

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 04/28/2025
NAME OF PROVIDER OR SUPPLIER Winslow Campus of Care		STREET ADDRESS, CITY, STATE, ZIP CODE 826 West Desmond Street Winslow, AZ 86047	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51124</p> <p>Based on observation, interviews, review of records, and review of facility policy and procedure, the facility failed to ensure a resident (#6) was not abused by another resident (#3). The deficient practice could lead to physical and psychosocial harm to residents.</p> <p>Findings Include:</p> <p>Regarding Resident #6:</p> <p>Resident #6 was readmitted to the facility on [DATE], with diagnoses that included senile degeneration of brain, paroxysmal atrial fibrillation, hypertension, chronic obstructive pulmonary disease, and type 2 diabetes mellitus.</p> <p>A quarterly minimum data set (MDS) assessment dated [DATE], revealed the resident had a brief interview for mental status (BIMS) score of 4, indicating severe cognitive impairment.</p> <p>A progress note dated April 18, 2025, revealed at 7:45 AM, the nurse was notified by certified nursing assistants (CNAs) that another resident hit Resident #6 in the right arm during breakfast. CNAs intervened and immediately separated the residents. Upon review of video recording, it was observed that the resident was trying to back up his wheelchair from the table. The other resident's wheelchair was bumped unintentionally, making the other resident offended, then hitting Resident #6 in the right arm. Resident #6 was assessed, with no injuries noted except for slight redness to his wrist. Notifications were made to the provider, the resident's family, and the administrator.</p> <p>Regarding Resident #3:</p> <p>Resident #3 was readmitted to the facility April 7, 2025, with diagnoses that included expressive language disorder, type 2 diabetes mellitus, hypertension, sepsis, Parkinsonism, and hemiplegia and hemiparesis affecting the left side.</p> <p>A quarterly MDS assessment dated [DATE], revealed the resident had a BIMS assessment that was unable to be completed.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated April 18, 2025, revealed at approximately 7:40 AM, Resident #3 was at breakfast in the main dining room and was sitting at his table when another male resident whom was sitting at another table next to each other had attempted to move his wheelchair backwards, and bumped into Resident #3. Both residents began to move themselves backwards and when Resident #3 was able to see the other male resident, Resident #3 hit the other male resident in the right arm. Resident #3 had used his own right hand to do this. Both residents were separated. Notifications were made.</p> <p>A witness statement dated April 18, 2025, by a CNA (Staff #8) revealed that Staff #8 was assisting a resident when she turned around and saw Resident #3 swing once at Resident #6 's right arm. Staff #8 quickly got between the residents and separated them. Staff #8 stated that he was hit in the chest.</p> <p>A witness statement dated April 18, 2025, by another CNA (Staff #32) revealed that at approximately 7:35 AM, in the dining room, Staff #32 witnessed Resident #3 swing and contact Resident #6's arm and chest area. Staff #32 and another CNA quickly separated the residents.</p> <p>A Facility Reportable Event Record dated April 24, 2025, revealed at approximately 7:39 AM, Resident #6 was seen pushing his wheelchair back to get away from the dining table and then Resident #3's chair is backed into in the process. While Resident #6 moved his chair back, Resident #3 attempted to move away. The two residents came side to side in their wheelchairs, and Resident #3 looked at Resident #6 and used his right arm to contact with a closed fist Resident #6's right forearm. Upon review of the incident, it was noted that Resident #6 was not in his usual seating area at the dining table. Staff were made aware due to Resident #6 wanting to leave when he was done with meals, to leave him in his original seating area, which is on the opposite side of the table. Both residents were assessed and no injuries were noted. In conclusion, the facility found that Resident #3 contacted Resident #6 in the right forearm.</p> <p>An observation was conducted on April 28, 2025, at 3:04 PM, of the video footage of the incident. Resident #6 and Resident #3 were positioned back to back at tables next to each other, sitting in their wheelchairs. The wheelchairs were very close to each other. Resident #6 attempted to back up and appeared to get his wheelchair wheels stuck against Resident #3's wheelchair wheels. The residents turned in their wheelchairs so they were positioned side by side, and then looked at each other. Resident #3 then hit Resident #6 in the right forearm with his fist. CNAs approached the residents and separated them.</p> <p>An interview was conducted with a CNA (Staff #8) on April 28, 2025, at 12:54 PM. Staff #8 stated that she was sitting at the same horseshoe-shaped table, and the other CNA (Staff #32) was looking at the residents and called out suddenly. Staff #8 looked, and Resident #3 already had his right arm extended. Staff #8 stated the residents backed into each other, and that Staff #8 believed Resident #3 hit Resident #6 in the chest. Staff #8 stated that she jumped up and separated the residents. Additionally, Staff #8 stated she asked Resident #6 where did he hit you? and that the Resident #6 answered my chest.</p> <p>An interview was conducted with Resident #6 with a translator on April 28, 2025, at 12:59 AM. Resident #6 stated he remembered the incident and that the other resident hit him in the chest and the hand.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An additional interview was conducted with Staff #32 on April 28, 2025, at approximately 1:10 PM. Staff #32 stated that she saw the incident and that Resident #3 hit Resident #6 in the chest and upper arm area approximately 2 to 3 times, and that it was somewhat forceful. Staff #32 stated the residents were separated.</p> <p>An interview was conducted with the Director of Nursing (DON / Staff #70) on April 28, 2025, at 2:58 PM. The DON stated that the facility does not tolerate any forms of abuse and that abuse is prevented by monitoring residents, assessing risk factors, and reporting any allegations of abuse. The DON stated that her understanding of the incident between Resident #6 and Resident #3 was that Resident #6 was not sitting in his usual spot in the dining room, and was positioned directly behind Resident #3. Resident #6 was attempting to back up in his wheelchair and bumped into Resident #3. Resident #3 turned to see who was backing into him and then struck out with his right hand and contacted Resident #6's right forearm. The DON stated that the residents were separated and have been monitored to ensure retaliation does not occur.</p> <p>Review of the facility's policy titled Abuse Prevention Policy and Procedure, revised April 2025, revealed that resident to resident physical altercations must be reported and include any willful action that results in physical injury, mental anguish, or pain. Examples include: hitting, slapping, punching choking, shoving. Abuse means the willful infliction of injury resulting in physical harm, pain, or mental anguish. Willful, as used in the definition means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p>