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 03/27/2025

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 - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553 Based on clinical record reviews, facility documentation, observation, staff interviews and policy review, the facility failed to ensure that one resident (#41) was free from physical abuse by a resident (#37). The deficient practice could result in further incidents of resident to resident abuse and could lead to injury. Findings include: Resident #41 was admitted to the facility on [DATE] with diagnoses that included nontraumatic subarachnoid hemorrhage, dementia without behavioral disturbance, and stage five chronic kidney disease. Review of the Minimum Data Set (MDS) dated [DATE] revealed that Resident #41 had a short-term memory problem and had a moderate impairment to decision making skills. Resident #37 was admitted to the facility on [DATE] with diagnoses that included dementia without behavioral disturbance, restlessness and agitation, and major depressive disorder. Review of Resident #37's care plan revealed a problem, initiated on November 27, 2024, which indicated that Resident #37 may show behaviors that included throwing items at staff or other residents, verbal aggression towards caregivers, hallucinations, and delusions. The goal in place was to minimize behaviors and to reduce the risk of harming self or others. Interventions included to offer the resident a baby doll, to document behaviors, and to make sure basic needs are met. Review of the MDS dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. The nursing progress note dated March 9, 2025 at 3:56PM revealed that Resident #37 was experiencing false beliefs that Resident #41 was her ex-husband. The note indicated that Resident #37 was telling Resident #41 that he should not be here and he need to leave. The note indicated that these comments occurred repeatedly, and the two residents were separated. (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 - Few	The nursing progress noted dated March 13, 2025 at 6:03PM revealed that shortly before dinner time, Resident #37 had gone into Resident #41's room and attempted to close the door behind her. When staff attempted to remove her from the room, Resident #37 became upset. The note indicated that Resident #37 believed Resident #41 was her abusive ex-husband. Staff were able to remove her from the room and calm her down. The nursing progress note dated March 14, 2025 at 5:48AM revealed that Resident #37 had stated that she wanted to hit Resident #41. Resident #37 stated that Resident #41 did not belong here, and that staff needed to get him out of her house. The note indicated that Resident #37 believed Resident #41 was her ex-husband and had changed his name. The staff redirected the resident and reassured her that she was safe. An additional note was added on March 14, 2025 at 1:40PM, indicating that Resident #37's Seroquel dosage was increased due to increased behaviors. A nursing note dated March 15, 2025 at 09:16PM revealed that at approximately 7:05PM, staff witnessed Resident #37 approaching Resident #41, and Resident #37 was stating that she had a restraining order on Resident #41. Resident #37 told Resident #41 that he should not be here. The two residents were separated. The nursing note indicated that staff checked the cameras and confirmed physical contact between the two residents. The note indicated that in the footage, Resident #37 could be seen approaching and kicking Resident #41's wheelchair and then placing him into a room. After Resident #41 exited the room, Resident #37 re-approached him and kicked his right leg. The note detailed that staff then intervened and separated both residents, and no injuries were noted to either resident. Review of the behavior charting note dated March 17, 2025 at 05:50AM revealed that Resident #37 was observed panicking upon seeing Resident #41 approaching. The note indicated that Resident #37 was triggered and anxious upon seeing Resident #37. Staff were able to assure Resident #37 that she was safe and that Resident #41 was staying on his side of the hall. A nursing note dated March 17, 2025 at 1:50PM revealed that Resident #37 and her family agreed to move Resident #37 to a room on a different hallway from Resident #41. An additional nursing note dated March 18, 2024 at 02:57AM revealed that Resident #37 appeared much calmer after moving to another unit, and the resident expressed that she was glad that she had moved. Interview was conducted on March 27, 2025 at 7:59AM with a Licensed Practical Nurse (LPN/Staff #26), who had witnessed a conflict between Resident #37 and Resident #41 that occurred on March 13, 2025. The LPN explained that Resident #37 had mistaken Resident #41 for her abusive ex-husband. The LPN explained that Resident #37 was crying and yelling at Resident #41 in the Navajo language. The resident then started going into his room. The LPN stated that the resident made it just past the doorway and attempted to close the door. The staff were able to grab under her arms and remove her from the room. The LPN stated that she was able to calm down Resident #37 by explaining that Resident #41 was not her ex-husband and that he would not hurt her. The LPN stated that she had heard of one or two prior incidents where Resident #37 mistook Resident #41 for her ex-husband and got upset, though staff did not immediately understand what had triggered Resident #37 to become so upset. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview was conducted on March 27, 2025 at 08:19AM with a Licensed Nursing Assistant (LNA/Staff #47), who also confirmed witnessing a conflict between Resident #37 and Resident #41 on March 13, 2025. The LNA reported that she was sitting in the hallway when she witnessed Resident #37 entering Resident #41's room. The LNA explained that Resident #37 was yelling at Resident #41, and Resident #37 began throwing the personal protection equipment (PPE) outside of the room at staff who had attempted to intervene. Staff were able to remove Resident #37 by hooking under her arms and re-directing her out of the room and closing Resident #41's door. The LNA stated that staff were able to calm the resident by reassuring her that Resident #41 was not her ex-husband and by telling her that he would not hurt her. When asked if this incident had been reported, the LNA stated that she had brought the incident up in the staff meeting the next day, and she had also reported it to the Assistant Director of Nursing (ADON). The LNA also stated that nightshift staff was aware of this pattern of behavior from Resident #37, which was directed at Resident #41. She stated that night shift had reported at least two times over a period of approximately one to two months to dayshift staff about these behaviors. Interview was conducted on March 27, 2025 at 10:48AM with the Director of Nursing (DON/Staff #55), who confirmed that on March 15, 2025 at approximately 7:05PM, Resident #37 approached Resident #41 and kicked him in the right leg. The DON stated that the nursing staff on duty during the incident heard Resident #37 tell Resident #41 that she had a restraining on him and that he should not be here. Following the event, the nursing staff placed Resident #41 in his room and walked Resident #37 to the other end of the hall. The DON stated that both residents were assessed and no injuries were noted. Additionally, Resident #37 was moved to a separate hall from Resident #41, as recommended by the consulting psychiatric physician. The DON stated that during the incident, staff re-assured Resident #37 that Resident #41 was not her ex-husband. When asked if the two residents had any history of behaviors or aggression toward each other, the DON stated that the two residents did not know each other prior to coming to the facility and that they had not had any resident to resident altercations prior to this incident on March 15, 2025. The DON then reviewed the nursing progress notes and noted that on March 13, 2025, it was noted by a nurse that Resident #37 believed Resident #41 was her abusive ex-husband. When asked if this had been reported to her or other management, the DON stated that the nursing note did not indicate that the nurse had notified other staff. The DON further reviewed the nursing progress notes and stated that on March 9, 2025, a nursing note was entered that indicated that Resident #37 was witnessed telling Resident #41 that he should not be here and that he needed to leave. The DON again stated that the nursing note did not indicate that staff brought this up to management or other staff. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the camera footage for March 15, 2025 at 7:00PM was conducted with the DON on March 27, 2025 at 11:58AM. In this footage, both residents can be seen at 7:02PM on opposite ends of the hallway. The DON identified both residents as Resident #37 and Resident #41. She stated that at this time, Resident #37 was seen looking down the hallway at Resident #41. At 7:03PM, Resident #37 was seen getting up from her seat. She attempted to enter a resident's room before turning and approaching Resident #41's wheelchair. At this time, Resident #37 kicked her leg out, though it was unclear what she had kicked. The DON stated that it appeared that she had kicked the wall beside Resident #41. The DON described the footage, stating that it appeared that Resident #37 was looking at Resident #41, touching the locks on his wheelchair, and pointing for him to go down the hall. At 7:04PM, Resident #37 kicked the wheel of Resident #41's wheelchair, causing him to turn slightly. Resident #37 then went behind Resident #41's wheelchair and began to push him down the hallway and pushed him into a resident's room. The DON identified that the room did not belong to Resident #37. Resident #37 then wheeled himself out of the room at 7:05PM. The DON described that the footage then revealed that Resident #37 re-approached Resident #41, who had turned toward Resident #37. Resident #37 was seen talking to Resident #41 before kicking his right leg and pushing him back into a room. At 7:06PM, staff was seen approaching the two residents and separating them. The DON identified the staff who assisted and stated that this staff had assisted Resident #41 into his room while Resident #37 walked down to the other end of the hall. In March 2025, the facility began Dementia Capable Care training for all nursing staff and certified nursing assistants, using the Crisis Prevention Institute program. Additionally, a meeting was held with the psychiatrist, medical director, administrator, nursing leadership, and admission coordinator to review the behavioral units. The discussion focused on current interventions and identifying changes to reduce resident-to-resident altercations and improve overall care. On March 18, 2025, a nursing meeting was conducted to review the changes made to the behavioral units. This included updates to care plans and the implementation of safety devices to prevent falls. Following this, on March 20, 2025, all staff received in-service training on the updates to the behavioral units. The facility has also held weekly interdisciplinary meetings involving nursing management, social services, and therapy staff. These meetings focus on reviewing fall incidents, updating care plans, and assessing the effectiveness of current safety measures. As a result of these reviews, therapy evaluations were ordered for certain residents, environmental safety devices were inspected and repaired as needed, and additional safety equipment was provided to ensure resident safety. Review of the facility policy titled, Abuse Prevention Policy and Procedure, indicated that it is the policy of the facility to take appropriate steps to prevent the occurrence of abuse, neglect, and mistreatment. The policy indicated that physical abuse included hitting, slapping, punching, biting, pinching, and kicking. This policy also indicated that the interdisciplinary team would attempted to identify residents whose personal histories may render them at risk for abusing other residents and develop intervention strategies to prevent occurrences and monitor for changes that would trigger abusive behavior.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553 Based on clinical record reviews, staff interviews, and review of facility documentation and policy, the facility failed to evaluate and implement effective care plan interventions related to falls for one resident (#11). The deficient practice resulted in the resident experiencing multiple falls in the facility, and could result in other residents failing to receive effective fall-prevention measures. Findings include: Resident #11 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance, cardiomyopathy, and pulmonary fibrosis. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Review of the resident care plan revealed a problem initiated on February 15, 2021, which indicated that the resident was at risk for falls related to advanced aging, dementia, and a history of falls. This problem also indicated that the resident refused to use the wheelchair and would get physically aggressive when this was suggested. Initial interventions initiated on February 15, 2021 included to provide an environment free of clutter, to leave a night light on, to keep the call light within reach at all times, and to give verbal reminders to not ambulate or transfer without assistance. Review of the resident observations charting in the Electronic Health Record (EHR) revealed six documented falls had occurred after the initial care plan entry, before a new care plan intervention was implemented. An additional review of the care plan problem related to falls revealed a new intervention was added on April 14, 2023 to include the addition of a Call, Don't Fall sign in the resident's room. Further review of resident observations charting revealed two additional unwitnessed falls occurred after the addition of the latest care plan intervention. A new care plan intervention was added on September 27, 2023 to include that staff change pull-ups regularly, per family request, so that the resident does not slip if urine gets onto the floor. The review of the resident observations charting revealed an unwitnessed fall occurred on October 24, 2023, and a new care plan intervention was therefore added on October 30, 2024 to indicate the usage of a bed alarm for the resident. Further review of resident observations charting revealed Resident #11 suffered three additional falls before a new care plan intervention was added on July 25, 2024, which instructed staff to encourage the resident to ask for assistance with toileting. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the observations charting and care plan revealed that the resident proceeded to have two more unwitnessed falls, on August 16, 2024 and December 23, 2024. New interventions were care planned for these falls appropriately, including the usage of a wheelchair pad alarm and for staff to ensure that alarms were on and working. The documented observations charting included that the resident experienced a witnessed fall on January 7, 2025 and an unwitnessed fall on February 4, 2025. No new interventions were added to the resident's care plan following these incidents. Further review of the charted observations revealed that the resident was found to have bruising to the right eyelid and complaints of pain to her right arm on March 15, 2025. At the time, staff were unsure of how the injury had occurred. The resident was sent to the hospital following this discovery, and returned the same day. The resident experienced an additional unwitnessed fall on March 16, 2025, and a new care plan intervention was added on this date to include that staff should ensure that the bed alarm is working properly every shift. Interview was conducted on March 27, 2025 at 07:59AM with a Licensed Practical Nurse (LNA/Staff #26), who stated that the facility had several interventions that could be utilized for fall prevention, such as safety belts, chair and bed alarms, padding around beds, wedges on beds, and floor mats. The LPN confirmed that she was familiar with Resident #11, and stated that the resident often wanted to do things her own way. The LPN stated she was aware of a few falls from Resident #11, which occurred due to the resident self-transferring. The LPN stated that she did not witness these falls but heard about them through report. She reported that interventions in place for this resident included reminding her to not self-transfer, safety belts, and alarms on her bed and wheelchair, which the resident would often remove. Interview was conducted on March 27, 2025 at 08:19AM with a Certified Nursing Assistant (CNA/Staff #47), who stated that fall risk residents would have care plan entries that identified them as a fall risk and any interventions in place for them. She identified some fall prevention techniques available at the facility to include safety belt alarms, bed alarms, chair alarms, bolsters on the beds, and floor mats. When asked what interventions are utilized for residents with frequent falls, the CNA identified multiple interventions that could be utilized. These interventions included having the resident begin physical therapy to keep them busy and occupied, walking with the resident, and the usage of dementia attendants that provide one-on-one activities for the resident. The CNA stated that the facility does not always have dementia attendants available for every hall, but they are added to the schedule as needed. The CNA also expressed that she felt that staffing was inconsistent to meet the needs of the residents. She stated that between CNAs and dementia attendants, she felt that some days had enough staff while others were lacking, especially on weekends. When asked about Resident #11, the CNA confirmed that she was familiar with the resident. The CNA stated that the resident often wanted to walk, and her steadiness varied day-to-day. The CNA revealed that she did not witness Resident #11's most recent fall, but had heard that the resident had fallen and hit the footboard to her bed. The CNA identified that Resident #11 had a bed and chair alarm in place, but stated that when staffing is lacking, it can be hard to respond to the alarms in a timely manner without leaving another resident in need unattended. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview was conducted on March 27, 2025 at 10:48AM with the Director of Nursing (DON/Staff #55). When asked how staff are to know what interventions or care is needed for a resident, the DON stated that staff obtain the needed information through report. She stated that if the staff have never cared for the residents before, they are expected to communicate with their peers and manager, and to reference the residents' care plans. She also stated that staff can determine what interventions should be utilized for fall-prevention by viewing a resident's orders and care plan. The DON revealed that falls are also discussed in meetings with all department heads to discuss what is in place and what is needed, and care plans will be adjusted if needed. The DON identified interventions available to use for fall-prevention to include safety devices (such as wheelchair alarms, self-release seatbelt alarms, bed alarms), low beds, fall mats, and bolsters on beds. The DON also stated that care plans are reviewed at the time of any events, such as when a fall occurs, to see if adjustments are needed. She stated that the care plan should be updated or reviewed after a fall occurs. When asked if she would expect new interventions to be placed for a resident after a fall, the DON stated that it would be on a case-to-case situation. The DON elaborated that if it was the resident's first fall, the staff would attempt to figure out why the fall occurred. The DON explained that if the resident was self-transferring, the staff would consider interventions such as more frequent rest periods if the fall occurred while attempting to get out of bed. If the fall occurred as the resident attempted to go to the restroom, more frequent toileting would be utilized. If the resident was attempting to ambulate, then staff would encourage more ambulation. The DON also stated that if the resident's fall occurred because they slid out of the wheelchair, adaptive safety devices would be considered for the wheelchair itself. When asked about Resident #11, the DON identified fall-prevention interventions in place for this resident to include: bed in lowest position, ensuring alarms were on and functional, wheelchair and bed alarms, giving verbal reminders to call for help, keeping the call light within reach, a night light on in the room, keeping the environment free of clutter, and encouraging asking for help with toileting. When reviewing the falls that Resident #11 had experienced, the DON identified that some falls had new interventions added, while others did not. The DON stated that some of the falls did not require new interventions due to the circumstances of the fall. For example, the DON stated that for the fall that occurred in December 2024, the resident slid out of the wheelchair, as opposed to attempting to self-transfer, so the DON did not believe new interventions were needed at that time. When asked if a dementia attendant or sitter was considered for Resident #11, the DON replied that this was not appropriate, as a dementia attendant would be assigned for a whole unit, not necessarily for one specific person. The DON also stated that sitters were only used for residents with consistent, frequent impulsiveness throughout the day, and the DON did not feel that the resident fit the criteria. Review of the facility policy titled, Fall Prevention Policy, revealed that each resident will be assessed for falls at least quarterly, annually, and when a significant change of status occurs. The policy also stated that a plan of care will be developed for a resident found to be at risk for falls on the comprehensive care plan that provides appropriate interventions and will be revised as necessary. The policy revealed that falls should be reviewed daily in the morning meets and staff should ensure that immediate interventions were in place and that the care plan had been updated. The policy also stated that interventions should be immediate after every fall, and the care plan approaches should be reviewed and revised as appropriate.