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	02/18/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, facility documentation, and policy review, the facility failed to ensure controlled medications were recorded, stored, and reconciled accurately for one of three sampled residents (#1). The deficient practice could result in the inability to ensure the safe and effective use of medication.Findings Include:Resident #1 was initially admitted on [DATE], and re-admitted on [DATE], with a diagnosis that included Senile degeneration of the brain, dementia, cellulitis of the toe, nutritional deficiency, psychotic disturbance, anxiety, Pneumonia, and chronic pain. The individual Resident Controlled Substances record dated March 4, 2025, for Resident #1 revealed that Morphine Sulfate was received in an amount of 30 mL (milliliter). It further identified that the dosage to be given to the resident was 0.25mL by mouth. The physician's order dated March 05, 2025, revealed orders for Morphine- Schedule II solution; 20 mg(milligram)/ 5mL (milliliter) (4mg/ml); amount 0.25mL; oral for pain, every 4 hours as needed. The medication was initiated on March 05, 2025.The care plan dated March 14, 2025, had a focused care area for Resident #1 for having an altercation in comfort related to end of life, aging, as evidenced by pain interview results, and pain medication use. Interventions included: addressing complaints of pain promptly with medications, administering pain medication as ordered, assessing characteristics of pain location, severity, on a scale of 1-10, type, and frequency, assessing the effectiveness of pain medication, monitoring for potential side effects of medication: altered mental status, anxiety, constipation, depression, dizziness, loss of appetite, nausea, pruritus, respiratory, depression, sedation, urinary retention or vomiting. The interventions also included to assure that pain medication is available if needed, notify the physician of any changes in level or frequency of pain, any increase in use of as-needed pain medication, and note side effects of pain medication, position resident for comfort using pillows if needed and report diaphoresis, moaning, restlessness, grimacing, & crying.The individual Resident Controlled Substance record for Resident #1 for Morphine Sulfate revealed a steady count down in increments of 0.25 until July 31, 2025, where there was an undated signature line below July 31, 2025, and above the next date of August 05, 2025. On July 31, 2025, the amount remaining was recorded at 25.25 mL. At the undated signature line, the amount remaining is documented at 20 mL. The next dose administered, on August 5, 2025, documents the administration of 0.25 mL with the remaining amount of medication recorded as 19.75 mL. The record continued to reveal a steady count down in increments of 0.25 until January 18, 2026, a dosage was given 0.25 and the remaining dosage left was recorded at 10.25ml. The medication administration record for Morphine- II solution; 20 mg/ 5mL (4mg/ml); amount 0.25mL; oral for pain, every 4 hours as needed for January 2026 revealed on January 18, 2026 the medication was administered. An observation was conducted on February 17, 2025, at 3:33 PM with the Licensed Practical Nurse (Staff #3) and Registered Nurse (RN/ Staff #2) verifying the narcotics count before starting the shift. In the process, one nurse reads the name and the written amount of the (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	narcotic from the narcotics book and another visibly reviews the medication and verifies the count. Additionally, observed was the narcotics book sign in and out sheet per shift or narcotic count. On February 17, 2026, at 3:13 PM a RN (Staff #2), stated that the facility's process for administering medication, including liquid narcotics, is to administer the narcotics separately from other regular medication. She stated that for morphine liquid, she pulls up the electronic medication administration record (eMAR) for the resident, double-checks the order, then open the narcotics drawer, prepares the medication, signs it out in the book, rechecks it on the eMAR, closes the drawer, and locks the med cart. She said she then administers the medication, and ensures the resident consumes it completely. She stated that morphine liquid medication comes in bottles along with a syringe, to measure with and deliver to the resident. Staff #2, stated there was a recent incident when she was doing her narcotics check prior to her shift when the narcotic count was not correct. She said that about 7 mL of Morphine Liquid was missing from what was actually documented for Resident #1. Then she immediately notified the Director of Nursing (DON). The RN stated that the bottles for Morphine medication came from Resident #1's hospice provider and did not have markings on the side of the bottle so she is unable to measure how much is left, and can only determine the amount by eyeballing it. She further stated that she does not know where the medication went. Additionally, on February 18, 2026, at 08:52 AM Staff #2, stated that when she administers medication, she uses measuring devices and syringes, and it is very obvious to her when they use syringes to administer medication how much is given by mouth. She said the reason it was hard to measure the morphine medication from hospice in liquid form was that the hospice usually gets the bottles from Safeway or Walmart where they do not have measuring lines on the side of the bottle. She stated that when the bottles from their own facility pharmacy, it comes colored and also has the measuring lines. She said that's the reason it took so long for them to know that medication was missing. She said that just glancing at the bottle for Resident #1, she knew it was missing liquid medication, and it was not 10mL. She stated the risk of not having measuring lines on the bottle would not allow for accurate measurements. Staff #2 stated that the only way for the nursing staff to accurately know the amount of liquid medication would be to pour the liquid medication into a measuring device. She stated that risk for this would be loss if every day nurses have opened the bottle to pour it into the measuring cup. There may be a spillage of the medication. Staff #2 stated that there were a couple of incidents where nursing staff would not write in the narcotics book that they had removed morphine medication or checked out in the eMAR on the computer, and vice versa, when they were checking the system after the incident. She said the risk to all of this would be improper measurement of the narcotics medications. On February 18, 2026, at 09:24 AM the DON (Staff #3), said that her role is to oversee the nursing team and ensure residents receive quality of care, staff members receive education, oversight, and they review policies and procedures and ensure they are updated with Centers for Medicare and Medicaid Services (CMS) guidelines. She stated that the facility's process for administering medications is to ensure it is the right dose, right patient, right route, right reason, and should be done before the medication administration. After the administration, the expectation is the nurse should do the follow-up tasks that need to be assessed and documented, for example, pain medication, as-needed medication (PRN), nausea medication, and bowel protocols.The DON stated that for pain medication administration, Nurses need to look over the order before administering, prepare the medication, identify that it is the correct time for the medication, identify the site of pain and review the physician order. The nurse should administer medication if it is appropriate, and sign out the medication on the eMar and on the narcotics sheet. She stated the process is the same for liquid morphine medication as for oral (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	narcotics. She stated that with a syringe that is provided with the medication you would draw the correct amount into the syringe. The DON said that morphine medication bottle types are dependent on the pharmacy. With USA Pharmacy, (the primary pharmacy the facility uses) morphine comes with a paper narcotics log sheet, and the medication arrives in bottles that have a clear panel top to bottom, and they have marking amounts (increments). She stated the medication can be either pink or blue. The DON stated the pharmacy bottles from hospice have a clear bottle panel top to bottom, but do not have increments on the side of the bottle. The hospice medication comes with the syringe. She also stated that it is hard to know with hospice bottles how much medication is left in there; there is no way to visualize it. Before the incident, they found the nursing staff would just look at the bottle, not fully measure or quantify. She further stated that prior to the incident the nurses would receive medication from the hospice provider, sign in the medication on the narcotics sheet and fill out the in-house count form. She stated that on January 26, 2026, staff #2 noticed that the bottle did not match what was recorded on the log for January 18, 2026. She stated that when she found the bottle, it did not have markings of the doses, and she viewed the bottle at eye level and it did not look like 10.25ml. She said she then pulled the medication remaining into a syringe it was not 10.25ml. DON stated this could pose a risk to residents because they could miss a medication dose, remain in pain, not receive medication at all. She stated with Resident #1's incident of missing medication, the documented amount on the narcotics log sheet did not to match the amount in the bottle. When the DON reviewed the narcotics log sheet she noticed that the staff was using in-house syringes because the provided syringe with the medication bottle was not sanitary. She stated that the in-house syringe is different than the one provided by hospice because it is leur-lock syringe. She stated that the tip of the syringe is different, and it is for administering IV medication The DON said that there was a risk the risk of keeping morphine medication in the lower space of the syringe. She further stated that this could also cause leakage of medication. She stated the risk of having a spillage and liquid trapped in the syringe, would be that the resident could run out of the medication. An LPN brought a morphine bottle in the interview, revealing that the hospice morphine medication bottle had no increments on the side of the bottle nor a measuring line. The DON that they are doing ongoing training and education with staff members, and also talking to hospice services to get medication from their pharmacy, monitoring bottles closely to ensure there is no discrepancy.The facility policy titled Medication Management, last revised October 2015, revealed that nurses shall follow the five rights of medication administration. Narcotics shall be kept in a separate locked drawer inside the med cart, and shall be accounted for at each shift change. Medication is stored in the original label container according to the instructions on the label.