STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035214	A. BUILDING _____ B. WING _____	04/11/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY-QUIBURI MISSION	850 SOUTH HIGHWAY 80 BENSON, AZ 85602

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 facility documentation, staff interviews, clinical record review, and policy review, the facility failed to implement their abuse policy regarding reporting and protection for an allegation of abuse for one of four sampled residents (#20). The deficient practice could result in the potential for further abuse of residents. Findings include: Resident #20 was admitted on [DATE] with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set assessment dated [DATE] revealed a score of 8 on the Brief Interview for Mental Status which indicated the resident had moderate cognition. The assessment included the resident required the assistance of one staff for bed mobility and transfers. Review of the facility's investigation report revealed that on 2/4/19 at 12:00 PM, resident #20's roommate reported to the Administrator (staff #56) and the Director of Nursing (DON/staff #46) that on the morning of 2/3/2019, she saw her roommate (resident #20) crying and asked her what was wrong and that resident #20 stated a Certified Nursing Assistant (CNA/staff#75) had threw her on the bed and that it caused her pain in her back. The report included the State Agency was notified on 2/4/19 at 1:23 PM and that staff #75 was placed on suspension on 2/4/19. Further review of the investigation report revealed that on 2/3/19, the Licensed Practical Nurse (LPN/staff #29) that was caring for the resident saw the resident crying and asked the resident what was wrong. The resident replied that a CNA had gotten her up and threw her in a chair. The report also revealed that staff #29 identified the CNA as staff #75 and that staff #75 told her that she did not think she was hurting the resident. However, the report did not include staff #75 was removed from caring from residents on 2/3/19 when the allegation was made and did not include the Administrator, State Agency, and Adult Protective Services were notified of the allegation within 2 hours on 2/3/19. An interview was conducted on 4/11/19 at 3:25 PM with the LPN (staff #29). Staff #29 stated that on 2/3/19 resident #20 was visibly upset. She stated that she asked resident #20 what was wrong and the resident stated that she was being treated roughly by a CN[NAME] Staff #29 stated that she did not notify the DON because she did not recognize the incident as an allegation of abuse at the time. Staff #29 said she did not speak to management regarding the allegation until the next day on 2/4/19. She stated that she did not think to place staff #75 on suspension and that staff #75 was allowed to continue working with residents. The LPN also stated that she has had abuse training which included prevention and reporting. An interview was conducted on 4/11/19 at 3:42 PM with the Administrator (staff #56). The Administrator stated that she was not informed of the allegation until 2/4/19 even though (staff #29) was aware of the allegation on 2/3/19. The Administrator stated that the nurse should have reported the allegation immediately to her. Staff #56 stated the nurse failure to report the allegation to her immediately, resulted in the allegation not being reported to the State Agency and APS within 2 hours. The Administrator also stated that after the allegation was made, the nurse should have suspended staff #75 immediately pending investigation. Review of the facility's policy regarding abuse revealed that if a staff member receives an allegation of abuse, the staff member will take measures to protect the resident and will then report the allegation to a supervisor. The charge nurse or licensed nurse will be notified immediately and will ensure that any potential for further abuse is eliminated by removing the accused staff from providing direct care to all residents. The accused staff will be placed on suspension pending the results of the investigation. The policy included that an allegation of abuse will be reported not later than two hours after the allegation is made to the Administrator and to other officials including the State Agency and Adult Protective 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 facility documentation, staff interviews, clinical record review, and policy review, the facility failed to ensure an allegation of abuse for one of four sampled residents (#20) was reported to the Administrator, State Agency, and Adult Protective Services (APS) within 2 hours after the allegation was made. Findings include: Resident #20 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the facility's investigation report revealed that on 2/4/19 at 12:00 PM, resident #20's roommate reported to the Administrator (staff #56) and the Director of Nursing (DON/staff #46) that on the morning of 2/3/2019, she saw her roommate (resident #20) crying and asked her what was wrong and that resident #20 stated a Certified Nursing Assistant (CNA/staff#75) had threw her on the bed and that it caused her pain in her back. The report included the State Agency was notified on 2/4/19 at 1:23 PM. Further review of the investigation report revealed that on 2/3/19, the Licensed Practical Nurse (LPN/staff #29) that was caring for the resident saw the resident crying and asked the resident what was wrong. The resident replied that a CNA had gotten her up and threw her in a chair. The report also revealed that staff #29 identified the CNA as staff #75 and that staff #75 told her that she did not think she was hurting the resident. However, the report did not include the Administrator, State Agency, and Adult Protective Services were notified of the allegation within 2 hours on 2/3/19. An interview was conducted on 4/11/19 at 3:25 PM with the LPN (staff #29). Staff #29 stated that she did not notify the DON because she did not recognize the incident as an allegation of abuse at the time. Staff #29 stated that she did not speak to management regarding the allegation until the next day on 2/4/19. An interview was conducted on 4/11/19 at 3:42 PM with the Administrator (staff #56). The Administrator stated that she was not informed of the allegation until 2/4/19 even though (staff #29) was aware of the allegation on 2/3/19. The Administrator stated that the nurse should have reported the allegation immediately to her. Staff #56 stated the nurse failure to report the allegation to her immediately, resulted in the allegation not being reported to the State Agency and APS within 2 hours. Review of the facility's policy regarding abuse revealed an allegation of abuse will be reported not later than two hours after the allegation is made to the Administrator and to other officials including the State Agency and Adult Protective Services.

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	(continued... from page 1)
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility documentation, staff interviews, clinical record review, and policy review, the facility failed to prevent further potential abuse, by failing to remove a staff member from providing direct care to residents regarding an allegation of abuse for one of four sampled residents (#20). The deficient practice could result in the potential for further abuse of residents. Findings include: Resident #20 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the facility's investigation report revealed that on 2/4/19 at 12:00 PM, resident #20's roommate reported to the Administrator (staff #56) and the Director of Nursing (DON/staff #46) that on the morning of 2/3/2019, she saw her roommate (resident #20) crying and asked her what was wrong and that resident #20 stated a Certified Nursing Assistant (CNA/staff#75) had threw her on the bed and that it caused her pain in her back. The report included staff #75 was placed on suspension on 2/4/19. Further review of the investigation report revealed that on 2/3/19, the Licensed Practical Nurse (LPN/staff #29) that was caring for the resident saw the resident crying and asked the resident what was wrong. The resident replied that a CNA had gotten her up and threw her in a chair. The report also revealed that staff #29 identified the CNA as staff #75 and that staff #75 told her that she did not think she was hurting the resident. However, the report did not include staff #75 was removed from caring from residents on 2/3/19 when the allegation was made. An interview was conducted on 4/11/19 at 3:25 PM with the LPN (staff #29). Staff #29 stated that she did not think to place staff #75 on suspension and that staff #75 was allowed to continue working with residents. An interview was conducted on 4/11/19 at 3:42 PM with the Administrator (staff #56). The Administrator stated that the nurse should have suspended staff #75 pending investigation immediately after the allegation was made. Review of the facility's policy regarding abuse revealed that if a staff member receives an allegation of abuse, the staff member will take measures to protect the resident and will then report the allegation to a supervisor. The charge nurse or licensed nurse will be notified immediately and will ensure that any potential for further abuse is eliminated by removing the accused staff from providing direct care to all residents. The accused staff will be placed on suspension pending the results of the investigation.
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, and policy review, the facility failed to ensure the Pre Admission Screening and Resident Review (PASARR) process was completed as required for 2 of 6 sampled residents (#29 and #12) by not completing the screening for one resident (#29) that changed from a convalescent care stay to a stay of over 30 days and by not making sure one resident (#12) was screened prior to admission for possible mental disorders, intellectual disabilities, and/or related conditions. The deficient practice could potentially result in residents not receiving the level of services they require. Findings include: -Resident #29 was admitted to the facility on (MONTH) 16, (YEAR) and readmitted (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED].Review of a nursing progress notes dated (MONTH) 16, (YEAR), revealed the resident was admitted from the hospital to the facility for physical therapy, occupational therapy, and speech therapy and would roll to long term care. Review of the clinical record revealed a PASARR Level 1 signed (MONTH) 5, (YEAR), that the resident had a convalescent care exemption. The form included the following for a convalescent care stay: admission from the hospital after receiving acute inpatient care, requires the nursing facility services for the same condition, and the physician has certified before admission to the nursing facility that the resident requires 30 days or less nursing facility services. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 13, 2019, revealed the date of this entry was (MONTH) 5, (YEAR) and that the resident was admitted from the hospital. On (MONTH) 11, 2019 at 8:50 a.m., the Administrator (staff #56) stated that the PASARR Level 1 dated (MONTH) 5, (YEAR) was the most recent one. An interview was conducted with the Administrator on (MONTH) 11, 2019 at 2:14 p.m. She stated that a PASARR Level 1 is required before a resident is admitted or upon admission. She stated that the importance of a PASARR Level 1 is that it helps determine the appropriate setting for the resident. The Administrator stated that she expects the PASARR to be filled out completely and accurately. She stated that she did not know the requirement if a resident stays over 30 days and/or changed from Short Term to Long Term Care but that she would find out. She stated that resident #29 is a Long Term Care resident and is not expected to leave within 30 days, so the PASARR Level 1 is not accurate regarding the resident's current status. A follow up interview was conducted with the Administrator (staff #56) on (MONTH) 11, 2019 at 3:16 p.m. She stated that for the resident that changes from convalescent care or has a change in level of care status, it is expected that another PASARR be completed. She stated that the PASARR for Resident #29 does not meet the requirement because she should have had a new PASARR completed when she changed to Long Term Care. -Resident #12 was admitted to the facility on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated (MONTH) 30, 2019 revealed the entry date was (MONTH) 27, (YEAR) and that the resident was admitted from the community. Review of the clinical record revealed no evidence a PASARR Level I had been completed for the resident. An interview was conducted with Registered Nurse (RN/staff #54) on (MONTH) 11, 2019 at 10:15 a.m. The RN stated that she was unable to locate a PASARR for resident #12. During an interview conducted with the Director of Nursing (DON/staff #46) on (MONTH) 11, 2019 at 12:55 p.m., the DON stated that the PASARR Level 1 screening is to be completed prior to admission to determine the potential needs of the resident and if specialize treatment would be required. An interview was conducted with the Administrator (staff #56) on (MONTH) 11, 2019 at 2:15 p.m. The Administrator stated that any resident admitted from the community needs to have a PASARR Level 1 completed. Staff #56 stated that the screening helps to determine if the facility would be an appropriate placement for the resident. Review of the facility's policy regarding PASARR revealed a PASARR is done to determine admission criteria for residents with mental illness and/or mental [MEDICAL CONDITION] and to ensure that individuals with [MEDICAL CONDITION], serious mental disorder or intellectual disability receive the care and services they need in the most appropriate setting. The policy included all prospective residents will be screened for possible serious mental disorders or intellectual disabilities and related conditions. The policy also included the State may choose not to apply the pre-admission screening if the resident is admitted to the location directly from a hospital after receiving acute inpatient care at the hospital, requires nursing services for the condition for which the individual received care in the hospital, and whose attending physician has certified, before admission to the location that the individual is likely to require less than 30 days of nursing services.

F 0685 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Assist a resident in gaining access to vision and hearing services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure one of one sampled resident (#43) was assisted with making a vision appointment. The deficient practice could result in decrease vision abilities. Findings include: Resident #43 was admitted to the facility on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED]. Review of the care plan dated (MONTH) 5, (YEAR), revealed the resident had impaired visual function related to wearing glasses for reading. Interventions included arranging a consultation with an eye care practitioner as required. Review of a care conference progress note dated (MONTH) 11, (YEAR), revealed the resident's representative was in attendance and asked about obtaining an eye appointment for the resident. The quarterly Minimum Data Set assessment dated (MONTH) 6, 2019, revealed a score of 15 on the Brief Interview for Mental

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F 0685 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) Status, which indicated the resident was cognitively intact. The assessment also included the resident had impaired vision.Review of a care conference progress note dated (MONTH) 20, 2019, revealed the care team discussed obtaining an eye appointment for the resident. Further review of the clinical record revealed no evidence that an eye appointment had been obtained for the resident from (MONTH) (YEAR) through (MONTH) 2019. During an interview conducted with the resident on (MONTH) 8, 2019 at 3:41 p.m., the resident stated I can't see to read. I would like to see an optometrist but don't know how to do it. An interview was conducted on (MONTH) 11, 2019 at 8:48 a.m. with the Case Manager (staff #49) and the Business Office Manager (staff #52). Staff #52 stated that she would normally arrange appointments for residents and social services would notify the resident and/or resident's representative of the appointments. Both staff #49 and staff #52 said they thought the resident had already seen the eye doctor, but they could not find a record of the appointment. Staff #52 stated that she believed the resident's representative had previously arranged an appointment for the resident. An interview was conducted on April, 11, 2019 at 9:24 a.m. with the resident's representative. She stated she was told when the resident was admitted to the facility that onsite appointments and referrals could be arranged. She said she had not arranged any appointments for the resident because she understood these appointments would be taken care of by the facility.An interview was conducted on (MONTH) 11, 2019 at 1:45 p.m. with the Director of Nursing (DON/staff #46). She stated that her expectation is that the vision appointment would have been obtained at the time of admission. She stated that there was no vision appointment made for the resident because we just missed it. Review of the facility's policy for Vision and Hearing Services revealed that if necessary, the facility will assist the resident in making appointments and arranging transportation to and from a practitioner specializing in the treatment of [REDACTED].
F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure one of two sampled residents (#30) was provided restorative range of motion services in accordance with the resident's plan of care. The deficient practice could result in a reduction in range of motion. Findings include: Resident #30 was admitted on (MONTH) 18, (YEAR) with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 24, (YEAR) revealed the resident had a need for restorative intervention due to Activities of Daily Living (ADL) self-care performance deficit/limited physical mobility related to muscular impairment evidenced by limit mobility. The goal was that the resident would maintain the current level of function. Interventions included passive Range of Motion (ROM) and stretching ROM to the bilateral upper and lower extremities for 15 minutes per day for 4 days per week. The Minimum Data Set assessment dated (MONTH) 23, 2019 revealed a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. The assessment included the resident required extensive assistance with all ADLs and had limited mobility in both lower extremities. The assessment also included the resident received ROM exercises on 2 days for at least 15 minutes during the 7 day look-back period. Review of the restorative services documentation for (MONTH) through (MONTH) 2019, did not reveal the resident was provided restorative services 4 days a week. The documentation revealed the following: -January 2019: the resident received restorative services (MONTH) 8, 15, 16, 21, 23, 24, 29, and 30. -February 2019: the resident received restorative services (MONTH) 7, 14, 18, 25, 26, 27, and 28. -March 2019: the resident received restorative services (MONTH) 4, 5, 11, 12, 13, 14, 19, 21, 25, and 27. The (MONTH) 2019 documentation revealed the resident received restorative services one time. During an interview conducted with the resident on (MONTH) 8, 2019 at 12:41 PM, the resident stated that she had not been receiving ROM exercises. An interview was conducted on (MONTH) 10, 2019 at 11:08 AM with the Restorative Nursing Manager (staff #49). Staff #49 stated that the Restorative Nursing Assistant (RNA) is out ill. She stated that a Certified Nursing Assistant (CNA) fills in for the RNA as much as possible. Staff #49 stated that they do not have a long term plan for when the RNA is absent for a week or longer. In a later interview with staff #49 at 1:22 PM, staff #49 stated that the RNA is responsible for providing ROM exercises to residents. She stated that if the RNA is assigned to work as a CNA, the restorative exercises are not always provided. The facility's policy for Restorative Nursing Care revealed each resident will receive restorative nursing care to the extent possible, based on individual strengths, needs, and problems as defined in nursing assessments. The policy included this restorative care will be outlined in the resident's nursing care plan. The policy also included the goal is to attain and maintain the maximum possible independence and/or prevent rapid declines through restorative interventions for each resident.
F 0791 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide or obtain dental services for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy and procedure, the facility failed to assist one of two sampled residents (#43) in obtaining dental care. The deficient practice could result in delayed dental services. Findings include: Resident #43 was admitted to the facility on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set assessment dated (MONTH) 4, (YEAR), revealed a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The assessment also included the resident had broken natural teeth, no mouth pain, or difficulty with chewing. Review of a care conference progress note dated (MONTH) 11, (YEAR), revealed the resident's representative was in attendance and asked about obtaining a dental appointment for the resident. A review of the dental assessments dated (MONTH) 27, (YEAR), (MONTH) 5, (YEAR), and (MONTH) 5, 2019, revealed the resident had some chipped or discolored teeth and that the last dental appointment and/or exam was unknown. The care conference progress note dated (MONTH) 20, 2019, revealed the care team again discussed scheduling a dental appointment for the resident for a chipped front tooth. However, further review of the clinical record revealed no evidence that a dental appointment had been scheduled for the resident from (MONTH) (YEAR) through (MONTH) 2019. During an interview conducted with the resident on (MONTH) 8, 2019 at 3:40 p.m., the resident stated My teeth are breaking. I need to see a dentist. I don't know how to do that. An interview was conducted on (MONTH) 11, 2019 at 8:48 a.m. with the Business Office Manager (staff #52) and the Nurse Manager (staff #49). Staff #52 stated that she was responsible for scheduling appointments for residents. Staff #52 stated that the possibility of obtaining a dental appointment for a resident would depend on the type of insurance the resident has and that some insurances only cover emergent services. Staff #49 stated that obtaining appointments for residents included checking the insurance coverage. An interview was conducted with the resident's representative on (MONTH) 11, 2019 at 9:24 a.m. The resident's representative stated that they were informed upon admission that appointments and referrals can be arranged. The representative stated that the insurance for the resident was changed and that the new insurance provided more coverage for dental. The representative stated that she has not been informed of any appointments that have been scheduled for the resident. A telephone interview was conducted on (MONTH) 11, 2019 at 10:35 a.m. with the resident's case manager. The case manager stated that the resident had dental coverage for routine and emergency dental services. During an interview conducted on (MONTH) 11, 2019 at 1:45 p.m. with the Director of Nursing (staff #46), she stated that her expectation is that the dental appointment should have been scheduled at the time of admission.

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F 0791 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) Review of the facility's policy for Dental/Oral Health Services and Assessments revealed that the facility would provide or obtain from an outside source routine and 24-hour emergency dental services. The policy included that basic dental/oral health assessments may be performed on residents by registered nurses, for the purpose of early identification and evaluation of any dental/oral health problems for treatment by a dentist or other professional to begin as early as necessary.