STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035231	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER Sierra Winds		STREET ADDRESS, CITY, STATE, ZIP CODE 17300 North 88th Ave Peoria, AZ 85382	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on clinical record review, staff interviews, and facility documentation and policy review, the facility failed to ensure adequate supervision was provided for two residents (#6) and (#7) to prevent further resident to resident altercations. The deficient practice could result in further incidents due to inadequate resident supervision. Findings include: Regarding residents #6 and #7: -Resident #6 was admitted to the facility February 1, 2024 with diagnosis including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, diabetes mellitus due to underlying condition with unspecified complications. A care plan initiated in April 2023 and revised July 2023 revealed the resident had a focus for communication problems related to dementia and wandering and impaired cognitive function/dementia or impaired thought processes related to short and long-term memory loss and dementia. Interventions included frequent visual checks, when conflict arises, remove residents to a calm safe environment and allow to vent/ share feelings. The quarterly MDS (minimum data set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 06, indicating severe cognitive impairment. Further review of the MDS revealed no indicators for mood or behaviors. The progress notes dated December 20, 2024 documented an alert note that revealed CNA reported that resident #6 was sitting in wheelchair at nurses' station. Resident #7 was sitting near her and they were conversing and holding hands. It was reported that as resident #6 wanted to wheel off to use the bathroom when resident #7 would not let go of the wheelchair, staff needed to intervene. No injury or harm noted to resident #6. Provider made aware and message with contact information for this nurse left for resident #6 family. -Resident #7 was admitted to the facility December 21, 2024 and discharged [DATE] with diagnosis including urinary tract infection, site not specified, altered mental status, unspecified, encephalopathy, unspecified, hallucinations, unspecified, depression, unspecified, unspecified hearing loss, unspecified ear. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The admission care plan initiated in December 2024 revealed the resident had a focus for behavior problems (verbal aggression) related to altered mental status and episodes of hallucinations and wandering/elopement related to cognitive impairment. Interventions included identifying if there is a pattern and purpose of wandering, administer medications as ordered. Monitor/document for side effects and effectiveness, intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed The admission MDS (minimum data set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 10 indicating moderate cognitive impairment. Further review of the MDS revealed indicators for behaviors, which included verbal behavioral symptoms directed toward others, other behavioral symptoms not directed toward others and wandering. The progress notes dated December 30, 2024 revealed two separate incidents for residents #7 and #6. resident #7 was holding resident #6 hand and wheelchair and refused to let go when the resident wanted to move. Staff intervened to free the resident's wheelchair from the resident. The second incident documented resident #7 was holding onto resident #6 wheelchair who was attempting to go to dinner and refused to let go. Staff had to intervene. Resident refused to have first aid treatment for small cut on her finger. Unable to redirect the resident's behavior. Further review of the progress notes for December 30, 2024 revealed resident #7 had increasing delusions and stated she was being held against her will. Resident #7 became very agitated and aggressive, removed dinner plates from the cart and started throwing them across the floor. The progress noted further revealed resident #7 grabbed the dinner cart and started ramming it into anyone and anything in the hallway. Unable to redirect and refused to go to dinner and was still holding onto the cart at 10:41p.m. A call was made to the DON and the provider. Resident #7 was transferred to the hospital for evaluation and treatment. Review of the facility investigation with discover date of December 30, 2024 included that both resident #6 and #7 were interviewed. Per the documentation, resident #6 and #7 were seated together holding hands when resident #6 left to go the restroom, Resident #7 held onto resident #6 wheelchair sustaining a skin tear. Residents #6 and 7 were immediately separated and assessed. Resident #7 behaviors continued to escalate during the evening. Per doctor's orders resident #7 was sent to the emergency room where she was admitted . Facility followed their policy for resident -resident event, An interview was conducted on January 14, 2025 at 10:29a.m. with Licensed Practical Nurse (LPN/ Staff #43). Staff #43 stated has worked for the facility for one year and has received abuse training through the facility online portal and it is the staff's responsibility to keep the residents safe and remove form the situation if there is a resident to resident altercation. Staff #43 stated she witnessed to separate incidents on December 30, 2024 involving residents #6 and #7. Staff # 43 stated the first Incident happened at approximately 2:30p.m. Staff #43 was coming down the hall and noticed staff standing around residents #6 and #7. Staff #43 stated she observed resident #7 had hold of resident #6 hand and wheelchair and resident #6 kept saying she needed to go to the bathroom. Resident #7 refused to let her go. Staff intervened and Resident #6 went to the bathroom. The incident happened the long-term care (LTC) unit, resident #7 resides on the skilled unit. Staff #43 stated resident #7 is kept on the LTC unit during the day, due to the number of staff that could have eyes on her due to her behaviors and wandering. Staff #43 stated when the facility has residents with behaviors or wandering concerns., the facility will keep them in a more populated area to keep eyes on them and that it is safer for resident #7. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Staff #43 stated the second incident happened at approximately 4:30p.m. Staff #43 stated resident #7 remained in the same spot on the unit and refused to move and grabbed resident #6 hand again and refused to let her go. She stated resident #7 said she would not let her go. Staff #43 stated she put hand between the two and told resident #7 to let go as resident #6 was trying to back away when resident #7 grabbed resident #6 wheelchair and sustained a skin tear. The residents were kept apart and are on different units. Staff #43 stated resident #7 would not allow her skin tear to be assessed after multiple attempts. Staff #43 stated the skin tear was located on the middle finger on the resident's right hand- 1cm or less with minimal bleeding. Staff #43 stated after dinner resident #6 was taken back to the skilled unit. Staff #43 stated resident #7 Nor started to take the dinner plates off the cart and tossed them down the hallway and refused to let go off the food cart. Staff #43 stated there were no residents in the hallway. Staff #43 stated she was called into another resident room to assist, leaving resident #7 alone on the unit unsupervised. Staff #43 stated as she went to exit the room she found that resident #7 had barricaded the doorway from the hallway with the treatment and linen cart. Staff #43 stated she was sitting outside the room with no one to supervise or monitor because they had to assist another resident. Staff #43 stated she called the doctor and director and informed of resident #7 escalated behavior and received orders for a psych eval. Staff #43 stated the residents behaviors escalated between 2p.m-9p.m Staff #43 stated they had seven resident plus #7 between herself and one CAN. Staff #43 stated resident #7 requires constant 1:1 supervision and monitoring due to her destructive behavior when bored, and had voice her concerns to the Director of Nursing (DON/Staff #61), but the facility did not want to provide the 1:1 supervision for the resident. Staff #43 stated the facility is responsible for providing the residents with supervision to keep the resident and other residents safe. Staff #43 stated she has found it very difficult with the facility nor providing the resident with the 1:1 care she required. Staff #43 stated the resident's family would be called when the facility needed someone to provide that 1:1 care, but the family would leave when resident #7 was violent with her husband who was also disabled. Staff #43 stated the resident's daughter would also come to provide 1:1, but would leave due to her escalated behaviors. Staff #43 stated resident #7 had Sundowners really bad in the evenings and does not feel they had the staff to provide resident #7 the supervision that she needed especially after administration would leave at five pm. An interview was conducted on December 14, 2025 at 11:19 a.m. with (Staff# 55/CNA). Staff #55 stated she has taken abuse training and it is her responsibility to report within the time limitations all reports of abuse to the nurse or the DON and to follow through. Staff #55 stated she observed resident #6 was intimidated by resident #7 due to resident & hanging onto resident #6 wheelchair and needing to go to the bathroom. Staff #55 stated resident #7 was sitting in her wheelchair and had hold of resident #7 arm and her wheelchair refusing to let go after asked to let go. Staff #55 stated later in the evening resident #7 was hanging onto the meal cart and refused to let go and when the staff had gone into another resident's room had thrown the plates down the hallway and had blocked the nurse and the CNA into another resident's room and could not get out. Staff #55 stated the facility does not have enough staff to provide 1:1 care and due to this, places the residents at risk for falls or ability hurt other resident's by wandering into other resident's rooms and disturbing them. An interview was conducted on December 14, 2025 at 11:47 a.m. with Director of Nursing (DON/Staff #61), stated the facility process for providing additional staff for supervision and monitoring of residents with escalated behaviors is the addition of extra staff if available and if there are none then the scheduled staff are able to monitor the residents and that the facility provides sufficient staffing. The DON stated the risks associated with not providing supervision and monitoring of residents with escalated behaviors are injury to themselves or others or a fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility policy titled Accidents and Supervision (Revised August 2024) states the resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents.