

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

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, and staff interviews, the facility failed to ensure one Resident (#88) out of one sampled residents were assessed and care planned for the ability to self-administer medications to include tube-feedings. The universe was 157. The deficient practice could result in incorrect administration of tube feedings, leading to aspiration, choking, severe infections, nutritional mismanagement, and tube clogging. Findings include: Resident #88 was re-admitted on [DATE] with diagnoses of intracranial injury with loss of consciousness of unspecified duration, traumatic brain injury, persistent mood disorder, dysphagia, hypertension, anxiety, gastrostomy, hyperglyceridemia, hyperglycemia, suicidal ideations, depression, and other mood disorder due to known physiological condition. A review of the Self-administration of Medication assessment for Resident #88, completed on March 10, 2026, revealed that resident was fully capable of self-administering eye drops, ear drops, topical creams and ointments. However, the assessment did not include assessment of self administering tube feeding. The clinical record revealed a physician order dated, March 30, 2026, for nothing by mouth (NPO), enteral feed every shift and to record residuals every shift, to check tube placement before initiation of formula, medication administration, and flushing of tube. An additional order revealed that the resident may self-administer tube feeding dated April 8, 2026. The Care plan revised on February 19, 2026 included that the resident is at nutritional risk r/t inadequate oral intake, NPO status, need for EN (Enteral Nutrition) to meet nutritional needs. Goal included that the resident will maintain adequate nutrition and hydration via tube feed and the resident will have no unplanned significant weight changes through next review. The Care plan did not reveal the resident ability to self administer tube feeding. An interview was conducted with Resident #88 on April 14, 2026 at 9:32 AM; the Resident stated that he has tube feeding and that he self-administers his own tube feeding. The Resident stated that he informs staff of any discomfort with his tube feeding site, and that he recently was hospitalized for the dislodging of his tube. The Resident stated that he always administers his own tube feeding. On April 17, 2026 at 8:11 AM, an interview was conducted with Staff #47, a certified nursing assistant (CNA) for Resident #88, who stated that the Resident is NPO and minimal care. She stated that the Resident informs staff of any needed assistance and informs them of his emotions and needs. Staff #47 stated that she had observed the Resident herself administering his own tube- feeding and that she knew the Resident had a physician order to self administer his tube feedings. An interview was conducted with Staff #232, Licensed Practical Nurse (LPN), on April 17, 2026 8:13 AM. Staff #232 stated that Resident #88 administers his own tube feeding, and that there is an order for his self-administration. Staff #232 stated that she does not personally supervise the Resident administering his tube feeding, and that the Assistant Director of Nursing (ADON) reviews resident's orders. Staff #232 does not have any concerns regarding the Resident's tube feeding. An interview was conducted with Staff #156, Assistant Director of Nursing (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(ADON), on April 17, 2026 8:16 AM, who stated that she reviews and follows-up on assessments for residents, pertaining to self-administrating medications. She stated that she only knows of Resident #88 being able to self-administer medication and that there is a physician order for it. Staff #156 stated that she completed the self-administration assessment on Resident #88 herself, and this was done by showing the Resident how to administer the tube feeding and to educate him on site cleaning, tube position, and how to administer tube feeding. The ADON had the Resident teach and show the process back to her. She stated that the order should be in the electronic medical records. The ADON stated that the process to assess a resident for self-administration is to have a physician's order for the particular medication, then conduct an assessment and document it. The ADON then provided documentation on the electronic health records to show a completed self-administration of medication assessment, although the document revealed no documentation for tube-feeding specifically for Resident #88. The ADON stated that the assessment did not include tube feeding specifically, but that it should have included tube-feeding specifically. She stated that without the documentation on an assessment for tube-feeding, this can put the Resident at risk for incorrectly self-administrating the medication, risk for infection, malnutrition, and improperly flushing of the tube. An interview was conducted with Staff #151, Director of Nursing (DON), on April 17, 2026 at 8:33 AM. The DON stated an assessment is conducted by the facility for self-administering medication by asking the resident if they know what the medication is for, how often they are to be taking the medication, and if the resident is able to open any containers or packaging the medication arrives in. Staff #151 further stated that the assessment determines if a resident can appropriately self-administer, this is then sent to the provider for review and an order is created. She stated that this is documented in the electronic health record of the resident. The DON stated that the process to determine if a resident is able to appropriately administer medication is by observing the resident with training and education. She stated that this would then be reflected in the physician's orders and documented on the resident's care plan. The DON stated that tube feeding formula is considered a medication, and that Resident #88 does have a physician order but no assessment documented. The DON stated that the current assessment for self-administrating medication for Resident #88 does not include tube-feeding on the assessment. The DON stated that the risks for not conducting an assessment for the self-administrating includes the risk for infection, adverse reactions, taking too much or little medication, and that staff could make errors on the Resident's limitations for self-administrating medication. The facility's policy on self-administrating medications states that residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident; by assessing residents on their cognitive and physical abilities to administer medications, and if it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **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 advance directives were accurate, consistent, and clearly defined in the medical record for 1 of 30 sampled residents (#8). The deficient practice could result in residents not receiving proper care according to their preferences or potential harm to the resident's life. Findings include: Resident #8 was readmitted to the facility on [DATE], with diagnoses that included dementia, schizoaffective disorder (bipolar type), atherosclerotic heart disease, type 2 diabetes, hypertension, hypothyroidism, gastro-esophageal reflux disease, cataracts, nicotine dependence, insomnia, muscle weakness, chronic obstructive pulmonary disease, edema, extrapyramidal and movement disorder, and hyperlipidemia. A signed advance directive statement form in Resident #8's Electronic Health Record (EHR) dated [DATE], revealed that the resident had a full code status, meaning that the resident, legal guardian, health care proxy, or representative (sponsor) has directed that cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used. A physician's order for 'full code' was initiated on [DATE]. A care plan focus revised on [DATE], revealed that the resident was a full code, and her wishes would be communicated and followed. A Quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. A signed advance directive statement form and orange sheet in Resident #8's Electronic Health Record (EHR) dated [DATE], revealed that the resident had a Do not Resuscitate (DNR) code status, meaning that the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used. A physician's progress note dated [DATE], at 2:44 p.m. revealed that the resident was a 'full code' status. A physician's order for 'DNR' was initiated on [DATE], however, the advance directive statement was initiated and signed on [DATE]. A care plan focus revised on [DATE], revealed that the resident was a DNR, and her wishes would be communicated and followed, with interventions to not resuscitate her. An interview was conducted on [DATE], at 1:26 p.m. with a Certified Nursing Assistant (CNA/Staff#54) who stated that she would know a resident's code status, either full code or DNR, by looking at the Point of Care (POC) EHR that CNAs have access to. The CNA logged into the POC application and stated that Resident #8's code status was DNR. The CNA also opened the hard copy of Resident #8's advance directive and stated that the resident was a DNR with a signed form dated [DATE]. An interview was conducted on [DATE], at 1:28 p.m. with a Licensed Practical Nurse (LPN/Staff#164) who stated that he would know a resident's code status by looking in the advance directives binder at the nurses' station, and it would also appear in the EHR banner when the physician puts an order in for their code status. The LPN stated that if there was a change in a resident's code status during their stay at the facility, they would need to get an updated physician's order at the time of the form being signed and the directive being changed. The LPN stated that the importance of having the correct order from the physician is for documentation and confirmation from the provider. The LPN further stated that the risk of inconsistency regarding advance directives would be a potential delay in care or not honoring a resident's wishes. The LPN stated that Resident #8 had a DNR code status initiated on [DATE], and that the DNR form was signed on [DATE]. The LPN stated that prior to [DATE], there was an order for full code status that was initiated on [DATE], and that the DNR order was not entered timely into the medical record. An interview was conducted on [DATE], at 1:43 p.m. with a Director of Nursing (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(DON/Staff#151) who stated that a resident's code status is known because there is a physician's order put into the medical record, and that the order will show in the EHR banner for each resident. The DON stated that CNAs would see code status through the POC application and that advance directives should be documented in the care plan and uploaded into the EHR. The DON also stated that if there was a change in a resident's code status, the forms would need to be redone, and the nurse would be notified of the change so that the physician's order could be updated, and the new forms would be uploaded. The DON stated that Resident #8 now has a DNR code status that was signed and completed on [DATE], and that the physician's order for DNR was initiated on [DATE]. The DON further stated that prior to [DATE], the order was for a full code status initiated on [DATE], with the previous full code form initiated on [DATE]. The DON stated that Resident #8's code status change was not communicated by medical records to the nurse manager, so the order was never changed in the record. The DON further stated that it did not meet her expectation, and that she would expect that whoever got the form signed would take the form to the nurse to update the order promptly. The DON stated that the risk of not having the correct advance directives order would be that they could inadvertently perform, or not perform, CPR in an emergency, which could potentially cause harm, and they would not be following the resident's wishes. Review of policy titled, Advance Directives, was revised in [DATE] and revealed that the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. The policy also revealed that advance directives were honored in accordance with state law and facility policy. The policy revealed that if a resident has an advance directive, the director of nursing services (DNS) or designee notifies the attending physician of advance directives, or changes in advance directives, so that the appropriate orders can be documented in the resident's medical record and plan of care. The policy also revealed that changes or revocations of a directive must be submitted in writing to the administrator, and that residents would not be treated against their own wishes.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of clinical record, and review of facility policy and procedure, the facility failed to ensure medications were not left at the bedside for two residents (Resident #94 and Resident #73) out of 30 sampled residents. The universe was 149. The deficient practice could increase the likelihood of medication overdose and residents having unrestricted access to medications. Findings include: Regarding Resident 73: Resident #73 was admitted on [DATE] with diagnoses that included hyperlipidemia, bipolar disorder, stage-2 chronic kidney disease, essential (primary) hypertension, obsessive-compulsive personality disorder, bilateral primary osteoarthritis of hip, dementia in other diseases classified elsewhere, muscle wasting and atrophy, unsteadiness on feet, myalgia, patient's other noncompliance with medication regimen for other reason, dysphagia, unknown psychosis, and senile degeneration of the brain. A review of the MDS (minimum data set) dated March 3, 2026, revealed a BIMS (brief interview for mental status) score of 12, which indicated resident #73 had moderate cognitive impairment. A review of the physician orders revealed no evidence of an order for medication self-administration. Physician orders revealed an order dated March 4, 2026 for medicated menthol-zinc oxide cream for resident #73. A review of the care plan revealed no evidence that the resident was authorized to self-administer medications. A review of IDT (interdisciplinary team) notes revealed no evidence that the resident was authorized to self-administer medications. A review of assessments within the electronic health record revealed no evidence that resident #73 was assessed to self-administer medications. During an initial observation of the resident's room on April 14, 2026 around 10:10 am, a tube of zinc oxide cream with approximately 50% of its content remaining was observed to be present on the resident's bedside table. The resident was not present at the time. Following the observation, an interview was conducted with a Licensed Practical Nurse (LPN/staff #236). Staff #236 identified the tube of cream as being medicated zinc oxide cream. Staff #236 stated that the cream should have been discarded, and not left at the resident's bedside. Staff #236 stated that the potential harm associated with leaving medication at a resident's beside is that a resident could ingest the cream or put it on themselves and that poison control would have to be contacted if a (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident consumed the zinc oxide cream. Following the interview, staff #236 was observed removing the cream from the resident's bedside and room. An interview was conducted on April 14, 2026 at 10:17 a.m. with certified nursing assistant (CNA/staff #186) who stated that the facility policy does not permit for medications to be left at a resident's bedside. Staff #186 advised that if she were to find a medication left at a resident's bedside, she would let a nurse know. Staff #186 stated that potential outcomes of leaving medications at the bedside is that another resident could get to the medication, or a resident would not take the medication and they were not observed taking the medication. An interview was conducted at the facility with the Director of Nursing (DON/staff #151) on April 16, 2026. Staff #151 stated that leaving a medication at a resident's bedside should not happen, that it is not compliant with the facility policy, and could result in the resident not taking the medication as needed or another resident accidentally taking the medication. Staff #151 stated that her expectation for how facility staff should handle medications found at a resident's bedside is that they should remove the medications from the resident's room and hand them over to a member of the nursing team. Staff #151 stated that in order for a resident to self-administer medications, a self-medication administration assessment must occur. If the assessment concluded the resident is safe to self-administer medications, the physician would be contacted for orders to self-administer. If the resident was assessed to not be safe to self-administer, the resident would be educated as to why they are unable to do so. Staff #151 then pulled up the orders for resident #73 and verified that the resident did not have orders to self-administer medications and that no progress notes or documentation was present that would indicate the resident was able to have medications left at the bedside. Staff #151 advised that if resident #73 was able to self-administer medications, documentation would be present in their care plan. Staff #151 stated that medications being left at a resident's bedside without orders to self-administer does not meet facility expectations. -Regarding Resident #94: Resident was re-admitted to the facility on [DATE] with diagnoses that included paraplegia, unspecified, unspecified open wound of abdominal quadrant without penetration into peritoneal cavity, sequela, and unspecified open wound, left lower leg, sequela. Review of a patient discharge instructions dated February 11, 2026 regarding a previous hospital stay revealed a new medication order for Silver Sulfadiazine topical (Silvadene 1 percent topical cream) to apply topically once a day for fourteen days. Review of the baseline care plan initiated on March 26, 2026 revealed a focus indicating Resident #94 was at risk for skin issues and pressure ulcers with interventions that included to administer treatments as ordered. There was no evidence within the care plan that indicated Resident #94 was authorized to self-administer medications. Review of the admission minimum data set (MDS) dated [DATE] revealed Resident #94 had a brief interview for mental status (BIMS) score of 15, indicating the resident was cognitively intact. Review of the MDS revealed Resident #94 had impairments on both lower extremities and was dependent on (continued on next page)		

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