STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035298	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Welbrook Yuma Opco LLC	2271 South Ridgeview Drive Yuma, AZ 85364

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** 51006 Based on clinical record review, facility documentation, and staff interviews, the facility failed to ensure that one resident (resident #129) was free from verbal abuse from a visitor. The deficient practice could result in further instances of verbal abuse from a visitor, creating an unsafe resident environment. Findings include: -Resident # 129 was admitted on [DATE] with the diagnosis of encounter for other orthopedic aftercare. Resident was discharged on [DATE]. An incident note dated May 17, 2024 revealed that an incident occured on May, 16, 2024. This note revealed the details of the incident, and that Resident #129 was separated from the alleged perpetrator (family member to resident #129), to which Resident #129 stated that they were afraid to return to their room and 'hoped' that the perpetrator had 'calmed down' by the time they returned to the room. This note also revealed that Resident #129 shared their history with the perpetrator, that the perpetrator had made Resident #129 cry prior to the incident. The note also revealed that the perpetrator was asked to leave the facility immediately, pending the investigation. A care plan focus was initiated on May 17, 2024, following the incident. The goal stated that the resident will have no indications of psychosocial well-being problems, as the focus of the goal were the potential for psychosocial well-being following the alleged verbal abuse. The interventions for this goal included allowing the resident time to answer questions and to verbalize their feelings and fears, to consult with social services, encourage resident participation from ma resident who depends on others to make their own decisions, to increase communication with the resident, family and caregivers about their care and living environment, and to remove the resident into a safe environment if further conflict arises. An admission MDS (minimum data set) dated May 20, 2024 revealed a BIMS (Brief Interview for Mental Status) score of 15, indicating that Resident #129 had an intact cognition. A progress note dated May 21, 2024 revealed that the investigation had been completed and that the perpetrator would be able to visit Resident #129. (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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NAME OF PROVIDER OR SUPPLIER Welbrook Yuma Opco LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2271 South Ridgeview Drive Yuma, AZ 85364	

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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.	There are no other progress notes and care plans interventions specifically addressing future interactions with the perpetrator, despite two witness statements indicating their observations of the incident of verbal abuse. Being that the perpetrator is a family member that consistently visited the resident, the perpetrator will be able to visit the resident following the incident, with no specific intervention for the future visits for Resident #129, creating the potential for further occurrences of verbal abuse. An interview was conducted on January 7, 2025 at 1:11PM with a physical therapist (PT/Staff #2) where staff #2 stated they can recall the incident, but did not witness the incident themselves. Staff #2 had also recalled the perpetrator and stated that they were 'firm' and 'blunt' when talking to the resident. An interview with an occupational therapist (OT/Staff #105) on January 7, 2025 was conducted at 1:23PM, where staff #105 stated that they witnessed the incident and reported the incident immediately (Staff #105 is one of two witnesses to the incident). Staff #105 stated that they were in Resident #129's room, with the resident, where they discussed the resident's ability to wheel themselves out and about in their room and the facility, and that it was encouraged by the facility. Then, stated that at this point in the incident, the perpetrator entered the room and interjected themselves into that conversation, and presented verbally aggressive in that situation. Staff #105 attempted to de-escalate the situation and had decided to take the resident to their rehabilitation room to chat with them without the perpetrator present. There in the rehabilitation room, the resident shared with Staff #105 that the resident 'hope' that the perpetrator 'calms down' before they head back to the resident's room. Staff #105 stated that they reported this incident immediately after this conversation with Resident #129, due to the resident stating feeling 'afraid' of the perpetrator and that the perpetrator had made the resident cry in the past. Staff #105 also stated during this interaction with Resident #129, that they get a sense that fear of retaliation to follow from the report from the perpetrator as the perpetrator called the resident a 'burden' to their family, and that the perpetrator is the only one who is willing to take care of the resident, and the resident should 'just listen' to the perpetrator. Staff #105 stated that the incident was viewed as verbal abuse as stated in their trainings from the facility, and from the training and education received for their profession and licensure. Staff #105 stated that they completed their part of the abuse reporting process as a mandated reporter, which included a completed witness statement, and the notification to the director of rehab, and the executive director. A phone interview with another witness (a previous employed occupational therapist/Staff #275) was attempted on January 7, 2025 at 2:26PM but was unsuccessful as she did not respond or return the call. (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.	An interview with the director of nursing (DON/ Staff # 162) was conducted on January 8, 2025 at 10:12AM where she shared their understanding of verbal abuse as threatening residents, telling the resident to 'not' do something if they do not want something to happen, telling a resident that they are taking something of theirs away, not taking them home or letting them leave, and, raising their voice and tone to a resident. The DON stated that any instances of alleged abuse, including verbal abuse, will be immediately reported to the executive director for further investigation. During this interview, a review of the incident report was done. Following this review, Staff #162 stated that their involvement with the reporting process does not extend into the investigation, but were familiar of the incident between the perpetrator and resident #129. Staff #162 stated that they spoke to the resident following the incident, where Resident #129 stated their sympathy for the perpetrator as the perpetrator is the only entity that takes care of the resident from her family, and what the occupational therapist saw was not true, and to let the perpetrator back to the facility. Staff #162 also stated that the conversation of alleging abuse is frequent with resident #129 and the perpetrator, as the perpetrator has stated to Staff #129 that this is not the first time she (the perpetrator) had been accused of abuse to resident #129. An interview with executive director (Staff #247) was conducted on January 8, 2025 at 10:25AM where the executive director stated that they received the allegation from an OT. During this interview, Staff #247 utilized their copy of the incident to ensure their accurate recollection. Staff #247 stated that following their investigation, they could not substantiate that Resident #129 was verbally abused from the perpetrator due to Resident #129 being informed of the investigation process, realized that the perpetrator would not be able to visit, and stated that the incident was a misunderstanding, despite having two mandated reporters complete full witness statements, and, with no plan to ensure a safe resident environment for Resident #129. A policy titled, Abuse prevention program revealed that the facility will protect residents from abuse by anyone including family and visitors. The policy also revealed that the facility requires staff to complete training and orientation that include the prevention, identify, and report abuse.