STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035254	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winslow Campus of Care	826 West Desmond Street Winslow, AZ 86047

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** 46606 Based on clinical record review, staff and resident interviews, facility documentation, policies and procedures, the facility failed to protect the rights of one resident (#525) to be free from abuse from visitors/family member. The deficient practice could result in further abuse of residents and appropriate action not taken. Findings include: Resident #525 (alleged victim) was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, dementia with behavioral disturbance, agitation, and psychotic disturbance, and hypertension. A behavioral care plan dated June 11, 2024 indicated that the resident may exhibit behaviors of rejection of care, physical aggression towards staff and verbal aggression towards staff related to her dementia with agitation. Interventions included document behaviors, and make sure all basic needs are met. Further review of the care plan did not reveal any reference regarding the resident's risk for abuse from visitors/family members. The facility's visitor log for resident #525 revealed that family members #1 and #2 came to visit the resident on June 11 and 13, 2023. The clinical record revealed no documentation that there was an incident between the resident and her family members on June 11, 2023. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 5, indicating that the resident has severe cognitive impairment. The MDS also included that the resident exhibited physical and verbal behavioral symptoms directed towards others occurred 1-3 days during the assessment period. (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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(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	The final facility investigation report dated June 17, 2024 revealed that the incident took place on June 11, 2024 at approximately 2:30 p.m. According to the facility report, resident #525 was socializing with other residents when her three family members arrived at the facility for a visit. It included that her family proceeded to remove the resident from the activity and pushed the resident's wheelchair back to her room. The report included that the resident's family closed the door to the resident's room; and, a few minutes later, there was yelling and arguing that could be heard coming from the room. Per the documentation, the family was heard asking the resident where the resident's money was; and that, if the resident do not tell, the family would sell the resident's cows for money. The report also included that when a staff attempted to enter the room, the family would stop talking. Further, the documentation included that resident #525 was heard yelling back at her family in Navajo. It also included that the family asked the resident again for the resident's money and bank card; and, the resident replied that she did not know. The facility report further revealed that two of the three family members left unhappy and angry; and that, the one who remained continued to be heard yelling at the resident. The report included that when the staff checked on the resident #525, she was found sitting on the edge of the bed crying. The report revealed no documentation that staff intervened during the incident on June 11, 2024 or asked the family members to leave. Further review of the report revealed that on the next family visit on June 13, 2023, the family members #1 and #2 were informed that when visiting the resident, the door to the resident's room must remain open at all times; and that, if verbal altercation or raised voices were observed, the family members will be asked to leave. The investigative report revealed that the facility concluded that emotional and verbal abuse occurred. An interview was conducted with a Registered Nurse (RN/staff #15) on June 26, 2024 at 2:03 p.m. The RN stated that if a staff member observed or suspected abuse, it was their responsibility to get the situation under control and report it immediately to the DON (Director of Nursing), administrator, charge nurse; and, complete the online report to the State Agencies. The RN said that if a visitor/guest was suspected or found to be abusive towards the resident, staff would ensure that the resident was safe, ask the visitor/guest to stop the behavior, and have them leave the facility. Further, the RN stated that when an incident occurs involving a visitor/guest, it was not appropriate for a visit from that visitor/guest to continue. The RN stated that staff would not be comfortable allowing the guests to stay if they are abusive; and, following an incident, staff would write a progress note to document who was involved and circumstances pertaining to the incident, let the DON, administrator know what occurred, and let the receptionist know not to allow them back in as part of interventions to ensure that the incident does not occur again. The RN said that the if a resident was subjected to abusive behavior, the resident will feel hurt, can be traumatic and they will not be able to trust people in general. The RN said that it would take time to build the resident's trust again. Regarding resident #525, the RN said that she was familiar with resident #525; and that, she did not witness the incident but she heard that the resident was involved in a verbal altercation with family members. According to the RN, she was told that visitors were yelling at resident #525; and because of this, staff were told to make sure the resident's room door stayed open when the resident's family comes for a visit and to keep a visual on the visitors. The RN stated that to prevent further incidents, staff were told to keep doors open and keep eyes on the family. The RN said the resident's family returned for a visit after the incident; and, the family asked for an ink print pad so that they could use it to get the resident's thumbprint for a document. The RN stated that knowing that these family members were yelling at the resident during their previous visit, the RN referred the family to the DON who spoke with the family members #1 and #2. (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 - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was conducted on June 26, 2024 at 2:32 p.m. with a Certified Nursing Assistant (CNA/staff #25) who stated that when staff observe or suspect abuse, she would report it to the nurse immediately and a summary of the incident is written. The CNA said that if a visitor/guest was suspected of or found to be abusive towards a resident, staff would check to see what happened and advocate for the resident, inform the perpetrator to stop, inform the charge nurse, and write up a report regarding the incident. The CNA also said that the alleged perpetrator (visitor) are then told to leave, and supervisor will intervene to determine what occurred. The CNA stated that residents subjected to abusive behavior becomes stunned, scared, need to be comforted, feel unsafe, and would need to be reassured. Regarding resident #525, the CNA stated that an incident occurred approximately 2-3 weeks prior; and that, resident #525 and family members engaged in a verbal altercation. The CNA said that on that day, resident #525 was in the common area socializing when three ladies (family members) approached the resident and took the resident to her room. The CNA stated that during that day, one of the family members asked her to take the resident to the restroom; and, after she was done, the door was open and she could hear them talking, asking about money, and the resident did not know what the family members were talking about. The CNA said that two of the of the family members left and one stayed; and, the resident's room door was closed and there was yelling inside the room. The CNA stated that the nurse came and opened the door; and that, the family member that stayed left the room and was mad. Further, the CNA stated that the resident's roommate (resident #530) informed the CNA that the lady was yelling at the resident and threatened to sell all the cattle because the resident cannot get money. The CNA also stated that the roommate was in the room with her privacy curtain up, had heard what transpired, and was concerned about resident #525. The CNA further stated that she does recall the family coming back after but also said that she does not normally work at that unit. The CNA said that she was not aware of what interventions were put in place to prevent further incidents; but, there was probably an alert for when resident had visitors/family. The CNA further stated that it was important to prevent instances of abuse from visitors/family members to protect the residents. An interview with resident #525 was attempted on June 26, 2024 at 2:57 p.m. with the help of a translator (staff #55). Initially, resident #525 agreed to be interviewed. However, once asked about the incident between her and her family members, the resident became upset and said that she did not say anything; and that, it was pointless talking to her since she cannot hear. Staff #55 said that it was cultural for resident #525 to refuse to answer questions about the incident because in the resident's culture, they do not want to get their family members in trouble so they do not talk about what happened. An interview with the resident's roommate (resident #530) was conducted on June 26, 2024 at 3:05 p.m. with the assistance of a translator (staff #55). The roommate stated that there were 4 people in their room (3 guests and the resident). One of the family members was mad because of the cattle and told resident #525 that the family members were going to take all her cattle. The roommate said that resident #525 did not say anything; and that, the family members were yelling saying that they want to get money and will sell the cattle. The roommate further stated that when she walked into the room the family members were already yelling/arguing about money and selling cattle to get money; and that, resident #525 looked mad after her family members left but did not say anything. (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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Receptionist (staff #30) conducted on June 26, 2024 at 3:40 p.m., the receptionist stated that her responsibility as a staff member was to report observed or suspected abuse to the charge nurse or DON (Director of Nursing). The Receptionist stated that if a visitor/guest was suspected or found to be abusive towards the resident, an alert is placed on the computer and a resident alert sheet of information is printed that the specific visitors were not allowed to visit. The receptionist also said that this information was also provided to the indicated guest/visitor; and, a code is also put in place by the family. The receptionist said that if a visitor does not know the code, they cannot visit. The receptionist said that the residents becomes afraid when they are subjected to abuse; and that, it was important to prevent instance of abuse since it terrifies/scares the residents and it is the facility's job to make the resident feel safe. Further, the receptionist said that when resident feels scared it can negatively impact their health to include their mental health. In an interview with the Activities Assistant (AA/staff #50) on June 26, 2024 at 3:52 p.m., the AA stated that if see observed or suspected abuse, she reports it to charge nurse or DON (Director of Nursing), and writes a statement regarding the event. The AA said that when a visitor/guest was suspected or found to be abusive towards a resident, she would get the nurse who will then assess the resident; and the alleged perpetrator would be told to leave the building. Regarding resident #525, the AA said that approximately 2 weeks ago and incident happened between the resident had her family members; and that, this happened twice. The AA said that the second time, the visitors were yelling at resident #525 in Navajo language, asking for money and truck keys; and that, this was reported to the nurse and the DON, and the resident's guests left. The AA stated that resident #525 and her roommate (resident #530) were present during the incident. Further, the AA said that it was important to prevent instances of abuse so that residents were not harmed, traumatized, or taken advantage. The Activities Assistant stated that the DON was trying to get the alleged perpetrators off the visitors list; and that, she was not aware if the alleged perpetrators have visited since the most recent incident due to them only working on weekends. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview with the Director of Nursing (DON/staff #5) was conducted on June 27, 2024 at 7:53 a.m. The DON stated that she first found out about the incident involving resident #525 on the night of the incident via phone call; and that, the full information regarding the event was not relayed until she reported it to the state agency. The DON said that she was told there were raised voices; and, she informed her staff to inform the parties involved to lower their voice and tell them to leave if they do not comply. The DON said that the following day, one of the family members (perpetrator) came in and asked for an ink pad in order to get the resident's finger print for a document. The DON said that she told the family member that the family member could not do that because the resident did not have cognitive impairment. The DON said that during the incident the family members were allowed to finish the visit; however, when the family members did not let the resident's roommate back into the room, the family members were asked to leave. The DON said that the next time the resident's family member visited, she spoke with them; and, one of the family members told her that the resident was hard of hearing. The DON stated that she informed the family members that going forward, the resident's room door will remain open, and they cannot raise their voices or they will be asked to leave. The DON explained that the report to the state agency occurred between the 1st and 2nd visit; and that, the facility decided not to restrict access because nothing physical had happened. However, the DON stated that they informed that the visit was basically supervised; and that, to her knowledge no one has come back after the second visit. The DON added that police was not contacted but APS (Adult Protective Services) was and had come out to the facility. Further, the DON stated that her expectation was that if a guest/visitor was exhibiting abusive behavior towards a resident, staff will go to the room and check on resident, call the DON immediately, separate resident from guest/visitor, ask the guest/visitor to leave, and start the investigation. She said that this was important since resident cannot intervene for themselves so it was the facility's job to protect the residents. She further stated that the when guest/visitors being abusive towards residents, this upsets the residents and staff, exposes the residents to a dangerous situation, and in the long term the resident was not able to understand what was going on. The facility policy titled Abuse Prevention Policy and Procedure revised June 2024, indicated that it is their policy to take appropriate steps to prevent the occurrence of abuse. Furthermore, it stated that upon notification of a suspected violation, the facility will take immediate action to stop the alleged or suspected abuse of a resident, and put in place protective measures to assure resident safety. Additionally, the policy noted that if the suspected perpetrator is a family member, said family member will be asked not to visit during the investigation or be required to have supervised visits only pending outcome of the investigation.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606 Based on clinical record review, staff interviews, review of facility documentation, policy and procedures the facility failed to implement their policy on abuse and resident protection for one resident (#525). The deficient practice could result in abuse continuing and not being prevented. Findings include: Resident #525 (alleged victim) was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, dementia with behavioral disturbance, agitation, and psychotic disturbance, and hypertension. The facility's visitor log for resident #525 revealed that family members #1 and #2 came to visit the resident on June 11 and 13, 2023. The final facility investigation report dated June 17, 2024 revealed that the incident took place on June 11, 2024 at approximately 2:30 p.m. According to the facility report, resident #525 was socializing with other residents when her three family members arrived at the facility for a visit. It included that her family proceeded to remove the resident from the activity and pushed the resident's wheelchair back to her room. The report included that the resident's family closed the door to the resident's room; and, a few minutes later, there was yelling and arguing that could be heard coming from the room. Per the documentation, the family was heard asking the resident where the resident's money was; and that, if the resident do not tell, the family would sell the resident's cows for money. The report also included that when a staff attempted to enter the room, the family would stop talking. Further, the documentation included that resident #525 was heard yelling back at her family in Navajo. It also included that the family asked the resident again for the resident's money and bank card; and, the resident replied that she did not know. The facility report further revealed that two of the three family members left unhappy and angry; and that, the one who remained continued to be heard yelling at the resident. The report included that when the staff checked on the resident #525, she was found sitting on the edge of the bed crying. The report revealed no documentation that staff intervened during the incident on June 11, 2024 or asked the family members to leave. However, the investigative report did not indicate that staff intervened during the incident or asked the family members to leave on June 11, 2024. There was also no documentation found that interventions were put in place to prevent the verbal altercation between the resident and her family members from happening again. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with a Registered Nurse (RN/staff #15) on June 26, 2024 at 2:03 p.m. The RN stated that if a staff member observed or suspected abuse, it was their responsibility to get the situation under control and report it immediately to the DON (Director of Nursing), administrator, charge nurse; and, complete the online report to the State Agencies. The RN said that if a visitor/guest was suspected or found to be abusive towards the resident, staff would ensure that the resident was safe, ask the visitor/guest to stop the behavior, and have them leave the facility. Further, the RN stated that when an incident occurs involving a visitor/guest, it was not appropriate for a visit from that visitor/guest to continue. The RN stated that staff would not be comfortable allowing the guests to stay if they are abusive; and, following an incident, staff would write a progress note to document who was involved and circumstances pertaining to the incident, let the DON, administrator know what occurred, and let the receptionist know not to allow them back in as part of interventions to ensure that the incident does not occur again. Regarding resident #525, the RN said that she was familiar with resident #525; and that, she did not witness the incident but she heard that the resident was involved in a verbal altercation with family members. According to the RN, she was told that visitors were yelling at resident #525; and because of this, staff were told to make sure the resident's room door stayed open when the resident's family comes for a visit and to keep a visual on the visitors. The RN stated that to prevent further incidents, staff were told to keep doors open and keep eyes on the family. The RN said the resident's family returned for a visit after the incident; and, the family asked for an ink print pad so that they could use it to get the resident's thumbprint for a document. The RN stated that knowing that these family members were yelling at the resident during their previous visit, the RN referred the family to the DON who spoke with the family members #1 and #2. A telephone interview was conducted on June 26, 2024 at 2:32 p.m. with a Certified Nursing Assistant (CNA/staff #25) who stated that when staff observe or suspect abuse, she would report it to the nurse immediately and a summary of the incident is written. The CNA said that if a visitor/guest was suspected of or found to be abusive towards a resident, staff would check to see what happened and advocate for the resident, inform the perpetrator to stop, inform the charge nurse, and write up a report regarding the incident. The CNA also said that the alleged perpetrator (visitor) are then told to leave, and supervisor will intervene to determine what occurred. The CNA stated that residents subjected to abusive behavior becomes stunned, scared, need to be comforted, feel unsafe, and would need to be reassured. The CNA said that she was not aware of what interventions were put in place to prevent further incidents for resident 525; but, there was probably an alert for when resident had visitors/family. The CNA further stated that it was important to prevent instances of abuse from visitors/family members to protect the residents. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Receptionist (staff #30) conducted on June 26, 2024 at 3:40 p.m., the receptionist stated that her responsibility as a staff member was to report observed or suspected abuse to the charge nurse or DON (Director of Nursing). The Receptionist stated that if a visitor/guest was suspected or found to be abusive towards the resident, an alert is placed on the computer and a resident alert sheet of information is printed that the specific visitors were not allowed to visit. The receptionist also said that this information was also provided to the indicated guest/visitor; and, a code is also put in place by the family. The receptionist said that if a visitor does not know the code, they cannot visit. The receptionist said that the residents becomes afraid when they are subjected to abuse; and that, it was important to prevent instance of abuse since it terrifies/scares the residents and it is the facility's job to make the resident feel safe. Further, the receptionist said that when resident feels scared it can negatively impact their health to include their mental health. The receptionist stated that she has not heard of incident involving resident #525 because she was not clinical. In an interview with the Activities Assistant (AA/staff #50) on June 26, 2024 at 3:52 p.m., the AA stated that if see observed or suspected abuse, she reports it to charge nurse or DON (Director of Nursing), and writes a statement regarding the event. The AA said that when a visitor/guest was suspected or found to be abusive towards a resident, she would get the nurse who will then assess the resident; and the alleged perpetrator would be told to leave the building. Regarding resident #525, the AA said that approximately 2 weeks ago and incident happened between the resident had her family members; and that, this happened twice. The AA said that the second time, the visitors were yelling at resident #525 in Navajo language, asking for money and truck keys; and that, this was reported to the nurse and the DON, and the resident's guests left. The AA stated that resident #525 and her roommate (resident #530) were present during the incident. Further, the AA said that it was important to prevent instances of abuse so that residents were not harmed, traumatized, or taken advantage. The Activities Assistant stated that the DON was trying to get the alleged perpetrators off the visitors list; and that, she was not aware if the alleged perpetrators have visited since the most recent incident due to them only working on weekends. A telephone interview with the Director of Nursing (DON/staff #5) was conducted on June 27, 2024 at 7:53 a.m. The DON stated that during the incident on June 11, 2023, the family members were allowed to finish the visit; however, when the family members did not let the resident's roommate back into the room, the family members were asked to leave. The DON said that the next time the resident's family member visited, she spoke with them; and, one of the family members told her that the resident was hard of hearing. The DON stated that she informed the family members that going forward, the resident's room door will remain open, and they cannot raise their voices or they will be asked to leave. The DON explained that the report to the state agency occurred between the 1st and 2nd visit; and that, the facility decided not to restrict access because nothing physical had happened. However, the DON stated that they informed that the visit was basically supervised; and that, to her knowledge no one has come back after the second visit. The DON added that police was not contacted but APS (Adult Protective Services) was and had come out to the facility. Further, the DON stated that her expectation was that if a guest/visitor was exhibiting abusive behavior towards a resident, staff will go to the room and check on resident, call the DON immediately, separate resident from guest/visitor, ask the guest/visitor to leave, and start the investigation. She said that this was important since resident cannot intervene for themselves so it was the facility's job to protect the residents. She further stated that the when guest/visitors being abusive towards residents, this upsets the residents and staff, exposes the residents to a dangerous situation, and in the long term the resident was not able to understand what was going on. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator (staff #10) conducted on June 27, 2024 at 9:48 p.m., the administrator stated there were no documentation regarding steps in place to prevent further incidents. However, the administrator stated that the DON had a discussion with the family; and that, the intervention was not a one-on-one supervised visit per say but that the staff will have to keep the resident's room doors open; and, the family members had to call prior to coming in for a visit so staff was aware. The facility policy titled Abuse Prevention Policy and Procedure revised June 2024, indicated that it is the policy of the facility to take appropriate steps to prevent the occurrence of abuse. Furthermore, it stated that upon notification of a suspected violation, the facility will take immediate action to stop the alleged or suspected abuse of a resident, and put in place protective measures to assure resident safety. Additionally, the policy noted that if the suspected perpetrator is a family member, said family member will be asked not to visit during the investigation or be required to have supervised visits only pending outcome of the investigation. The undated facility policy titled Charting and Documentation indicated that among the information that is documented in the resident's medical record includes events, incidents or accidents involving the resident. Review of the undated facility policy titled Visitation stated that some visitation maybe subject to reasonable restrictions that protect the safety, security and/or rights of the residents such as denying or providing limited supervised visits from persons who are known or suspected to be abusing, exploiting or coercive to the resident.