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	11/19/2025

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** Based on observation, interviews, review of records, and review of facility policy and procedures, the facility failed to ensure that two sampled residents (#88 and #71) were not physically abused by residents (#76 and #84). The sample size was 6. The deficient practice could lead to physical and psychosocial harm to residents.Findings Include:-Regarding residents #88 and #76Resident #88 was admitted to the facility on [DATE] with diagnoses including: unspecified dementia, with other behavioral disturbance, and insomnia.An admission minimum data set (MDS) assessment dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 7, indicating severe cognitive impairment. Review of the care plan for resident #88 reveals a focus starting on July 16, 2025, for exhibiting behaviors of pacing in common areas, wandering, invading others personal space.A nursing progress note dated September 12, 2025 revealed that resident #88 was self-ambulating in the hallway when another female resident (#76) approached her while sitting in a wheelchair and kicked resident #88 in the leg. Residents were separated and assessed for physical injuries. No physical injuries were noted in skin assessments.Resident #76 was admitted to the facility on [DATE] with diagnoses including: dementia with psychotic disturbance, anxiety disorder, and hearing loss.A quarterly minimum data set (MDS) assessment dated [DATE] revealed resident #76 had a brief interview for mental status (BIMS) score of 9, indicating severe cognitive impairment. Further, resident #76 was noted to have physical behavioral symptoms directed towards others 1 to 3 days per week.A nursing progress noted dated September 12, 2025 at 7:30 a.m. revealed that resident #76 was sitting in her wheelchair outside her room door and when she saw resident #88 self-ambulating. Resident #76 self-propelled her wheelchair towards resident #88, stopped resident #88 in hallway, and kicked her in the leg. Staff members separated both female resident from each other. When interviewed by staff, resident #76 stated she was upset with resident #88 for entering her room and taking her things.An interview was conducted on September 30, 2025 at 9:05 a.m. with staff Licensed Practical Nurse (LPN/staff #89) Staff #89 stated that on September 12, 2025, shortly after 7:00 a.m., she witnessed resident #88 walking and was stopped by resident #76. Staff #89 stated she witnessed resident #76 kick resident #88, Staff #89 then called out to resident #76 to stop. Staff #89 then immediately separated the residents and assessed both residents for injuries. She saw no physical injuries to either resident.An interview was conducted on September 30, 2025 at 11:28 a.m. with the Director of Nursing (DON/staff #108). She stated that the surveillance video for September 12, 2025 was no longer accessible. DON #108 stated that she had reviewed the footage before its deletion and saw the video of resident #76 kick resident #88. DON #108 stated that the events would be considered abuse and did not meet her expectations. -Regarding residents #71 and #84Resident #71 was admitted to the facility on [DATE] with diagnoses including: unspecified dementia, with behavioral disturbance, insomnia, sleep apnea, chronic pain, encephalopathy, and age-related physical debility.An admission minimum data set (MDS) assessment dated [DATE] revealed resident #71 had a brief interview for mental status (BIMS) score of 5, indicating severe cognitive impairment. No indicators for behaviors were noted in the MDS. A nursing progress note dated September 23, 2025 at 6:14 p.m. revealed that at 4:17 p.m. Registered (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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(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	Nurse (RN/staff #62) witnessed an altercation between resident #71 and another resident. Resident #71 was noted to have no physical injuries from the incident. Skin assessments revealed no physical injuries to either resident.Review of the care plan for resident #71 revealed a focus dated September 24, 2025 that resident #71 may strike out at men that are in her area and that she is fearful of men she doesn't know.Resident #84 was admitted to the facility on [DATE], with diagnoses including: Altered mental status, reduced mobility, depression, alcohol abuse, chronic pain, and dysphagia.A quarterly minimum data set (MDS) assessment dated [DATE] revealed resident #84 had a brief interview for mental status (BIMS) score of 6, indicating severe cognitive impairment. No behaviors were noted in the MDS assessment.A nursing progress note dated September 23, 2025, at 6:10 p.m. revealed that at 4:17 p.m. resident #84 was witnessed by staff #62 hitting another resident before both residents were separated by staff. An interview was conducted on September 30, 2025 at 10:11 a.m. with staff #62. Staff #62 stated that she witnessed residents #84 and #71 sitting in their wheelchairs in the television room as she was working at the med cart nearby. Staff #62 stated that on September 23, 2025 in the afternoon, she observed residents #71 an #84 hitting and slapping towards each other. Staff #62 separated both residents. Staff #62 stated she was unsure if either resident made contact with the other. Staff #62 assessed both residents and no physical injuries were noted.On September 30, 2025 at 11:21 a.m. video surveillance of the incident was reviewed. Video timestamp revealed that the incident occurred at 4:17 p.m. on September 23, 2025. Video showed resident #71 sitting in her wheelchair when resident #84 self-propelled himself next to resident #71. The two residents exchanged words for several seconds and resident #71 began making slapping motions towards resident #84. Resident #84 then began slapping resident #71 and making contact. Staff #62 arrived to the scene and separated the two residents.An interview was conducted on September 30, 2025 at 11:28 a.m. with DON #108. DON #108 stated that this incident would be considered abuse and did not meet her expectations for the facility and could result in psychosocial and physical harm.Review of the facility's abuse policy titled Abuse Prevention Policy and Procedure; revised April 2025 revealed that it is the policy of the facility to take appropriate steps to prevent the occurrence of abuse. The policy defines abuse is defined at willful inflection of injury, intimidation or punishment, irrespective of any mental or physical condition.