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	04/16/2026

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 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** Based on clinical record review, staff and resident interviews, and facility policy review, the facility failed to ensure care and services were provided to one resident (#35) related to change in urine color. The deficient practice could result in delayed recognition of a change in condition and subsequent complications. Findings include: Resident #35 was admitted to the facility on [DATE] with medical diagnoses that included acute systolic (congestive) heart failure, myoneural disorder and stage 1 through stage 4 chronic kidney disease. The care plan dated March 28, 2026 revealed the resident had renal insufficiency CKD (chronic kidney disease), and the resident will have no signs/symptoms of complications related to fluid overload. Interventions included to monitor and report changes in mental status, lethargy, tiredness, fatigue, tremors and seizures. An admissions Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition. During an observation on April 14, 2026 at 2:10 PM, the resident's catheter had red-tinged urine. Resident #35 stated around 10:00 AM her urine changed to a red color and that only the Physical Therapist had noticed it and indicated he would notify the nurse. During an observation on April 16, 2026 at 11:56 AM, resident #35's catheter was noted to contain red-tinged urine. Following the observation, resident #35 was interviewed. Resident reported that on April 15, 2026 a registered nurse (RN, staff #107) flushed the catheter, after which the urine remained clear for the remainder of the day. The resident further stated that since the morning of April 16, 2026, the urine had become dark red and it had not been addressed by staff, except for the physical therapist who reportedly observed the dark red urine again. The resident also reported experiencing burning with urination and back pain. However, there was no documentation in the medical record indicating that the RN, staff # 107, reported hematuria (blood in the urine) or flushed the resident's catheter on April 15, 2026. The review of clinical records revealed no documentation of staff noting red- tinged urine. An interview was conducted on April 16 2026 at 12:19 PM with a Certified Nursing Assistant (CNA , staff # 115) who stated that she did not observe red colored urine when she emptied resident #35's catheter bag at 8:00 AM on April 16, 2026. An interview was conducted on April 16, 2026 at 12:24 PM with Licensed Practical Nurse (LPN ,staff #4), who stated she did not notice a change in urine color when she saw resident #35 that morning. At 12:25 PM the CNA informed staff # 4 that resident #35's urine was dark red. The LPN then donned PPE (Personal Protective Equipment), entered resident #35's room and assessed the resident. The LPN asked resident about the urine color, and the resident stated, yes, it has been dark red since 10:00 AM. The LPN observed dark red urine and stated to the resident, I do see there is a bit of hematuria, I just noticed it now but I do not see any blood clots. I will tell your provider to see what we can do. The LPN further asked the resident about symptoms and resident #35 stated she was experiencing irritation and burning. Resident also reported to the LPN that on April 15, 2026 the RN (staff #117) emptied the resident's catheter bag when the urine was red. During another interview with Staff #4 on April 16, 2026 at 12:30 PM, Staff #4 stated again that resident's urine was clear when she saw the resident that morning. Staff #4 further stated she did hear about the hematuria by night shift nurse, however there is no progress notes of the observation by the night shift nurse in the clinical record. Staff #4 stated staff usually record (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observations such as hematuria in progress notes. Staff #4 stated the risk of not recording in the clinical record is for the concern not being communicated with the rest of staff. She stated hematuria not being written in the clinical record can put residents at greater risk of not getting care that the residents needed and complications like infection and dehydration, blood clots can occur. During an interview with LPN (staff #119) on April 16, 2026 01:56 pm, staff #119 stated she will document any changes to resident's catheter in progress notes. She stated there is risk for residents not receiving care and treatment that they need if the staff fails to document changes in resident's catheter output. During an interview with the Director of Nursing (DON, Staff #116) on April 16, 2026 at 2:42 PM, the DON confirmed that there was no mention of RN observing residents hematuria in resident's clinical record. The DON stated it is important to document in clinical records so that staff can follow up with residents, monitor and order labs if needed. The risk of not being documented in clinical records can cause residents to be at risk for UTI complications for not ordering necessary labs needed or sending residents to hospital if needed. The DON stated this does not meet her expectations and will do more in-service training regarding documentation. A policy titled Change in Resident's Condition or Status, revised February 2021 revealed, The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy, the facility failed to ensure that medication to regulate hypertension were administered within physician's ordered parameters for one resident (#35). The deficient practice can result in further inaccurate management of blood pressure, potentially leading to worsening outcomes. Findings Included:Resident #35 was admitted to the facility on [DATE] with medical diagnoses that included hypertensive heart and chronic kidney disease with heart failure.An admissions Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview Mental Status (BIMS) score of 14, indicating intact cognition. Further review of the MDS revealed the resident had an active diagnosis of hypertension and heart failure. Review of Physician's order with start date of April 2, 2026 included following medications:1) Amlodipine Besylate 5 mg oral tablet, give one tablet by mouth one time a day for HTN (Hypertension) hold if SBP (Systolic Blood Pressure) less than 120 or HR (Heart Rate) less than 55.2) Lisinopril oral tablet 5 mg, give one tablet by mouth one time a day for HTN hold if SBP is less than 120. The medication administration record (MAR) for April 2026 revealed that on April 9, 2026 Amlodipine Besylate 5mg and Lisinopril 5mg tablets were administered to the resident when the resident's SBP was less than 120. It was documented that the residents blood pressure (BP) was 114/64. Both medications were given outside the physician's ordered parameter. Additionally, there were no documentation in clinical record that indicated the reason Amlodipine Besylate 5mg and Lisinopril 5mg tablets were administered on April 9, 2026 outside the physician's ordered parameter. An interview was conducted on April 16, 2026 with Registered Nurse (RN, staff# 128) at 1:30 PM. Staff #128 confirmed that both Amlodipine Besylate 5mg and Lisinopril 5mg were given out of parameters and did not follow physician orders on April 09, 2026 as resident's BP was at 114/64. Staff #128 stated that both medications should have been held. Staff #128 stated that the risks of administering medications outside parameters can cause blood pressure to drop more causing symptoms of dizziness, hypertension and more risks for resident. An interview was conducted with Licensed Practical Nurse (LPN, staff #119) on April 16, 2026 at 1:51 PM. Staff #119 stated that Amlodipine Besylate and Lisinopril medications were administered on April 09, 2026 when it should have been held due to BP being 114/64. The LPN stated the risk of administering medications can cause blood pressure to go down real quick, can cause dizziness, headache and in the worst case hospitalization. An interview was conducted with Director of Nursing (DON, Staff #30) who confirmed that both Amlodipine Besylate 5mg and Lisinopril 5mg were given out of parameters and staff did not follow physician orders on April 09, 2026. The DON stated by administering medications outside physician's ordered parameters imposes risks of hypotension (low blood pressure). The DON stated this does not meet her expectation, and that an in-service training is done requiring staff to document blood pressure as soon as medication is passed just so staff double alerted. A policy titled, Administering Medications, dated April 2019, revealed Medications are administered in a safe and timely manner, and as prescribed. The following information is checked/verified for each resident prior to administering medications , allergies to medications; and vital signs, if necessary.