Printed: 04/01/2026
Form Approved OMB
No. 0938-0391

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	01/05/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and review of policies, the facility failed to ensure one resident (#61), did not receive medication prescribed to another resident (#71). The deficient practice could result in complications and adverse medication side effects.Findings include:-Regarding resident #61Resident #61 was admitted on [DATE] with diagnoses that included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and primary anxiety.Resident #61 had medication orders for over the counter (OTC) calcium carbonate as needed, claritin (OTC) once a day, famotidine (OTC) at bedtime, lidocaine pain relief adhesive patch (OTC) twice a day, Systane eye drops (OTC) four times a day, and Tylenol as needed.Resident #61 had no orders for any prescription medication to be administered.A minimum data set (MDS) quarterly assessment dated [DATE] identified the resident's cognition as continuously inattentive with disorganized thinking. Resident scored a 04 on a brief interview for mental status (BIMS) indicating severely impaired cognition.Review of resident #61's care plan that was reviewed on November 5, 2025 identified a problem of cognitive impairment and that the resident displayed confusion, forgetfulness and inattention at times. This problem also included that the resident speaks and understands Navajo language. Interventions were identified. A progress note, dated December 31, 2025 at 12:29 pm, documented that the resident was observed lying on the floor in the dining room next to a chair she had been sitting in. The note revealed the resident (#61) was responsive but was very tired and her speech was slow. The progress note further revealed that the resident was breathing more rapidly than normal, she was unable to stand on her own and staff assisted her to a sitting position. Additionally, the note revealed that the resident denied pain and was moving around but was very confused. It was documented that the on-call [provider] was notified, an order was received and the resident was sent to the emergency department (ED) for evaluation.Facility documentation of vital signs for this event were recorded in the nursing documentation.December 31, 2025 at 11:50 am: respirations: 28 per minute, temperature: 97.6 F, pulse: 57 per minute, blood pressure: 62 / 40 mmHg, O2 Saturation: 87 %, and pain: 0 of 10.An ED physicians note on December 31, 2025 at 12:26 pm documented that the resident (#61) had an unwitnessed fall out of her w/c in dining hall at the facility. Per this physician report there was a report per emergency medical services (EMS) that they were called to the nursing home for a concern of an elderly woman who accidentally got another patient's trazodone and seroquel. This documentation further included that a report from the nursing home indicated that she took 150 mg of Seroquel and 75 mg of trazodone that was mixed in another resident's drink. Also noted was that when EMS arrived the patient (resident #61) was breathing comfortably and her oxygen level was 93% on 2 liters of oxygen. EMS reported that her blood pressure was in the 90's systolic. This physicians note revealed that it was unclear exactly when she fell, how she fell, or if she struck her head and that the resident (#61) was found by nursing home staff about an hour prior to arrival in the ED, and the ingestion occurred sometime with breakfast this (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	morning.ED Assessment of resident revealed no bony extremity injury and resident #61 was mildly somnolent but arousable to voice, oriented x 0, moves all extremities at baseline.The ED physician note documented that poison control was contacted by nursing and recommended that the patient could go home once she is at her baseline, but that it could take 6 to 8 hours for her to be less sleepy. Patient was observed in the ED for several hours until she was more alert and could be discharged back to the nursing home in stable condition. -Regarding resident #71Resident #71 was admitted most recently on July 6, 2025 with diagnoses that included Unspecified dementia, unspecified severity, with other behavioral disturbance.Resident #71 had medication orders that included seroquel (quetiapine) tablet; 100 mg; amt: 1; oral07:00 am - 11:00 am and quetiapine tablet; 50 mg; amt: 1 tablet; oral with special instructions: give in addition to scheduled doses, twice a day 07:00 am - 11:00 am, evening 07:00 pm - 11:00 pm (this would equal a dosage of 150mg for the 7 am to 11am dose). Also noted was an order for trazodone tablet; 50 mg; amt: 1/2 tab = 25 mg; oral, three times a day 07:00 am - 09:30 am, noon 11:00 am - 01:00 pm, evening 07:00 pm - 09:00 pm.A minimum data set (MDS) quarterly assessment dated [DATE] identified the resident's cognition as continuously inattentive with disorganized thinking. Resident scored a 04 on a brief interview for mental status (BIMS) indicating severely impaired cognition.Resident #71's care plan that was reviewed on December 24, 2025 identified a problem of cognitive impairment and that the resident displayed forgetfulness and confusion. This problem also included that the resident speaks and understands English. Interventions were identified.A progress note, dated December 31, 2025 at 3:55pm, revealed that the resident (#71) refused her initial medication administration that morning when it was first offered to her crushed in pudding. This note further documented that the resident (#71) was refusing medications whole and crushed in pudding when she was on the other unit and nursing began giving her the medications crushed in hot chocolate. The note revealed the resident accepted and said she liked it that way. Additionally, the progress note identified that on this day the resident (#71) started to drink the hot chocolate, as usual, with the medication in it, but then later pushed the cup away and tried to give the medication to another resident sitting at the table in the dining room with her.On January 2, 2026 at approximately 1:15 pm an observation of the central dining area revealed no medications at any table or unattended. Observation of all four units revealed no medications at bedside, no medications in dining areas, no medications unattended, and no medications were observed in any common areas. An interview with a licensed practical nurse (LPN), Staff # 12, was conducted on January 2, 2026 at approximately 2:32 pm. During this interview the LPN stated that the morning medication pass is not a heavy medication pass however it can be difficult as some residents will not take their medications if you don't get them to them while they are eating as they think it is more food and refuse to take them. The LPN stated that she does pass medications on both behavioral halls.Staff #12 stated that crushed medications are usually put in pudding but that there are a couple residents who prefer medications in a drink such as a Boost or in hot chocolate. The LPN said she will usually mix the medication in a little hot water to help dissolve the medication.The LPN stated that it is not typical of me to leave medication ever. The LPN stated that last week when working with a resident (resident#71) the LPN identified that the resident does not care to be watched when taking her medications. The LPN stated that once resident #71 picks up the cup she usually drinks the entire thing. The LPN said that while watching from the door, she saw resident #71 pick up the cup and once the LPN saw the resident sipping from the cup the LPN stated I made a poor judgement this one time and felt the resident would finish the drink so I walked away before she drank it all.During the interview the LPN explained that later resident #61 fell out of her chair and they called the LPN to assess her. The LPN said the resident (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(#61) was lethargic but able to talk and move. The LPN also stated that resident #61 couldn't walk and she normally could walk with a boost from the floor. The LPN verbalized that the cup (from resident # 71) was in front of where resident #61 was sitting and the LPN assumed it was a good possibility that resident #61 had ingested some of the medication. The LPN further stated that resident #61 had no obvious signs of injury but was sent her to the ED for evaluation. The LPN explained that the ED sent resident #61 back to the facility and that her vitals were fine and CT was negative. Additionally, the LPN revealed the when the resident (#61) came back she was able to walk and talk per usual and there was no bruising or abrasions seen.This LPN (Staff # 12) remarked that they had worked with resident #71 for eight months and had learned or thought they had learned her patterns. The LPN stated I made a mistake and the resident should not have been left until the medication was gone.The LPN staff # 12 stated that if a resident refuses medication the goal is to try again a couple times and if they still refuse the medications are destroyed.The LPN stated that residents with behaviors are often difficult with medications and habits and behaviors have to be learned.During an observation on January 2, 2026 at approximately 3:20 pm medications were observed to be delivered and taken under observation of a nurse for 5 residents.An observation of all four units revealed no medications at bedside, no medications in dining areas, no medications unattended, and no medications in any common areas. Medication carts were either attended or locked. Medication storage rooms were locked. On January 2, 2026 at approximately 3:40 pm an interview was held with the Director of Nursing, staff # 33. The DON stated that her expectations of nurses performing medication administration would be to follow the five rights of medication administration that include: the right drug, right dose, right resident, right time, and right route.The DON stated that if a medication is refused the expectation of the nurse is to return and attempt again and if refused then to mark the medication as refused and dispose of the medication.The DON explained that with an order, medications for residents can be mixed in applesauce or pudding or a drink if that is preferred.The DON stated that the expectation of the nurse is to ensure that residents take all of the medication delivered.The DON clarified that leaving medications on a medication cart, leaving the medication cart unlocked or leaving a medication with a resident that has not been completed would constitute leaving medications unattended. DON stated this would include crushed medications in pudding or hot chocolate.The DON expressed that the expectation was that if the medications were not fully consumed they should not have been left with the resident.On January 2, 2026 at approximately 3:45 PM a video was reviewed with the DON that showed resident #71 with a blue cup, that was identified by DON as having medication in it, sitting in front of her (resident #71) as she was shuffling and appeared to be sorting papers. Resident #71 lifted the cup and appeared to take a sip and thenresident#71 handed the cup to her left to resident #61who appears to take the cup from resident #71 at approximately 10:57 am. Resident #61 was seated with her back to the camera however resident #61appeared to be making extended drinking motions. At approximately 11:38 am resident #61 appears to slump over and falls to the floor. At this time there is no blue cup seen. The facility was unable to provide a copy of this video. Review of the RN, LPN Charge Nurse included in the nurses duties and responsibilities is the responsibility to ensure that prescribed medication for one resident is not administered to another.Review of the facility policy titled Medication Management and dated effective or revision date 10/15 [sic] revealed that only medications ordered by a medical practioner should be administered to a resident. In addition the policy identified staff shall not leave medication unattended.