STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035158	A. BUILDING _____ B. WING _____	03/29/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY-PRESCOTT VILLAGE	1030 SCOTT DRIVE PRESCOTT, AZ 86301

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	**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 review, interviews, facility documentation and policy and procedures, the facility failed to ensure 1 of 2 sampled residents (#6) was free from verbal abused by a staff member. The deficient practice could result in other residents being abused. Findings include: Resident #6 was admitted to the facility on (MONTH) 4, 1990, with [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment dated (MONTH) 4, (YEAR) included the resident had a BIMS (Brief Interview for Mental Status) score of 15, which indicated intact cognition. Review of a care plan revealed the resident had impaired cognitive function/developmental delay, as evidenced by child like coping mannerisms and disorientation. A care conference note dated (MONTH) 5, (YEAR) included the resident stated that everything was going fine and she enjoys the activities which she attends and that she chooses what she wants to go to. A mood and behavior note dated (MONTH) 15, (YEAR) included no behaviors were noted. Review of the progress notes for March, (MONTH) and (MONTH) (YEAR) revealed no evidence that the resident was expressing negative feelings. Review of a facility's investigation revealed that a certified nursing assistant (CNA/staff #50) approached the Director of Nursing Services (DNS/staff #33) on (MONTH) 25, (YEAR) and reported that she felt that she needed to say something about what happened approximately 1 month ago (around (MONTH) 25). Staff #50 explained that she was sitting in the main dining room at meal time assisting residents with their meals, and heard another CNA (staff #117) laughing loudly. Resident #6 was sitting at a table and was 5-7 feet away from resident #6. She said resident #6 asked staff #117 what he was laughing about and staff #117 said to the resident Why don't you look in the mirror. Per the report, the resident continued to eat her lunch and did not appear to be affected by what was said. Staff #117 was suspended. The report included that another CNA (staff #113) also witnessed this incident. Resident #6 was interviewed and said that she did not like staff #117, because he treated her mean and told her that she could not do things. Other residents were also interviewed and reported that they did not care for staff #117, because he could be rude and made jokes that were not appropriate. The report further included that verbal abuse was substantiated and staff #117 was terminated. The facility's investigation also included a written statement by staff #113 who reported that she was in the dining room at lunch time with staff #117, when she heard resident #6 ask staff #117 what he was laughing at. Staff #113 said that staff #117 responded Take a look in the mirror. The statement included that she did not think of the incident as verbal abuse at the time, and was unsure if the resident heard staff #117, because she did not respond and kept eating her lunch. The report included a statement by staff #117 who stated that he did not remember this incident ever happening at all. The report also included a written interview with staff #50 who reported that she was sitting in the dining room assisting residents with their meals, when staff #117 was heard laughing loudly. Staff #50 said that resident #6 asked staff #117 what he was laughing about and staff #117 responded to resident #6, Why don't you look in the mirror? She stated it happened during lunch time one month ago in the main dining room. In a phone interview with a CNA (staff #117) on (MONTH) 26, 2019 at 9:57 a.m., he stated that he remembered this resident, but stated that this incident did not happened, and that he was never rude to any residents. He stated that he was put on suspension right away for over two weeks and was then terminated. An interview with staff #50 was conducted on (MONTH) 26, 2019 at 1:35 p.m. She said that staff #117 was obnoxiously laughing out loud, when resident #6 asked him what he was laughing about. She stated that she heard staff #117 reply to the resident, Look in the mirror. She stated that she felt like this statement was not something you should say to a resident and the residents should not be treated like that. She stated his demeanor was like a bully. She said resident #6 did not appear to be affected by staff #117's statement, as she may not have been able to comprehend what he said. She said there were no other resident's around when staff #117 made this comment. She said that she has had training on recognizing types of abuse and the procedure to report them, but she did not report this incident because she was scared to say something. She stated looking back now she should have said something sooner, and if she saw something like that today, she would report it right away. In an interview with staff #113 on (MONTH) 27, 2019 at 10:51 a.m., she stated that staff #117 said something rude to resident #6. She said that she was not sure if the resident heard what staff #117 said, as she did not seem affected. She stated that staff #117 could be mean towards the residents, but she thought it was just his personality and he was not intentionally being mean. In an interview with the DNS (staff #33) on (MONTH) 27, 2019 at 12:05 p.m., she stated a CNA (staff #50) came to her and stated that she felt uncomfortable about something she overheard. She stated the facility began an investigation into the incident. She stated she had previously done some coaching and counseling with staff #117 regarding his treatment of [REDACTED]. She stated his behavior did improve some after speaking with him. She stated this incident was the first time she had heard that his behavior was directed toward a resident. She stated her expectation is that all allegations of abuse be reported to the nurse immediately and then the nurse is to report it to her. She stated she keeps her phone on 24/7 and staff are encouraged to call her with any concerns they have. Review of staff #117's personnel record revealed he signed a pledge dated (MONTH) 23, (YEAR) stating he understood the facility has a zero tolerance policy for abuse and neglect. Review of the facility's policy titled, Abuse and Neglect dated (MONTH) (YEAR) included The resident has the right to be free from abuse, neglect Residents must not be subjected to abuse by anyone, including, but not limited to, location employees, other residents, consultants or volunteers, employees of other agencies serving the resident, family members or legal guardians, friends or other individuals. Further, the facility provides education and training to employees and volunteers in regards to abuse, neglect, mistreatment and misappropriation of property.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to implement their abuse policy, by failing to report an allegation of verbal abuse immediately to the administrator/designee for 1 of 2 sampled residents (#6). The deficient practice could result in the potential for further abuse of residents.

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Findings include: Resident #6 was admitted to the facility on (MONTH) 4, 1990, with [DIAGNOSES REDACTED]. Review of a facility's investigation revealed that a certified nursing assistant (CNA/staff #50) approached the Director of Nursing Services (DNS/staff #33) on (MONTH) 25, (YEAR) and reported that she felt that she needed to say something about what happened approximately 1 month ago (around (MONTH) 25). Staff #50 explained that she was sitting in the main dining room at meal time assisting residents with their meals, and heard another CNA (staff #117) laughing loudly. Resident #6 was sitting at a table and was 5-7 feet away from resident #6. She said resident #6 asked staff #117 what he was laughing about and staff #117 said to the resident Why don't you look in the mirror. Per the report, the resident continued to eat her lunch and did not appear to be affected by what was said. Staff #117 was suspended. The report included that another CNA (staff #113) also witnessed this incident. Resident #6 was interviewed and said that she did not like staff #117, because he treated her mean and told her that she could not do things. Other residents were also interviewed and reported that they did not care for staff #117, because he could be rude and made jokes that were not appropriate. The report further included that verbal abuse was substantiated and staff #117 was terminated. The facility's investigation also included a written statement by staff #113 who reported that she was in the dining room at lunch time with staff #117, when she heard resident #6 ask staff #117 what he was laughing at. Staff #113 said that staff #117 responded Take a look in the mirror. The statement included that she did not think of the incident as verbal abuse at the time, and was unsure if the resident heard staff #117, because she did not respond and kept eating her lunch. The report also included a written interview with staff #50 who reported that she was sitting in the dining room assisting residents with their meals, when staff #117 was heard laughing loudly. Staff #50 said that resident #6 asked staff #117 what he was laughing about and staff #117 responded to resident #6, Why don't you look in the mirror? She stated it happened during lunch time one month ago in the main dining room. An interview with staff #50 was conducted on (MONTH) 26, 2019 at 1:35 p.m. She stated that staff #117 was obnoxiously laughing out loud, when resident #6 asked him what he was laughing about. She stated that she heard staff #117 reply to the resident, Look in the mirror. She stated that she felt like this statement was not something you should say to a resident and the residents should not be treated like that. She stated his demeanor was like a bully. She said resident #6 did not appear to be affected by staff #117's statement, as she may not have been able to comprehend what he said. She said that she has had training on recognizing types of abuse and the procedure to report them, but she did not report this incident because she was scared to say something. She stated looking back now she should have said something sooner, and if she saw something like that today, she would report it right away. In an interview with staff #113 on (MONTH) 27, 2019 at 10:51 a.m., she stated that staff #117 said something rude to resident #6. She said that she was not sure if the resident heard what staff #117 said, as she did not seem affected. She stated that staff #117 could be mean towards the residents, but she thought it was just his personality and he was not intentionally being mean. In an interview with the DNS (staff #33) on (MONTH) 27, 2019 at 12:05 p.m., she stated a CNA (staff #50) came to her and stated that she felt uncomfortable about something she overheard. She stated the facility began an investigation into the incident. She stated she had previously done some coaching and counseling with staff #117 regarding his treatment of [REDACTED]. She stated his behavior did improve some after speaking with him. She stated this incident was the first time she had heard that his behavior was directed toward a resident. She stated her expectation is that all allegations of abuse be reported to the nurse immediately and then the nurse is to report it to her. She stated she keeps her phone on 24/7 and staff are encouraged to call her with any concerns they have. Review of a facility policy titled, Abuse and Neglect dated (MONTH) (YEAR) included the facility provides education and training to employees and volunteers in regards to abuse, neglect, mistreatment and misappropriation of property. Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator and to other officials in accordance with state law. In the absence of the administrator from the location, the following individuals have the administrative authority of the administrator for purposes of immediate reporting of alleged violations: the Director of Nursing Services or the Director of Social Services.
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 review, facility documentation, interviews and policy review, the facility failed to ensure that an allegation of verbal abuse was reported immediately to the administrator/designee for 1 of 2 sampled residents (#6). The deficient practice could result in the potential for further abuse of residents. Findings include: Resident #6 was admitted to the facility on (MONTH) 4, 1990, with [DIAGNOSES REDACTED]. Review of a facility's investigation revealed that a certified nursing assistant (CNA/staff #50) approached the Director of Nursing Services (DNS/staff #33) on (MONTH) 25, (YEAR) and reported that she felt that she needed to say something about what happened approximately 1 month ago (around (MONTH) 25). Staff #50 explained that she was sitting in the main dining room at meal time assisting residents with their meals, and heard another CNA (staff #117) laughing loudly. Resident #6 was sitting at a table and was 5-7 feet away from resident #6. She said resident #6 asked staff #117 what he was laughing about and staff #117 said to the resident Why don't you look in the mirror. Per the report, the resident continued to eat her lunch and did not appear to be affected by what was said. Staff #117 was suspended. The report included that another CNA (staff #113) also witnessed this incident. Resident #6 was interviewed and said that she did not like staff #117, because he treated her mean and told her that she could not do things. Other residents were also interviewed and reported that they did not care for staff #117, because he could be rude and made jokes that were not appropriate. The report further included that verbal abuse was substantiated and staff #117 was terminated. The facility's investigation also included a written statement by staff #113 who reported that she was in the dining room at lunch time with staff #117, when she heard resident #6 ask staff #117 what he was laughing at. Staff #113 said that staff #117 responded Take a look in the mirror. The statement included that she did not think of the incident as verbal abuse at the time, and was unsure if the resident heard staff #117, because she did not respond and kept eating her lunch. The report also included a written interview with staff #50 who reported that she was sitting in the dining room assisting residents with their meals, when staff #117 was heard laughing loudly. Staff #50 said that resident #6 asked staff #117 what he was laughing about and staff #117 responded to resident #6, Why don't you look in the mirror? She stated it happened during lunch time one month ago in the main dining room. An interview with staff #50 was conducted on (MONTH) 26, 2019 at 1:35 p.m. She stated that staff #117 was obnoxiously laughing out loud, when resident #6 asked him what he was laughing about. She stated that she heard staff #117 reply to the resident, Look in the mirror. She stated that she felt like this statement was not something you should say to a resident and the residents should not be treated like that. She stated his demeanor was like a bully. She said resident #6 did not appear to be affected by staff #117's statement, as she may not have been able to comprehend what he said. She said that she has had training on recognizing types of abuse and the procedure to report them, but she did not report this incident because she was scared to say something. She stated looking back now she should have said something sooner, and if she saw something like that today, she would report it right away. In an interview with staff #113 on (MONTH) 27, 2019 at 10:51 a.m., she stated that staff #117 said something rude to resident #6. She said that she was not sure if the resident heard what staff #117 said, as she did not seem affected. She stated that staff #117 could be mean towards the residents, but she thought it was just his personality and he was not intentionally being mean. In an interview with the DNS (staff #33) on (MONTH) 27, 2019 at 12:05 p.m., she stated a CNA (staff #50) came to her and stated that she felt uncomfortable about something she overheard. She stated the facility began an investigation into the incident. She stated she had previously done some coaching and counseling with staff #117 regarding his treatment of [REDACTED]. She stated his behavior did improve some after speaking with him. She stated this incident was the first time she had heard that his behavior was directed toward a resident. She stated her expectation is that all allegations of abuse

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) be reported to the nurse immediately and then the nurse is to report it to her. She stated she keeps her phone on 24/7 and staff are encouraged to call her with any concerns they have. Review of staff #50's personnel record included a form titled General Orientation Checklist, with a date of hire of (MONTH) 28, (YEAR). The form included that staff #50 received orientation on the first day regarding abuse and neglect prevention, mandated reporting and reporting of suspected crimes. Staff #50 also signed a form titled, Our Pledge on (MONTH) 28, (YEAR) which included, I understand that the (name of facility) has a zero tolerance policy as it relates to abuse and neglect and that I am a mandated reporter of any suspected incidents of abuse or neglect. Review of a facility policy titled, Abuse and Neglect dated (MONTH) (YEAR) included the facility provides education and training to employees and volunteers in regards to abuse, neglect, mistreatment and misappropriation of property. Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator and to other officials in accordance with state law. In the absence of the administrator from the location, the following individuals have the administrative authority of the administrator for purposes of immediate reporting of alleged violations: the Director of Nursing Services or the Director of Social Services.