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	12/17/2025

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, and staff interviews, the facility failed to ensure that residents are free from abuse from another resident (Residents #1 and #3). The deficient practice could lead to additional resident-to-resident altercations, thereby creating an unsafe environment.Findings include:-Regarding Resident #1:Resident #1 was admitted on [DATE], with diagnoses that included unspecified dementia, unspecified severity, with other behavioral disturbance, and unspecified dementia, severe, with psychotic disturbance.A quarterly MDS (Minimum Data Set) assessment dated [DATE], revealed a BIMS (brief interview for mental status) score of 05, indicating that the resident had severe cognitive impairment. The MDS assessment also revealed that within the last seven days before the assessment, Resident #1 exhibited verbal behavioral symptoms directed towards others one to three days out of the seven; other behavioral symptoms not directed towards others occurred four to six days, but not daily; rejection of care and wandering occurred daily.An order dated December 1, 2025, revealed that Resident #1 exhibited aggressive/combative behavior, and to move the resident to a quiet room until the episode is resolved; to remove potentially harmful objects from the immediate environment; protect other residents in the immediate area from harm; and to document behavior in the progress notes for 72 hours every shift.A progress note dated December 1, 2025, at 7:05 PM revealed that Resident #1 had been in the dining room when she took the food off of another resident's plate. The note also documented that the other resident swatted at Resident #1 and proceeded to grab her right breast. The progress note also noted that Resident #1 had an assessment completed, reporting three scratches on the right breast measuring 3.5 cm (centimeters), 5 cm, and 2 cm. The note also documented that the two residents were separated immediately and that contact was made with the DON (Director of Nursing), the police, and APS (Adult Protective Services). A progress note dated December 1, 2025, at 9:22 PM, revealed that Resident #1 will be on behavior charting and exhibited no further behaviors towards the other resident, or signs or symptoms of distress or discomfort. The note also documented no signs of infection to the three scratches on the right breast of Resident #1. A progress note dated December 2, 2025, at 1:39 PM, revealed that Resident #1 was still on behavior charting and exhibited no further behaviors or signs or symptoms of distress or discomfort. A care plan focus, dated December 2, 2025, revealed that Resident #1 had scratches on her right breast related to a resident-to-resident altercation, with a target goal to have the scratches heal without complication. A progress note dated December 3, 2025, at 4:26 AM, revealed that Resident #1 was still on behavior charting for the resident-to-resident altercation, as well as an unrelated fall, and exhibited no further behaviors or signs or symptoms of distress or discomfort. A behavioral health consult note, dated December 4, 2025, revealed that Resident #1 had been seen for a resident-to-resident altercation in which Resident #1 attempted to grab another resident's food from the dining room table. The other resident grabbed Resident #1's right hand, then squeezed her right breast. The note also documented that staff will implement monitoring during meal times as an intervention to avert further interactions.A progress note dated December 6, 2025, at 3:46 AM, revealed that Resident #1 was still on behavior charting and exhibited no further behaviors or signs or symptoms of distress or discomfort. The note also documented that the scratches on her breast are healing appropriately.-Regarding Resident #3:Resident # 3 was re-admitted on [DATE], with diagnoses that included vascular dementia, unspecified severity, with other behavioral disturbance, and unspecified mood affective disorder.An order dated December 1, 2025, revealed that Resident #3 had been involved in a resident-to-resident altercation and directed that the altercation be documented in progress notes.An annual MDS assessment dated [DATE], revealed a BIMS score of 99, indicating that the resident was unable to complete the interview.A progress note dated December 1, 2025, at 7:21 PM, revealed that Resident #3 had been sitting at a dining room table during dinner when another resident approached her and attempted to grab at her food. The note also revealed that Resident #3 grabbed the hand of the other resident to push that arm away, and then grabbed, twisted, and scratched the right breast of the other resident. The progress note also documented that the two residents were separated, placed on behavior monitoring to be kept apart, and that contact was made with the DON (Director of Nursing), the police, and APS. A progress note dated December 1, 2025, at 9:24 PM, revealed that Resident #1 was still on behavior charting due to a resident-to-resident interaction and exhibited no further behaviors or signs or symptoms of distress or discomfort. A progress note dated December 2, 2025, at 1:43 PM, revealed that Resident #1 was