

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 05/06/2025
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 0689</p> <p>Level of Harm - Minimal harm or potential for 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51158</p> <p>Based on resident and staff interviews, observation, clinical record review, and policy review, the facility failed to ensure one sampled resident (#22) was provided adequate supervision to prevent elopement. The deficient practice could result in other residents eloping.</p> <p>Findings include:</p> <p>Resident #22 was admitted on [DATE] with diagnoses that included displaced fracture of left tibia, dementia, disorientation, concussion and need for assistance with personal care.</p> <p>An admission elopement risk assessment dated [DATE] revealed the resident was a moderate risk with a score of 6.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] indicated that the resident had a Brief Interview for Mental Status (BIMS) summary score of 10 indicating moderate cognitive impairment.</p> <p>A BIMS assessment conducted on April 15, 2025 revealed that the resident had a summary score of 3/15 indicating severe cognitive impairment.</p> <p>Review of the clinical record revealed an order on April 24, 2025 at 13:00 by the primary care physician (PCP) that the resident may have a wanderguard due to potential for elopement.</p> <p>Further review revealed another order on April 24, 2025 at 21:41 by the PCP that the wanderguards function was to be monitored.</p> <p>An alert charting progress note dated April 28, 2025 at 21:08 revealed the resident was last seen at 19:00 at the nurses station engaging in conversation with the nursing staff. The note further reveals that around 19:28 the nurse was notified by another nurse that hospital staff at the nearby emergency center recognized the resident sitting in the emergency room . The note states that the patient (PT) was dropped off at the emergency room without knowledge of the facility staff.</p> <p>A communication progress note dated April 28, 2025 at 21:58 indicated that staff contacted the residents Power of Attorney (POA) and advised them of the elopement. The note stated that the POA was aware of the resident's BIMs score and wandering.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An activity progress note dated April 28, 2025 at 23:49 indicated that an inservice was completed with the overnight shift on the wanderguard system and door alarms.</p> <p>An observation and interview was conducted on May 6, 2025 at 1:30 p.m. for resident #22. The resident was easily agitated and was noted to be on one:one supervision. The resident stated that she wasn ' t aware it would be such a big issue to leave but could not recount the elopement.</p> <p>An interview was conducted on May 6, 2025 at 12:24 p.m., with a Licensed Vocational Nurse (LVN/staff #97). The LVN stated that the facility process is to visually check on the residents, if they have a wanderguard check its placement and check doors when the alarms go off. The LVN further stated that the resident ' s baseline cognition was that she had short term memory impairments.Staff #97 stated that the resident had a wanderguard in place and is now a one:one assist. The LVN recounted that around 7:00 p.m. she was passing meds and noticed the resident at the nurses station with the Director of Nursing (DON). She further stated that around 7:30 p.m. she was notified by another nurse on the unit that resident #22 was at the emergency room and she quickly notified her supervisor. Staff #97 stated that she ensured the resident was okay once she returned to the facility and that her wanderguard was in place. The LVN stated that the wander guard did not set off alarms at the time of the resident ' s elopement. Staff #97 identified the risks to be major or minor injury to the resident.</p> <p>An interview was conducted on May 6, 2025 at 12:37 p.m., with a certified nursing assistant (CNA/staff #58). The CNA stated that residents who are identified as an elopement risk are placed on wanderguards. The CNA stated that resident #22 had a wander guard the night that she eloped. Staff #58 stated that the resident was not a high risk resident when she first arrived but when altered levels of cognition were identified she was placed on the wanderguard. The CNA stated that she was the staff member who left to retrieve the resident and bring her back to the facility.</p> <p>An interview was conducted on May 6, 2025 at 1:38 p.m., with the Director of Nursing (DON/staff #14). The DON stated that residents who are elopement risks have a wanderguard bracelet in place and there are elopement binders at the nurses station. Staff #14 stated that if the resident gets too close to a door the alarms will go off and staff has to respond. The DON further stated that the resident was at first immobile but once she regained mobility became an elopement risk. The DON stated that her wanderguard was in place at the time of the elopement but the front door alarm was not working and she exited through there. Staff #14 stated that she was notified of the elopement at 7:35 p.m. and was told the resident knocked on the door of a nearby ' casita ' . The resident of said ' casita ' called 911 and the resident was taken to the emergency room . The DON identified risks to be massive injury or even death if a resident does elope.</p> <p>The facility's policy and procedure revised August of 2020 titled, ' Wandering and Elopement ' indicated that the facility will reinforce proper procedures for leaving the facility for residents assessed to be at risk of elopement.</p>		