STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035158	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and review of facility policy and procedure, the facility failed to ensure a care plan was developed and implemented to meet the needs of a resident (#2) regarding falls. The deficient practice could result in residents not receiving necessary individualized care and services to meet their specific needs.-Findings include:Resident #2 was admitted to the facility on [DATE], with diagnoses that included unspecified intracranial injury without loss of consciousness, Alzheimer's disease with late onset, bipolar disorder, chronic obstructive pulmonary disease, and major depressive disorder.A quarterly minimum data set (MDS) assessment dated [DATE], revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Section GG revealed the resident had no upper or lower extremity functional range of motion impairments on one side. Additionally, Section GG revealed the resident required supervision or touching assistance to perform rolling in bed to the left and right side.A care plan dated August 23, 2022, revealed Resident #2 has had an actual fall due to poor communication/comprehension, poor balance, and self-transfers from bed. Interventions included to keep bed in low position and to place fall mat beside bed on floor when resident is in bed. There was no evidence to specify whether a fall mat should be placed on the left side, the right side, or on both sides of the bed. Review of the clinical record revealed no evidence to specify that a fall mat should be placed on the left side, the right side, or on both sides of the bed.A Weekly Skin Check dated June 13, 2025, revealed Resident #2 had no skin impairments.An e-Interact Summary for Providers note dated June 17, 2025, revealed that the resident's change of condition was related to a fall, and that Resident #2 complained of lower back pain during brief changes. Provider feedback included to administer Tylenol and monitor for any increase in pain. A late entry General Progress Note effective June 17, 2025, and created by the Director of Nursing (DON / Staff #16) on June 22, 2025, revealed the staff nurse assessed the resident on the floor for injuries, no visible injuries noted. The resident was assisted to the bed with two staff assistance using a hoyer lift. The resident's vital signs were within normal limits, and neuro checks administered per protocol after an unwitnessed fall.The clinical record was reviewed and revealed no evidence of whether the resident's bed was low, or that a fall mat was beside the bed at the time of the fall, or if the resident fell onto the fall mat, or what side of the bed the resident fell from.A Health Status Note dated June 18, 2025, revealed the provider was called due to Resident #2's lower back pain, and a new order was received for lumber spine and pelvic x-rays.A Medical Practitioner Note dated June 18, 2025, revealed that Resident #2 was seen because of a fall that occurred during the night. The note revealed that the resident does have a fall mat on one side of bed, but fell on the other side. The resident was in bed, and was found on the floor. The resident complained of back pain and when examined, she was complaining of pain over the left sacral area and left hip area.A Weekly Skin Check dated June 19, 2025, revealed the resident had a nickel size abrasion on the front of the right knee and bruising to the top of the right foot probably from her fall.An interview was conducted on August 27, 2025, at 9:47 a.m. with a Certified Nursing Assistant (CNA / Staff #33) who was the scheduled CNA on Resident #2's hallway during day shift of June 17, 2025. Staff #33 stated that she was not working at the time Resident #2 fell on June 17, and that Staff #33 believed the resident fell after her shift ended. Staff #33 stated that she did not know if Resident #2 was supposed to have a fall mat on the left side, the right side, or both sides of the bed.On August 27, 2025, at 9:55 a.m, a telephonic interview was attempted with a Registered Nurse (RN / Staff #90), who was the scheduled day shift nurse on June 17, 2025, and who was no longer employed by the facility. A voicemail was left for a return call. The staff member did not return the call.A telephonic interview was conducted on August 27, 2025, at 10:17 a.m. with a CNA (Staff #53) who stated that she remembered Resident #2 and her fall on June 17, 2023, and that she was working on the resident's hallway that date. Staff #53 stated that it was around the time of shift change in the evening, and that Staff #53 and the floor nurse (Staff #81) entered Resident #2's room and found her on the floor. Staff #53 stated that the resident's bed was not low, and that right away we saw the bed was high. Additionally, Staff #53 stated that the resident did not have a fall mat at the bedside. Staff #53 stated that Resident #2 is supposed to have fall mats on both sides because she moves around in the bed a lot, and that because the resident has dementia and impaired cognition, she cannot be instructed to only get out of bed on one side. Staff #53 stated that Staff #81 assessed the resident right away and that they assisted the resident with a hoyer lift back into the bed. Staff #53 stated that the resident started screaming in pain when she was back in