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

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on resident and staff interviews, facility documentation and policy review, the facility failed to ensure the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week. The census was 100 residents. The deficient practice could result in residents not receiving appropriate care and treatment that they need.Findings include: The Payroll-Based Journal (PBJ) Staffing Data Report revealed that the facility consistently triggered for one star staffing rating for all four quarters of 2025. The PBJ also revealed that the facility triggered No RN Hours for quarters 1 and 2 of 2025. Per the report, No RN hours were submitted on the following dates:November 16 and 28, 2024December 14 and 15, 2024January 1, 4, and 5, 2025February 16, 2025 The facility assessment updated on November 2025, revealed that the facility was licensed for 119 residents, had an average daily census of 95-100 residents, and had an average number of 3 admissions per week and average number of 1 discharge per week. Staffing plan included the following: Licensed nurses providing direct care 92.5 hours per day and other nursing personnel including those with administrative duties at 112 hours per week. Further review of the assessment revealed that the scheduled hours for nursing did not delineate between RNs and Licensed Practical Nurses (LPN) hours. The facility plan documented that in the event of nurse call offs, the facility will shift responsibilities for coverage while we contact off duty personnel to come in if possible or have a nurse manager work the shift, or contacting contracted nursing agency to fill the vacancy.Review of the facility staff postings revealed no RN hours posted during the following dates:November 6, 8, 12,13,15, and 26th 2024.January 1, 15 and 29, 2025. Review of the facility payroll system revealed that no RN had worked on November 16, 2024. The facility payroll system confirmed an RN worked on November 6, 8, 12,13,15, 26, and 28 2024.Review of the facility payroll system for the month of December 2025 confirmed an RN had worked on December 14 and 15, 2024.Review of the facility payroll system revealed no evidence that an RN worked January 1, 4, and 5, 2025. The facility payroll system confirmed an RN worked on January 15 & 29, 2025. Review of the facility payroll system for February 16, 2025 revealed no evidence that an RN worked on that date.An interview with Activity Director (Staff # 12) on May 14, 2026 at 2:10 p.m. who stated that sometimes the facility is staff challenged but has improved since last year. Staff #12 stated that she works as manager on duties on some weekends and staffing can be really challenging as call offs happen. Staff # 12 stated when a call off happens she calls the manager of the department to notify and start reaching out their staff to cover, if they can not get someone to come in then they reach out to agency. Staff #12 stated that her activity department helps keep the residents occupied during the day to hep alleviate the effects of a call off giving nurses time to attend to all the residents.An interview as conducted with a Certified Nursing Assistant (CNA/Staff #36) on May 14, 2026 at 2:57 p.m. Staff #36 stated that most of the time it feels like they work short staffed and have to help cover other shifts and work overtime. CNA states that the nurses she works with on the floor are primarily Licensed Practical Nurses (LPNs) she does not work much or see RNs during her shift. Staff #36 stated that she does work a lot with agency staff but more with other CNAs and LPNs. An interview conducted on May 15, 2026 at 8:20 a.m. with Business Office Director (Staff # 174), who stated that her department is responsible for submitting (continued on next page)

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

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the staffing hours for the PBJ. Staff # 174 stated that a third party payroll system tracks all hours and submits the worked hours for the PBJ. Staff # 174 stated that January 2025 they had switched payroll systems and during the switch had caused some time cards to be lost. Staff # 174 stated that they had to manually enter those dates by hand but some of the pay cards were lost and they do not have the information.An interview conducted on May 15, 2026 at 10:16 a.m. with Director of Nursing (DON/Staff #98), who stated that currently she staffs one RN to be charge nurse during the day Monday through Friday. Staff # 98 stated that she also can utilize her Assistant Director of Nursing (Staff #7) as well for coverage. Staff #98 stated that all of the RNs are the facilities staff and no agency is utilized for RN services. The DON stated that back in 2024 to 2025 the facility changed to a new payroll system that would document staffing hours better than the previous system. The DON stated that during the switch they had lost a lot of staffing hour data and had to manually go back and enter lost time into the payroll. The DON stated that included the ADON's (Staff #7) hours they had covered. The DON stated that is why the hours are not matching with postings and PBJ during this time period. The DON had reviewed the missing PBJ and staff posting RN hours and stated that an RN had worked on January 1, 4, and 5, 2025 but they did not have the payroll time sheet to prove those dates were worked. The DON could not supply the RN name or confirmation worked for February 16, 2025. The DON confirmed that no RN had worked on November 16, 2024. The DON explained that the concern when there is no RN working 8 consecutive hours in a day is that there is no clinical oversight and certain medications and procedures can not be performed unless it is by an RN which places the residents at risk for delay of treatment.A request was placed for the Facility Staffing Policy, on May 15, 2026 at 9:28 a.m. The DON documented that the facility had no staffing policy. Review of the Facility Assessment, updated November 2025, revealed that the facility resources needed to provide competent support and care for the resident population, every day and during emergencies, included Nursing services. The Facility assessment listed RNs, Charge Nurses, and wound nurses as part of the nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Number of residents sampled: Number of residents cited: Based on observations, staff interviews, and facility policy review, the facility failed to ensure proper hand hygiene was conducted during medication administration. The deficient practice could result in contaminated medications being administered to residents along with medication contamination, and potential infection . Findings:During the Medication Administration observation with the Licensed Practitioner Nurse (LPN / Staff #196) on May 14, 2026, at 9:00 AM in the 400 hallway, it was observed that the LPN (Staff #196) had nearly finished administering medications to Resident # 410. The LPN then returned to the medication cart without performing hand hygiene and proceeded to administer the medications to another resident # 499. No hand hygiene was performed during this time. The LPN crushed all medications, mixed them with yogurt, and administered them to Resident # 499.After administering medications to Resident #499, staff # 196 picked up trash from the floor and discarded it in the trash bin. Without performing hand hygiene, the LPN (Staff #196) then began preparing medications for another resident #550 by pouring them into a cup. The LPN (Staff #196) opened a Divalproex capsule with bare hands and emptied it into the cup. The LPN (Staff #196) then put on gloves, opened a Duloxetine 60 mg capsule into the same cup, crushed all medications, and administered them to Resident # 550. The LPN crushed all medications, mixed them with yogurt, and administered them to Resident # 550.An Interview was conducted on May 14, 2026 at 10:36 AM with a Registered Nurse (RN/Staff # 136) stated that all nurses typically clean the medication cart with disinfectant wipes before beginning their shift, and each patient's medications are prepared individually according to the medications due on the eMAR at that time. Hand sanitizer and gloves are kept on each cart to support proper infection control practices. Only one resident's medications are prepared at a time, and the nurse locates the resident to administer the medications directly. She further stated that staff ensure the resident has swallowed the medication before discarding the medication cup, performing hand hygiene, and preparing the next resident's medications. For eye drops, proper protocol includes sanitizing hands, wearing gloves, and providing the resident with a tissue to wipe away tears after administration. She stated gloves are then discarded, hand hygiene is performed, and the medication is returned to the cart before moving on to the next resident. Staff #136 stated that when administering capsule medications, the capsule is opened into a separate medication cup while wearing gloves, and the empty capsule shells are discarded appropriately. After administering the medication, gloves are removed and hands are sanitized. She stated that if a staff member touches a dirty surface, such as the floor, during medication pass, they should immediately stop and perform hand sanitization before continuing care with another resident. Staff #136 stated that failure to follow these infection control procedures places residents at risk of exposure to harmful organisms that could negatively impact their health. The RN stated that touching capsules or medications without proper hand hygiene or gloves significantly increases the risk of contamination and potential illness for the resident. Staff #136 stated that these practices are not acceptable and do not comply with facility protocols for hand sanitization, sanitary procedures, or established standards during medication administration. An Interview was conducted on May 15, 2026 at 09:15 AM with the Director Of Nursing (DON/Staff # 98) who stated that the expectation is that staff administering medications maintain proper hygiene practices between residents, including performing hand hygiene before and after each patient interaction. She stated while there may not be a specific policy for hand hygiene during medication administration, the general hand hygiene protocol still applies throughout the process. Staff #98 stated that if a staff member touches a dirty floor or picks up trash during medication pass, hand hygiene should be performed immediately to prevent cross-contamination, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection, and contamination of the workspace. She stated that picking up trash and then opening medications without proper hand hygiene or gloves can also contaminate the medication itself. The DON stated that staff are expected to wear gloves before opening capsules or handling medications. Staff #98 further stated that failure to follow these practices is not acceptable and indicates that the facility's infection control and hygiene policies were not followed properly. A facility policy and procedure titled Hand Hygiene states that staff must follow proper handwashing practices and may also use routine hand decontamination before direct contact with patients.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on a review of clinical records, staff and resident interviews, and facility policies and procedures, the facility failed to ensure that pain medication for one (Resident # 111) of the five sampled residents was administered in accordance with physician orders. This deficient practice had the potential to result in either overmedication or undermedication of the resident. Findings include:Resident #111 was admitted to the facility on [DATE] with diagnoses that included senile degeneration of the brain, acute kidney failure, dementia, cellulitis of the right lower limb, gastro-esophageal reflux disease with esophagitis, H.pylori and chronic pain.Resident # 111's care plan dated February 19, 2026 revealed that the facility must anticipate the resident's need for pain relief and respond immediately to any complaint of pain. During every shift, the facility is expected to evaluate the effectiveness of pain interventions, review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition.Review of the physician's order dated February 19, 2026 revealed that Morphine concentrate 0.25 ml, should be administered orally or sublingually as needed, every two hours for pain levels of 4-10/10 or for shortness of breath.Review of the Medication Administration Record (MAR) dated February 2026 and March 2026 revealed that five times, Morphine concentrate was administered when the documented pain level was zero. Those dates and reported pain levels included:February 22, 2026 - Pain level 0 - Morphine administered at 8:34 PMFebruary 24, 2026 - Pain level 0 - Morphine administered at 8:56 PMMarch 6, 2026 - Pain level 0 - Morphine administered at 6:34 PMMarch 9, 2026 - Pain level 0 - Morphine administered at 7:02 PMMarch 16, 2026 - Pain level 0 - Morphine administered at 1:59 PMReview of the Medication Administration Record (MAR) dated February 2026, March 2026 and April 2026 revealed that four times, Morphine concentrate was not administered when pain levels of 4 or 5 were noted in the pain task. Those dates and reported pain levels included:February 19, 2026 - Pain level 4 - Morphine was not administered.February 26, 2026 - Pain level 4 - Morphine was not administered.March 12, 2026 - Pain level 4 - Morphine was not administered.April 21, 2026 - Pain level 5 - Morphine was not administered.An interview was conducted on May 14, 2026, at 10:36 AM with a Registered Nurse (RN/Staff #136), who stated that the facility administered both scheduled and PRN pain medications. The RN (Staff # 136) explained that PRN pain medications were administered by nurses in accordance with physician orders and pain scale parameters. Nurses assessed residents' pain levels daily to determine whether medication administration was appropriate. For example, if a resident reported a pain level of 4 or higher and the physician's order indicated that PRN medication should be administered at that level, the resident should have received the medication. If the resident reported no pain, pain medication should not have been administered unnecessarily.The RN (Staff # 136) further stated that failure to administer pain medication when a resident was experiencing pain could have resulted in unmanaged discomfort, behavioral changes, elevated blood pressure, and a decreased quality of life. Conversely, administering pain medication when a resident was not in pain could have negatively impacted the resident's quality of life and exposed the resident to unnecessary medication effects.The RN (Staff # 136) acknowledged that there was a documented discrepancy involving morphine administration for Resident #111 and confirmed the inconsistency in administration practices. The RN stated that this was not an acceptable practice and that improvements were needed to ensure consistent and accurate pain medication administration in accordance with facility policy and physician orders.An interview was conducted on May 15, 2026, at 9:15 AM with the Director of Nursing (DON/Staff #98), (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who stated that when a resident experienced pain that fell within the ordered pain parameters, the expectation was for staff to administer the medication if the resident permitted. If the resident refused, staff were expected to attempt alternative methods for pain relief. The DON (Staff #98) stated that failure to administer pain medication when indicated could have resulted in the resident continuing to experience pain without relief and emotional distress, and would have constituted a medication error.The DON (Staff #98) further stated that administering pain medication when it was not needed, particularly narcotic medication, could have resulted in oversedation, respiratory depression, altered mental status, and injury to the resident. The DON (Staff #98) acknowledged that an opioid medication had been administered in a manner that did not follow the physician's order and stated that this was not an acceptable practice.The DON (Staff #98) stated that staff required additional education on following physician orders and appropriately adhering to pain scale parameters.Regarding the consequences of the medication error for Resident #111, the DON (Staff #98) stated that the resident's needs were not met when pain medication was indicated, and the resident was overmedicated when it was not required. The DON (Staff #98)further stated that because the resident had dementia, the improper administration of Morphine could have negatively affected the resident's mental status and safety, impaired swallowing ability, decreased oral intake due to oversedation, and exacerbated the resident's Failure to Thrive.A facility policy and procedure titled Medication Management - Medication Administration states that nurses holding current licensure through the Arizona State Board of Nursing are authorized to administer medications pursuant to the order of a medical practitioner.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, facility documents, and policy, the facility failed to ensure a call system was operational for 1 out of 20 residents sampled (# 5). The universe was 100 residents. The deficient practice could place residents' safety at risk.Findings include:Resident # 5 was admitted [DATE] with diagnoses that included unspecified heart failure, hypotension, type 2 diabetes mellitus, and major depressive disorder. A significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 13 indicating the resident's cognitive function is intact. The MDS assessment revealed that Resident # 5 had a fall in the last 2-6 months prior to admission. A Work Order created on May 8, 2026 at 3:11 p.m. revealed that Resident # 5's call light does not work. Further review of the work order documented that the order remained open, no work had been logged on the order, and no alternative call systems were provided to the Resident. An interview was conducted with Resident # 5 on May 12, 2026 at 12:51 p.m. who stated that I can't call for staff when I need something because the button came off a while ago. Resident # 5 stated that the facility is aware that it is broke and they have not fixed the box yet. An observation was conducted in Resident #5's room on May 12, 2026 at 12:51 p.m. revealed the resident's call button hanging over the back the resident's wheelchair not in reach from the bed. Further observation revealed the box where the call light button is connected to was pulled out of the wall with wires connecting the box visible. The call box itself was dangling by the wires. A comprehensive care plan reviewed on May 13, 2026 revealed that Resident #5 was at risk for falling. Interventions included keeping call light within reach at all times and place a 'Call, Don't Fall' sign in room.An interview was conducted with Certified Medical Assistant (CMA/Staff #178) on May 14, 2026 at 8:52 a.m. who stated that she was not aware the resident's call light was not working. Staff #178 went into Resident #5's room and pressed Resident #'s button and walked out of the room to see the light did not come on. Staff #178 went to ask about the call light to maintenance and return stating that maintenance was aware and he had told administration about it. Staff # 178 stated that the resident typically uses he call light a lot when it was working. An interview was conducted with Environmental Services manager (Staff #3) on May 14, 2026 at 8:58 a.m. Staff #3 stated that he was alerted last week that the cord to the call light system had been pulled out and no longer working. Staff #3 stated that they have tried to get the system fixed but the call system is obsolete and parts are no longer available for it. Staff #3 stated that the facility is working on getting a contractor out to work on the whole system but is unsure when the work will be completed. Staff #3 stated that when a call light is not working, the Resident should receive a bell in order to call the facility. Staff #3 went into the room to look for the bell but stated he did not see one and does not know why a bell is not in the room.Another interview was conducted with Resident #5 on May 14, 2026 at 9:05 a.m. who stated he does not have a bell and never got a bell when the call light broke. Resident #5 stated that he usually hollers in the hallway to try and get attention to staff to get help. An interview was conducted on May 15, 2025 at 8:41 a.m. with Assistant Director of Nursing (ADON, Staff #7) who stated that she was made aware on May 14th by staff that the call light was not working in Resident #5's room. Staff #7 stated that as soon as she found out that it was not working they moved both Residents in the room to a different room with a working call light. The ADON stated the concern of not having a way for residents to call for staff is that the resident could not get the care they needed without the ability to notify staff. An interview was conducted on May 15, 2025 at 10:27 a.m. with Director of Nursing (DON, Staff # 98) who stated that it is her expectation that if resident's do not have an operational call light that another system such as a bell is supplied until the call light can be fixed or the resident can be relocated to a room with an operational call light. The DON stated the concern for a resident with out a working call light is patient does not receive the appropriate care. A policy and procedure titled Fall Prevention Policy, dated September 2024, revealed that a plan of care will be developed for a resident (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	found to be a risk of falls on the comprehensive care plan that provides appropriate interventions. The fall prevention policy revealed suggested interventions which include assessing the environment and making the appropriate changes including call light is within in reach.