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	01/31/2025

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 - Some	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** 42319 Based on observations, clinical record review, staff interviews and facility policy, the facility failed to ensure that 7 residents were not abused (72, 76, 92, 42, 67, 54, 32 and 19). The deficient practice could result in physical and emotional harm to residents. Findings include: Regarding the incidents between resident #72 and unknown victim -Resident #72 was admitted on [DATE] with diagnoses of traumatic brain injury, other frontotemporal neurocognitive disorder and mild cognitive impairment. A care plan dated February 5, 2024 included this resident may exhibits the behaviors of verbally rude to staff and other residents and short temper with other residents. Interventions include document behaviors and psychiatric consult. A progress note [DATE] included that the writer overheard a Certified Nursing Assistant (CNA) in the hallway saying (Resident #72) Stop!. This note included that Resident #72 was observed holding onto another male resident's wheelchair handles and aggressively shaking the wheelchair with attempts to push into the wall and that staff were trying to hold the male resident's wheelchair steady while telling [NAME] to let go. This note included that multiple staff responded to area and Resident #72 was cursing and yelling at all staff. An interview was conducted on [DATE] at 9:04 AM with Social Services (staff #171) who said that he was not there when this incident happened but that he was told about it. This staff said that he believed that it happened because the resident often believed that others were talking about him and would leave abruptly if he asked a question and was not given the answer he was looking for. Regarding the incidents between resident #76 and resident #92 -Resident #92 was admitted on [DATE] with diagnoses of moderate intellectual disabilities, Major depressive disorder, and metabolic encephalopathy. A care plan dated [DATE] included that this resident may exhibit the behaviors of (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wandering into other rooms, eating meals off of other resident's plates. He may also do things to trigger unwanted responses from other residents. An intervention dated [DATE] included that if staff sees resident having triggering behaviors towards another resident, remove resident from the situation to de-escalate. A progress note dated [DATE] included This nurse was notified by CNA of altercation between 2 residents. Per camera review, at approx. 3:30 pm, a male resident was preventing (resident #92) from entering the common TV room area. Male resident observed speaking to (resident #92) along with hand gestures(pointing) and noted lifting of right leg towards (resident #92). (resident #92) reacted by kicking back towards other resident and making contact with male resident's right foot. (Resident #92) then backed himself backwards away from male resident in wheelchair. Staff did separate both residents. No injuries noted. Resident denies any pain or discomfort . A progress note dated [DATE] included Witnessed on camera another resident wheeling self toward (resident #92), other resident swung arm out and made contact with (resident #92). All documentation completed, appropriate agencies notified. Residents interviewed. Continuing to monitor -Resident #76 was admitted on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction, aphasia, and need for assistance with personal care. A care plan dated [DATE] included that this resident may exhibit the behaviors of combative with staff during cares and that he also may display verbal and/or physical aggression towards other residents. This care plan included an intervention dated [DATE] that if the resident appears agitated, to remove him from areas where he could harm others. A progress note dated [DATE] included This nurse was notified by CNA of altercation between 2 residents. Per camera review, at approx. 3:30 pm, (resident #76) was preventing another male resident from entering the common TV room area. (resident #76) observed speaking to male resident along with hand gestures (pointing) and noted lifting of right leg towards male resident. Other resident reacted by kicking back towards (resident #76) and making contact with (resident #76) ' right foot. Staff did separate both residents. No injuries noted. Resident denies any pain or discomfort to right foot. A progress note dated [DATE] included Resident was witnessed on camera wheeling self toward another resident and swung out arm and made contact with upper arm. All documentation completed, appropriate agencies notified. Residents interviewed. Continuing to monitor An observation and interview was conducted on [DATE] at 12:45 PM of a video of this altercation with Behavioral Director (staff #239). This staff pointed out resident 76 and 92 on the video and notes that resident 76's foot hangs over the chair and that he is kicking at resident #92 and pointing at him. Then this staff said that resident #92 brings his leg up and got resident #76's foot. This staff then said that from what could see resident #92 got his foot and #76 brings his foot up again and resident #92 is backing away and removes himself from the area. This staff said that right now we have someone sitting with #92, It looks like around the 26th they put a sitter in place. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview was conducted on [DATE] at 11:17 AM with the Registered Nurse Behavioral Health Unit Manager (RN/staff #129) who said that she watched the [DATE] interaction on the camera, and that she could see resident #76 approach resident #92 from behind, and hit him. This nurse said Resident #92 just looked and moved forward. The video was turned on and that staff said that the video was in the bird room, and that the resident in the plaid shirt was resident #92 and behind him is resident #76 and that resident #76 comes up and hits him on the back of the arm, then a CNA walks between them and takes resident #76 out of there. An interview was conducted on [DATE] at 10:20 AM with the Director of Nursing (DON/staff #244) regarding the incident between resident #76 and #92 included that her expectation was that residents should not be kicking each other and that a resident kicking or hitting another resident by definition is abuse. This DON said that it does not meet her expectation that abuse is happening in her facility. Regarding resident #72, this DON said that she is unaware who the resident in the wheelchair was and that pushing a wheelchair into a wall is abuse. This DON said that residents should be free of abuse. 49399 Regarding the Altercation Between Resident #19 and Resident #42 -Resident #19 [alleged victim] was admitted at the facility on [DATE] and reentered the facility on [DATE] with a diagnosis that include vascular dementia, Alzheimer's disease, and major depressive disorder. Review of care plan dated [DATE] revealed resident shows cognitive impairment related to neurocognitive disorder. Resident speaks in clear English, at times very demanding with staff. He can make needs and wants known. The intervention included be sure resident can hear you. Review of care plan dated [DATE] revealed resident has decreased communication skills related to neurocognitive disorder. Resident may not always understand completely what is said to him. Give resident time to comprehend. The interventions included adjust voice and repeat as needed and make sure all basic needs are met. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 6.0 indicating severe cognitive impairment. Resident has not exhibited physical and verbal behavioral symptoms, wandering and rejection of care. Review of clinical records dated [DATE] revealed a nursing progress notes that stated licensed practical nurse (LPN)/staff #256 was in hallway charting when a sound of a slap was heard, looked over and resident #42 was standing over resident. He heard a certified nursing assistant (CNA) yell out for resident #42 to not do that and to move away from resident. Staff #256 was notified by CNA that resident #42 had struck resident #19 on the right arm. He talked to residents after incident why they hit each other and both exclaimed I don't know. Staff #256 notified Adult Protective Services (APS), Department of Health Services (DHS), director of nursing (DON), law enforcement, Administrator, family member, and the case manager. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #42 [alleged perpetrator] was admitted at the facility on [DATE] with a diagnosis that included cerebrovascular accident (CVA), unspecified dementia, wandering, and Alzheimer's disease with early onset. Review of annual MDS dated [DATE] revealed a BIMS score of 3.0, indicating severe cognitive impairment. Physical and verbal behavioral symptoms were not exhibited. And, wandering behavior occurred. Review of clinical record dated [DATE] revealed a nursing progress notes by LPN/Staff #256. Staff #256 stated that he was in hallway charting when a sound of a slap was heard, looked over and resident #42 was standing over resident, heard CNA yell out for resident #42 to not do that and to move away from resident, staff #256 was notified by CNA that resident #42 had struck resident #19 on the right arm. He spoke to both residents after incident why they hit each other and both exclaimed I don't know. Staff #256 notified APS, DHS, DON, law enforcement, Administrator, family member, and the case manager. Review of care plan dated [DATE] revealed resident may exhibit the behaviors of verbalizing delusions, anger outbursts, rummaging through others belongings related to dementia. The interventions included trade her one of her belongings if she does take something of someone else's thinking it is hers, if she tries to help staff after meals (because she thinks it's her job) offer her towels to fold or yarn to roll. She does have a set of plastic dishes she can wash and sort. Staff can tell her she is on vacation and not needing to work. And, make sure all basic needs are met. Review of care plan dated [DATE] revealed resident shows cognitive impairment related to dementia and refusal to participate. Resident is alert and able to communicate in both English and Navajo. Resident is often confused, but can answer simple questions. The interventions included are to be sure resident can hear you, speak in resident's usual language, and make every effort to have interpreter available if needed. An attempt to interview CNA/staff #269 on [DATE] at 02:07 PM via phone was unsuccessful. An interview was conducted on [DATE] at 02:12 PM with CNA/Staff #300. She stated that she works day shift from 6 am to 6 pm. She stated that regarding resident #42, resident is supervision/touch assistance, the resident requires supervision when ambulating, resident can follow direction fairly well. Staff stated that usually when resident to resident incident happens, she will separate the residents and let her nurse know of the incident. Regarding her training, she stated that she receives an online class, her course last year had 30 modules such as behavioral, cardiopulmonary resuscitation (CPR) related, deescalating a situation and how to provide better care for her residents. Regarding resident #19, she stated that resident needs assist with transfer, brief change, changing clothes, and he can get up and stand but she has not seen him take steps. Resident is on his wheelchair and can only pivot transfer. Regarding resident's behavior, resident #19 has been involved in yelling help and it annoyed his roommate. Furthermore, staff stated that for any abuse such as physical, emotional, and verbal, she will report it to her chain of command, to her nurse, charge nurse or the DON or report it directly to state. She reports it because she is a mandatory reporter, and to prevent the abuse incident from happening again. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on [DATE] at 02:30 PM with LPN/staff #207. Staff #207 stated that she works day shift, she passes medications, she does wound care treatments, and applying lotion and bio freeze. She has not witnessed any abuse incident recently and has no knowledge regarding resident #19 and resident #42 altercation. She stated that if she witnessed or is made aware of any allegations of abuse, she will separate the residents, report it to her DON, and contact the case manager and family. The types of abuse she will report are physical, verbal, emotional, financial and anything that will harm the resident in any shape or form. She gets training through in-services every month, training on various things, such as on resident to resident altercation. An interview was conducted on [DATE] at 10:21 AM with LPN/Staff #256. Staff #256 stated that he works from 7am to 7pm shift, he gets reports from the nurse on how the patients were, any issues or concern during night shift, and he usually works on Thursdays, Fridays, and Saturdays. Staff stated that regarding resident to resident altercation that occurred between resident #19 and resident #42, he did not see what happened. Staff stated that resident #19 was sitting close by to him, resident #42 hit resident #19 like a slap on the arm, it happened last week on Thursday, he was working that shift. The incident occurred about 5:30 pm, in the a hall in the hallway right pass the double doors. After the incident, he stated that he took resident #42 and sat her with the dementia aid staff. The other resident, resident #19, stayed close to his room because his room is close to the double doors. Staff #256 stated that he asked both residents what had happened and both residents said they do not know. Staff made sure the residents were distant apart after the incident. Staff stated that he was doing his behavioral charting standing by his nurses' cart and that is when he heard the slap, the other staffs were down in the dining room because some residents were still eating, another staff, Staff #167 was bringing resident out of the dining room and she was the one that saw the incident when resident #42 hit him, and he heard staff #167 say No (resident #42's name) don't do that. Furthermore, staff stated that after the incident, the process is to do a report, notify staff to monitor residents and do their 72-hour monitoring. Regarding his training, he has continuing in-services on how to talk to resident and how to handle those types of incident, and reporting to APS. He stated that resident to resident altercation is consider a form of abuse and the incident is reported to the DON and administrator. An attempt to contact CNA/Staff #167 on [DATE] at 10:48 am was unsuccessful. An interview was conducted on [DATE] at 11:15 am with the DON/Staff #244, and present during the interview was nurse consultant/staff #305. DON stated that their abuse process is that it should be reported to the nurse assigned to the unit, the witnesses will report it, the nurse assigned to that unit is responsible in reviewing and investigating the claim made, and if found suspicious and is reportable then it must be report within 2 hours. The DON stated that their staff receive training through their healthcare academy as well as in person in-services and what they are told to do. Regarding training, for training purposes they define the types of abuse, who the abuse needs to be reported to, time sensitivity of reporting to the right department and the notification that need to be made. The DON stated that regarding resident #42, the CNA heard a slapping sound. The DON stated that they have camera surveillance throughout the building located in their television room, reception area, dining hall, their nurse station located in each hall, in the main nurse station, and in the cubby of nurses' station . The DON stated that the types of abuse can be emotional, financial, sexual, physical, and she described hitting, punching, slapping, biting as a form of abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's policy titled, Abuse Prevention Policy and Procedure, revised date [DATE] revealed that it is the responsibility of all employees to immediately report any suspected or alleged violation of abuse, neglect, injury of unknown source and/or misappropriation of resident property to the administrator, director of nursing, charge nurse or department head. Such violations or alleged violations are also reported to the State agencies in accordance with existing State law. Each alleged violation will be investigated thoroughly. 51159 Regarding the altercation between Resident #54 and Resident #32 Resident #54 [alleged victim] was admitted to the facility on [DATE] with diagnoses of dementia, cardiomyopathy, and gastro-esophageal reflex. Review of resident #54 care plan dated [DATE] revealed a goal of minimizing behaviors, and to reduce the risk of harming himself and/or others. A review of the quarterly assessment MDS, dated [DATE] reveals resident #54 had a BIMS score of 3 which indicated the resident was severely cognitive impaired. Review of clinical records dated [DATE] revealed a nursing progress revealed that a certified nursing assistant (CNA) informed nurse that resident #54 was hit in the chest by another resident. Resident # 32 [alleged perpetrator] was admitted to the facility [DATE] with a diagnosis of dementia, alzheimer's, and hypertension. A review of the quarterly assessment MDS, dated [DATE] reveals residents # 32 had a BIMs score of 99 which indicated assessment was not completed. Review of resident # #32 care plan dated [DATE] revealed a goal of minimizing behaviors and reducing the risk of harming themself and/or others. Review of clinical records dated [DATE] revealed a nursing progress notes revealed that a certified nursing assistance (CNA) informed nurse that resident #32 hit another resident on the chest. A review of a witness statement completed by Staff #179 revealed that at 6:38 PM resident # 54 wheeled her wheelchair toward resident # 32. The witness statement further revealed staff #179 witnessed resident #32 hit resident # 54 on the chest. A review of the camera view incident document dated [DATE] revealed that resident #32 pushed resident #54 left upper arm to move resident # 32 out of their way. This document further revealed that resident # 32 swung her arm toward resident # 54 hitting her with the back of hand on the upper left chest/arm area. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A video camera review was conducted on [DATE] at 10:06AM with behavior unit director Staff 239 who stated resident # 54 is wearing a blue jacket and it has designs on it. Staff # 239 stated that resident # 54 leaded forward toward resident # 32 and resident # 32 moved resident # 54 out of her way. She further stated that resident # 32 used the back of her hand on resident #54 and resident # 32 held resident #54 arm from getting in her face. An interview was conducted on [DATE] at 11:15 am with the DON/Staff #244, and present during the interview was nurse consultant/staff #305. DON stated that their abuse process is that it should be reported to the nurse assigned to the unit, the witnesses will report it, the nurse assigned to that unit is responsible for reviewing and investigating the claim made, and if found suspicious and is reportable then it must be reported within 2 hours. The DON stated that their staff receive training through their healthcare academy as well as in person in-services and what they are told to do. Regarding training, for training purposes they define the types of abuse, who the abuse needs to be reported to, time sensitivity of reporting to the right department and the notification that need to be made. The DON stated that the types of abuse can be emotional, financial, sexual, physical, and she described hitting, punching, slapping, biting as a form of abuse. -Regarding to resident # 67 and resident #54 Resident #67 [alleged victim] was admitted to the facility on [DATE] with diagnoses of dementia, hypertension, and hypercholesterolemia. A review of the admission assessment Minimum Data Set (MDS), dated [DATE] , revealed resident #67 had a Brief Interview for Mental Status (BIMS) score of 99 which indicated the resident assessment was not completed. A review of resident's # 67 care plan dated [DATE] revealed that it was revised on [DATE] and included a a goal of minimizing behaviors and reducing the risk of harming themself and/or others. A review of a progress note dated [DATE] revealed that resident # 67 was in the hall at the CNA station in her wheelchair. This document further revealed that a staff had witness resident # 54 tell resident # 67 that she was in the way and resident # 57 reached over slapping resident # 67. Related to resident #54- Resident #54 [alleged perpetrator]was admitted to the facility on [DATE] with diagnoses of dementia, cardiomyopathy, and gastro-esophageal reflex. A review of the quarterly assessment MDS, dated [DATE] reveals resident #54 had a BIMS score of 3 which indicated the resident was severely cognitive impaired. A review of the progress note, dated [DATE] revealed that staff # XX witness resident #54 tell resident #67 that she was in her way and resident number #54 reached over slapping resident #67 on the thigh. Review of resident #54 care plan dated [DATE] revealed a goal of minimizing behaviors and to reduce the risk of harming himself and/or others. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the video footage was conducted on [DATE] at 10:31 AM with behavior unit director Staff # 239who stated that in the video footage of the incident resident # 67 is wearing a black or blue pants with a printed top. Staff #239 stated that resident # 54 starts to come and moves the trash can out of her way. Staff #239 stated that resident # 54 came close to resident # 67 and in the video resident # 54 turns in her wheelchair and it appears that both resident wheelchairs are scraping together. She also states that it looks like resident # 54 brushed her two fingers on the knee of resident #67. She further stated that this incident had happened right when residents were done eating. An interview was conducted on [DATE] at 11:15 am with the DON/Staff #244, and present during the interview was nurse consultant/staff #305. DON stated that their abuse process is that it should be reported to the nurse assigned to the unit, the witnesses will report it, the nurse assigned to that unit is responsible for reviewing and investigating the claim made, and if found suspicious and is reportable then it must be reported within 2 hours. The DON stated that their staff receive training through their healthcare academy as well as in person in-services and what they are told to do. Regarding training, for training purposes they define the types of abuse, who the abuse needs to be reported to, time sensitivity of reporting to the right department and the notification that need to be made. The DON stated that the types of abuse can be emotional, financial, sexual, physical, and she described hitting, punching, slapping, biting as a form of abuse. Review of facility's policy titled, Abuse Prevention Policy and Procedure, revised date [DATE] revealed that it is the responsibility of all employees to immediately report any suspected or alleged violation of abuse, neglect, injury of unknown source and/or misappropriation of resident property to the administrator, director of nursing, charge nurse or department head. Such violations or alleged violations are also reported to the State agencies in accordance with existing State law. Each alleged violation will be investigated thoroughly.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48814 Based on observation, record review, interviews, and facility policy, the facility failed to ensure that monitoring and evaluation of physical restraints are completed for the continued use of physical restraints for one resident (Resident #36). The deficient practice could lead to increased isolation and/or other psychosocial harm. Findings include: Resident #36 was initially admitted into the facility on [DATE], with the diagnosis of atrial fibrillation, depression, pain in right and left knee, unspecified dementia and anxiety. Review of the nursing progress note dated May 31, 2024 by licensed practical nurse (LPN, staff # 450), revealed that the resident had a fall and hit his head. However, no visible injuries were noted. Resident was very weak and unsteady on his feet. Resident granddaughter was notified and nurse implement an order for a bed/wheelchair alarm for safety. Review of an order dated May 31, 2024, revealed that resident has an order for bed alarm on while in bed. Review of an order dated May 31, 2024, revealed that resident has an order for a wheel chair alarm. Review of an order dated November 29, 2024, revealed the discharged from self-releasing seat belt alarm. Review of the nursing progress note dated December 19, 2024 by register nurse (RN, staff # 170), revealed that the resident was found sitting on the floor in his room by the CNA. No injuries noted on exam. Resident denies hitting head. Self-releasing seat belt alarm was in place and activated. Bed alarm on bed was activated. Review of the Medication Administration Record dated December, 2024, revealed that the resident was monitored for the wheel chair alarm the entire month. Review of the Medication Administration Record dated January, 2025, revealed that the resident was monitored for the wheel chair alarm the entire month. On January 29, 2024 at 10:28 a.m. an observation was done on Resident #36, where Resident #36 was observed sitting on his wheelchair and a seat belt was tied to his waist. An interview was conducted with certified medication assistant (staff #202) who stated that resident had multiple falls in the past and is unstable, so for his safety, he was put on a wheelchair belt alarm and it notifies us when he tries to get up. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on January 30, 2025 at 1:01 p.m. with certified nurse assistance (CNA, staff # 425). The CNA stated that there are days when resident #36 is not stable. The CNA stated that the resident #36 tries to get up himself without the use of call device and is at fall risk and incontinent. The CNA then stated that the resident #36 has been on a bed and wheelchair alarm for about a year. The alarm alerts staff when he attempts to transfer himself. She also stated that facility got a new alarm and it does not go off even if the resident unbuckled it because there is a little switch at the bottom of the alarm which resident does not know and staff can only turn it off and on. During the interview, it was also observed that a loud alarm sound was coming from the room of resident #36. The CNA then went to the room and found that the resident #36 was on the wheelchair, unbuckled the seat belt alarm. The CNA then buckled the seat belt again and turned off the alarm. She asked resident #36 if he needed anything. Resident #36 expressed that he wanted to use the bathroom and the CNA assisted the resident to the bathroom. An interview was conducted on January 30, 2025 at 2:27 p.m. with the certified medication assistance (CMA, staff # 226). The CMA stated that resident #36 is one-person assist and is incontinent. The resident has bed and seatbelt alarm since May 31, 2024, because he does not ask for help and he just get up and subsequently falls. The CMA stated that the alarm alerts staff when he tries to get up and can be heard from nurse station. The CMA further stated that the seat belt alarm is not a restraint because he can open and get up. CMA stated that she is not sure about any non-pharmacological interventions that were used prior to using this device. An interview was conducted on January 30, 2025 at 2:27 p.m. with licensed practical nurse (LPN, staff #426). The LPN stated that resident #36 has had a bed/wheelchair alarm since May 31, 2024, because he is impulsive and unsteady on his feet and doesn't ask for help. The LPN then stated that a self-releasing seatbelt alarm was discontinued by the assistant director of nursing (ADON, staff #216) on November 29, 2024 and she did not know the reason of discontinuation. She also stated that the seat belt alarm was on the resident today and she was not sure about any non-pharmacological interventions that were used prior to using this alarm. An interview was conducted on January 30, 2025 at 3:16 p.m. with the director of nursing (DON, staff #244) who stated that resident #36 is a one-person assist, impulsive and at a fall risk. She stated that resident #36 wasn't using call device as instructed to him so we put him on bed and chair alarm to prevent falls. She stated that the order started on May 31, 2024. The DON then stated that no fall assessment was done prior to putting the resident on an alarm. She, also stated that the risk for not properly assessing resident includes identifying if there is a need for the device. She then stated that alarm is part of our event order and when residents have fall then the charge nurse determines whether resident needs bed or chair alarm. The DON also stated that resident/representative consent for self-releasing seat belt alarm is not needed because it is not a restraint, as residents are able to release the seatbelt independently. However, the granddaughter was notified. The DON then stated that the resident should not be on a self-releasing seat belt alarm, as the order was discontinued on November 29, 2024 by the ADON staff #216. And the risk would be having an additional safety device on him that is not needed. Review of the Restraint Policy revealed that Resident will be provided an environment that is restraint-free, unless a restraint is necessary to treat a medical symptom, in which case the least restrictive measures will be used. It further revealed that If a resident is assessed as appropriate for a restraint, the physician will be contacted and an order obtained which states type of restraint, medical symptom, and when the restraint is to be used.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51159 Based on clinical record review, staff interviews, and facility policy review, the facility failed to ensure a copy of the notice of one of one discharges for one resident (# 101) to a representative of the Office of the State Long-Term Care Ombudsman. The failure may result in residents not having the advocacy and support from the State Long-Term Ombudsman during the discharge process. Findings include: Resident # 101 was admitted on [DATE] with a diagnosis of dementia, hypertension, and dysphagia. The quarterly review Minimum Data Set assessment (MDS) on September 05, 2024 , revealed a Brief Interview of Mental Status (BIMS) score of 99 . Indicating that the resident assessment was not completed. A review of clinical records of progress notes dated November 09, 2024 revealed residents were sent out to the Emergency Department. An interview was conducted on January 30, 2025 at 11:30AM with Social Service (staff #171) who stated that the ombudsman will be notified at the start of each month. Staff # 171 also stated that the resident family member and their physician will be notified by phone. An interview was conducted on January 30, 2025 at 11:50 AM with Licensed Practical Nurse (LPN/Staff #256) who stated that the resident did not appear to be responsive. (LPN/staff #256) stated that when the resident's arm and sternum was rubbed the resident did not respond. He stated that they checked the resident advance directive which was do not resuscitate (DNR) . He stated that the resident should be sent out to the hospital when vitals are out of range to get treatment. (LPN/Staff #256) stated that the resident was sent out to the emergency department for further evaluation. He stated that they have a packet that includes resident information, name, family that was contacted, and current vitals, code status along with medication list. (LPN/ staff #256) stated that this packet will be faxed to case management, a copy will go to the resident to the emergency department or Emergency medical services, and one given to the Director of Nursing. An interview was conducted on January 30, 2025 at 3:06 PM with Director of Nursing (DON/ Staff #244) who stated the transfer for this resident was facility initiated and that the nurse practitioner was notified of the residence status change. She further stated that the resident was sent out of the hospital for further evaluation. A further interview was conducted on January 31, 2025 at 7:48 AM with (DON/ Staff # 244) who stated that social services has not been notified by the ombudsman for transfer and discharge of residents. She also stated that social services should be the ones who notify the ombudsman for residents' discharges and transfers. A review of the policy titled Transfer/Discharge/Facility Closure revealed that A copy of the notice must be sent to the Office of the State Long Term Care Ombudsman.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319 Based on observations, clinical record review, staff interviews and facility policy, the facility failed to ensure that residents care plans were revised as needed for 3 residents (#72, #76, and #45). Findings include: - Resident #45 was admitted on [DATE] with diagnoses of dementia, muscle weakness, and adult failure to thrive. An annual Minimum Data Set (MDS) dated [DATE] included that this resident requires extensive assist for dressing. An annual MDS dated [DATE] includes that the resident was dependent for all cares. A care plan with a start date of September 14, 2020 includes that this resident requires assistance with self-cares related to dementia, adult failure to thrive and muscle weakness. However, there was no care plan regarding this resident's physical decline or a care plan related to therapy. -Resident #72 was admitted on [DATE] with diagnoses of traumatic brain injury, other frontotemporal neurocognitive disorder and mild cognitive impairment. A care plan dated February 5, 2024 included this resident may exhibits the behaviors of verbally rude to staff and other residents and short temper with other residents. Interventions include document behaviors and psychiatric consult. A progress note dated October 21, 2024 included that the CNA approached the nurse concerned that resident may have hit another resident in the dining room and that per camera review, resident became agitated towards female resident who was attempting to pass behind resident and wheelchairs had gotten caught up on each other. This note included that this resident and the female resident were attempting to both push and then this resident became upset and was observed pushing his wheelchair back, slightly turned around towards other resident, made fist and did backwards swinging motion. This note included that there was no physical contact and a CNA separated the residents. A Progress note dated November 20, 2024 included that on November 16, 2024 this resident was cursing and staff and kicked another resident's wheel chair. This note included that this staff redirected resident and that the resident's behavior was unchanged. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note December 27, 2204 included that the writer overheard a Certified Nursing Assistant (CNA) in the hallway saying (Resident #72) Stop!. This note included that Resident #72 was observed holding onto another male resident's wheelchair handles and aggressively shaking the wheelchair with attempts to push into the wall and that staff were trying to hold the male resident's wheelchair steady while telling [NAME] to let go. This note included that multiple staff responded to area and Resident #72 was cursing and yelling at all staff. However, no new care plan interventions were added for this incident. However, no care plans regarding this resident's behaviors were found prior to February 5, 2024. -Resident #76 was admitted on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction, aphasia, and need for assistance with personal care. A care plan dated June 13, 2024 included that this resident may exhibit the behaviors of combative with staff during cares and that he also may display verbal and/or physical aggression towards other residents. No new revisions were found for this care plan from June 13, 2024 until January 26, 2025. A progress note dated January 19, 2025 included This nurse was notified by CNA of altercation between 2 residents. Per camera review, at approx. 3:30 pm, (resident #76) was preventing another male resident from entering the common TV room area. (resident #76) observed speaking to male resident along with hand gestures (pointing) and noted lifting of right leg towards male resident. Other resident reacted by kicking back towards (resident #76) and making contact with (resident #76) ' right foot. Staff did separate both residents. No injuries noted. Resident denies any pain or discomfort to right foot. However, no care plan revisions were found for this incident. A progress note dated January 26, 2025 included Witnessed on camera another resident wheeling self toward (resident #92), other resident swung arm out and made contact with (resident #92). All documentation completed, appropriate agencies notified. Residents interviewed. Continuing to monitor An observation and interview was conducted on January 31, 2025 at 8:31 AM with the Registered Nurse Behavioral Health Unit Manager (RN/staff #129) who said that the MDS coordinator does the care planning for the resident's behaviors and that the MDS nurse goes to the behavioral health meeting during the week. An observation and interview was conducted on January 31, 2025 at 9:04 AM with Social Services (staff #171) who said that while he attends the care plan meetings, the MDS nurse is the one that updates the care plans. This staff said that care plans are entered if something new occurs, but if a incident occurs that the staff will add to it or modify it if they need to. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on January 31, 2025 at 9:14 AM with the MDS nurse (staff #251) who said that she initiates all careplanning on admission and that they have careplan meetings around that same time and then every quarter after that. This staff said that nurses can and should update careplans as needed or that they will text her and then she will update the care plan. This nurse said that for incidents of behaviors, it can be the Behavior director, nurse on the hall or herself and that if she knows about she'll do it and that if she doesn't know about it, it might get missed until later. This nurse reviewed the care plans for resident #72 and said that she did not see interventions added to the care plan but that she could enter it now. This staff said that for resident #76, that a intervention was added but that it should have been added sooner. An interview was conducted on January 31, 2025 at 10:20 AM with the Director of Nursing (DON/staff #244) included that for resident #45 that the MDS nurse should have updated the care plan as it was a change in condition, for resident #92, there was not a new intervention put into place for the December 22, 2024 incident or the January 19th incident, and for resident #72, this DON said that there was not a care plan intervention put in place. This DON said that these behavioral care plans should have had a review and if needed an update. A policy titled Care Plan Development dated October 2017 revealed that the interdisciplinary team shall devleop a comprehensive, individualized plan of care for each resident that is reviewed and revised in accordance with State and Federal regulations and professional standards of nursing care and that the Care Plan guides the care and treatment provided to each resident. This document included the Care Plan is reviewed and updated as necessary, but not less than quarterly or when there is a change in the resident's condition An Activities of Daily Living Policy dated November 2024 included individualized care plans that identify strengths and weaknesses, shall be developed that reflect the resident's self-performance and the amount and type of support needed and that the MDS/Care Plan Coordinator, is responsible for keeping the ADL plan of care current.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 51159 Based on clinical record review, staff interviews, and review of facility policy and procedure, the facility failed to ensure that one of one sampled residents (#304) was safe to self-adminster medication. The deficient practice could result in a medication overdose. Findings Include: Resident #304 was initially admitted on [DATE] with a diagnosis of dementia, type 2 diabetes, and dysphagia. Review of physician orders revealed active orders for the following medications: Bisacodyl 10mg Polyethylene glycol 3350 power solution Melatonin 3 mg tab Docusate sodium 100mg cap Quetiapine 25 mg tablet Acetaminophen 325 mg tab Diclofenac sodium 1 percent topical cream A in progress Admission Assessment Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. Review of the clinical records of progress notes dated January 29, 2025 revealed that a CNA (Certified Nurse Assistance) found a bag of medication in a plastic bag in the residents room when looking for residents clothing and that a Nurse accompanied CNA into the room of the residents and took the medication. This progress note further revealed that residents were told that medication can not remain in their room. An observation was conducted on January 29, 2025 approximately 9:40 AM where a surveyor heard one staff member tell a Nurse about medications being at resident bedside. Surveyor went into the room of resident # 36 along with Certified Nurse Assistant (CNA/ staff #225)and License Practical Nurse (LPN, Staff #79) . An interview was conducted on January 29, 2025 at 9:43 AM with License Practical Nurse (LPN/Staff #79) in the resident #36 room . (LPN/Staff #79) stated that they would need to take out the medication out of the resident room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on January 29, 2025 at 9:47 AM with License practical nurse (LPN/ staff #137) who stated that this resident is a new admin that came in on January 29, 2025 . The (LPN/ staff #137) stated that this resident has dementia, diabetes, constipation, chronic pain, and difficulty swallowing. The (LPN/staff #137) stated that the CNA (Certified Nursing Assistance) discovered the medication in the resident room and brought it to her. The (LPN/Staff #137) stated that the medication will be put in the inventory and locked. The (LPN/Staff #137) stated the resident does not have medication self administration and this is a reason why the resident should not have medication in her room. The (LPN/Staff #137) stated that the risk would be that the resident would self administer. An interview was conducted on January 29, 2025 at 9:56 AM with Certified Nurse Assistance (CNA/Staff #225) who stated that she was planning to give the resident a shower and was looking for residents clothes and saw a plastic bag with medication under the resident's pillow. (CNA/Staff #225) stated that she just got the Nurse to give her the medication. (CNA/Staff # 225) stated that the risk for the resident would be the resident taking too much medication or giving it to others , and that the medication should have been locked up. An interview was conducted on January 29, 2025 at 2:45 PM with Director of Nursing (DON/Staff #244). The (DON/Staff #244) stated that when medication is in a resident room like over the counter or ointment the family will be instructed to not bring those medications in. She also stated that any medication that is found in the residents room must be brought to the nurse's attention that is assigned to that unit. She stated that at some point the Assistance Director of Nursing and Director of Nursing will be notified in regards to the medication found in the resident room. (DON/Staff #224) stated that no one in the building has medication self assessment in order to do so. A review of the policy title Medication Management revealed self-administration of medication resident choosing to self-administer their own medication may do so only after the completion of the Facility Medication Self-Administration assessment .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49399 Based on observations, staff interviews, facility process and procedures, the facility failed to ensure that dishes and utensils were cleaned using professional standards of practice for sanitary conditions. The deficient practice could result in residents becoming ill. Findings include: On January 28, 2025 at 12:17 PM, a brief kitchen inspection was conducted with the kitchen manager/Staff #201. Staff #201 stated that they use low temperature dishwashing machine. They have to run the dishwashing machine a few times so temperature will reach to par at 120 degrees Fahrenheit (F) because the pipes get cold. At 12:27 PM, staff #201 run the low dishwashing machine twice, then the dishwashing machine reached to 120 degrees F. In addition, Staff #201 stated that they use sanitizer/chlorine for the dishwashing machine. At this time, Staff #201 conducted a test strip to determine sanitation. Staff #201 stated that the strip is between 100 parts per million (ppm) and 200 ppm, and stated that it is about 150 ppm. On January 30, 2025 at 12:05 PM, surveyor received the requested documents for the Dish Machine Temperature log for the low temperature machine for the months of November through December 2024 and January 2025. The document titled, Food Nutrition: Dish Machine Temperature Log-Low Temperature Machine, revealed a two-column table, one column on the left side is for Proper Temperature Wash: 120 Degrees F and the other column on the right side is for Rinse: 50-100 PPM of Sanitizer. Review of the document, Food Nutrition: Dish Machine Temperature Log-Low Temperature Machine, logs from November 2024 through January 2025 revealed for breakfast, lunch and dinner wash column has daily logged temperatures of over 120 degrees F and the breakfast, lunch and dinner rinse column has daily logged over 100 ppm of sanitizer. Additional interview was conducted on January 30, 2025 at 1:11 PM with the kitchen manager/Staff #201. Staff #201 stated that they use a low temperature dishwashing machine, use a chlorine sanitizer, use a low temperature dish machine sanitizer designated for the dishwashing machine, which is a 3-bucket container, one container is for detergent, second container is for rinse and then the third container is for sanitizer, and each container is in the manufacturer labeled container. Staff #201 stated that these are all the chemicals they use for their low dishwashing machine. On January 30, 2025, surveyor received a copy of the manufacturer's instruction for low dishwashing machine titled, American Dish Service Installation Instructions, revision 3.0, June 7, 2013. At 2:10 PM, a call was placed and spoke with staff #400. Staff #400 stated that they manufacture the machine, and they do not have nothing to do with the chemicals for the machine. A review of the document, American Dish Service Installation Instructions, revision 3.0, June 7, 2013, revealed on page 9 states, Do not exceed 50 parts-per-million (PPM) free or available chlorine, using higher than 50 ppm will be dependent on local health requirements. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additional interview was conducted on January 30, 2025 at 2:34 PM with the kitchen manager/Staff #201. Staff #201 stated that for their dishwashing machine, they use Staff #360 services for their dishwashing machine so when it breaks down they call Staff #360. Their detergents are ordered through Staff #405, and for their rinse additive, they use low temperature dish machine sanitizer, and a liquid dish machine detergent. Their safety data sheet tells them how to utilize the detergent, for instance, when changing it from low or empty container, they replace it with a full new bucket. And when they run the machine, they do a wash cycle then have the temperature at 120 degrees F, the rinse and chlorine will go in at the same time and they document the temperature. Regarding where their ppm log is located, Staff #201 stated that their log sheet does not record the ppm test results, but they perform the test strip. He stated that they do not have a log for the ppm test result when their log sheet was reimplemented. They use to have an old one where it has the ppm test results documented, but when they had consulted Staff #420, a new form was developed and recommended for them to use. They do not log the ppm test result because it is not on the log sheet even though they do the test strip but has not documented it because the form does not give them the option to write it down. Staff #201 stated that the ppm for their low temperature dish machine should be 50 ppm. On January 30, 2025 at 2:44 PM, staff #201 turned on the low dishwashing machine to conduct another ppm test strip. At 2:45 PM staff #201 stated that the ppm test strip reading is between 50 and 100 and it is about 75 ppm. Staff stated that he does not have the ppm log. He stated that he will revamp the sheet to put the ppm test results. In addition, staff #201 added that when Staff #420 came in 2024, the old sheet they were using only has two times a day for temperature and ppm documentation results, even though they run the machine three times a day. So, that is why Staff #420 gave them the new sheet which is what they are currently using for documentation, and the sheet does not have the ppm test results documented. On January 30, 2025 at 3:00 PM an interview was conducted with the administrator/Staff #177. The administrator stated that he is familiar that they use a low temperature dish machine and that's about it. The administrator was informed of the ppm test strip level ranging from high of 150 ppm and 75 ppm during two observations and that there was no ppm test results documentation log. Review of facility's policy titled, Cleaning Dishes/Dish Mchine, 2018 revealed all flatware, serving dishes, and cookware will be cleaned, rinsed, and sanitized after each use. The dish machine will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319 Based on observations, clinical record review, staff interviews and facility policy, the facility failed to ensure that resident #45 received specialized services to meet therapeutic needs. Findings include: Resident #45 was admitted on [DATE] with diagnoses of dementia, muscle weakness, and adult failure to thrive. A care plan with a start date of September 14, 2020 includes that this resident requires assistance with self-cares related to dementia, adult failure to thrive and muscle weakness. However, there was no care plan regarding this resident's physical decline or a care plan related to therapy. An annual Minimum Data Set (MDS) dated [DATE] included that this resident requires extensive assist for dressing. However, an annual MDS dated [DATE] includes that the resident was dependent for all cares. Review of the clinical record did not include any other assessment of the resident's loss of ability or any therapeutic interventions for this loss. An interview was conducted on January 30, 2025 at 9:52 AM with a Certified Nursing Assistant (CNA/staff #226) who said that this resident used to help put her shirt on. This CNA included that this resident is now dependent on staff for cares, and that she's starting to get contractures in her left hand. This staff said that nursing communicates with therapy or that therapy communicates with her. An interview was conducted on January 30, 2025 at 3:07 PM with a Licensed Practical Nurse (LPN/staff #133) who said that if she sees a resident decline, that she will check vitals, and ask the physician to do labs, let provider know where the patient was at and go from there. I would ask therapy to see if they see a decline as well, ask them if limited in function before. This staff said that she thinks that therapy assesses some residents but that she thinks assessments are dependent on the residents' insurance. This staff said this resident is completely dependent for cares. An interview was conducted on January 30, 2025 at 9:40 AM with the Director of Therapy (staff #125) who said that residents generally get an order to assess when they come in on Medicare part A and when they are admitted with orders for therapy. This staff said that some long term care patients will have orders if family has request patients get screened, or patients who have fallen or declined, then therapy will see see if a physical or occupational therapy evaluation is needed. This staff said that if the nursing department reports a decline then they can request a patient evaluation through the patient's doctor. This staff said that this patient is long term care and that he did not do a baseline assessment of this resident's physical abilities or a screening and that he knows that this resident has not received one. This staff said that he does not believe that this resident has ever had an evaluation ordered and that he does not believe that she can functionally improve and that he does not believe that she has declined, however he states that he had not evaluated her to know for sure. (continued on next page)

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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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow up interview with this staff (#125) on January 30, 2025 at 3:17 PM included that he does not know if nursing staff or the MDS nurse would trigger residents who have declines on their MDS's. An interview was conducted on January 31, 2025 at 10:20 AM with the Director of Nursing (DON/staff #244) included that her expectations for staff is that if they notice a change in condition to notify the provider on call with their concerns. This staff said that for resident #45's loss of ability that she believes that a change of condition policy was submitted. This staff that they are working on setting up a restorative department. She said that she is not aware of a change other than what was seen on the resident's MDS and that she would say from the MDS that there has been a change of condition and that her expectation would be that the provider would be notified and that accommodations be made. A policy titled Activites of Daily Living dated November 2024 revealed that the functional status of each resident's ability to perform his/her ADLs, including the identification of a resident's need for assistance, shall be determined through the MDS assessment process. This document included that the Charge Nurse is responsible for communicating each resident's individualized needs for the appropriate level of assistance with ADLs and monitoring assistance being provided to residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48814 Based on interviews, record review, facility document review, and facility policy review, the facility failed to ensure that one resident (#66) was offered pneumococcal vaccine. The deficient practice could pose the risk of the residents contracting pneumonia and its associated complications. Findings included: Resident #66 was initially admitted on [DATE] with diagnoses of acute respiratory failure with hypoxia, seizure, major depressive disorder, and pneumonia. Review of a document titled, Consent/Pneumonia Vaccine revealed a signed consent to receive the pneumonia vaccine on the initial admitted in August 08, 2022. The record revealed that resident #66 would like to receive an immunization of Pneumococcal Prevnar13 vaccine and there was no evidence that the resident received the vaccine. The admission quarterly minimal data set (MDS) dated [DATE] revealed a brief Interview for mental status (BIMS) score of 09 indicating moderate cognitive impairment. An interview was conducted on January 29, 2025 at 12:56 PM with the Assistant Director of Nursing (ADON) / Infection Preventionist (IP) (staff #239). ADON/IP stated that immunization depends on individual basis and if the resident chooses to get one then it is offered in-house, but at [NAME] Indian Health. We help the resident with transportation. We also receive a copy if the resident refused or accepted the immunization from [NAME] Indian Health. During the interview, the ADON verified the record for resident #66 and confirmed that the resident had consented to receiving the vaccination but did not receive the pneumonia vaccine since admission. The ADON also stated that risk of not getting a pneumonia vaccination would include the resident becoming more susceptible for respiratory infections and pneumonia. Review of the facility policy Flu and Pneumonia immunization revealed that upon admission, each resident shall be presented with a Flu and Pneumonia Vaccine Authorization consent. This consent shall remain in effect until the resident or the resident's responsible party revokes the consent.