STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035298	A. Building B. Wing	12/29/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, review of facility documentation and policies, the facility failed develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime for one resident (# 95) with an allegation of physical abuse. The sample size was one.Findings include, Resident # 95 was admitted to the facility on [DATE], with diagnoses that included subsequent encounter for closed fracture of left femur with routine healing, other fall on same level due to collision with another person, need for assistance with personal care, anxiety disorder, and depression. A clinical admission progress note dated December 12, 2025, documented that the resident presented with racing thoughts, unwanted behaviors, anxiety related to a neighbor that consumes alcohol (Neighbor #38). In addition, the note indicated that a bruise observed on the resident's left breast was attributed to Neighbor #38. The note further stated that Resident #95 was reassured of her safety and that the director was notified of the reported abuse. A Skin and Wound Evaluation note, dated December 12, 2025, revealed a bruise, present on admission, was reported to the provider.A progress note, dated December 16, 2025, revealed the Executive Director (ED/Staff # 6) met with Resident #95, regarding the December 12,2025 allegation of abuse. The note revealed that the resident stated that she did not feel abused or was abused by Neighbor # 38, but rather that this neighbor abused alcohol. A care plan, dated December 16, 2025, revealed an area of focus for Resident #95's risk for psychosocial well-being related to family discord; included a precaution that would not allow neighbor #38 entry into the facility. However, the care plan did not support evidence of a focus or intervention for this risk prior to December 16, 2025. An incident note, dated December 17, 2025, revealed the Director of Nursing (DON/Staff #52) met with Resident #95 to gain further clarification on the allegation of abuse reported on admission. The note revealed that during the discussion, the guest stated that the abuse allegation report was a misunderstanding, and that neighbor #38 abused alcohol, not that he had abused her. Review of the clinical recorded revealed no evidence that Law Enforcement officials were notified of the allegation. A review of the Brief Interview for Mental Status (BIMS) evaluation, dated December 17, 2025, revealed a score was 14, which indicated intact cognition. The Facility Reported Incident follow up report, submitted December 17, 2025 revealed the facility reported the allegation of abuse to the Adult Protective Services (APS) and the Ombudsman on December 16, 2025 at 6:30 p.m. The report also revealed that on December 12, 2025, the administrator was notified, who then notified the Department of Health Services (DHS) via online portal. However, the report revealed no evidence that Law Enforcement was notified regarding the allegation, per the facility policy.A review of the facility's Self-Report Complaint form, in reference to the date and time of alleged incident/violation at December 12, 2025 at 5:21 p.m., revealed no date of submission to DHS. Review of DHS Long-term Care Complaint Portal, revealed no evidence that a facility reported incident was submitted regarding Resident #95's complaint of abuse on December 12, 2025. An un-successful attempt to contact the resident was conducted on December 29, 2025 at 11:10 a.m. An interview was conducted on December 29, 2025, at approximately 11:30 a.m. with Certified Nurse Assistant (CNA/Staff #41). Staff #41 stated that if bruising or injuries are observed on a newly admitted resident, the nurse is immediately notified. The CNA reported receiving abuse prevention training upon hire, annually, and during in-services. The CNA also served as the facility's shower aide and stated they were trained to pay attention to residents' bodies during showers and to notify the nurse of any concerns. Staff #41 recalled showering the resident only once and stated the resident was very nice and did not observe any fresh bruising at that time.An interview was conducted on December 29, 2025, at approximately 1:28 p.m. with a Registered Nurse (RN/Staff #24), who stated that upon admission the resident appeared anxious. While assessing and repositioning the resident, staff #24 stated bruising was observed on the resident's body. The RN also reported that the resident spoke repeatedly about a neighbor (Neighbor # 38), and stated Neighbor # 38 had abused her and a friend. The RN stated that the resident's conversation frequently returned to the neighbor topic and described the interaction as tangential. The RN also stated that he listened to the resident's concern about abuse, and provided information regarding courses of action. The RN further stated the resident confirmed that he felt the incident constituted abuse. Staff # 24 stated that the resident as agreeable to report the concern of abuse to the appropriate authorities. The RN stated that the resident did not express being fearful at the time, but did reveal to the nurse, not feeling safe around Neighbor # 38. The RN voiced that he made sure to clarify the allegation with the resident, in order to ensure accuracy when