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	05/15/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 staff interviews, review of clinical record and policy review, the facility failed to protect the rights of 2 of 21 residents sampled (#70, #37) to be free from physical abuse between residents. The universe was 100 residents. The deficient practice could result in resident injury, psychological, or behavioral harm as well as continued resident to resident abuse.Findings include:Regarding Resident #70:Resident #70, the alleged victim, was admitted [DATE], with diagnoses that included unspecified dementia, maxillary fracture unspecified side, nausea with vomiting, urinary tract infection, and depression. A physician's order initiated September 23, 2025 revealed that Resident #70 should be monitored for combative behavior and determine unmet needs as needed. The care plan initiated on September 24, 2025 revealed the resident is fearful of men she does not know and may strike out at men in her area. Interventions included documenting behaviors, female caregivers if possible, and making sure all basic needs are met. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 3, indicating that the resident had severe cognitive impairment. The MDS documented that the Resident had disorganized thinking and inattentive. The MDS revealed no behaviors exhibited. A progress note dated April 23, 2026 at 2:19 a.m. documented that Resident #70 was in the hallway/tv room area watching TV at 7:25 p.m. when Resident # 37 appeared to punch Resident #70 on her left leg. The progress note further documented that the Assistant Director of Nursing (ADON/Staff #7) reviewed the video footage and determined there was not contact. The progress note revealed that the residents were separated from each other and assessed for injuries. Regarding Resident #37:Resident # 37, the alleged perpetrator, was admitted on [DATE] with diagnoses that included severe dementia in other diseases classified elsewhere with psychotic disturbance.An admission MDS assessment dated [DATE] revealed a BIMS score of 0 due to the inability to complete the exams. The MDS assessment documented Resident #37 had behaviors of delusions, verbal and other behavioral symptoms which put the resident at significant risk for physical illness or injury. The MDS assessment revealed that the resident is administered antipsychotic medication on a routine basis. A progress note dated April 22, 2026 at 7:25 p.m. written by Licensed Practical Nurse (LPN/Staff # 84) which documented that Resident #37 was exit seeking at 7:10 pm and was moved to the TV room for the resident to watch TV. The progress note revealed that at 7:25 p.m. Staff # 84 observed Resident #37 swat at Resident #70. The progress note documented that Resident # 37 balled up his fist and appeared to punch Resident #70 on her left leg. The progress note revealed that Staff #84 asked Resident #37 if he meant to hurt Resident #70 he nodded his head yes. The progress noted documented that Resident #70 was aggressive and agitated after the incident with behaviors that included, balling up his fist at another female resident and telling staff to 'get the hell away from me'. Staff #84 documented that she contacted the Director of Nursing (DON/Staff#98) and the police to file a report. The progress note revealed that the ADON (Staff #7) came to the facility and reviewed the camera footage and determine that no contact was made.Review of Resident #37's census report revealed that on April 23, 2026 Resident #37 was relocated from his room [ROOM NUMBER]-2 to the secured unit in room [ROOM NUMBER]-2. A (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: The nursing home is disputing this citation.	physician's order dated April 27, 2026 revealed monitoring of Resident #37 for aggression every shift. The order further revealed if behavior is present, document in the progress note.An interview was conducted on May 14, 2026 with the ADON/Behavioral Unit Director (Staff #19) who stated that she oversees the behavioral units (300 and 400) while ADON Staff #7 and DON Staff #98 oversee the other units (100 and 200). Staff #19 revealed that any abuse allegations including resident to resident abuse that occur in the behavioral units she would report to her DON, police, state agency, Adult Protective Services and Ombudsman. Staff #19 stated that she would then conduct her investigation talking to staff and residents. Staff #19 stated then she would review the camera footage to see if there is visual evidence of the abuse. Staff #19 stated that she would complete her investigation within 5 days and send it over for the DON to review and the investigation gets sent to the state agency. Staff #19 revealed that the video footage only saves for 14 days then is cleared from the system. Staff #19 revealed that if the alleged abuse takes place in the 100 or 200 units then ADON Staff #7 will do the same process. Staff #19 stated that Resident # 37 was moved into the behavioral unit because he was getting aggressive in the 100 hall so it was determined that he would be a better fit in the 300 hall. An interview was conducted with LPN Staff #84 on April 14, 2026 at 2:36 p.m. via telephone. Staff #84 stated that on the night of April 22, 2026 Resident #37 was exit seeking so she moved him to the TV room near the 100 hall where she could keep eyes on him. Staff #84 stated that Resident #70 was sitting facing toward the bird cage while Resident #37 was next to her facing more toward the tv. Staff #84 stated that they were conversing and Resident #70 started laughing and giggling which made Resident #37 agitated. Staff #84 stated that Resident #37 pulled back and hit Resident #70 in the left leg. Staff #84 said she separated the residents and called the police to file a report and the DON. Staff #84 stated that the ADON Staff #7 came to the facility and reviewed the camera footage. Staff #84 stated that the ADON determined that no contact was made and sent the Police home with out investigating. An interview was conducted with ADON Staff #7 on April 15, 2026 at 8:41 a.m. who stated that if there is a resident to resident altercation they first make sure the residents are safe then they investigate the incident while also making contact to DON, adult protectives services, police and state agencies. Staff #7 stated that she takes witness statements and reviews the camera footage to see if they can see what happened during the incident. Staff # 7 stated that once the investigation is concluded then it is submitted to DON who then submits the 5 day investigation report to the state agency. Staff #7 said she was notified by the DON to come in on April 22, 2026 to review an altercation between Resident #70 and Resident #37. Staff # 7 stated that she reviewed that camera footage and it appeared to her that Resident # 37 never made contact with Resident #70 and Resident #37 was moving his hand like 'shooing her away'. Staff #7 stated that the residents were separated. The ADON stated that the police did arrive because Staff #84 had called them but Staff #7 stated that she told the police no contact was made and they left without investigating. Staff #7 stated that the next day Resident #37 was transferred to the behavioral unit due to verbal outbursts towards staff. Staff #7 stated that the video footage of the incident was never saved because the video only saves for 14 days. An interview was conducted with the DON Staff #98 on May 15, 2026 at 10:27 a.m. who stated that her expectation if resident to resident abuse takes place that first the nurses need to get the residents to safety then notify the DON or administrator. Staff #98 stated then she would start the investigation process getting witness statements from staff and if able residents, while that is being done notifications are made to police and state agency, APS, ombudsman. family and case managers. Staff #98 stated that once the investigation is complete it is sent to the the state agency. Staff #98 stated that Staff #84 had contacted her about a potential altercation with Resident #37 and Resident #70. The DON stated that Staff #84 sounded unsure if the abuse took place so the DON sent Staff #7 to investigate. The DON stated that Staff #7 told her that no contact was made. Staff #84 reviewed the Progress note on Resident #37 regarding the altercation. Staff #37 stated that does not sound like Staff #84 was unsure what happened. Staff #84 stated that if residents hit each other then that is abuse with the concern of causing injury to other (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	residents. Staff #98 stated that she thought that if they could confirm that no contact was made they did not have to complete a full investigation and report to the appropriate state agencies. The DON stated that the video of the incident was not saved because it is beyond the 14 days. A policy and procedure titled Abuse Prevention Policy & 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 also revealed the definition of physical abuse as hitting, slapping, pinching, and kicking.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, staff interviews, and policy review, the facility failed to implement their abuse policy involving an allegation of abuse with 2 of 21 residents (#70 and #37). The universe was 100 residents. The deficient practice could result in the appropriate State Agencies not being notified and allegations of abuse not being thoroughly investigated. Findings include:Regarding Resident #70:Resident #70, the alleged victim, was admitted [DATE], with diagnoses that included unspecified dementia, maxillary fracture unspecified side, nausea with vomiting, urinary tract infection, and depression. A physician's order initiated on September 23, 2025 revealed that Resident #70 should be monitored for combative behavior and determine unmet needs as needed. The care plan initiated on September 24, 2025 revealed the resident is fearful of men she does not know and may strike out at men in her area. Interventions included documenting behaviors, female caregivers if possible, and making sure all basic needs are met. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 3, indicating that the resident had severe cognitive impairment. The MDS documented that the Resident had disorganized thinking and inattentive. The MDS revealed no behaviors exhibited. A progress note dated April 23, 2026 at 2:19 a.m. documented that Resident #70 was in the hallway/tv room area watching TV at 7:25 p.m. when Resident # 37 appeared to punch Resident #70 on her left leg. The progress note further documented that the Assistant Director of Nursing (ADON/Staff #7) reviewed the video footage and determined there was not contact. The progress note revealed that the residents were separated from each other and assessed for injuries. Regarding Resident #37:Resident # 37, the alleged perpetrator, was admitted on [DATE] with diagnoses that included severe dementia in other diseases classified elsewhere with psychotic disturbance.An admission MDS assessment dated [DATE] revealed a BIMS score of 0 due to the inability to complete the exams. The MDS assessment documented Resident #37 had behaviors of delusions, verbal and other behavioral symptoms which put the resident at significant risk for physical illness or injury. The MDS assessment revealed that the resident is administered antipsychotic medication on a routine basis. A progress note dated April 22, 2026 at 7:25 p.m. written by Licensed Practical Nurse (LPN/Staff # 84) which documented that Resident #37 was exit seeking at 7:10 pm and was moved to the TV room for the resident to watch TV. The progress note revealed that at 7:25 p.m. Staff #84 observed Resident #37 swat at Resident #70. The progress note documented that Resident #37 balled up his fist and appeared to punch Resident #70 on her left leg. The progress note revealed that Staff #84 asked Resident #37 if he meant to hurt Resident #70, he nodded his head yes. The progress noted documented that Resident #70 was aggressive and agitated after the incident with behaviors that included, balling up his fist at another female resident and telling staff to 'get the hell away from me'. Staff #84 documented that she contacted the Director of Nursing (DON/Staff# 98) and the police to file a report. The progress note revealed that the ADON (Staff #7) came to the facility and reviewed the camera footage and determine that no contact was made.Review of Resident #37's census report revealed that on April 23, 2026 Resident #37 was relocated from his room [ROOM NUMBER]-2 to the secured unit in room [ROOM NUMBER]-2. A physician's order dated April 27, 2026 revealed monitoring of Resident #37 for aggression every shift. The order further revealed that if behavior is present, staff are to document in the progress note.An interview was conducted on May 14, 2026 with the ADON/Behavioral Unit Director (Staff #19) who stated that she oversees the behavioral units (300 and 400) while ADON Staff #7 and DON Staff #98 oversee the other units (100 and 200). Staff #19 revealed that any abuse allegations including resident to resident abuse that occur in the behavioral units she would report to her DON, police, state agency, Adult Protective Services and Ombudsman. Staff #19 stated that she would then conduct her investigation talking to staff and residents. Staff #19 stated then she would review the camera footage to see if there is visual evidence of the abuse. Staff #19 (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	stated that she would complete her investigation within 5 days and send it over for the DON to review and the investigation gets sent to the state agency. An interview was conducted with LPN Staff #84 on April 14, 2026 at 2:36 p.m. via telephone. Staff #84 stated that on the night of April 22, 2026 Resident #37 was exit seeking so she moved him to the TV room near the 100 hall where she could keep eyes on him. Staff #84 stated that Resident #70 was sitting facing toward the bird cage while Resident #37 was next to her facing more toward the tv. Staff #84 stated that they were conversing and Resident #70 started laughing and giggling which made Resident #37 agitated. Staff #84 stated that Resident #37 pulled back and hit Resident #70 in the left leg. Staff #84 said she separated the residents and called the police to file a report and reported the alleged abuse to the DON. Staff #84 stated that the ADON Staff #7 came to the facility and reviewed the camera footage. Staff #84 stated that the ADON determined that no contact was made and sent the Police home without investigating. An interview was conducted with ADON Staff #7 on April 15, 2026 at 8:41 a.m. who stated that if there is a resident-to-resident altercation they first make sure the residents are safe then they investigate the incident while also reporting to the DON, adult protectives services, police and state agencies. Staff #7 stated that she takes witness statements and reviews the camera footage to see what happened during the incident. Staff #7 stated that once the investigation is concluded then it is submitted to DON who then submits the 5-day investigation report to the state agency. Staff #7 said she was notified by the DON to come in on April 22, 2026 to review an altercation between Resident #70 and Resident #37. Staff #7 stated that she reviewed that camera footage and it appeared to her that Resident #37 never made contact with Resident #70 and Resident #37 was moving his hand like 'shooing her away'. The ADON stated that the police did arrive because Staff #84 had called them but Staff #7 stated that she told the police no contact was made and they left without investigating. Staff #7 stated no other agencies were contacted including the state agency and the investigation concluded without staff interviews or resident interviews. An interview was conducted with the DON Staff #98 on May 15, 2026 at 10:27 a.m. who stated that her expectation if resident to resident abuse takes place that first the nurses need to get the residents to safety, then notify the DON or administrator. Staff #98 stated then she would start the investigation process getting witness statements from staff and if able residents, while that is being done notifications are made to police and state agency, APS, ombudsman. family and case managers. Staff #98 stated that once the investigation is complete it is sent to the state agency. Staff #98 stated that Staff #84 had contacted her about a potential altercation with Resident #37 and Resident #70. The DON stated that Staff #84 sounded unsure if the abuse took place so the DON sent Staff #7 to investigate. The DON stated that Staff #7 told her that no contact was made. Staff #98 reviewed the Progress note on Resident #37 regarding the altercation. Staff #98 stated that does not sound like Staff #84 was unsure what happened. Staff #98 stated that if residents hit each other than that is abuse with a concern of causing injury to other residents. Staff #98 stated that she thought that if they could confirm that no contact was made, they did not have to complete a full investigation and report to the appropriate state agencies. A policy and procedure titled Abuse Prevention Policy & 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 documented that such violations are also reported to State agencies in accordance with existing Stat law and the facility investigates each alleged violation thoroughly and reports the results of all investigations to the Administrator or designee, as well as to State agencies as required by State and Federal law.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation, and policy review, the facility failed to implement its policy to ensure that an allegation of abuse for 2 out of 21 residents (#70, #37) was reported to all applicable state agencies. The universe was 100 residents. The deficient practice could result in further allegations of neglect not being reported. Findings include:Regarding Resident #70:Resident #70, the alleged victim, was admitted [DATE], with diagnoses that included unspecified dementia, maxillary fracture unspecified side, nausea with vomiting, urinary tract infection, and depression. A physician's order initiated on September 23, 2025 revealed that Resident #70 should be monitored for combative behavior and determine unmet needs as needed. The care plan initiated on September 24, 2025 revealed the resident is fearful of men she does not know and may strike out at men in her area. Interventions included documenting behaviors, female caregivers if possible, and making sure all basic needs are met. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 3, indicating that the resident had severe cognitive impairment. The MDS documented that the Resident had disorganized thinking and inattentive. The MDS revealed no behaviors exhibited. A progress note dated April 23, 2026 at 2:19 a.m. documented that Resident #70 was in the hallway/tv room area watching TV at 7:25 p.m. when Resident # 37 appeared to punch Resident #70 on her left leg. The progress note further documented that the Assistant Director of Nursing (ADON/Staff #7) reviewed the video footage and determined there was not contact. The progress note revealed that the residents were separated from each other and assessed for injuries. Regarding Resident #37:Resident # 37, the alleged perpetrator, was admitted on [DATE] with diagnoses that included severe dementia in other diseases classified elsewhere with psychotic disturbance.An admission MDS assessment dated [DATE] revealed a BIMS score of 0 due to the inability to complete the exams. The MDS assessment documented Resident #37 had behaviors of delusions, verbal and other behavioral symptoms which put the resident at significant risk for physical illness or injury. The MDS assessment revealed that the resident is administered antipsychotic medication on a routine basis. A progress note dated April 22, 2026 at 7:25 p.m. written by Licensed Practical Nurse (LPN/Staff # 84) which documented that Resident #37 was exit seeking at 7:10 pm and was moved to the TV room for the resident to watch TV. The progress note revealed that at 7:25 p.m. Staff # 84 observed Resident #37 swat at Resident #70. The progress note documented that Resident #37 balled up his fist and appeared to punch Resident #70 on her left leg. The progress note revealed that Staff # 84 asked Resident #37 if he meant to hurt Resident #70, he nodded his head yes. The progress noted documented that Resident #70 was aggressive and agitated after the incident with behaviors that included, balling up his fist at another female resident and telling staff to 'get the hell away from me'. Staff #84 documented that she contacted the Director of Nursing (DON/Staff# 98) and the police to file a report. The progress note revealed that the ADON (Staff #7) came to the facility and reviewed the camera footage and determine that no contact was made.An interview was conducted on May 14, 2026 with the ADON/Behavioral Unit Director (Staff #19) who stated that she oversees the behavioral units (300 and 400) while ADON Staff # 7 and DON Staff #98 oversee the other units (100 and 200). Staff #19 revealed that any abuse allegations including resident to resident abuse that occur in the behavioral units she would report to her DON, police, state agency, Adult Protective Services and Ombudsman. An interview was conducted with LPN Staff #84 on April 14, 2026 at 2:36 p.m. via telephone. Staff #84 stated that on the night of April 22, 2026 Resident #37 was exit seeking so she moved him to the TV room near the 100 hall where she could keep eyes on him. Staff #84 stated that Resident #70 was sitting facing toward the bird cage while Resident #37 was next to her facing more toward the tv. Staff #84 stated that they were conversing and Resident #70 started laughing and giggling which made Resident #37 agitated. Staff (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	#84 stated that Resident #37 pulled back and hit Resident #70 in the left leg. Staff #84 said she separated the residents and called the police to file a report and the DON. An interview was conducted with ADON Staff #7 on April 15, 2026 at 8:41 a.m. who stated that if there is a resident-to-resident altercation they first make sure the residents are safe then they investigate the incident while also reporting to the DON, adult protectives services, police and state agencies. Staff #7 said she was notified by the DON to come in on April 22, 2026 to review an altercation between Resident #70 and Resident #37. Staff #7 stated that she reviewed that camera footage and it appeared to her that Resident #37 never made contact with Resident #70 and Resident #37 was moving his hand like 'shooing her away'. The ADON stated that the police did arrive because Staff #84 had called them but Staff #7 stated that she told the police no contact was made and they left without investigating. Staff #7 stated no other agencies were contacted including the state agency.An interview was conducted with the DON Staff # 98 on May 15, 2026 at 10:27 a.m. who stated that her expectation if resident to resident abuse takes place that first the nurses need to get the residents to safety, then notify the DON or administrator. Staff #98 stated then she would start the investigation process getting witness statements from staff and if able residents, while that is being done notifications are made to police and state agency, APS, ombudsman. The DON stated that Staff #7 told her that no contact was made while observing the video. Staff #98 stated that she thought that if they could confirm that no contact was made, they did not have to report to the appropriate state agencies. The DON stated that the concern if the appropriate agencies are not contacted is that alleged abuse may not get not fully investigated. A policy and procedure titled Abuse Prevention Policy & Procedure, revised April 2025, revealed that it is the responsibility of all employees to immediately report any suspected or alleged violation of abuse. The policy documented that the facility will take appropriate steps to ensure that all suspected or alleged violations of Federal or State laws which involve abuse are reported immediately, but no later than 2 hours after the allegation is made if the events that cause the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involved abuse and do not result in serious bodily injury, the the Administrator and to other officials including the State Survey Agency and Adult Protective Services where State law provides for jurisdiction.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical records, review of facility documentation, staff interviews and review of policy and procedure facility failed to ensure an allegation of abuse for 2 of 21 residents (#70, #37) was fully investigated. The universe was 100 residents. The deficient practice could result in allegations of abuse not being thoroughly investigated and abuse occurring in the facility.Findings include:Regarding Resident #70:Resident #70, the alleged victim, was admitted [DATE], with diagnoses that included unspecified dementia, maxillary fracture unspecified side, nausea with vomiting, urinary tract infection, and depression. A physician's order initiated on September 23, 2025 revealed that Resident #70 should be monitored for combative behavior and determine unmet needs as needed. The care plan initiated on September 24, 2025 revealed the resident is fearful of men she does not know and may strike out at men in her area. Interventions included documenting behaviors, female caregivers if possible, and making sure all basic needs are met. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 3, indicating that the resident had severe cognitive impairment. The MDS documented that the Resident had disorganized thinking and inattentive. The MDS revealed no behaviors exhibited. A progress note dated April 23, 2026 at 2:19 a.m. documented that Resident #70 was in the hallway/tv room area watching TV at 7:25 p.m. when Resident # 37 appeared to punch Resident #70 on her left leg. The progress note further documented that the Assistant Director of Nursing (ADON/Staff #7) reviewed the video footage and determined there was not contact. The progress note revealed that the residents were separated from each other and assessed for injuries. Regarding Resident #37:Resident # 37, the alleged perpetrator, was admitted on [DATE] with diagnoses that included severe dementia in other diseases classified elsewhere with psychotic disturbance.An admission MDS assessment dated [DATE] revealed a BIMS score of 0 due to the inability to complete the exams. The MDS assessment documented Resident #37 had behaviors of delusions, verbal and other behavioral symptoms which put the resident at significant risk for physical illness or injury. The MDS assessment revealed that the resident is administered antipsychotic medication on a routine basis. A progress note dated April 22, 2026 at 7:25 p.m. written by Licensed Practical Nurse (LPN/Staff #84) which documented that Resident #37 was exit seeking at 7:10 pm and was moved to the TV room for the resident to watch TV. The progress note revealed that at 7:25 p.m. Staff #84 observed Resident #37 swat at Resident #70. The progress note documented that Resident #37 balled up his fist and appeared to punch Resident #70 on her left leg. The progress note revealed that Staff #84 asked Resident #37 if he meant to hurt Resident #70, he nodded his head yes. The progress noted documented that Resident #37 was aggressive and agitated after the incident with behaviors that included, balling up his fist at another female resident and telling staff to 'get the hell away from me'. Staff #84 documented that she contacted the Director of Nursing (DON/Staff# 98) and the police to file a report. The progress note revealed that the ADON (Staff #7) came to the facility and reviewed the camera footage and determine that no contact was made.Review of Resident #37's census report revealed that on April 23, 2026 Resident #37 was relocated from his room [ROOM NUMBER]-2 to the secured unit in room [ROOM NUMBER]-2. A physician's order dated April 27, 2026 revealed monitoring of Resident #37 for aggression every shift. The order further revealed if behavior is present, the staff are to document in the progress note.An interview was conducted on May 14, 2026 with the ADON/Behavioral Unit Director (Staff #19) who stated that she oversees the behavioral units (300 and 400) while ADON Staff # 7 and DON Staff #98 oversee the other units (100 and 200). Staff #19 revealed that any abuse allegations including resident to resident abuse that occur in the behavioral units she would report to her DON, police, state agency, Adult Protective Services and Ombudsman. Staff #19 stated that she would then conduct her investigation talking to staff and residents. Staff #19 stated then she would review the camera footage to see if there is visual evidence of the abuse. Staff #19 stated that she would complete her (continued on next page)

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	05/15/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	investigation within 5 days and send it over for the DON to review and the investigation gets sent to the state agency. An interview was conducted with LPN Staff #84 on April 14, 2026 at 2:36 p.m. via telephone. Staff #84 stated that on the night of April 22, 2026 Resident #37 was exit seeking so she moved him to the TV room near the 100 hall where she could keep eyes on him. Staff #84 stated that Resident #70 was sitting facing toward the bird cage while Resident #37 was next to her facing more toward the tv. Staff #84 stated that they were conversing and Resident #70 started laughing and giggling which made Resident #37 agitated. Staff #84 stated that Resident #37 pulled back and hit Resident #70 in the left leg. Staff #84 said she separated the residents and called the police to file a report and reported the alleged abuse to the DON. Staff #84 stated that the ADON Staff #7 came to the facility and reviewed the camera footage. Staff #84 stated that the ADON determined that no contact was made and sent the Police home without investigating. An interview was conducted with ADON Staff #7 on April 15, 2026 at 8:41 a.m. who stated that if there is a resident-to-resident altercation they first make sure the residents are safe then they investigate the incident while also reporting to the DON, adult protectives services, police and state agencies. Staff #7 stated that she takes witness statements and reviews the camera footage to see what happened during the incident. Staff # 7 stated that once the investigation is concluded then it is submitted to DON who then submits the 5-day investigation report to the state agency. Staff #7 said she was notified by the DON to come in on April 22, 2026 to review an altercation between Resident #70 and Resident #37. Staff # 7 stated that she reviewed that camera footage and it appeared to her that Resident # 37 never made contact with Resident #70 and Resident #37 was moving his hand like 'shooing her away'. The ADON stated that the police did arrive because Staff #84 had called them but Staff #7 stated that she told the police no contact was made and they left without investigating. Staff #7 stated no other agencies were contacted including the state agency and the investigation concluded without staff interviews or resident interviews. An interview was conducted with the DON Staff # 98 on May 15, 2026 at 10:27 a.m. who stated that her expectation if resident to resident abuse takes place that first the nurses need to get the residents to safety, then notify the DON or administrator. Staff #98 stated then she would start the investigation process getting witness statements from staff and if able residents, while that is being done notifications are made to police and state agency, APS, ombudsman. family and case managers. Staff #98 stated that once the investigation is complete it is sent to the state agency. Staff #98 stated that Staff #84 had contacted her about a potential altercation with Resident #37 and Resident #7. The DON stated that Staff #84 sounded unsure if the abuse took place so the DON sent Staff #7 to investigate. The DON stated that Staff #7 told her that no contact was made. Staff #98 reviewed the Progress note on Resident #37 regarding the altercation. Staff #98 stated that does not sound like Staff #84 was unsure what happened. Staff #98 stated that if residents hit each other than that is abuse with a concern of causing injury to other residents. Staff #98 stated that she thought that if they could confirm that no contact was made, they did not have to complete a full investigation. A policy and procedure titled Abuse Prevention Policy & 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 documented that the Administrator or DON will designate the individual who is to conduct each investigation depending on the circumstances of the incident. The policy documented that the investigation may include interviews with employees, visitors, and residents who may have knowledge of the alleged incident. The abuse policy revealed that the results of the investigations are reported to the Administrator and to the appropriate State agency as required by State law, with a copy of the investigation report submitted to the Department of Health Services within five working days of the alleged violation.