STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035254**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **09/12/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 -** Actual harm **Residents Affected -** Few	**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 clinical record reviews, staff interviews, facility documentation and policies and procedures, the facility neglected to ensure one resident (#4) was free from physical abuse involving another resident (#265). The deficient practice has the potential for further abuse resulting in physical harm to residents. Findings include: -Resident #4 was admitted to the facility on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 6, (YEAR) included the resident had short and long term memory problems and was severely impaired with cognitive skills for daily decision making. The MDS also included the resident required extensive to total dependence with activities of daily living. The care plan for behavioral symptoms included the resident has a history of showing verbal and physical aggression. Interventions included cares provided per resident's unique preferences and routines, document any and all behaviors every shift and to report any change in behaviors. Regarding the incident on (MONTH) 22, 2019: Review of a program manager progress note dated (MONTH) 23, 2019 revealed that on (MONTH) 22, 2019, a CNA (Certified Nursing Assistant) heard loud talking in the resident's room. The CNA entered the room, and the resident's roommate (resident #265) was standing next to resident #4 and her covers had been removed. Resident #265 was telling resident #4 to get up and resident #4 then hit the hand of resident #265, then resident #265 hit resident #4 in the chest. A nursing note dated (MONTH) 23, 2019 included that resident #4 had no complaints of acute pain related to hitting roommate's hand and after being shaken and hit by her roommate (resident #265). Regarding the incident on (MONTH) 30, 2019: A physician note dated (MONTH) 30, 2019 included that yelling was heard and a CNA found resident #4 face down next to the bed, with the bolster propped open, and blood was noted on resident #4's head. Resident #4 was awake, readily consoled, was cooperative and was no longer crying. Physical examination included a laceration to the right forehead measuring 2.5 cm (centimeters) to 3 cm, the right eye was swollen shut, right cheek was bruised and swollen, had a right knee bruise and had a periorbital bruise. A fall from the bed landing face down was suspected and the resident was transported to the ED (emergency department). The hospital emergency room documentation dated (MONTH) 30, 2019 included the resident had a fall with laceration and direct blow. The character of symptoms included pain, bleeding, swelling, ecchymosis, abrasion and contusion. Location of the injury was right forehead, face and periorbital eye(s). Physical examination included swelling and ecchymosis, 5.5 cm (centimeters) of full thickness avulsed, stellate laceration of the right eyebrow and right forehead, superficial skin tear to the right dorsal wrist and dorsal swelling of the right wrist with mild deformity. The x-ray of the right wrist revealed a comminuted [MEDICAL CONDITION] distal radius. Impressions included closed head injury, right facial laceration 5.5 cm with complex repair, skin tear to right wrist, comminuted [MEDICAL CONDITION] distal radius, right knee contusion and closed nasal fracture. A nursing note dated (MONTH) 31, 2019 included that resident #4 was heard screaming from her room. Resident #4 was lying face down on the floor next to the bed and was crying. The roommate (resident #265) was standing next to her and was holding the bedding of resident #4. The note also included that resident #4 was bleeding from her head and nose, and was transported to the ED. Another nursing note dated (MONTH) 31, 2019 revealed the report from the hospital included the resident sustained [REDACTED].A physician progress notes [REDACTED]. Per the note, resident #4 stated Mother hit her. The note included the resident had bilateral nasal fractures, the right had sutures over the right eyebrow and the eye was less swollen and she was able to open it. -Resident #265 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. A behavior care plan dated (MONTH) 5, (YEAR) revealed the resident exhibited behaviors of striking out, wandering and refusing medications. A goal was that the resident would not cause harm to self or others. Approaches included the use of a wander guard, documenting behaviors and to make sure all basic needs were met. Regarding the incident on (MONTH) 22, 2019: Review of the physician progress notes [REDACTED].#265 was frequently hitting staff and trying to elope. Under assessment it included the resident had dementia with behaviors. The care plan for cognitive loss and dementia dated (MONTH) 11, 2019 included the resident had physical and aggressive behavioral symptoms towards other residents and/or staff. The care plan included that others had been hit, struck, kicked, shoved and/or scratched by resident #265. The goal was the resident will not harm self or others. Approaches included avoiding over-stimulation and maintain a calm approach and a calm environment for the resident. A program manager progress note dated (MONTH) 16, 2019 revealed that resident #265 wandered into other resident's rooms and laid on their beds. According to a neurology consultation note dated (MONTH) 18, 2019, the resident continued to have significant behavior issues and ongoing aggressive behaviors of hitting at staff and attempts to elope from the facility. Under assessment it included a [DIAGNOSES REDACTED]. A nursing progress note dated (MONTH) 20, 2019 included the resident continued to wander from room to room and needed constant redirection. Another nursing progress note dated (MONTH) 20, 2019 revealed that resident #265 continued to need redirection and close supervision during interaction with other residents, was wandering/pacing down the hallways and was wandering into other resident's rooms and invading on their privacy. On (MONTH) 21, 2019, a nursing progress note documented the resident was wandering into various rooms and required constant redirection from staff. Resident #265 was refusing assistance and use of the wheelchair, was constantly looking for children and attempted to open all locked doors. A nursing progress note dated (MONTH) 22, 2019 included the resident displayed exit seeking behaviors and had asked staff to open the patio exit, so she could go home. Per the note, the resident verbalized delusions and asked staff where the little boy went and that she was looking for her baby. It also included the resident wandered into other resident rooms to lie down and sleep. Review of a facility's investigative report revealed that on (MONTH) 22, 2019 at 6:22 a.m., a CNA (staff #13) reported that

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

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.

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F 0600

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 1)
she heard yelling from the room of resident #4 and resident #265. The CNA reported that resident #265 pulled off the bed linens of resident #4 and was yelling at the resident to get up. Resident #265 was pulling and shaking resident #4. Resident #4 then hit the hand of resident #265, who then hit resident #4 on the chest. The residents were separated.
Further review of the facility's investigative report revealed the facility substantiated abuse and resident #265 was placed on 1:1 supervision.
The care plan for cognition loss and dementia was revised on (MONTH) 22, 2019 to reflect the need for 1:1 supervision 24/7.
Review of the MAR for (MONTH) 2019 revealed the resident was found hitting and shaking her roommate on (MONTH) 22 and was on 1:1 supervision.
A program manager progress note dated (MONTH) 23, 2019 included that on (MONTH) 22, 2019, a CNA witnessed resident #265 shaking resident #4 and telling her to get up. Resident #4 hit the hand of resident #265, who then hit resident #4 back. Resident #265 was directed to her bed and insisted that she needed a match to start a fire.
However, there was no further clinical record documentation that resident #265 was provided 1:1 supervision after (MONTH) 22, and there was no documentation of the rationale as to why the 1:1 supervision was discontinued, as the care plan included for 1:1 supervision 24/7. In addition, the documentation included that resident #4 and #265 remained roommates.
Continued review of the (MONTH) 2019 MAR indicated [REDACTED].
Regarding the incident on (MONTH) 30, 2019:
A social service note dated (MONTH) 23, 2019 included the facility was considering transferring resident #265 to a higher level of care, due to multiple behaviors with a most recent resident to resident occurrence.
CNA documentation on (MONTH) 30, 2019 included the resident manifested wandering behaviors, which placed the resident at a significant risk for danger, by intruding on privacy or activity of others.
The nursing progress note dated (MONTH) 30, 2019 revealed that resident #265 came out of the room pushing a male resident in his wheelchair and asked staff where the male resident was supposed to go.
Another nursing progress note dated (MONTH) 30, 2019 revealed that resident #265 took a female resident's belt alarm and began to push this resident in the hall.
Further review of the clinical record revealed there was no evidence that the neurologist was notified regarding the resident's escalating behaviors, as per the neurologist note from (MONTH) 18.
Review of the facility's investigative report revealed that at approximately 10:35 p.m. on (MONTH) 30, 2019, resident #4 was found face down on the floor in her room by a CNA (staff #40). The CNA immediately requested the help of a nurse and the medical director who was in the facility at the time of the incident. Resident #265 was found standing over resident #4 and was holding the bed pad of resident #4 in her hands.
Review of a written statement from a CNA (staff #40) revealed that on (MONTH) 30, 2019 at approximately 10:35 p.m., he was charting when he heard talking from down the hall which seemed more like short bursts of fairly loud argument and then sounded more like a loud cry. Staff #40 reported that the light was on in the room of resident #265 and resident #4, and he found resident #4 face down on the floor. He reported that resident #265 was holding a bed pad and was standing over resident #4, and the bed bolster was standing against the wall near the bed. It also included that the pillow from the bed of resident #4 was on the bed of resident #265. He reported that he then noticed the head of resident #4 was in a puddle of blood. The statement also included that the nurse and physician arrived on the scene and 911 was called.
A written statement from a licensed practical nurse (LPN/staff #136) included that on (MONTH) 30, 2019 at 10:45 p.m., staff #40 asked for assistance and when she rushed to the room, resident #4 was face down on the floor next to her bed and she was screaming. Staff #136 reported there was blood on the floor and her face was bloody. She reported that resident #265 was just walking around the room carrying the bed pad of resident #4.
A statement from another LPN (staff #148) revealed that at approximately 10:45 p.m., staff #40 informed him that someone was seriously injured. He and the physician went into the room and found resident #4 face down on the floor next to her bed and there was a pool of blood on the floor. The resident was bleeding from a laceration to the right side of her face and forehead.
Further review of the facility's investigative report revealed that resident #4 and #265 were interviewed and both residents could not tell what happened. The report also included that the allegation of physical abuse was unable to be substantiated based on the results of the resident interviews, and that the incident was unwitnessed.
A nursing progress note dated (MONTH) 31, 2019 included that resident #265 was believed to have pulled her roommate (resident #4) off the bed onto the floor, while she was sleeping. Resident #4 sustained serious injuries to the head and face and was sent to the emergency room . The note also included that resident #265 was now placed on 1:1 observation until the resident could be transferred to a higher level of care.
A physician's orders [REDACTED].
Per the documentation on the MARs, the resident was provided 1:1 supervision 24/7 until discharged .
A program manager note dated (MONTH) 1, 2019 revealed that resident #265 was discharged to home with family.
An attempt was made to conduct an interview with resident #4 on (MONTH) 11, 2019 at 8:34 a.m., however, she was unable to respond to questions appropriately.
An interview was conducted on (MONTH) 11, 2019 at 11:24 a.m., with a CNA (staff #40 who found resident #4 on the floor). He stated that he was working the night shift when he heard someone crying out and went into the room of resident #4 and #265 who were roommates. He stated the bed of resident #4 was in lowest position and resident #4 was crying and sobbing loudly and she was on the floor face down. He stated that he could not remember if there was blood on the floor. He said resident #265 was holding the bed pad of resident #4 and she was standing over resident #4. He said the resident was sent to the hospital because of a large open wound in the forehead and right temple.
Regarding resident #265, staff #40 stated that resident #4 and #265 had been roommates for at least a month or more and had altercations in the past, but the altercation had not happened on his shift. He said resident #265 had behaviors such as resistive to care and could be aggressive. He stated that prior to the incident, resident #265 was not acting different from the ordinary, but ordinary was on the aggressive side.
An interview with a LPN (staff #136) was conducted on (MONTH) 11, 2019 at 12:15 p.m. She stated the night of the incident on (MONTH) 30, staff #40 reported there was something going on in the room of resident #4 and #265. She stated when she went into the room, resident #4 was on the floor crying, but she could not tell her what happened. Staff #40 said there was blood on the floor and the resident was bleeding from her nose all over her face. She stated resident #4 was sent to the hospital and resident #265 was placed back to bed on 1:1, meaning someone was with the resident all the time.
In an interview with a registered nurse (RN/staff #76) conducted on (MONTH) 11, 2019 at 1:46 p.m., she stated that all staff in the unit are involved with the supervision of residents. She said residents are parked in their wheelchair in the hallway, so the nurse can supervise the residents while the CNA's are providing cares. She stated when a resident is on 1:1, it means any staff in the hall is responsible in providing 1:1 when able, and there is no specific staff assigned to a resident who requires 1:1 supervision. She further stated the only occasion when the administrator assigns one person per shift for 1:1, is when a resident is verbally and physically aggressive.
An interview was conducted on (MONTH) 12, 2019 at 7:06 a.m. with the CNA (staff #13 who reported the incident on (MONTH) 22, 2019). She stated that she heard resident #265 yelling and when she entered the room, resident #265 took the blanket off resident #4. She stated the bed of resident #4 was in low position and resident #265 was standing over her bed. She said resident #265 was asking resident #4 to get up and help find her kids/babies. She stated that she redirected resident #265 out of the room and she stayed in the hall for the rest of the shift. She said resident #4 went back to sleep and resident #265 was watched closely and placed on every 15 minute checks. However, she stated the 15 minute checks she conducted were not documented because there was no place to document them any where in the clinical record.
Regarding resident #265, staff #13 stated the behaviors of resident #265 included resisting cares, refusing medications, could be combative with staff or other residents and could be verbally and physically aggressive to staff and other residents. She said resident #265 would yell at other residents who would then yell back and that resident #265 had a tendency to hit residents. She stated that resident #265 would not sleep for 2-3 days and then would sleep for one whole day and then would be awake again for 2-3 days. She stated if the resident did sleep at night, it was usually only for 45 minutes and then she would be awake the entire time. She stated that during the night time, resident #265 is the only resident wandering in the hallway, so staff can closely monitor her. She stated after the incident on (MONTH) 22, 2019, resident #265 was on close watch and every 15 minute checks, but there was no specific staff assigned to resident #265 for

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F 0600

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 2)
1:1, until after the second incident that resulted in the transfer of resident #4 to the hospital. She further stated that both residents remained as roommates after the incident on (MONTH) 22.
Regarding resident #4, staff #13 stated the resident was sweet and did not have any temperament and would just keep to herself. She stated that she has not seen resident #4 to have any behaviors and had not seen resident #4 provoke resident #265 or any other residents.
During an interview with the Director of Nursing (DON/staff #98) conducted on (MONTH) 12, 2019 at 1:24 p.m., she stated that on (MONTH) 22, 2019 it was reported to her that resident #265 pulled the blanket off of resident #4 and tried to wake her up and had swatted resident #4, who then swatted her back. She said the facility substantiated the allegation of abuse on (MONTH) 22 because the CNA (staff #13) witnessed the incident. She stated that resident #4 and #265 continued to be roommates after this incident, because she did not think it was abuse because both residents had dementia and they did not know what they were doing. She stated resident #265 was care planned for and was placed on 1:1 supervision, meaning there was one staff assigned to care for resident #265 the entire shift starting (MONTH) 22, and that the assigned staff changes after every shift. She said when resident #265 was redirected, she became aggressive and would hit staff or other residents. However, she could not find documentation that 1:1 supervision was provided after (MONTH) 22, 2019.
During the above interview, the clinical record was reviewed with the DON and the Assistant Director of Nursing (staff #47 who later joined the interview). Staff #47 provided documentation of resident #265 being on 15 minute checks from (MONTH) 23-30, 2019. The DON stated that resident #265 was placed on 1:1 supervision on (MONTH) 22. However, both staff #98 and #47 stated that they could not find documentation that resident #265 was provided 1:1 supervision after (MONTH) 22, as care planned.
Regarding the incident on (MONTH) 30, 2019, staff #98 stated she was not at the facility when the incident happened and she learned about the incident the next day. She stated facility unsubstantiated the allegation because the facility really did not know if resident #265 did something to resident #4 or if resident #4 just rolled out of bed and resulted in injury. She said the bed of resident #4 was in the low position, meaning it was approximately one and a half feet from the floor. She said because resident #4 has a [DIAGNOSES REDACTED]. She said resident #4 was found on the floor and resident #265 was holding the incontinent pad also known as bed pad from the bed of resident #4. She said the bed pad is usually placed on top of the sheet of a resident's bed. She stated that the medical director was at the facility at the time of the incident and assessed resident #4 and ordered the transfer to the hospital.
Staff #98 continued to say that she reviewed the video surveillance on the date and time of the incident and stated that prior to the incident, the video showed that resident #265 pushed her wheelchair out of her room, re-entered her room and came out later with either a blanket or a pillow and was placing these items on her wheelchair. She stated there were no other persons seen in the video entering their room other than resident #265, until staff #40 entered the room at the time of the incident.
Review of the policy on Behavior Management revealed the facility takes a cautionary and safe approach in treating and caring for individuals who exhibit challenging behaviors that may pose a threat to the health or safety of the resident or other individuals in the facility.
Review of the Abuse Prevention policy revealed the facility will take appropriate steps to prevent the occurrence of abuse. It also stated, Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm pain or mental anguish. Physical Abuse includes hitting, slapping, pinching and kicking.
The policy also included that the IDT (Interdisciplinary Team) will attempt to identify residents whose personal histories may render them at risk for abusing other residents and develop intervention strategies to prevent occurrences and monitor changes that would trigger abusive behavior. Additionally, the IDT team will attempt to identify those residents whose personal histories may render them at risk for abuse and develop intervention strategies to protect them.
The policy further included the facility makes reasonable efforts to determine the cause of the alleged violation and takes corrective action consistent with the investigation findings and to eliminate any ongoing dangers to the resident. It also stated that appropriate steps are taken by the facility to prevent recurrence of abuse. If a suspected violation occurs, the facility shall take immediate action to stop the alleged or suspected abuse, neglect or exploitation of a resident. If the suspected perpetrator is another resident, the DON or designee separates the residents so they do not have access to each other until the circumstances of the alleged incident can be determined.

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.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY >
Based on clinical record reviews, staff interviews, facility documentation and policy review, the facility failed to ensure that allegations of abuse involving resident (#4) and resident (#265) were reported to the State Agency and to Adult Protective Services (APS), within two hours after the allegation was made. The deficient practice could result in the appropriate State agencies not being notified of allegations of abuse as required.
Findings include:
-Resident #4 was admitted to the facility on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED].
-Resident #265 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED].
Regarding an incident on (MONTH) 22, 2019:
Review of the facility's investigative report revealed that on (MONTH) 22, 2019 at 6:22 a.m., a CNA (staff #13) reported that she heard yelling from the room of resident #4 and resident #265. The CNA reported that resident #265 pulled the bed pad off of resident #4's bed and was yelling at her to get up and was pulling and shaking resident #4. Resident #4 then hit the hand of resident #265, who then hit resident #4 on the chest.
Continued review of the facility's investigative report revealed the facility substantiated abuse.
However, further review of the facility's investigation revealed there was no evidence that the allegation of abuse was reported to APS.
Regarding an incident on (MONTH) 30, 2019:
Review of the facility's investigative report revealed that at approximately 10:35 p.m. on (MONTH) 30, 2019, resident #4 was found face down on the floor in her room by a CNA (staff #40). The CNA immediately requested the help of a nurse and the medical director who was in the facility at the time of the incident. Resident #265 was found standing over resident #4 and was holding the bed pad of resident #4 in her hands.
Review of a written statement from a CNA (staff #40) revealed that on (MONTH) 30, 2019 at approximately 10:35 p.m., he was charting when he heard talking from down the hall which seemed more like short bursts of fairly loud argument and then sounded more like a loud cry. Staff #40 went to the room of resident #265 and resident #4, and resident #4 was face down on the floor. He reported that resident #265 was standing over resident #4 and the head of resident #4 was in a puddle of blood. The statement also included that the nurse and physician arrived on the scene and 911 was called.
A written statement from a licensed practical nurse (LPN/staff #136) included that on (MONTH) 30, 2019 at 10:45 p.m., staff #40 asked for assistance and when she rushed to the room, resident #4 was face down on the floor next to her bed screaming. Staff #136 reported there was blood on the floor and her face was bloody.
A statement from another LPN (staff #148) revealed that at approximately 10:45 p.m., staff #40 informed him that someone was seriously injured. He and the physician went into the room and found resident #4 face down on the floor next to her bed and there was a pool of blood on the floor. The resident was bleeding from a laceration to the right side of her face and forehead.
Further review of the facility's investigative report revealed that resident #4 and #265 were interviewed and both residents could not tell what happened. The report included that the allegation of physical abuse was unable to be substantiated based on the results of the resident interviews, and that the incident was unwitnessed.
The investigative report also included that the incident was not reported to the State Agency until (MONTH) 31, 2019 at 1:30 a.m., which was more than 3 hours after the allegation was made. There was also no evidence that the incident was reported to APS.
An interview with the Director of Nursing (DON/staff #98) was conducted on (MONTH) 12, 2019 at 1:24 p.m. During the

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) interview, the investigative reports for the incidents on (MONTH) 22 and (MONTH) 30 were reviewed. Staff #98 stated she could not find any documentation that both incidents were reported to APS and that she did not know why. She also stated that based on the documentation, the incident on (MONTH) 30 was reported to the State Agency on (MONTH) 31 at 1:30 a.m., which was approximately 3 hours after the incident. She stated their policy was to report any incident with serious injury to the State Agency within 2 hours. Review of the Abuse Prevention policy revealed it is the responsibility of all employees to immediately report any suspected or alleged violation of abuse, neglect, injuries of unknown source and/or misappropriation of resident property. It also included the facility will take appropriate steps to ensure that all suspected or alleged violations of Federal or State laws which involve mistreatment, neglect, abuse, injuries of unknown source, exploitation and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegations is made to the Administrator and to other officials including the State Survey Agency and APS where State law provides for jurisdiction.