STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035176	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beatitudes Campus	1712 West Glendale Avenue Phoenix, AZ 85021

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure that an allegation of abuse for one resident (#34) was reported to the State Agency. Findings include: Resident #34 was admitted to the facility on [DATE] with diagnoses that included dementia, epilepsy, and major depressive disorder. Review of the Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Review of the facility's grievances revealed a grievance filed which indicated that Resident #34 had reported to a nurse on May 14, 2025 that a Certified Nursing Assistant (CNA) had pulled her hair while caring for her. The grievance indicated that Resident #34 did not know why it had happened. This grievance form indicated that an investigation was initiated and that the allegation was reported to the appropriate parties, including the State Agency. This grievance was marked as resolved on May 19, 2025. A nursing progress note dated May 15, 2025 revealed that the resident was provided care with two staff members on this date. The note detailed that no behaviors were noted and no concerns were voiced by the resident. Further review of the progress notes revealed a progress note, dated May 16, 2025, which indicated that an Adult Protective Services (APS) worker was at the facility due to Resident #34's report. There was no evidence found in the progress notes to indicate that any allegations or reports were made on behalf of Resident #34, nor any details about the situation. On May 19, 2025 at approximately 2:15PM, a list of the facility's self-reported incidents within the last ninety days was requested. The Director of Nursing (DON/Staff #11) provided a statement, dated May 19, 2025, which revealed that the facility did not have any self-reports within the last three months. Later, on May 19, 2025 at 4:26PM, the [NAME] President of Health Services (VP/Staff #23) provided a statement which also indicated that the facility did not have any self-reports in the last ninety days. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of complaints and facility self-reports submitted to the state agency revealed no evidence that the facility had submitted a self-report for Resident #34's allegation of staff-to-resident abuse on or about May 14, 2025. Interview was conducted on May 20, 2025 at 10:18AM with a Social Worker (Staff #7), who stated that if she received a grievance relating to abuse, she would report it to the VP and DON to report and investigate. The Social Worker explained that since the VP was the abuse coordinator, she would take charge but would also delegate to the DON or to the Social Worker to investigate any allegations of abuse. The Social worker stated that typically, an abuse investigation would consist of interviewing the resident who made the allegation, other residents, and staff. When asked about the grievance filed by Resident #34, the social worker explained that the DON had obtained the initial report and filed the grievance for the resident. She further explained that the DON and Social Worker had jointly conducted the interviews to investigate the allegation. She stated that no residents that she interviewed had any concerns with their care or with staff. When asked where the investigation and results were documented, the Social Worker was unsure where the investigation was documented, but suggested that the VP would typically maintain a folder for investigations. Interview was conducted on May 20, 2025 at 10:27AM with the Director of Nursing (DON/Staff #11), who explained that she had submitted a self-report online to the state agency regarding Resident #34. She explained that she had submitted the report online on May 14, 2025 and followed the steps to verify her email, but had not heard back. The DON provided an email from the state agency, dated May 14, 2025 at 2:38PM, which instructed the user to click a link to verify the email address after a request of complaint submission by the facility tto show that the complaint had been received by the state agency. The email stated that once the email address was verified, the complaint would be submitted to the state agency for review. The DON stated that she had clicked the link as instructed. The DON did not provide any further documentation to show that the complaint had been finalized and submitted. Follow-up interview was conducted on May 20, 2025 at 10:38AM with the Director of Nursing (DON/Staff #11), who stated that she would expect any allegations of abuse, which included sexual, physical, emotional, and mental abuse, to be reported to the abuse coordinator right away. She explained that the allegation should then be reported to the state agency, APS, police, the ombudsman, family, and the provider. The DON stated that the morning of May 14, 2025, Resident #34 stated that a CNA had pulled her hair and she did not know why. The DON again explained that she had reported Resident #34's allegation of abuse to the state agency and other required parties on May 14, 2025 at approximately 07:40AM. The DON also stated that an investigation was completed of the allegation. Interview was conducted on May 20, 2025 at 11:05AM with the [NAME] President of Health Services (VP/Staff #23), who stated that all allegations of physical abuse should be reported within two hours to the appropriate agencies. The VP stated that Resident #34's allegation of abuse was reported immediately on May 14, 2025, and the five-day facility investigation was completed on May 19, 2025. The VP stated that the facility was unable to substantiate the allegation of abuse due to lack of evidence. The VP explained that if any hair pulling occurred when staff was changing the resident's clothing, that it would have been accidental. When asked why this investigation was not included when requesting the last ninety days of self-report investigations, the VP stated that it must have been an oversight, as the facility just completed the five-day report on the day that this was requested. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Abuse, Neglect and Exploitation, revealed that all alleged violations should be reported to the administrator, state agency, adult protective services and to all other required agencies within specified timeframes, which include: immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.