

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/25/2025
NAME OF PROVIDER OR SUPPLIER  Good Samaritan Society-Prescott Village		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, staff interviews, and facility documentation and policy review, the facility failed to ensure that one resident (#2) was assessed timely and that notification was provided to the physician and the resident's family following an incident resulting in injury. The deficient practice could result in a delay of care to a resident, and/or a physician and resident's family not being aware of the resident's condition, leading to harm.</p> <p>Findings include:</p> <p>Resident #2 was admitted to the facility on [DATE], with diagnoses including unspecified open wound of right foot, multiple fractures of pelvis with stable disruption of pelvic ring, hypothyroidism, epilepsy, and disorder of bone density and structure.</p> <p>Review of the quarterly minimum data set (MDS) assessment dated [DATE], revealed the resident had a BIMS (brief interview for mental status) score of 15, indicating Resident #2 was cognitively intact.</p> <p>Review of the physician orders revealed no evidence of orders for monitoring a change of condition for Resident #2 on March 9, 2025.</p> <p>A physician order dated March 10, 2025, at 11:45 AM, indicated for an x-ray of the right femur / of the right knee. There was no evidence that this was a STAT (short turn around time) order.</p> <p>A physician order dated March 12, 2025, at 1:45 PM, indicated to send the resident to the emergency room (ER) for further evaluation of the right knee.</p> <p>Review of the clinical record revealed no evidence of any progress notes, or incident report (risk management report), or incident log was completed for an incident involving Resident #2 and a hooyer lift transfer on March 9, 2025.</p> <p>Review of the assessment list revealed no evidence of any assessment completed on March 9, 2025 for Resident #2.</p> <p>There was no evidence of notification to the physician or the resident's family on March 9, 2025 regarding an incident.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Medication Administration Record and a linked e-MAR progress note dated March 9, 2025, at 2:26 PM, indicated that the resident requested medication for right leg discomfort and acetaminophen was administered for a pain scale level of 3. An additional e-MAR progress note indicated the resident's follow up pain scale the same day at 4:31 PM was 1.</p> <p>Prior to March 9, 2025, there was no evidence on the MAR for March 2025, that the resident received any hydrocodone-acetaminophen for pain. On March 9, 2025, at 9:19 PM, the MAR and a linked e-MAR progress note revealed the resident was administered hydrocodone-acetaminophen for leg pain for a pain scale level of 8. An additional e-MAR progress note indicated the resident's follow up pain scale, 5 minutes later, at 9:24 PM, was 1. There was no evidence of communication to the provider at this time.</p> <p>The MAR and a linked e-MAR progress note dated March 10, 2025, at 10:07 AM, revealed the resident was administered hydrocodone-acetaminophen for right leg pain for a pain scale level of 7. An additional e-MAR progress note indicated the resident's follow up pain scale at 12:14 PM, was 5.</p> <p>A Health Status progress note dated March 10, 2025, revealed new pain and possible injury to the resident's right leg as of yesterday, discussed with the medical doctor. Right femur and right knee x-rays were ordered and will be done tomorrow per the staff member with the mobile x-ray company.</p> <p>A Change of Condition Evaluation effective March 10, 2025, however signed on March 17, 2025, by a Registered Nurse (RN / Staff #26), revealed the change in condition was that patient injured on 03/9 while being transferred with hooyer. Additionally, the resident was having difficulty with mobility due to new onset of right femur pain. The pain was indicated as acute, and a pain scale level of 8, on the right lower femur. The note indicated the medical provider was notified on March 10, 2025, at 11:00 AM, and an x-ray was ordered.</p> <p>A Health Status note dated March 11, 2025, at 11:00 AM, indicated an x-ray of the resident's right knee and femur was completed this morning, and that Resident #2's family was present.</p> <p>A Medical Practitioner Note dated March 11, 2025, revealed Resident #2 was seen because of an injury to the right lower extremity. The resident was being transferred in a hooyer lift on March 9, 2025, and developed extreme pain in the right knee. The note indicated that the resident was evaluated by the nurse who noted that the straps on the hooyer lift were not the right ones for the resident. The assessment indicated a contusion to the right knee, and that x-rays pending to rule out fracture.</p> <p>A mobile x-ray report dated March 11, 2025, revealed slight distal cortical disruption with findings consistent with distal femur facture.</p> <p>A Change of Condition Evaluation signed March 12, 2025, revealed the change in condition was for trauma and new or worsening pain in the right knee, starting on March 9, 2025. The musculoskeletal pain was indicated as marked localized bruising, swelling, or pain over joint or bone, and that there was an abnormal x-ray result on March 11, 2025.</p> <p>A Medical Practitioner Note dated March 12, 2025, revealed the right femur x-ray shows cortical fracture and the resident is sent to the ER.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Hospital records revealed a progress note dated March 13, 2025, indicating the resident had transferred from the ER to hospital admission and presents with concerns of right knee pain suffered during a hooyer lift transfer. A right knee x-ray report indicated an oblique fracture involving the distal aspect of the right femur.</p> <p>A hospital discharge summary note dated March 14, 2025, indicated the resident was treated non-operatively for a closed fracture of the right distal femur, and to wear a knee extension brace on the right leg at all times.</p> <p>A facility Reportable Event Record dated March 18, 2025, revealed on March 9, 2025, two Certified Nursing Assistants (CNAs), Staff #51 and Staff #30, were transferring Resident #2 from her wheelchair to her bed using a hooyer lift. When they started lifting her, the resident said that her leg was still strapped to the wheelchair. The CNAs lowered her back down to the chair, unstrapped her leg, then transferred the resident to the bed. During the transfer, the resident complained of pain in her leg due to the placement of the sling. The nurse was notified that the resident was in pain within 5 minutes. The nurse administered Tylenol. On March 10, 2025, the physician was notified and an x-ray was ordered. The x-ray was completed on March 11, 2025, indicating findings consistent with distal femur fracture. The resident was sent to the ER, and was transferred to a different hospital for further assessment.</p> <p>A Witness Statement signed March 14, 2025, by a CNA (Staff #18) revealed on March 9, 2025, during the incident, the CNA was in a different room providing care to another resident. Staff #30 came to the room and asked for assistance with Resident #2. When Staff #18 arrived to the room, Resident #2 was in bed and needed transferred back to her wheelchair. During and after, resident became very upset (yelling and screaming). Staff #18 tried to calm her. After the resident was transferred back in the wheelchair, the resident stated that one of the CNAs forgot to unstrap her foot, and during the lift it pulled on her leg. Staff #18 left the room to care for other residents.</p> <p>A Witness Statement, undated, and signed by a Licensed Vocational Nurse (LVN / Staff #60), revealed on March 9, 2025, after 2:00 PM, staff approached this nurse reporting that the resident was requesting Tylenol. The nurse went to the resident's room and the resident was sitting in her wheelchair. There were two CNAs in the room, and one reported that the sling had slipped in transfer. The nurse asked the resident if she wanted a Tylenol. The resident stated Yes, for my leg. The resident was given Tylenol at 2:26 PM. No visual injuries were noted at this time. At supper time, this nurse asked the resident if the Tylenol helped, and the resident stated that yes, it's better. The resident had no further complaints the rest of the shift.</p> <p>A Witness Statement signed March 15, 2025, by an RN (Staff #26) revealed on March 10, 2025, at 8:00 AM, Resident #2 stated that over the weekend, her right leg became injured after two CNAs used the wrong hooyer sling and that since then, the resident had a lot of pain with movement in her right leg. Resident #2 required frequent pain medication to stay comfortable. That morning, the resident's daughter came to see the resident and stated that the resident's leg appeared slightly bent and that this was abnormal because her leg has a rod in it and is normally straight. The doctor was notified, and x-rays were ordered.</p> <p>An observation was conducted on March 24, 2025, at 12:45 PM, of Resident #2 sitting in her wheelchair in her room. The resident had her right leg propped on an elevating leg rest, and on the resident's right leg was a leg immobilizing brace.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted at this time with Resident #2. The resident stated that she was injured during an incident, had a leg fracture, and is now to wear a leg brace. The resident stated that she screamed during the transfer, and that the strap for the hoier sling was at the wrong place, and was lower down on her leg than it should have been.</p> <p>A telephonic interview was conducted with a CNA (Staff #30) on March 24, 2025, at 1:57 PM. Staff #30 stated when they used the hoier lift to raise the resident up, the resident started screaming, and then they lowered the resident back down to the wheelchair. She stated that Resident #2 was indicating her right knee was hurting her and kept putting her hands toward her knee. She stated that the resident usually has a blue strap around her right foot to the wheelchair, and that this strap was still attached. She stated that then she got the other CNA (Staff #18), and then notified the nurse (Staff #60).</p> <p>A telephonic interview was conducted with a CNA (Staff #51) on March 24, 2025, at 2:03 PM, who confirmed that she was an agency CNA contracted to work at the facility. Staff #51 stated that then, the two CNAs lifted the resident up in the hoier lift and the resident still had a strap on her right foot. She stated that this strap was on her foot to hold the resident's foot on the wheelchair legrest to keep it from sliding off. The nurse was notified and was there within 5 minutes.</p> <p>A telephonic interview was conducted with Resident #2's daughter on March 24, 2025, at 2:29 PM. The resident's daughter stated that she was notified about the incident when the facility knew it was something serious.</p> <p>An additional telephonic interview was conducted with a CNA (Staff #18) on March 24, 2024, at 2:38 PM. The CNA stated that he witnessed the aftermath when he walked into the resident's room and saw that the two CNAs that were in the room with Resident #2 were not able to calm her down. Staff #18 stated that the resident was clearly in pain and distress. Staff #18 stated that there was nothing he could do except diffuse the situation and try to calm Resident #2 down. He stated that Resident #2 has fear now and now she's scared of everybody.</p> <p>An interview was conducted with the Director of Nursing (DON / Staff #9) on March 24, 2025, at 4:37 PM. The DON stated that if an incident were to occur during care, that CNA staff should notify the nurse, and the nurse notifies the physician immediately, and to notify the DON, and that this would be documented in the incident report, in a progress note, and in the assessment or change of condition note.</p> <p>The interview continued, and the DON stated that regarding the hoier lift incident with Resident #2, she was told by the nurse that the resident only complained of a little pain. The DON stated that the day after the incident, the nurse stated that the resident asked for pain medication three times in 24 hours, and that is when we knew something was wrong and called the doctor. The DON stated that we had a STAT (short turn around time) x-ray in the building, and the resident was sent to the ER and was diagnosed with a fracture in her femur above the knee.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with an RN (Staff #26) on March 25, 2025, at 8:31 AM, who stated that if an incident or accident were to happen to a resident that it would be reported to the nursing director or administrator, then documented on an incident report and a change of condition note. Staff #26 stated that he was not in the facility on the day that the incident occurred with Resident #2 and the hoyer transfer, but was the resident's nurse the following day on March 10, 2025. The RN stated that the night nurse told him there had been an injury the day before, that maybe there was a wrong sling that was used and caused her leg to hurt. Staff #26 stated he assessed the resident's pain, and that day the resident was having an unusual amount of pain. He stated he contacted the doctor that morning and put in orders for the x-rays. Additionally, Staff #26 stated we don't get STAT x-rays, so the x-ray was scheduled for the following day. Staff #26 stated that he did not do an incident report because the incident did not happen on his shift. Also, Staff #26 stated that the facility staff informed him he needed to document a change of condition evaluation, however this was on a later date. Staff #26 then reviewed the clinical record and stated he could not find an incident report for Resident #2 for this incident.</p> <p>A follow-up interview was conducted with the DON (Staff #9) on March 25, 2025, at 10:27 AM. The DON stated that if an incident or accident occurs with a resident, that staff are to report to the nurse, and the nurse reports to the DON or abuse coordinator. The nurse will complete a head to toe assessment, an incident report, and a change of condition evaluation and whichever assessments are appropriate to the situation. The DON stated that if a change of condition is noted, then the staff are supposed to document in a progress note and an assessment that is relevant. The DON stated that if these steps are not completed, then the resident could have a negative outcome with the resident's quality of life if not assessed properly. The MAR for March 2025 was reviewed, and the DON stated that the onset of pain requiring frequent pain medication would indicate a change of condition for Resident #2. The DON stated that there was no evidence in the clinical record that the physician was notified when the incident occurred on March 9, 2025. Additionally, the clinical record was reviewed, and the DON stated that no progress note, no change of condition evaluation, no assessments, no incident report, and no risk management report regarding the incident were documented on March 9, 2025. The DON stated that this would not meet her expectation.</p> <p>Review of the facility policy titled Change of Condition - Observing, Reporting and Recording, dated May 2017, revealed it is the policy of the facility to inform the resident, the resident's physician and if indicted the resident's responsible party of the following: an accident or incident involving the resident, which results in injury and has the potential for requiring physician intervention; and a significant change in the resident's physical, mental or psychosocial status, such as a deterioration in health, mental, or psychosocial status, in life-threatening conditions, or clinical complications. After resident changes in condition including injuries, conduct a thorough assessment and compare against baseline. The attending physician should be notified as soon as possible if immediate attention is required, or as soon as feasible if the resident is stable. Complete an incident report if indicated (fall, injury etc.). Documentation is to include: date, time condition change was identified, pertinent assessment findings, who was notified and when, and disposition of resident. Communication is to include: the change in condition and interventions related to the change will be documented on the 24-Hour Report form on the shift that the change occurred, and the licensed nurse(s) and nursing assistant will communicate to the oncoming shift orally and through the 24-Hour report form the change in condition and interventions.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Change of Condition Notification, dated June 2020, revealed the purpose of the policy is to ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. An acute change of condition (ACOC) is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains. Members of the Interdisciplinary Team (IDT) are expected to report and document signs and symptoms that might represent an ACOC. The facility will promptly inform the resident, consult with the resident's attending physician, and notify the resident's legal representative when the resident endures a significant change in their</p> <p>condition caused by, but not limited to an injury/accident. The licensed nurse will notify the resident's attending physician when there is an: incident/accident involving the resident; an accident involving the resident which results injury and has the potential for requiring physician intervention; or a significant change in the resident's physical, mental or psychosocial status. The licensed nurse will assess the resident's change of condition and document the observations and symptoms. A licensed nurse will document the following: date, time, and pertinent details of the incident and the subsequent assessment in the nursing notes, the time the attending physician was contacted, the incident and brief details in the 24-Hour Report, complete an incident report per facility policy, and a licensed nurse will document each shift for at least seventy-two (72) hours.</p> <p>Review of the facility policy titled Documentation - Nursing, dated June 2020, revealed any communication with family or physician is to be noted in nurse's notes. Alert charting is documentation done to track a medical event for a period of 72 hours or longer. Events may include, but not limited to suspected or actual change in condition. Alert charting describes the resident's condition, use the resident's own words if needed, describe interventions, and how the resident responds to the actions.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on clinical record review, staff interviews, and facility documentation and policy review, the facility failed to ensure safe assistance was provided for one resident (#2) to prevent an accident during a hooyer lift transfer. The deficient practice could result in further incidents of staff providing unsafe assistance, resulting in harm to residents.</p> <p>Findings include:</p> <p>Resident #2 was admitted to the facility on [DATE], with diagnoses including unspecified open wound of right foot, multiple fractures of pelvis with stable disruption of pelvic ring, hypothyroidism, epilepsy, and disorder of bone density and structure.</p> <p>Review of the quarterly minimum data set (MDS) assessment dated [DATE], revealed the resident had a BIMS (brief interview for mental status) score of 15, indicating Resident #2 was cognitively intact.</p> <p>A care plan dated December 11, 2024, revealed the resident has an activity of daily living (ADL) self care deficit and requires mechanical hooyer lift for transfers.</p> <p>Review of the physician orders revealed no evidence of orders for monitoring a change of condition for Resident #2 on March 9, 2025.</p> <p>Review of a physician order dated March 10, 2025, documented at 11:45 AM, indicated for an x-ray of the right femur / of the right knee.</p> <p>Review of a physician order dated March 12, 2025, documented at 1:45 PM, indicated to send the resident to the emergency room (ER) for further evaluation of the right knee.</p> <p>Review of a Health Status progress note dated March 10, 2025, revealed new pain and possible injury to the resident's right leg as of yesterday, discussed with the medical doctor. Right femur and right knee x-rays were ordered and will be done the following day per the staff member with the mobile x-ray company.</p> <p>A documented Change of Condition Evaluation effective March 10, 2025, signed on March 17, 2025, by a Registered Nurse (RN / Staff #26), revealed the change in condition was that, patient injured on 03/9 while being transferred with hooyer. Additionally, the resident was having difficulty with mobility due to new onset of right femur pain. The pain was indicated as acute, and a pain scale level of 8, on the right lower femur. The note indicated that the medical provider was notified on March 10, 2025, at 11:00 AM, and an x-ray was ordered.</p> <p>A Medical Practitioner Note dated March 11, 2025, revealed Resident #2 was seen because of an injury to her right lower extremity. The resident was being transferred in a hooyer lift on March 9, 2025, and developed extreme pain in the right knee. The note indicated that the resident was evaluated by the nurse who noted that the straps on the hooyer lift were not the right ones for the resident. The assessment indicated a contusion to the right knee, and that x-rays pending to rule out fracture.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A mobile x-ray report dated March 11, 2025, revealed slight distal cortical disruption with findings consistent with distal femur fracture.</p> <p>A Medical Practitioner Note dated March 12, 2025, revealed the right femur x-ray shows cortical fracture and the resident is sent to the ER.</p> <p>Hospital records revealed a progress note dated March 13, 2025, indicating the resident had transferred from the ER to hospital admission and presents with concerns of right knee pain suffered during a hooyer lift transfer. A right knee x-ray report indicated an, oblique fracture involving the distal aspect of the right femur.</p> <p>A hospital discharge summary note dated March 14, 2025, indicated the resident was treated non-operatively for a closed fracture of the right distal femur, and to wear a knee extension brace on the right leg at all times.</p> <p>A facility Reportable Event Record dated March 18, 2025, revealed that on March 9, 2025, two Certified Nursing Assistants (CNAs), Staff #51 and Staff #30, were transferring Resident #2 from her wheelchair to her bed using a hooyer lift. When they started lifting her, the resident said that her leg was still strapped to the wheelchair. The CNAs lowered her back down to the chair, unstrapped her leg, then transferred the resident to the bed. During the transfer, the resident complained of pain in her leg due to the placement of the sling. The CNAs got another CNA (Staff #18) to help get the resident back to bed. Staff #18 came to the room and brought a different sling. The nurse was notified that the resident was in pain within 5 minutes. The nurse administered Tylenol. On March 10, 2025, the physician was notified and an x-ray was ordered. The x-ray was completed on March 11, 2025, indicating findings consistent with distal femur fracture. The resident was sent to the ER, and was transferred to a different hospital for further assessment. No surgical intervention were completed, and the resident returned to the facility on March 14, 2025. Interventions implemented after the incident included, staff were provided transfer education and proper sling sizing and placement; and that staff involved in the incident received additional education and demonstrated proper lift mechanics.</p> <p>A Witness Statement signed March 13, 2025, by a CNA (Staff #51) revealed that on March 9, 2025, at 1:30 PM, Resident #2 needed assistance with changing. The CNA got assistance from a second CNA for a hooyer lift transfer. During the transfer, the resident complained about pain in the inner thigh from the sling straps because of the type of sling being a crossed strap sling. While the resident was being lifted, the resident noticed a strap on her leg and told the CNAs to remove the strap. The resident was lowered back down, and the resident was complaining of pain. Another coworker came to assist. The resident was changed and then offered a different sling, and was then transferred back into the wheelchair.</p> <p>A Witness Statement signed March 14, 2025, by a CNA (Staff #18) revealed on March 9, 2025, during the incident, the CNA was in a different room providing care to another resident. Staff #30 came to the room and asked for assistance with Resident #2. When Staff #18 arrived to the room, Resident #2 was in bed and needed transferred back to her wheelchair. During and after, resident became very upset (yelling and screaming). Staff #18 tried to calm her. After the resident was transferred back in the wheelchair, the resident stated that one of the CNAs forgot to unstrap her leg, and during the lift it pulled on her leg. Staff #18 apologized that it had happened to her, and then left the room to care for other residents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A Witness Statement signed March 18, 2025, by a CNA (Staff #30) revealed on March 9, 2025, at 2:00 PM, Resident #2 was in the wheelchair, and Staff #30 was asked by another CNA (Staff #51) to assist with the transfer. Staff #51 had put the hoier sling under the resident. The sling was attached to the hoier. The staff attempted to raise the resident from the wheelchair with the mechanical lift, and then heard the resident yell, and the resident was lowered back down. Another CNA (Staff #18) was called for help, and then Staff #30 was called to another room to provide care.</p> <p>A Witness Statement, undated, and signed by a Licensed Vocational Nurse (LVN / Staff #60), revealed on March 9, 2025, after 2:00 PM, staff approached this nurse reporting that the resident was requesting Tylenol. The nurse went to the resident's room and the resident was sitting in her wheelchair. There were two CNAs in the room, and one reported that, the sling had slipped in transfer. The nurse asked the resident if she wanted a Tylenol. The resident stated, Yes, for my leg. The resident was given Tylenol at 2:26 PM. No visual injuries were noted at this time. At supper time, this nurse asked the resident if the Tylenol helped, and the resident stated that yes, it's better. The resident had no further complaints the rest of the shift.</p> <p>A Witness Statement signed March 15, 2025, by an RN (Staff #26) revealed on March 10, 2025, at 8:00 AM, Resident #2 stated that over the weekend, her right leg became injured after two CNAs used the wrong hoier sling and that since then, the resident had a lot of pain with movement in her right leg. Resident #2 required frequent pain medication to stay comfortable. That morning, the resident's daughter came to see the resident and stated that the resident's, leg appeared slightly bent and that this was abnormal because her leg has a rod in it and is normally straight. The doctor was notified, and x-rays were ordered.</p> <p>An In-Service Training Report, dated March 18, 2025, revealed a one-on-one training occurred with a CNA (Staff #30) on the subject of mechanical lift.</p> <p>An observation was conducted on March 24, 2025, at 12:45 PM, of Resident #2 sitting in her wheelchair in her room. The resident had her right leg propped on an elevating leg rest, and on the resident's right leg was a leg immobilizing brace.</p> <p>An interview was conducted at this time with Resident #2. The resident stated that she was injured during an incident, had a leg fracture, and now has to wear a leg brace. She stated that the incident occurred during a hoier transfer, when two CNAs who did not really know her used the wrong hoier sling, that was for, a much bigger person. The resident stated that she screamed during the transfer; and that, the strap for the hoier sling was at the wrong place, and was much lower down on her leg than it should have been. She stated that during the transfer, my leg was down. She stated, it was the strap that caused the break in her leg. Additionally, she stated that afterward, Staff #18 came into the room and told the two CNAs that he would take over. She stated she has not seen the two CNAs again since the incident.</p> <p>A telephonic interview was conducted with an LVN (Staff #60) on March 24, 2025, at 1:07 PM. The LVN stated that one of the CNAs had come to her and said that the hoier lift sling had slipped; and that, Resident #2 was requesting pain medication because her leg was hurting. She stated that the CNAs were not specific in what went wrong with the hoier transfer. When she went to the resident's room, the resident was sitting up in her wheelchair with a hoier sling underneath her. She stated the resident asked for pain medication and the nurse administered it.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Good Samaritan Society-Prescott Village		STREET ADDRESS, CITY, STATE, ZIP CODE  1030 Scott Drive Prescott, AZ 86301	
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A telephonic interview was conducted with a CNA (Staff #30) on March 24, 2025, at 1:57 PM who stated that herself and the agency CNA, whom she could not recall the name, assisted Resident #2 with putting on a hoier sling -- because the resident did not have a sling under her initially while she was sitting in the wheelchair. Staff #30 stated that when they used the hoier lift to raise the resident up, the resident started screaming, and then they lowered the resident back down to the wheelchair. She stated that Resident #2 was indicating her right knee was hurting her and kept putting her hands toward her knee. She stated that the resident usually has a blue strap around her right foot to the wheelchair, and that this strap was still attached. She stated that then she got the other CNA (Staff #18), and then notified the nurse (Staff #60). She stated that Staff #18 and the agency CNA then transferred the resident back to the bed while Staff #30 had to go answer call lights. She stated that as a result of this incident, that she received training and reviewed the whole hoier transfer process, and had to sign a paper.</p> <p>A telephonic interview was conducted with a CNA (Staff #51) on March 24, 2025, at 2:03 PM, who confirmed that she was an agency CNA contracted to work at the facility. The CNA stated that she was not assigned to Resident #2 on the day of the hoier transfer incident, but that she was answering a request to transfer Resident #2 from the wheelchair to the bed to provide care. Staff #51 stated that she thought the resident required a hoier lift to transfer and went to get another staff member. She stated that she requested assistance from Staff #30; and that, the resident did not have a hoier sling under her in the wheelchair, and that Staff #30 went to get a hoier sling. Staff #51 stated that she believed from observing the way that the resident was sitting in the wheelchair, that the type of sling that should have been used was a sling that was whole. However, Staff #51 stated that the sling that Staff #60 brought was a different type, it was a sling that, you have to slide in the back of the resident and then cross between the legs. She stated that she was not sure what type of sling to use, but she knew Staff #30 had worked with the resident before, so they put the sling on the resident. Staff #51 stated that then, the two CNAs lifted the resident up in the hoier lift and the resident still had a strap on her right foot. She stated that this strap was on her foot to hold the resident's foot on the wheelchair legrest to keep it from sliding off. She stated that when using the hoier, that they had the resident lifted almost to the bed and then had to lower the resident back down. Staff #51 stated that Staff #30 should have removed the foot strap before the transfer because it was on her side, however Staff #51 stated that she unstrapped the resident's foot quickly as soon as she noticed. Then, she stated that Staff #18 walked into the room and helped to, take over the situation, and the resident was then assisted to the bed. Then, the nurse was notified and within 5 minutes assessed the resident. Staff #51 stated that the hoier sling should never have been missing from the chair originally; and that, there were no other hoier slings that herself or Staff #30 could find.</p> <p>A telephonic interview was conducted with Resident #2's daughter on March 24, 2025, at 2:29 PM. The resident's daughter stated that her understanding of the incident was one agency staff member and one, not too experienced staff member were using a hoier to transfer the resident. The resident's daughter stated that, we are trying to set up a meeting where the facility is going to reconstruct the incident to figure out what angle could have caused the injury. She stated that staff at the facility have used phrases such as, the sling slipped to describe what happened during the incident. Additionally, she stated the facility staff have informed her that they will no longer have agency staff care for Resident #2 while she is using the hoier.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An additional telephonic interview was conducted with a CNA (Staff #18) on March 24, 2024, at 2:38 PM who stated that he was in a different room at the time of the hooyer transfer incident involving Resident #2. He stated that he witnessed the aftermath when he walked into the resident's room and saw that the two CNAs that were in the room with Resident #2 were not able to calm her down. Staff #18 stated that the resident was, clearly in pain and distress. Staff #18 stated that there was nothing he could do, except diffuse the situation and try to calm Resident #2 down. He stated that it was clear that at some point during the transfer that the two CNAs assisting had made mistakes, so he asked what had happened. He stated that he was told that one of the CNAs did not position the sling correctly and additionally, that they, forgot to unstrap her leg from the wheelchair legrest. He stated that because the resident has dropfoot on her right foot and had a fused right knee, that she requires a strap to keep her foot from sliding off of the leg rest, and that during the hooyer transfer incident, this strap had not been unstrapped by the CNAs, keeping the resident's foot secured to the leg rest as the resident was being raised in the hooyer lift. He stated that Resident #2, has fear now and, now she's scared of everybody.</p> <p>An interview was conducted with the Director of Nursing (DON / Staff #9) on March 24, 2025, at 4:37 PM, who stated that her expectation for staff to keep residents free from accidents is to follow best practice and the facility policy. She stated for hooyer transfers, there should be two staff members assisting; and that, staff check with the therapy department if they are not sure how to assist a resident with a transfer.</p> <p>The interview continued, and the DON stated that her understanding of the hooyer lift incident with Resident #2 was that a staff CNA and an agency CNA were going to transfer Resident #2 back to bed from her wheelchair. The staff put the sling on the resident, and when the staff lifted the resident, she yelled, and they lowered her back down to her wheelchair. The staff then got additional help from another CNA. The DON stated that statements had been taken from staff, and that nobody had informed her that anything was done incorrectly during the transfer. The DON stated that, we had a stat x-ray in the building, and resident was sent to the ER was diagnosed with a fracture in her femur above the knee. She stated that there was supplemental training done with all staff on hooyer transfers and that each resident's sling will be left in their room.</p> <p>An interview was conducted with an RN (Staff #26) on March 25, 2025, at 8:31 AM. Staff #26 stated that he was not in the facility on the day that the incident occurred with Resident #2 and the hooyer transfer, but was the resident's nurse the following day on March 10, 2025. The RN stated that the night nurse told him there had been an injury the day before, that, maybe there was a wrong sling that was used and caused the resident's leg to hurt.</p> <p>On March 25, 2025, the regional Director of Operations (DO / Staff #89) signed a statement that the facility had no other policies for accidents or incidents other than the policy titled Incident Log.</p> <p>Review of the facility policy titled, Incident Log, dated June 2020, revealed the purpose is to provide a system for the facility to track incidents and analyze trends to identify root cause and improve the quality of care provided to residents. The facility will log incident reports as they occur. In the event of an incident, a licensed nurse or the individual who first witnesses the incident will complete an Incident/Accident Report Form and ensure the following is included: resident name, day and shift which the incident occurred, type, injury, location, severity, and medication/treatment error.</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Review of the facility procedure titled How to Use a Hoyer Lift, dated October 2013, revealed the U-Sling is a type of hoyer sling that wraps around the thigh and crosses between the legs of the consumer.</p> <p>Review of the facility procedure titled Patient Lifts Safety Guide, undated, revealed that before using a patient lift, check the patient's weight and physical condition to make sure you have the correct lift and sling for the patient's condition. Assess patient's size, weight, and hip measurement. Choose the size of sling based on manufacturer's recommendation for patient's measurement. Choosing correct sling size is critical for safe patient transfer. If the sling is too large, the patient may slip out. If the sling is too small, the patient may fall out or the sling may worsen a patient's condition. Using the wrong type of sling may cause serious injury. Some factors that may affect sling choice between the U-sling and the full-body hammock style sling are patient's size and weight, pressure sensitivity, need for padding, and patient's preferred or medically appropriate position.</p> <p>Review of the manufacturer's instructions for the utilized facility Lift equipment, revised October 24, 2024, revealed the procedure for using the U-Sling included the note that if the patient's legs are extremely rigid, it may work better to bring the left sling leg under the right thigh and the right sling leg under the left thigh instead of threading between the patient's legs. The top of the sling must reach just above the patient's shoulders and the base of the sling should be 2 inches below their tailbone. If you have gone under both legs with the sling legs for a rigid patient, bring the loops straight up along the outside of the legs and hook on the longest loop. Crossing the leg straps is the most common procedure, however caregivers must assess the condition of the patient to determine what method is appropriate.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record reviews, staff interviews, and facility policy and procedure review, the facility failed to ensure that the medical record for one resident (#2) was complete and accurate, and additionally that requested facility documentation for one resident (#8) was provided in a timely manner. The deficient practice resulted in decreased or delayed care for a resident, and/or a delay in the survey process.</p> <p>Findings Include:</p> <p>-Regarding Resident #2:</p> <p>Resident #2 was admitted to the facility on [DATE], with diagnoses including unspecified open wound of right foot, multiple fractures of pelvis with stable disruption of pelvic ring, hypothyroidism, epilepsy, and disorder of bone density and structure.</p> <p>A physician order dated March 12, 2025, at 1:45 PM, indicated to send the resident to the emergency room (ER) for further evaluation of the right knee.</p> <p>Review of the clinical record revealed no evidence of any progress notes, or incident report (risk management report), or incident log was completed for an incident involving Resident #2 and a hooyer lift transfer on March 9, 2025.</p> <p>Review of the assessment list revealed no evidence of any assessment completed on March 9, 2025 for Resident #2.</p> <p>There was no evidence of notification to the physician or the resident's family on March 9, 2025 regarding an incident.</p> <p>A Health Status progress note dated March 10, 2025, revealed new pain and possible injury to the resident's right leg as of yesterday, discussed with the medical doctor. Right femur and right knee x-rays were ordered and will be done tomorrow per the staff member with the mobile x-ray company.</p> <p>A Change of Condition Evaluation effective March 10, 2025, however signed on March 17, 2025, by a Registered Nurse (RN / Staff #26), revealed the change in condition was that patient injured on 03/9 while being transferred with hooyer. Additionally, the resident was having difficulty with mobility due to new onset of right femur pain. The pain was indicated as acute, and a pain scale level of 8, on the right lower femur. The note indicated the medical provider was notified on March 10, 2025, at 11:00 AM, and an x-ray was ordered.</p> <p>A Medical Practitioner Note dated March 11, 2025, revealed Resident #2 was seen because of an injury to the right lower extremity. The resident was being transferred in a hooyer lift on March 9, 2025, and developed extreme pain in the right knee. The note indicated that the resident was evaluated by the nurse who noted that the straps on the hooyer lift were not the right ones for the resident. The assessment indicated a contusion to the right knee, and that x-rays pending to rule out fracture.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A mobile x-ray report dated March 11, 2025, revealed slight distal cortical disruption with findings consistent with distal femur fracture.</p> <p>A facility Reportable Event Record dated March 18, 2025, revealed on March 9, 2025, two Certified Nursing Assistants (CNAs), Staff #51 and Staff #30, were transferring Resident #2 from her wheelchair to her bed using a hooyer lift. When they started lifting her, the resident said that her leg was still strapped to the wheelchair. The CNAs lowered her back down to the chair, unstrapped her leg, then transferred the resident to the bed. During the transfer, the resident complained of pain in her leg due to the placement of the sling. The nurse was notified that the resident was in pain within 5 minutes. The nurse administered pain medication. On March 10, 2025, the physician was notified and an x-ray was ordered. The x-ray was completed on March 11, 2025, indicating findings consistent with distal femur fracture. The resident was sent to the ER, and was transferred to a different hospital for further assessment.</p> <p>A telephonic interview was conducted with a Licensed Vocational Nurse (LVN / Staff #60) on March 24, 2025, at 1:07 PM. The LVN stated that regarding the incident, that one of the CNAs had come to her and said that the hooyer lift sling had slipped, and that Resident #2 was requesting pain medication because her leg was hurting. She stated that the CNAs were not specific in what went wrong with the hooyer transfer. When she went to the resident's room, the resident was sitting up in her wheelchair with a hooyer sling underneath her. She stated the resident asked for pain medication and the nurse administered it. She stated that she looked at the leg visually and couldn't tell anything different on it. She stated that the facility staff had reached out to her on a later date asking what happened.</p> <p>An interview was conducted with the Director of Nursing (DON / Staff #9) on March 24, 2025, at 4:37 PM. The DON stated that if an incident were to occur during care, that CNA staff should notify the nurse, and the nurse notifies the physician immediately, and to notify the DON, and that this would be documented in the incident report, in a progress note, and in the assessment or change of condition note.</p> <p>An interview was conducted with a Registered Nurse (RN / Staff #26) on March 25, 2025, at 8:31 AM, who stated that if an incident or accident were to happen to a resident that it would be reported to the DON or administrator, then documented on an incident report and a change of condition note. Staff #26 stated that he was not in the facility on the day that the incident occurred with Resident #2 and the hooyer transfer, but was the resident's nurse the following day on March 10, 2025. The RN stated that the night nurse told him there had been an injury the day before, that maybe there was a wrong sling that was used and caused her leg to hurt. Staff #26 stated that he did not do an incident report because the incident did not happen on his shift. Also, Staff #26 stated that the facility staff informed him he needed to document a change of condition evaluation, however this was on a later date. Staff #26 then reviewed the clinical record and stated he could not find an incident report for Resident #2 for this incident.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A follow-up interview was conducted with the DON (Staff #9) on March 25, 2025, at 10:27 AM. The DON stated that if an incident or accident occurs with a resident, that staff are to report to the nurse, and the nurse reports to the DON or abuse coordinator. The nurse will complete a head to toe assessment, an incident report, and a change of condition evaluation and whichever assessments are appropriate to the situation. The DON stated that if a change of condition is noted, then the staff are supposed to document in a progress note and an assessment that is relevant. The DON stated that if these steps are not completed, then the resident could have a negative outcome with the resident's quality of life if not assessed properly. The clinical record was reviewed, and the DON stated that no progress note, no change of condition evaluation, no assessments, no incident report, and no risk management report regarding the incident were documented on March 9, 2025. The DON stated that this would not meet her expectation.</p> <p>Review of the facility policy titled Change of Condition - Observing, Reporting and Recording, dated May 2017, revealed it is the policy of the facility to inform the resident, the resident's physician and if indicted the resident's responsible party of the following: an accident or incident involving the resident, which results in injury and has the potential for requiring physician intervention; and a significant change in the resident's physical, mental or psychosocial status, such as a deterioration in health, mental, or psychosocial status, in life-threatening conditions, or clinical complications. After resident changes in condition including injuries, conduct a thorough assessment and compare against baseline. The attending physician should be notified as soon as possible if immediate attention is required, or as soon as feasible if the resident is stable. Complete an incident report if indicated (fall, injury etc.). Documentation is to include: date, time condition change was identified, pertinent assessment findings, who was notified and when, and disposition of resident. Communication is to include: the change in condition and interventions related to the change will be documented on the 24-Hour Report form on the shift that the change occurred, and the licensed nurse(s) and nursing assistant will communicate to the oncoming shift orally and through the 24-Hour report form the change in condition and interventions.</p> <p>Review of the facility policy titled Documentation - Nursing, dated June 2020, revealed any communication with family or physician is to be noted in nurse's notes. Alert charting is documentation done to track a medical event for a period of 72 hours or longer. Events may include, but not limited to suspected or actual change in condition. Alert charting describes the resident's condition, use the resident's own words if needed, describe interventions, and how the resident responds to the actions.</p> <p>-Regarding timely documentation requests:</p> <p>On March 24, 2025, at 3:09 PM, a formal request was made to the facility for therapy documentation for Resident #8.</p> <p>On March 24, 2025, at 4:55 PM, the regional Director of Operations (DO / Staff #89) was notified of the previously requested therapy documentation request that had not been provided by the facility. The DO stated that he was still working on it and was waiting on access to the records.</p> <p>On March 24, 2025, at 5:10 PM, the DO was notified of the expected 2-hour turnaround time for document requests and the necessity of timeliness for the survey process. Additionally, the DO was notified of the possibility of a finding of noncompliance if the facility did not provide requested documentation within the expected timeframe.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On March 24, 2025, at 5:15 PM, the surveyor left the facility for the day and notified the facility of return the following day.</p> <p>On March 25, 2025, at 9:05 AM, a request was made to review the personnel file of Staff #51. The DO reviewed the files in the HR office and confirmed there was no file present for Staff #51. The DO stated that the facility does not do any orientation, training, or competency checklists with contracted agency staff, that it is completed through the contracted agency company.</p> <p>On March 25, 2025, at 9:11 AM, a formal request was made to the facility for documents regarding staff qualification and training for Staff #51.</p> <p>On March 25, 2025, at 9:46 AM, an email was received from the DO containing attached documents for Staff #51, however there was no evidence of a facility orientation that was completed, or a skills / competency checklist for Staff #51. The DON was notified that this was missing.</p> <p>On March 25, 2025, at 10:08 AM, the DO was notified that the therapy notes for Resident #8 requested the previous day, was not yet received, and that it exceeded the expected 2-hour turnaround time for documentation requests.</p> <p>On March 25, 2025, at 10:36 AM, an email was received from the DO containing the requested therapy documentation for Resident #8.</p> <p>On March 25, 2025, at approximately 11:00 AM, the DON stated that she may have the requested documents for Staff #51 in a box somewhere and would have to look later. The DON and the DO were informed that the surveyor was exiting and to send the requested documentation for Staff #51, if found, by email this date.</p> <p>The following day, on March 26, 2025, at 5:57 PM, an email was received from the DON containing the skills checklist for Staff #51.</p> <p>Review of federal regulation 483.70 (i) revealed a facility must maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized. Medical records must be retained for the period of time required by State law; or five years from the date of discharge when there is no requirement in State law. The medical record must contain a record of the resident's assessments, the comprehensive plan of care and services provided, and physician, nurse, and other licensed professionals progress notes.</p>		