

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024
NAME OF PROVIDER OR SUPPLIER Winslow Campus of Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932</p> <p>Based on clinical record review, interviews, facility surveillance footage, the State Agency (SA) complaint tracking system, and policy review, the facility failed to ensure resident #3 was free from abuse from resident #4. The deficient practice could result in further resident abuse.</p> <p>Findings include:</p> <p>Related to resident #3-</p> <p>Resident #3 was admitted to the facility on [DATE] with diagnoses of dementia, anxiety and hypertension.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated [DATE], revealed resident #3 had a Brief Interview for Mental Status (BIMS) score of 0 which indicated the resident was cognitively impaired.</p> <p>A review of a Progress Note, written by Registered Nurse (RN, staff #78) and dated December 1, 2024 at 10:35 AM, noted that at 9:00 AM a Certified Medical Assistant (CMA, staff # 19) notified the nurse (staff # 78) that resident #3 and another resident (#4) were kicking each other and then were immediately separated. The progress note also indicated that a video recording captured resident #3 approaching (resident #4) and hit him. The note also revealed that both residents were being physical with each other prior to being separated from staff members.</p> <p>A review of resident #3's care plan revealed that it was revised on December 1, 2024 and included a new goal of minimizing behaviors to address the issue of resident #3's agitation and physical aggression towards other residents. Interventions included ensuring the resident's basic needs were being met and to monitor and document verbal or attempted physical aggression towards other residents.</p> <p>Related to resident #4-</p> <p>Resident #4 was admitted to the facility on [DATE] with diagnoses of congestive heart failure, chronic pain, and type two diabetes.</p> <p>A review of the admission MDS, dated [DATE], reveals resident #4 had a BIMS score of 14 which indicated the resident was cognitively intact.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note, dated December 1, 2024 at 10:30 AM indicated that staff #19 notified staff #78 that two residents were kicking each other and were immediately separated. The note also noted that video surveillance showed the other resident (resident #3) approaching resident #4 and started hitting him in the left arm. The note indicated that the video revealed resident #4 attempting to push the other resident (resident #3) away and they go back and forth. The note also indicated that resident #4 was assessed for injuries and none was noted.</p> <p>Review of resident #4's care plan revealed that it was revised on December 1, 2024 and included a new goal of minimizing behaviors and to reduce the risk of harming himself and/or others. Interventions included documenting behaviors and ensuring that resident #4's basic needs were being met.</p> <p>An interview was attempted on December 2, 2024 and December 3, 2023 with resident #4 but was unsuccessful.</p> <p>Review of intake information submitted by the facility to the SA complaint tracking system on December 1, 2024 at 10:13 AM revealed that the facility had video available for evidence.</p> <p>An interview was conducted on December 2, 2024 with staff #19 at 1:57 PM. Staff #19 confirmed she was working on December 1, 2024. She indicated it was in the morning before breakfast and she had come out of the restroom and had observed both resident #3 and resident #4 trying to kick each other. Staff #19 explained she separated the residents and then went to get the Registered Nurse (staff #78). Staff #19 shared that resident #4 has had no issues regarding being physical with others in the past but resident #3 will get mad because he is not able to verbalize his needs. Staff #19 also indicated that she wasn't aware of resident #3 of physically attacking others in the past.</p> <p>An interview was conducted with Licensed Practical Nurse (LPN/Staff #60) on December 2, 2024 at 3:23 PM. Staff #60 confirmed that she was sitting at the nurses' station at the time of the altercation. However, she explained that from where she was sitting, she could not see the altercation take place and was not aware of it until staff #19 came out of the restroom. Both residents were in wheelchairs and staff #60 saw the incident that took place when she reviewed the video surveillance.</p> <p>An interview was conducted with the Director of Nursing (DON/staff #113) on December 3, 2024 at 2:17 PM. She explained that the incident took place over the weekend and she is out of the building on Mondays so she was just getting up to speed regarding the incident. Staff #113 indicated that she was told that both residents had a physical altercation next to the nurses' station. When asked if she had seen the video surveillance of the altercation, she indicated that she hadn't. Staff #113 reviewed the video surveillance recording and explained the video as follows:</p> <p>Staff #113 explained that she saw resident #3 start to roll toward resident #4 and then stops next to him. She then explained that she observed resident #3 hit resident #4 in the upper left arm first and then resident #4 struck back. Staff #113 also confirmed that she observed staff #19 come into the picture and saw her calling someone that staff #113 knew to be the manager on-call. Staff #113 also added that she observed staff #60 at the nurses' station during the altercation and both residents had a lot of interaction time before staff intervened. She also explained that the open common area off to the side of the nurses' station does not have a room monitor assigned during the weekends which is when the altercation took place.</p> <p>(continued on next page)</p>		

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