioral disturbances, mood disorder, and other comorbid conditions. At the time of the investigation, Resident #63 remained at the facility. The Minimum Data Set (MDS) dated [DATE], indicated that Resident #63 had a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment, impairments in both upper and lower extremities, and was dependent on staff for activities of daily living, including wheelchair mobility and transfers from chair to bed. A behavioral treatment plan dated May 6, 2026, indicated that Resident #63 used racial slurs, cursed, and exhibited verbally aggressive behavior during periods of frustration, anger, confusion, overstimulation, or difficulty communicating his needs appropriately. The behavioral treatment plan directed staff to respond in a calm, natural, and professional manner while maintaining clear boundaries regarding respectful communication. The plan further indicated that the resident required periods of isolation and instructed staff to provide regular supportive check-ins while encouraging participation in activities, meals, and social interactions in a calm, non-pressuring manner that respected Resident #63's need for personal space.-Regarding Resident #69 Resident #69 was admitted to the facility on [DATE], with pertinent diagnoses of dementia with agitation, depression, epilepsy, chronic pain, and other comorbid conditions. At the time of the investigation, Resident #69 remained at the facility. A review of Resident #69's MDS assessment dated [DATE], indicated that Resident #69 had a BIMS score of 12 indicating moderate cognitive impairment. The MDS also exhibited physical behavioral symptoms directed toward others for three days and other behavioral symptoms not directed toward others for four to six days. The assessment further indicated that these behaviors placed others at significant risk of physical injury. A behavioral care plan revised on June 18, 2026, identified behavioral problems related to dementia with agitation, with goals that included timely staff intervention to protect others and monitoring for episodes of physical aggression. A review of Resident #69's cognition care plan indicated that he had impaired cognitive function and impaired thought processes related to dementia with agitation. Interventions included monitoring for changes in cognitive function, decision-making ability, recall, general awareness, level of consciousness, and mental status. A review of a nursing note dated June 28, 2026, at 11:00 a.m., documented by Staff Nurse #29, indicated that while she was in Resident #69's room, she heard Resident #63 yelling and using profanity and racial slurs from his room. According to the nursing note, (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 - Minimal harm or potential for actual harm Residents Affected - Few	Resident #69 stated to Staff #29 that Resident #63 should not be yelling and using that kind of language in the house. Staff #29 redirected Resident #69; however, Resident #69 exited his room and attempted to confront Resident #63 in the hallway. Staff #29 intervened and separated the two residents, redirecting Resident #69 to the dining hall. The nursing note further documented that a few minutes later, Resident #69 approached Staff #29 at the nursing station requesting juice. While Staff #29 went behind the nursing station to retrieve the juice, Resident #69 ran down the hallway toward Resident #63's room. Staff #29 and Staff #5 ran after Resident #69. The nursing note stated that Staff #5 reached Resident #63's room first and removed Resident #69 from the room. Staff #29 subsequently escorted Resident #69 to the day room. A subsequent nursing note documented by Staff Nurse #5 on June 28, 2026, at 3:09 p.m., indicated that Staff #5 accompanied Staff #29 when Resident #69 headed toward Resident #63's room. Staff #5 documented that he was unable to intercept Resident #69 before he entered the room. Staff #5 stated that upon arriving at the doorway, he observed Resident #63 seated in his wheelchair near his bed while Resident #69 stood next to him. He observed both residents slapping each other and immediately separated them while both residents were swearing and threatening one another. The nursing note further documented that Resident #69 repeatedly attempted to return to Resident #63's room. Staff redirected Resident #69 to another location and initiated 15-minute safety checks. An interview with Staff #29 was conducted on July 14, 2026, at 11:30 a.m. Staff #29 stated that she was in Resident #69's room preparing him for the day at approximately 11:00 a.m. on June 28, 2026. She stated that she heard Resident #63 yelling from the hallway outside his room. According to Staff #29, Resident #63 continued yelling profanity, including the words bitch, whore, and racial slurs while wheeling himself through the hallway. Staff #29 stated that Resident #69 got up, stepped out of his room, and told Resident #63, Hey, you can't call out names like that. Staff #29 stated that Resident #63 responded, I can say whatever the fuck I want to. Staff #29 reported that she attempted to distract and redirect Resident #69 to the dining room while a certified nursing assistant (CNA) took Resident #63 to his room and reassured him that he would be assisted back to bed after lunch. Staff #29 stated that Resident #63 had recently returned from dialysis and wanted assistance transferring from his wheelchair to his bed. Staff #29 further stated that after the situation had initially settled, Resident #69 approached the nursing station a few minutes later requesting a drink. Staff #29 provided the drink, and while she returned to the nursing desk, Resident #63 again began yelling, cursing, and screaming from his room. According to Staff #29, Resident #69 placed his drink down and ran into Resident #63's room. Staff #05 also attempted to stop Resident #69 but was unable to prevent him from entering the room. Staff #29 stated that she heard sounds of hitting but could not see the interaction. At this time, Staff #5 was inside the room separating the residents. Staff #29 then escorted Resident #69 to the dining hall for lunch, and Resident #69 complied with her directions. Staff #29 stated that she later returned to check on Resident #63; however, Resident #63 continued yelling and directing racial slurs toward her, so Staff #29 left the room while a CNA remained with Resident #63. Staff #29 further stated that Resident #69 was new to the facility and reacted very quickly to the yelling and profanity, making the incident occur rapidly despite her attempts to intervene. A subsequent interview with Staff #5 was conducted on July 14, 2026, at 12:00 p.m. Staff #5 recalled that during the incident, Resident #63 was yelling continuously and swearing from his room. He stated that Resident #63 had recently returned from dialysis and wanted to go to bed. According to Staff #5, Resident #63 was waiting for staff assistance with a transfer from his wheelchair to his bed because the CNAs had not yet responded. Staff #5 could not recall the reason for the delay in CNA response. Staff #5 stated that while he was in the hallway with Staff #29, he observed Resident #69 ran toward Resident #63's room. Staff #5 stated (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that he attempted to catch up to Resident #69 but was unable to reach him before he entered the room. Upon entering the room, Staff #5 observed Resident #69 standing next to Resident #63 while both residents were pushing, slapping, yelling, and threatening each other. Staff #5 stated that he separated the residents and reiterated that Resident #69 continued attempting to return to Resident #63 later that day. An interview with the Assistant Director of Nursing Services (ADON), Staff #11, was conducted on July 14, 2026, at 12:40 p.m. Staff #11 stated that she became aware of the resident-to-resident altercation through a report from the nursing staff on the unit. She stated that she immediately reported the incident to the Administrator, relocated Resident #69 to another area of the facility, and later moved Resident #63 to a different hallway away from Resident #69. Staff #11 further stated that the facility reported the incident to the appropriate authorities within the required timeframe and conducted a self-reported investigation. During interviews, staff consistently stated that hitting another resident, striking the head, slapping, using profanity, and making threats constituted examples of physical and verbal abuse. A review of the facility policy titled Abuse Policy, revised July 2017, revealed that the facility was committed to preventing and prohibiting all forms of abuse and neglect. The policy stated that the facility was responsible for establishing a safe environment by identifying, correcting, and intervening in situations in which abuse was more likely to occur. The policy further required ongoing staff education and orientation addressing abuse prevention, identification and reporting of abuse, stress management, and management of verbally or physically aggressive resident behavior. In addition, the policy emphasized maintaining sufficient staffing levels to meet residents' needs and ensuring that assigned staff were knowledgeable regarding each resident's care needs and behavioral symptoms.		