

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 02/20/2025
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 - Some</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** 49399</p> <p>Based on clinical record review, facility documentation, and staff interviews, the facility failed to ensure eight residents (#1, #2, #3, #4, #5, #6, #7 and #8) were provided adequate supervision to prevent resident abuse. The deficient practice could result in residents being at risk for abuse.</p> <p>Findings included:</p> <p>Regarding Resident #1 and Resident #2:</p> <p>-Resident #1 was admitted to the facility on [DATE] with diagnoses of chronic kidney disease, dysphasia, and anemia.</p> <p>Review of care plan dated March 7, 2023 revealed resident has decreased communication skills related to hard of hearing. The interventions included adjust voice and repeat as needed, communicate in the resident's language whenever possible, make sure all basic needs are met, and use quiet setting as needed.</p> <p>Review of care plan dated March 7, 2023 revealed resident has minimal visual impairment. The interventions included assist resident through doorways, and around corners and objects as needed.</p> <p>Review of resident's quarterly MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 8.0, indicating moderately impaired.</p> <p>Review of clinical record dated February 4, 2025 revealed a progress note stating a Resident to Resident altercation occurred at approximately 1414 in activity room. Resident #2 was motioning back and forth with a closed fist towards alleged victim/resident #1 as if to provoke him when resident #1 entered the activity room via his wheelchair. As resident #1 passed resident #2, Resident #1 made a fist to resident #2 per resident #1. Resident #2 then struck resident #1 on the right wrist/hand according to resident #1. Resident #1 then hit resident #2 in the right arm. Per staff, resident #2 tried striking resident #1 again but staff was able to separate residents before that occurred. Resident #1 was evaluated for injuries and he denies pain or discomfort. No bruising or marks observed. The director of nursing (DON), resident #2's nurse, provider, case manager, and family were all notified. Resident was placed on alert charting.</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 - Some</p>	<p>-Resident #2 was admitted to the facility on [DATE] with diagnoses of mood disorder due to known physiological condition, anxiety disorder, major depressive disorder, and recurrent moderate impulse disorder.</p> <p>Review of resident's admission MDS assessment dated [DATE] revealed a BIMS score of 99.0, indicating that there is no BIMS score.</p> <p>Review of care plan dated October 30, 2024 revealed resident shows cognitive impairment. He does have mumbled speech and unable to communicate with others. The interventions included to minimize background noise, speak in resident's usual language. Make every effort to have interpreter available if needed.</p> <p>Review of care plan dated November 20, 2024 revealed resident #2 may exhibit the behaviors of wandering into other rooms, eating meals off of other resident's plates. He may also do things to trigger unwanted responses from other residents. The interventions included resident will have 1one to one when available from 8a-8p, if staff sees resident having triggering behaviors towards another resident, remove resident from the situation to de-escalate, resident responds better to male redirections. If a male certified nursing assistant (CNA) is available, ask for assistance.</p> <p>Review of clinical record dated February 4, 2025 revealed a progress note stating nurse was notified by helping hand of altercation between two residents. Per camera review, at approximately 1414 pm, per staff, resident #2 was motioning back and forth with a closed fist towards victim as if to provoke him when the other resident entered the same room. As other resident was passing resident #2, the other resident made a fist towards resident #2 and per the other resident, resident #2 hit him in the hand/wrist. The other resident then hit resident #2 in the right arm. No words were exchanged. Per staff resident #2 tried hitting again but before this occurred, residents were separated. No injuries noted. Resident denies any pain or discomfort. Vital signs were stable. The provider, DON, case manager, family, law enforcement, and administrator were notified.</p> <p>Regarding Resident #3 and Resident #4:</p> <p>-Resident #3 was admitted to the facility on [DATE] with diagnoses of unspecified dementia.</p> <p>Review of care plan dated December 5, 2022 revealed that resident may exhibit the behaviors of agitation, verbalizing hallucinations, verbal aggression, and physical aggression toward other residents. The intervention included monitor for and document any verbal or attempted physical aggression toward other residents. Remove from situation immediately to a calm area.</p> <p>Review of care plan dated December 13, 2022 revealed that resident shows cognitive impairment related to aging and dementia. The interventions included minimize background noise, speak in resident's usual language, and make every effort to have interpreter available if needed.</p> <p>Review of care plan dated December 13, 2022 revealed that resident has visual impairment related to aging and glaucoma. The interventions included assist resident through doorways, around corners and objects as needed, and identify yourself and what you plan to do before providing care.</p> <p>Review of resident's quarterly MDS assessment dated [DATE] revealed a BIMS score of 4.0 indicating severely impaired.</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 - Some</p>	<p>Review of clinical record dated February 9, 2025 revealed a progress note that states nurse, (licensed practical nurse (LPN)/Staff #20) was standing in a hall just outside dining room talking with staff. The dementia aid (staff #70) and resident exited the dining room into hallway and the aid stated that the other resident just punched resident #3 in the arm. Staff #20 and a registered nurse (RN) reviewed the camera footage. At 17:46 it is observed that the dementia aid who is on one on one with a resident attempt to escort resident from the dining room after dinner. The resident is seen resisting and reenters the room and walks over to a table where resident #3 is seen sitting alone and trying to fold her cloth bib. The other Resident approaches and attempts to take the cloth from resident #3. There is a brief tug and pull back and forth and the dementia aid is seen trying to intervene when the other resident with her right arm punches resident #3 in the left arm. Resident #3 looks up at her. The aid then removed the other resident from the dining room.</p> <p>-Resident #4 was admitted to the facility on [DATE] with diagnoses of unspecified dementia, wandering, and major depressive disorder.</p> <p>Review of care plan dated November 1, 2024 revealed resident may exhibit the behaviors of wandering, verbalizing hallucinations, making false accusations, packing belongs/bed linens, physical and verbal aggression towards staff and others behaviors related to dementia. The interventions initiated on December 2024 included monitor interactions with others and remove from situation if showing agitation, aggressiveness, one on one monitoring from 8a-8p and as needed, staff to be with her when wandering, or in dining area/activity room, provide conversation, snacks, fluids and redirection away from other residents as needed, and make sure all basic needs are met.</p> <p>Review of resident's MDS assessment dated [DATE] revealed a BIMS score of 8.0 indicating moderately impaired.</p> <p>Review of care plan dated November 20, 2024 revealed resident shows cognitive impairment, does prefer to speak in native language, and resident will need a translator. The interventions included minimize background noise, speak in resident's usual language and make every effort to have interpreter available if needed.</p> <p>Review of care plan dated November 20, 2024 revealed resident has decreased communication skills related to impaired cognition. The interventions included adjust voice and repeat as needed, communicate in the resident's language whenever possible, and make sure all basic needs are met.</p> <p>Review of clinical records dated February 9, 2025 revealed a progress note stating LPN/Staff #20 was standing in a hall just outside dining room talking with staff. The dementia aid/Staff #70 and resident #4 exit the dining room into hallway and aid states that resident #4 just punched another resident in the arm. This nurse/Staff #20 and a RN reviewed the camera footage. At 17:46 it is observed that the dementia aid who is on a one on one with resident #4 attempts to escort resident #4 from the dining room after dinner. Resident #4 is seen resisting and reenters the room and walks over to table where the other resident is seen sitting alone and trying to fold her cloth bib. Resident #4 approaches and attempts to take the cloth from resident. There is a brief tug and pull back and forth and the dementia aid is seen trying to intervene when resident #4 with her right arm punches resident #3 in the left arm. The aid then removes resident #4 from dining room. DON notified by phone and followed protocol for reporting altercation.</p> <p>Regarding Resident #5 and Resident #6:</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 - Some</p>	<p>-Resident #5 was admitted to the facility on [DATE] with diagnoses of unspecified dementia, Alzheimer's disease, unspecified psychosis not due to a substance or known physiological condition, and major depressive disorder.</p> <p>Review of resident's quarterly MDS assessment dated [DATE] revealed a BIMS score of 99.0, indicating no score available.</p> <p>Review of clinical record dated February 12, 2025 revealed a progress note stating Resident was being wheeled to room by staff when staff attempted to maneuver around a female resident which was combative at this time and as they passed by, the female swung her arm and hit resident #5 in the arm. Staff intervened and removed the female resident from the area. Nurse assessed resident and no injury was observed and resident denies pain or discomfort. Vitals signs were obtained and protocol for resident to resident were followed.</p> <p>Review of care plan dated June 15, 2021 revealed resident has visual impairment related to macular degeneration. The interventions included assist resident through doorways, around corners and objects as needed, and identify yourself and what you plan to do before providing care.</p> <p>Review of care plan dated July 25, 2018 revealed resident shows cognitive impairment and has communication skills related to dementia and hard of hearing. The interventions included adjust voice and repeat as needed, be sure resident can hear you, communicate in the resident's language whenever possible, make sure all basic needs are met, and use quiet setting as needed.</p> <p>-Resident #6 was admitted to the facility on [DATE] with diagnoses of dementia, major depressive disorder, and Alzheimer's disease with early onset.</p> <p>Review of quarterly MDS assessment dated [DATE] revealed a BIMS score of 3.0 indicating severely impaired.</p> <p>Review of resident's care plan dated February 23, 2021 revealed resident shows cognitive impairment, has visual impairment, and has impairment hearing The interventions included be sure resident can hear you, minimize background noise, speak in resident's usual language, make every effort to have interpreter available if needed, assist resident through doorways, around corners and objects as needed eye exam as needed or appropriate, adjust voice and repeat as needed and identify yourself and what you plan to do before providing care.</p> <p>Review of clinical record dated February 11, 2025 revealed a behavioral charting progress note stating Staff was attempting to remove resident from dining room after lunch because resident was attempting to take food of other residents' plates after everyone was cleared from dining room. Resident was becoming combative with staff. This nurse intervened and distracted resident and was able to redirect her with an offer of a boost shake. Resident then complained she was cold and blanket provided. Resident then calmed down and was sitting in hall with no further behaviors observed at this time.</p> <p>Review of clinical record dated February 11, 2025 (Recorded as Late Entry on February 12, 2025) revealed a progress note stating Resident was removed from dining room and this agitated her. Staff wheeled resident down hall and resident then wheeled over yelling at a male resident. Another staff was wheeling a male resident to his room and attempted to go passed resident and she swung her arm and hit the male resident in his arm. Staff separated resident and removed her from others.</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 - Some</p>	<p>An interview was conducted on February 19, 2025 at 2:16 pm with a certified medical assistant/Staff #40. Staff stated that she works in their long term care unit. She stated that she was not aware of any resident to resident altercation. She added that if there is a resident to resident altercation, she will report it immediately, separate the residents, have someone stay with the residents, and report it to DON. She stated that resident #1 was in the hospital and came back, and no issues with the resident. Staff identified resident #1 who is in dining room having bingo activity.</p> <p>An interview was conducted on February 19, 2025 at 2:22 pm with the Behavior unit director/Staff #12 in her office in the 400 unit. She stated that they had two incidents of resident to resident altercations which involved resident #3 and resident #4 and another incident which involved resident #5 and resident #6. Surveyor 49399 in staff #12's office to watch the video camera footage of the incidents. Staff stated that they can only look at the video camera for the last 14 days and anything pass that, they cannot see. At 2:25pm, looking at resident #3 and resident #4 incident on February 9, 2025 at 5:45pm. Staff stated that resident #4 is standing with the dementia unit attendant/Staff #70. Staff stated that the dementia unit attendant is trying to redirect resident #4 and resident #4 is resistive. The other resident, resident #3 is folding a crumb catcher, then resident #4 approaches resident #3 , Staff #70 was trying to intervene, as resident #4 is reaching for the crumb catcher, Staff #70 hand was in between them, to keep resident #4 from getting the crumb catcher, resident #3 is pulling back the crumb catcher, and Staff #70 was trying to let resident #4 to let go, resident #4 is pulling the crumb catcher, Staff #70 has both hands trying to let resident #4 to let go, Resident #4 right hand makes contact with resident #3's left arm. Staff #12 stated that resident #4 is on a one on one, and was placed on provider's visit list to be seen tomorrow. Staff #12 added that Staff #70 or one of the CNAs notified the nurse of what had happened. Staff #12 described the incident as a willful act, a resident to resident altercation, and whether the resident meant to harm the other resident or not. In addition, staff stated that there was no bruising, no pain, and neither one of the residents remembered it the next day.</p> <p>On February 19, 2025 at 2:41 pm, Staff #12 was viewing the video camera footage of resident #5 and resident #6. Staff stated that the incident happened in one of the hall, on February 11, 2025 at 6:10 pm, during the time they were bringing residents back from the dining room. Resident #6 was sitting in the wheelchair in the hallway, then resident #6 moved herself from sitting against the wall over by the nurses' cart parked to the left, resident #5 sitting in a wheelchair was being pushed by the CNA, trying to pass by resident #6 from her right side because resident #5's room is next to the nurses' cart. They were coming up to pass resident #6, and looks like resident #6 made contact with her right arm with resident #5's left arm, the CNA/staff #74 got resident #5 in his room, and resident #6 was taken further down the hallway so others can get by. Staff #12 stated that resident #6 made contact with her arm, making contact is a resident to resident altercation, and added that it does not matter how hard it is, it is a willful act. Staff #12 stated that the nurse was notified, and then the nurse notified the DON and the administrator, and completed a report. Staff #12 stated that the two incidents were the only ones that she can show through the video camera due to video timeframe of 14 days.</p> <p>On February 19, 2025 at 2:58 pm, an attempt to speak with resident #6 and resident is sleeping, not available for interview.</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 - Some</p>	<p>An interview was conducted on February 19, 2025 at 2:59 pm with activities assistant/staff #32. Staff stated that she has no knowledge of any recent resident to resident altercation. She stated that for any resident to resident altercation, she will get the residents apart and notify the nurse. She stated that she receives her abuse training from their healthcare academy, and as needed training with her supervisor.</p> <p>An interview was conducted on February 19, 2025 at 3:05 pm with resident #5 who was in the activity room, and reading a magazine. Resident #5 stated that he is alright.</p> <p>On February 19, 2025 at 3:08 pm, observed resident #4 in the activity room sitting at the round table with three other residents, and helping hand/staff #25 stated that last week resident #6 was getting upset, and resident #6 hit resident #5 on his arm as they were wheeling them after dinner. Staff #25 stated that while they strolled by resident #6, resident #6 hit resident #5 by the arm.</p> <p>On February 19, 2025 at 3:14pm resident #3 was sitting in her wheelchair watching television by the hallway, holding a doll, and CNA/staff #30 stated that she is not aware of any resident to resident altercation.</p> <p>An interview was conducted on February 19, 2025 at 3:18 pm with LPN/staff #20. Staff stated that between resident #5 and resident #6 incident, resident #6 has tendency to get upset when told to leave the dining room, so the dietary aid can clean the dining room and mop the floor and the resident can go back to do activities there. Staff remembered the incident that happened the first week of February. She stated that one of the staff removed resident #6 from the dining room, and resident became combative by grabbing rails, and then the staff took resident #6 in the hallway. While resident #6 is in the hallway, resident #6 wheels over to another resident. And, when another aid was pushing resident #5's wheelchair to go around resident #6, resident #6 wacked resident #5 in the arm. Resident #6 was removed from the crowd. She took vital signs and assessment, and resident #5 denied being hurt, and there were no marks or bruise. Staff stated that she discussed the incident with the behavioral unit/staff #12. When asked where staff #20 was during the incident, she stated that she was at the nurses' station about 6:00 pm charting and they came and told her that an incident occurred so she watched the video camera footage by the nurses' station and after reviewing the camera footage she made her report. Since then, they no longer force resident #6 to leave the dining room to prevent resident from getting agitated. In addition, Staff #20 remembered the other incident in the other hall involving the incident with resident #1. She stated that the aid came out and stated that resident #1 was the aggressor and hit resident #2. Resident #2 hit resident #1 first, he was the initial aggressor, happened during activities, and staff were present at the time. Resident #1 was coming to the activities, resident #2 raised his fist and resident #1 raised his fist, and when they pass by each other resident #2 hit resident #1 first, and then resident #1 reacted. Staff stated that resident #2 has been on a one on one, and that means that a staff is dedicated to one resident, to interact with the resident and stay with the resident. Furthermore, staff stated that when she worked another hall, resident #4 also is on a one on one always with a dementia aid. Staff stated that when she is made aware of resident incident, she will separate the residents, remove the residents from the situation, redirect and calm them down, and assess both residents for any injuries. Staff stated that nobody had any injuries for those two incidents she described and after this type of incident, they do 3-day alert charting. Regarding abuse training, she stated that abuse includes physical, verbal, emotional, they cannot restraint residents, and abuse is anything that cause harm to residents.</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 - Some</p>	<p>An interview was conducted on February 20, 2025 at 10:38 am with helping hand/staff #80. Staff stated that her role as a helping hand is to check briefs, restock rooms with briefs, gloves, clean drawers, tables, spills in the room, and make beds on shower days. She added that she has been on a one on one sitter for resident #4 and resident #2. Staff stated that regarding the incident on February 4, 2025 with resident #1 and resident #2, the incident happened in the activities room around the afternoon after lunch. She stated that she had been with resident #2, and that resident #2 wanted to get up and when they got in the activity room they sat there at the round table. Resident #2 pulled away from her because she had to put the snack on top of the popcorn machine because resident #2 is on puree diet and is not to have crackers. Resident #2 got upset. Since her role is helping hand, she cannot transfer resident #2 back to bed. Then, resident #2 removed himself from the beside while she removed the snack and placed it were resident #2 could not reach it. She stated that resident #2 was facing towards the door and she thought that resident was just waving him in and both resident #1 and resident #2 were side by side and resident #1 made a gesture by extending his arm and making a fist and resident #2 took it as a threat and went and swung his right arm to resident #1. Resident #1 went and swung back at resident #2 and that is when she got up while sitting by the table, and separated the residents, and after that she ask one activity staff to get her the nurse. Regarding her abuse training, she stated that abuse is financial, mental, physical, and emotional. She stated that the incident is physical because they were trying to hurt each other with their hands. In addition, she stated that her abuse training is done in the computer and they have monthly trainings through videos and from their care academy.</p> <p>An interview was conducted on February 20, 2025 at 11:02 am with activity assistant/staff #50. Staff stated that yesterday in the dining room while playing bingo game, resident #7 went to the table where he calls the bingo numbers, while he left to go to a resident who had won a bingo game. When he turned around, he saw resident #7 standing up and resident #8 was on his wheelchair. When he turned around, he saw resident #8 trying to get around resident #7. He stated that he did not see the part where resident #8 bumped resident #7's leg. He was not aware of it until he looked at the camera footage with the DON. Resident #7 got really upset and grabbed resident #8's jacket, and that is when he got in between them and separated the residents. Staff stated that the incident would be probably a physical altercation between two resident because one resident grabbed one's jacket and if he has not step in the middle, resident would have hit the other resident. Staff stated that resident #7 was very upset, and very angry looking. Staff stated that he is not aware of any behavior in the pass between the two residents. He added that once they separated them, another activity staff was there and he stayed while he went to the DON office to report the incident.</p> <p>An interview was conducted on February 20, 2025 at 11:46 am interview with resident #8. Resident #8 stated that he was playing bingo, they were giving present away, he was hit on his left leg, pointing on his left leg, and staff #50 saw it and said don't do that. He stated that he did not do anything with resident #7 because he is an old. Resident stated that there is nothing wrong with his leg now, and it is not hurting. Resident stated that they split them up after it happened.</p> <p>On February 20, 2025 at 11:53 am resident #7 was observed walking with his walker from the hall towards the dining room. Resident did not want to stop and speak with the surveyor.</p> <p>(continued on next page)</p>		

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 02/20/2025
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 - Some</p>	<p>An interview was conducted on February 20, 2025 at 11:59 am with the DON/Staff #10 and present during the interview is ADON/Staff #90. DON stated that regarding abuse, abuse is sexual, physical, verbal, financial, and is reported immediately to appropriate agencies and investigated. DON stated that regarding resident #1 and resident #2 incident, it took place in the activity room, resident #1 raised his arm with closed fist, resident #2 raised his right hand with closed fist and make contact with resident #1's right hand, and resident #1 responded with his closed fist and made contact with resident #2. DON stated that it is a resident to resident altercation, classified under their physical abuse policy. DON stated that regarding resident #3 and resident #4 incident, resident #4 was seen walking over to resident #3 at the dining room table. Resident #4 attempted to take the cloth from resident #3, they had a tug, the dementia aid attempted to intervene, resident #4 made contact with her left arm to resident #3. DON stated that it is a resident to resident altercation. They do their best to prevent it. It is a reportable incident classified under their physical abuse policy. DON stated that regarding resident #5 and resident #6 incident, resident #6 swung her arm and made contact with resident #5's arm. DON stated that it is classified under their physical abuse policy for a resident to resident altercation. DON stated that regarding resident #7 and resident #8 incident, resident #7 was standing at the dining area attempting to go around , resident #7 loses balance and pushes William's wheelchair. Resident #7 became upset and grabbed resident#8's jacket sleeve, there were 2 activity staff there, and they intervened and separated the residents. DON stated that it is under their physical abuse policy for a resident to resident altercation abuse policy. Regarding interventions, the DON stated that they have done in-services to staff in regards to resident to resident altercation, and they plan to add dementia intervention training from their health care academy dementia training.</p> <p>During the interview with the DON, at 12:13</p>		