STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145773	A. BUILDING _____ B. WING _____	C 07/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN HOME	**2130 HARRISON STREET QUINCY, IL 62301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 more falls in a month. A fall summary dated 9/11 which summarizes R3's falls on 9-02-11 and 9-15-11 does not contain a root cause analysis or an evaluation of the effectiveness of the fall interventions that were in place. There was no fall summary provided for R3's six falls occurring between 11-06-11 and 11-30-11. R3's 1/12 fall summary report includes 11 falls dating from 12-29-11 to 1-18-12. The fall summary does not include a root cause analysis for five of the six falls. The 1/12 fall summary does not include an evaluation of the effectiveness of the fall prevention interventions that were already in place. E2 did not provide fall summaries for R3's eight falls occurring after 1-18-12. A care plan dated 5-24-12 does document the addition of R3's falls on 6-10-12 and 6-29-12 but does not document any additional fall prevention interventions. The care plan also does not document an evaluation of the effectiveness of the interventions that were already in place.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care	F9999		

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plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These Requirements are NOT MET as Evidenced by:

Based on observation, interview and record review the facility failed to recognize environmental hazards, provide adequate supervision to residents while on a facility outing, and failed to provide clear instructions for boarding facility transportation which resulted in an accident with injury for one of three residents (R1) reviewed for falls in the sample of three. As a result of these failures, R1 fractured both her legs and bones in her face.

Findings include:

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1. A facility incident report dated 6-13-12 at 1:15p.m. documents that R1 fell from a wheelchair and sustained "bilateral femur fractures and facial fractures."

On 7-10-12 at 9:40a.m., E2 (Associate Administrator) stated that on 6-13-12 the facility was having a picnic at a shelter in a local park. E2 stated that she was assisting residents to get on the buses to return to the facility when she "heard something" and turned to see that R1 had just fallen down some steps while in a wheelchair. E2 stated that she thought R1 had propelled her wheelchair too close to the stairs and that the wheelchair fell down the steps throwing R1 forward from the wheelchair.

A Physician's order sheet (POS) dated 7-01-12 to 7-31-12 documents that R1 has diagnoses which include: Senile Dementia and Depression. The POS also documents that R1 has medications which include Cymbalta 30mg (milligrams) daily.

An annual Minimum Data Set (MDS) indicates that R1 has inattention and disorganized thinking which fluctuates.

A care plan dated 4-18-12 documents that R1 needs, "extensive to total assist with ADL's (activities of daily living) due to impaired physical mobility and cognitive impairment." The care plan also documents that R1 has "a problem hearing" when in a group setting. The care plan further indicates for staff to seat R1, "near the speaker when in a group setting. Staff is to make sure, "R1 is "hearing what they are doing and explain all procedures before performing." The care plan also instructs for "staff to be sure and stand in

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front of," R1 "when speaking to" R1, "face," R1 "while speaking using eye-to-eye contact," and "give clear and simple direction."

On 7-10-12 at 10:30a.m., E4 (Social Services Director) stated that "It was a big shelter house," where the picnic was held. "There's a two-stair entry way and a wheelchair ramp." E4 stated that she was cleaning and removing table cloths in the shelter when she heard someone shout, "No (R1), you can't go that way!" E4 stated that R1, "purposely went forward onto the stairs, thinking she could go down the stairs, but fell."

On 7-10-12 at 1:05p.m., E6 (Clinical Services Administrator) stated: "We were loading people into the vans. I was on the wheelchair ramp. I heard, 'No, you can't do that!' I turned around and saw (R1). Her first two wheelchair wheels were tipped onto the first step (to the picnic shelter). The rear wheels were still on the shelter (floor). The oxygen tubing was stretched and (R1) was face first on the concrete."

On 7-11-12 at 9:45a.m., E9 (Certified Nurse Aide) stated that during the facility picnic, "I had my back turned to everyone because I was taking a resident to the van. I heard everyone yell and I turned and she (R1) was falling." E9 stated that she could not remember hearing an announcement that the picnic was over or that staff would assist residents to the facility vans. E9 stated that "we were cleaning up and the residents may have realized it was time to go." E9 stated that "we" were taking the ambulatory residents to the buses first, "because we could get five ambulatory residents and five wheelchair residents on a bus at the same time." E9 stated

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that of the nine archways and two doors to the shelter, only one was blocked off with a buffet table. E9 also stated that she had thought during the picnic that "they should have put caution tape or chairs around," the arches to keep residents away from the stairs. E9 also stated that the residents in wheelchairs were not taken to the buses in any particular order. E9 stated that after R1 fell and left in the ambulance, facility staff decided to start supervising the stairs leading onto the shelter. E9 stated that staff also moved the remaining residents into the center of the shelter to avoid another accident.

On 7-11-12 at 9:20a.m., E2 (Associate Administrator) stated that she did not remember hearing a formalized announcement that the picnic was over and that it was time for residents to return to the facility. E2 also stated that she did not remember having a formalized plan on how residents would be guided from the shelter, down the wheelchair ramp, and onto the buses. E2 stated that during the picnic when staff "saw that a resident looked ready or maybe getting restless," to leave, they (staff) would help that resident go down the wheelchair ramp to board the bus to return to the facility. E2 was unable to state how many staff members and volunteers were assigned to the picnic to assist with resident care but stated that she thought there were "at least 20." E2 agreed with E9's statement that after R1 left in the ambulance, facility staff decided to supervise the stairs leading onto the shelter and that staff also moved the remaining residents into the center of the shelter to avoid another accident.

On 7-11-12 at 10:00a.m., Z1 (A resident from the

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independent living cottages) stated that during the picnic, buses arrived to return residents to the facility. Z1 stated, " They had loaded the first batch. We were all in the shelter waiting for our turn. I guess she (R1) decided she didn't want to wait and she went to the stairs and went down. I think she didn't realize there were steps there." Z1 stated that there was, "no announcement I don't think. It was an assumption on our part because the buses pulled up and they started cleaning up." Z1 stated that there were no barriers around the openings to the stairs at the shelter and "we were all pretty close to the edge." Z1 stated that after R1 fell, "several of the girls working for the home stood in front of the steps so no one else could do what (R1) did."

On 7-11-12 at 11:15a.m., E10 (Activities Director) stated that the facility had been using the same shelter for resident outings "for a long time." E10 stated that "the program team," consisting of facility supervisory staff, meet periodically to plan big events and "select a site." E10 stated the program team had selected the shelter in the park because "we've used that pavilion before because there is a restroom there." E10 stated that the program team has, "discussed parks in the past and drove there and assessed if it is wheelchair accessible and if there is a restroom for wheelchairs." E10 was unaware whether the shelter at the park had been evaluated for being a potential accident hazard to residents. E10 stated that all residents were invited to the picnic and that approximately 120 residents attended. E10 stated that as the picnic was concluding, no formalized announcement was made for residents to begin boarding the buses. E10 indicated that there are some residents "who are

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impatient and when they want to go, they want to go now!" E10 stated that she has "a mental list of people who are impatient and want to go first," but had no specific plan outlined for staff to know which residents should board the buses first.

On 7-11-12 at 7:15a.m., the area in the park where the facility held the picnic was noted to have a four-sided shelter which has ten archway entrances and two doorways. Each archway and door has two steps to climb in order to get onto the shelter. The two steps equal a height of approximately 16 inches. There is also one wheelchair ramp located on the front of the shelter which has one access point from the far left of the shelter.

On 7-10-12 at 10:30a.m., E4 (Social Services Director) stated that "anyone who knows (R1)," knows "she acts on impulse," and stated that there "are concerns with safety issues." E4 also stated that when R1 "wants something, she wants it now." On 7-11-12 at 10:25a.m., E3 (Director of Nursing) stated that R1 can be impulsive and impatient. On 7-11-12 at 9:45a.m., E9 (Certified Nurse Aide) stated that "I've taken care of this resident before and she's kind of impatient."

On 7-10-12 at 11:20a.m., E5 (Resident Care Coordinator) stated that R1 has contractures to her hands and can only self propel her wheelchair short distances.

(A)