

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 01/06/2025
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** 51124</p> <p>Based on observations, record review, interviews, and review of facility documentation and policy, the facility failed to ensure two residents (#2, and #3) were not abused by one resident (#1). The deficient practice could lead to physical harm, mental anguish, and psychosocial harm to a resident.</p> <p>Findings include:</p> <p>Regarding Resident #2 and Resident #1:</p> <p>-Resident #2 was admitted on [DATE], with diagnoses that included dementia, type 2 diabetes mellitus, and hypertension.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed that Resident #2 had a Brief Interview for Mental Status (BIMS) assessment score that was unable to be assessed due to the resident being rarely or never understood. Additionally, Section E revealed that Resident #2 had physical behavioral symptoms directed toward others occurring between 4 and 6 days, and verbal behavioral symptoms toward others occurring between 1 to 3 days.</p> <p>A Progress Note dated December 23, 2024, revealed that at 11:45 AM, the nurse was notified by a Certified Nursing Assistant (CNA) of physical contact between another female resident and Resident #2. Another female resident walked past Resident #2 and shoved her on her right shoulder. As staff were attempting to redirect the other resident, the other resident turned and walked back toward Resident #2 and pushed Resident #2 on the upper back. No bruising or other injuries were observed at that time during the assessment.</p> <p>-Resident #1 was readmitted to the facility on [DATE] with diagnoses that included dementia, hypotension, and osteoporosis.</p> <p>The MDS assessment dated [DATE], revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) assessment score of 08, indicating moderate cognitive impairment.</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 23, 2024, revealed that the Resident #1 ambulated into the dining room, and as Resident #1 walked past another female resident, that Resident #1 shoved the other resident on her right shoulder. Staff then tried to redirect Resident #1 away from other residents. Resident #1 began walking toward a table and then pushed another resident on the upper back area. Resident #1 was then escorted down the hall by staff. A nurse assessed both residents and determined no injury. The resident was placed on 1 to 1 monitoring. The Director of Nursing (DON), administrator, provider, and family were notified of the incident.</p> <p>A witness statement form dated December 23, 2024, signed by a dementia aide (DA / Staff #16) revealed that the staff member witnessed Resident #1 hit Resident #2 on the right shoulder, and 3 minutes later, as the staff was attempting to redirect Resident #1, Resident #1 hit Resident #2 on the right side of her neck.</p> <p>A reportable event record, dated December 27, 2024, revealed that the facility's internal investigation regarding the event concluded that the event is being substantiated as abuse.</p> <p>An interview was conducted on January 6, 2025, at approximately 10:00 AM with Staff #16. Staff #16 stated that in regard to the incident, that he had witnessed it. He stated that he observed Resident #1 get up and walk toward Resident #2, and hit her on her right arm. He stated he tried to redirect Resident #1, and that the resident was yelling at him to get away. He stated that he had started to redirect her to take her down the hall and that Resident #1 walked back and hit Resident #2 again. He stated that it was approximately 5 minutes in between the hits. He stated that he believed the force of the hit could have left a bruise, and that the nurse assessed the residents right away to see if there were any injuries.</p> <p>Regarding Resident #3 and Resident #1:</p> <p>Resident #3 was admitted [DATE], with diagnoses that included dementia and urinary tract infection.</p> <p>The quarterly Minimum Data Set assessment dated [DATE], revealed that Resident #3 had a BIMS assessment score of 06, indicating severe cognitive impairment.</p> <p>A progress note dated December 27, 2024, revealed that Resident #3 was sitting at a CNA station with the activities assistant who informed the nurse that another resident hit Resident #3 in the arm. Both residents were assessed right away and separated. The note indicated that proper notifications were made.</p> <p>The clinical record for Resident #1 was reviewed, and revealed that a progress note dated December 27, 2024, indicated that Resident #1 hit another resident in the upper left arm. A nurse assessed the two residents for injury, and the residents were separated. When asked why Resident #1 hit the other resident, Resident #1 stated she's telling lies about me.</p> <p>A reportable event record submitted December 1, 2024, revealed that Resident #3 and Resident #1 were sitting in the hallway with the activities assistant when Resident #1 hit Resident #3. The record revealed that the facility's internal investigation substantiated the event as abuse, and that Resident #1 would be placed on 1 to 1 monitoring from 8:00 AM to 8:00 PM.</p> <p>(continued on next page)</p>		

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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 telephonic interview was conducted at 9:00 AM on January 6, 2024, with the activities assistant (Staff #36) who stated that he witnessed the resident to resident incident between Resident #1 and Resident #3. He stated that he was sitting next to Resident #3 and that Resident #1 was sitting on the other side of Resident #3. He stated that Resident #1 was sleeping and woke up suddenly, and said stop talking about me. Resident #1 then hit Resident #3 on the shoulder. He stated that it was an actual strike, not a tap. He stated that a nurse assessed the residents right away.</p> <p>An interview was conducted with the facility administrator (Staff #5) who stated he was aware of the resident to resident incidents regarding Resident #1 and #2 and Residents #1 and #3, as the facility had reported the incidents to all required entities. He stated that his expectation for staff is to report cases of alleged abuse immediately and within the required 2-hour timeframe. He stated that the facility's abuse policy is that they do not allow abuse to occur. He further stated that staff try to ensure that residents are protected by doing one to one monitoring when needed and by doing everything that they can to prevent abuse.</p> <p>Review of the facility policy titled Abuse Prevention Policy and Procedure, revised June 2024, revealed that it is the policy of the facility to take appropriate steps to prevent the occurrence of abuse. Abuse is defined as the willful infliction of injury, where the individual acted deliberately. Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, pinching, and kicking. The interdisciplinary team will attempt to identify residents whose personal histories may render them at risk for abusing other residents and develop intervention strategies to prevent occurrences.</p>