

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society-Quiburi Mission		STREET ADDRESS, CITY, STATE, ZIP CODE 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319</p> <p>Based on staff interviews, clinical record review, facility documents and facility policy, the facility failed to ensure that a resident (#52) was free from abuse from another resident (#53). Failure to ensure the resident was free from abuse resulted in an trochantric hip fracture.</p> <p>Findings include:</p> <ul style="list-style-type: none"> -Resident #53 was admitted on [DATE] with diagnoses of dementia, emotional lability, and post traumatic stress disorder. <p>Review of this resident's care plan did not include interventions for aggressive behaviors towards other residents.</p> <p>A progress note dated 9/13/23 included, Resident has been restless throughout the shift, unable to get R to sit down for any length of time. Resident has been going in and out of other R rooms taking things and then giving them to other Rs. Resident becomes verbally aggressive with other R and staff when redirect is attempted .</p> <p>A self report filed on 10/15/23 included Residents (#53) and (9#) both reside in the special care unit. Resident (#9) pushed on the entry/exit door, causing an alarm. (Resident #53)'s room is next to this door, and she frequently rearranges her closet. In response to the alarm, (Resident #53) hit (Resident #9) with the plastic clothing hangers she was holding. Residents separated, PCP notified.</p> <p>A progress note dated 10/25/2023 which included that Resident #53 threw a blanket at another R when the other R attempted to give (resident #53) her personal items back.</p> <p>However, review of the care plan did not find care planning interventions added for the incidents on 10/15/23 or 10/25/23.</p> <ul style="list-style-type: none"> -Resident #52 was admitted on [DATE] with diagnoses of unspecified dementia. <p>A facility self report dated 10/26/2023 included that Nurse in Special Care Unit heard loud noise from resident (#53)'s room, which is in the special care unit. Saw resident (#52) on the floor and resident (#53) standing. When asked what happened, (resident #53) stated I pushed her. (resident #53) has been placed on 1:1 care. (resident #52) will be transported to the hospital for evaluation.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Hospital records for 10/26/23 from Tucson Medical Center included that this resident was admitted for a left trochanteric fracture and was provided a nailing trochanteric fixation.</p> <p>A care plan dated 10/27/20 included that the resident has a behavior symptom related to dementia with intervention to intervene as necessary to protect the rights and safety of others and to redirect if wandering becomes a danger to her or other residents.</p> <p>A progress noted dated 10/27/2023 included that the writer and the Director of Nursing Services notified Resident #52's daughter via telephone that resident #52 had a fall yesterday as a result of a resident to resident altercation, and was sent to the hospital per doctor order. This note included that this resident was at Tucson Medical Center and has a left hip fracture.</p> <p>During an interview conducted on 3/8/2024 at 11:59 AM with a Registered Nurse Clinical Care Leader (RN/staff #61) who said that she recalled there were two incidents with resident #53 and that the staff would redirect. She reviewed resident #53's care plan and said that she did not see the care plan was updated after the incident on 10/15/2023 or on 10/25/2023.</p> <p>An interview was conducted on 3/8/2024 at 12:30 PM with the Director of Nursing (DON/staff# 57) who said that care plans need to be updated immediately when there is an incident. The DON stated that resident #53 said she had pushed resident #52 when she was in resident #53's room. The DON further added that the two resident had always intermingled well together in the past. She said that her expectations are that we do not have abuse and that we have interventions to keep the residents safe.</p> <p>A policy titled Abuse and Neglect - Rehab/Skilled, Therapy & Rehab reviewed 7/6/23 revealed that the purpose of this policy was to ensure that residents are not subject to abuse by anyone, including but not limited to other residents.</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49199</p> <p>Based on record review, staff interviews, and review of policy, the facility failed to notify the Ombudsman of transfer/discharge for two residents (#23, #2).</p> <p>Findings included:</p> <p>-Resident #23 was admitted to the facility on [DATE] with diagnoses of respiratory failure unspecified with hypoxia, heart failure, and transient cerebral ischemic attack.</p> <p>Review of the most recent MDS (Minimum Data Set) revealed a BIMS (brief interview of mental status) score of 15, indicating no cognitive impairment.</p> <p>Facility census list revealed resident #23 was on a hospital leave on August 8, 2023 until August 14, 2023 and again on September 2, 2023 until September 9, 2023.</p> <p>An interview was conducted on March 6, 2024 at 2:18 P.M. with the Administrator (staff #12) and Director of Nursing (DON)staff #57). Staff #12 stated that no notification of transfer to the hospital was given to the family of resident #23 because resident was her own representative. In addition, the administrator stated they do not notify the ombudsman of any transfers/discharges, so there was no notification of transfer for resident #23.</p> <p>49325</p> <p>-Resident # 2 was admitted into the facility on [DATE] with diagnoses of acute respiratory failure with hypoxia, anxiety disorder, heart failure, and depression.</p> <p>A review of the admission MDS dated [DATE], revealed the resident had a BIMS score of 15, indicating cognitively intact.</p> <p>Review of an order summary report dated February 26, 2024, revealed Home Health was ordered to evaluate and treat for skilled nursing to monitor for signs and symptoms of acute respiratory failure, complications with chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure after stay at skilled nursing facility following hospitalization for acute respiratory failure. Will need occupational and physical therapy to consult for safety and possible treatment in home.</p> <p>Review of a Discharge Summary report revealed resident was discharged on [DATE] at 10:30 AM.</p> <p>On March 07, 2024 at 10:12 AM a document request for Ombudsman notification of resident #2's discharge was made to the Social Service Director (staff #55) and he stated that he did not update ombudsman about any discharges. Staff #55 further stated that the administrator would likely be the one responsible for most of the communication with the ombudsman.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted with the Administrator (Staff #12) on March 07, 2024 at 10:15 AM. The administrator stated that discharges are approached as an interdisciplinary team. Further, the administrator stated that facility policy was that ombudsman should be notified of discharges and was something they have to work on. He further stated that he realized that they needed improvement on the discharge process and that if it is in the facility policy that it should be done to meet the facility's expectations. Staff #12 stated per regulation the ombudsman should be notified of facility-initiated discharges because they are a spokesperson for the resident so they are not discharged against their will. Staff #12 reiterated ombudsman was the voice for the residents and that they needed to improve their process.</p> <p>Review of facility policy titled, Discharge and Transfer - Rehab/Skilled, Therapy & Rehab reviewed/revised on January 3, 2024, revealed that with a facility-initiated transfer or discharge, the location must send a copy of the GSS # 223A or other state-required form to a representative of the Office of the State Long-Term Care Ombudsman.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>49325</p> <p>Based on review of clinical records and policy, observations, and staff interviews the facility failed to ensure the environment remained free of accident hazards existing from unattended medications. The deficient practice of unattended medications does not align with accepted professional standards of practice and may result in undesirable medication-induced harm.</p> <p>Findings included:</p> <p>On March 6, 2024 at 9:14 AM a medication blister pack was observed unattended at the nurse's station where it was accessible to residents. The medication was Metformin Hydrochloride 500 milligram, a medication for diabetes mellitus. This observation prompted an interview with a nearby Licensed Practical Nurse (LPN/Staff # 77) who stated overhearing that a nurse had removed it from the medication cart after learning it had been discontinued for a resident (# 28). Staff #77 stated it should not have been left where it was but instead be placed in the medication room and notify pharmacy to have the medication picked up. Staff # 77 counted how many tablets were left on the blister pack which were 55 total. Staff #77 stated the risk with leaving the medication unattended were it may cause residents to have an allergic reaction or have hypoglycemia if taken by a resident who does not have diabetes. Staff # 77 assured medications should be locked away and then proceeded to take the medication blister pack to the medication room after the interview.</p> <p>An interview was conducted on 06, 2024 at 12:00 PM with Director of Nursing (DON/Staff # 9) who stated that the risks of leaving the unattended medication, Metformin is upset stomach or allergy. If they take one, it would possibly not cause much, but who is to say they might not take many. Staff # 9 stated leaving medication unattended did not meet facility expectations.</p> <p>Review of the facility's Clinical Services Policy titled, Medication: Acquisition Receiving Dispensing and Storage (reviewed/revised 03/02/2023) revealed: -Medication will be stored in a locked medication cart, drawer or cupboard. Only the person passing medications and the director of nursing services and/or designee will be permitted to have access to the keys to the medication storage areas.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911</p> <p>Based on clinical records, staff interviews, and the facility policy and procedures, the facility failed to follow the catheter care in accordance with professional standards for one resident #18. The deficient practice could increase the risk for resident discomfort, injury and infection.</p> <p>Findings include:</p> <p>Resident #18 was admitted on [DATE] with diagnosis including muscle wasting and atrophy, nutritional deficiencies, anxiety disorder, adult failure to thrive, age-related physical debility, protein-calorie malnutrition and palliative care.</p> <p>A review of the quarterly MDS (minimum data set) dated September 06, 2023 revealed a BIMS (brief interview of mental status score of 08, suggesting moderate cognitive impairment. The MDS further revealed that resident #18, currently has an in-dwelling catheter in place.</p> <p>A review of the physician orders revealed an order dated May 17, 2022 for a suprapubic catheter size 16 French with a 10 ml balloon, contingent on drainage.</p> <p>A review of the care plan dated December 20, 2023 revealed that a suprapubic catheter was in place for an anatomical abnormality. The care plan further notes interventions of monitoring for pain or discomfort, monitoring for UTI's (urinary tract infections), catheter care per shift and reporting any unusual observations to the nurse.</p> <p>An observation was conducted on March 4, 2024 at 2:45 PM. Resident #18 was seated in his wheelchair, being pushed by a Licensed Practical Nurse (LPN/staff #23) and the catheter bag was observed to be dragging on the floor underneath the wheelchair.</p> <p>An observation was conducted on March 6, 2024 at 8:50 AM. Resident #18 was observed seated in his wheelchair outside of the room on hall 300. The catheter bag was observed to be touching the floor underneath the resident's wheelchair.</p> <p>An observation was conducted on March 6, 2024 at 10:20 AM. Resident #18 was still observed in his wheelchair with the catheter bag touching the floor.</p> <p>An interview was conducted on March 6, 2024 at 10:05 AM with a Certified Nursing Assistant (CNA/ staff #84). The CNA stated that that regarding catheter bags, she would check for color of the output, ensure that the bag is covered for dignity and that it is off the ground.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on March 6, 2024 at 10:11 AM with staff #77 an LPN. Staff #77 stated that she would always check for the amount and color of the output when a resident is on a urinary catheter. She stated that she would make sure that the bag is covered and that it is not directly on the floor. She further stated that if the catheter bag was on the floor, it could pull out and cause damage to the resident. When resident #18 was pointed out to staff #77, she stated that the bag should not be on the floor. Staff #77 applied gloves and looked underneath the wheelchair and stated that she would have to see about how the bag could be elevated off the floor as she was unable to adjust it higher. She further stated that the tubing was yucky and needed to be changed as well.</p> <p>An interview was conducted on March 6, 2024 at 10:29 AM with the Director of Nursing (DON/staff #9). She stated that her expectation is that catheter bags stay low enough for drainage but stated that they should never touch the ground. She further stated that the risk could be an infection control issue.</p> <p>A review of the facility policy entitled catheter care, revised February 10, 2023 revealed that catheter tubing should never be allowed to touch the floor. The policy further states that in order to prevent urethral injury, avoid pulling or placing tension on the catheter. However, on several occasions the catheter bag was observed directly on floor with the potential for causing tension as the bag fills.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911</p> <p>Based on observations, staff and resident interviews, and policy review, the facility failed to ensure one resident #18 was assessed for the safe use of enabler bars prior to installation and informed of the risks and benefits of their use. The sample size was 16. The deficient practice could impact the residents knowledge of the risks and benefits of enabler bars and cause potential injury if the resident was not an appropriate candidate for enabler bars.</p> <p>Findings include:</p> <p>Resident #18 was admitted on [DATE] with diagnosis including muscle wasting and atrophy, anxiety disorder, adult failure to thrive, age-related physical disability, protein-calorie malnutrition, and palliative care.</p> <p>A review of the quarterly MDS (minimum data set) dated September 06, 2023 revealed that the resident has a BIMS (brief interview of mental status) score of 08, suggesting moderate cognitive impairment. Section G of the MDS revealed that resident #18 is an extensive 2-person assist with transfers, and bed-mobility. Section P of the MDS revealed that bed rails are not used; however, enabler bars were present on the resident's bed.</p> <p>A review of the physician orders revealed no evidence of an order for enabler bars.</p> <p>A review of the care plan revealed that resident #18 had an ADL (activities of daily living) performance deficit and that he required 1-2 staff assistance and weightbearing support as well as 1-2 staff assistance for bed mobility. Transfers were noted to require a total lift with a medium high back sling and 2 staff.</p> <p>A review of the electronic health record, under all sections for resident #18, revealed no evidence of an assessment for enabler bars.</p> <p>An observation on March 04, 2024 at 2:36 PM revealed the presence of enabler bars on the resident's bed.</p> <p>A subsequent observation on March 06, 2024 at 8:18 AM revealed an enabler bars on the resident's bed. The enabler bars were observed to have a little wiggle when touched.</p> <p>An interview was conducted on March 06, 2024 at 8:20 AM with staff #84 a CNA (Certified Nursing Assistant). Staff #84 stated she believes that residents are assessed for grab or enabler bars. She further stated that if staff observe any concerns after the bars are installed that they would immediately alert maintenance and submit a work order. She stated that the turn-around is generally the same day.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on March 06, 2024 at 8:23 AM with staff #75 LPN (Licensed Practical Nurse). Staff #75 stated that residents are assessed for suitability of grab or enabler bars. She stated that maintenance installs the bars and periodically reviews them. She stated that if staff observe any concerns, the issues is reported, a work order placed and generally resolved the same day.</p> <p>An interview was conducted on March 06, 2024 at 8:45 AM with staff #27, the Maintenance Director. Staff #27 stated that he had just reviewed the safety of the grab and enabler bars on hall 300 and had not observed any concerns. He stated that he was not familiar with the resident assessment portion but did reveal that the enabler bars were directly attached to the bed frame via a bolt and pin actions, which is designed to have a little give to facilitate the up and down movement of the bars. Staff #27 reviewed the installation, security and safety of the enabler bars for resident #18. No further concerns for the installation of the enabler bars.</p> <p>An interview was conducted on March 6, 2024 at 9:40 AM with staff #77 a LPN. Staff #77 stated that an evaluation and mobility assessment is conducted prior to the installation of grab bars. She stated that the grab or enabler bars should also be care planned. She stated that she was unsure if a consent was needed. She stated that the expectation is that these steps are completed prior to installation on the resident's bed. Staff #77 stated that the risk could include impact on the resident's ability to safely transfer.</p> <p>An interview was conducted on March 06, 2024 at 12:30 PM with staff #9 the DON (Director of Nursing). Staff #9 stated that the expectation is to follow procedures as set forth in the facility policy. She stated that this would entail an resident assessment, data collection and an informed consent. She stated that there was no evidence of the assessment and consent for resident #18 in the record. Staff #9 stated that the risk is that it could be construed as a type of restraint for the resident.</p> <p>A review of the facility policy entitled Bed Safety with a review date of September 28, 2023 revealed that placement of bed rails, side rails and assist bars are applied for a medical provider-identified medical necessity. The policy further stated that medical necessity is supported by a resident assessment and data collection documentation which denotes that the resident is able to assist or be independent with bed mobility. The polcny further revealed that an informed consent would be obtained from the resident and/ or family and then documented in the medical record; however, the record revealed no evidence of data collection for enabler bars, assessment or an informed consent for resident #18.</p>		