STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	C 04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	**205 NORTH ADAMS FLANAGAN, IL 61740**

(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 000	INITIAL COMMENTS Investigation of Resident Incident of 3/30/16/IL 84558	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to notify the family and physician of an abuse allegation and a bruise of unknown origin for two of three resident's (R1, R2) reviewed for notifications in the sample of three. Findings Include: 1. R1's Minimum Data Set (MDS) dated 3/6/16 documents that R1 has severe cognitive impairments. On 4/6/16 at 8:45 am, R1 was sitting in R1's wheelchair at the nurses station. R1 had a dark purple bruise to the right wrist and backside of the right hand. R1 was not able to state what happened to cause the bruising or how R1 was treated by staff at the facility. E9 Licensed Practical Nurse (LPN) stated, "I don't know what happened, nothing was passed on in report." E9 checked R1's file and stated, "there is nothing documented as to what happened or when they were noticed." On 4/6/16 at 9:15 am, E2 Director of Nursing (DON) stated, "(R1) was part of an abuse allegation last week {3/30/16}, it was reported that a nurse was pinching (R1's) nose and holding (R1's) head while giving medications and that the CNA's had been asked to hold (R1's) hands down by the nurse. I did an assessment of (R1) on 3/31/16 and there was no bruising at that time, there was no injury." After doing a new assessment of R1, E2 confirmed that R1 does have bruising on the wrist and back of hand and stated, "nobody reported this." E2 confirmed that	F 157		

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F 157	Continued From page 2	F 157		

it appears that if someone's hand was on top of R1's hand and the other persons thumb was in a resting position, that it would be placed on the wrist. E2 stated, "that is definitely a suspicious bruise, especially due to the location of the bruise on the wrist, but I promise you, it wasn't there on 3/31/16 after the abuse allegation. When the bruise was noticed, it should have been reported to the nurse and documented so that we could keep an eye on it for further breakdown, and the physician should be notified."

On 4/6/16 at 9:50 am, E11 Certified Nursing Assistant (CNA) stated, "I noticed those bruises on (R1's) hand and wrist since last week, I don't know how (R1) got it but I told (R12 Registered Nurse) about it at the time."

R1's Nursing Progress Notes dated 3/16 - 4/6/2016 does not document any allegation of abuse, bruises or that R1's family or physician had been notified of the allegation of abuse and bruises.

On 4/6/16 at 10:00 am, E2 provided the abuse file which contained R1's abuse investigation and report. E2 stated, "the investigation started on 3/31/16 and we just finished it yesterday {4/4/16}." There was no documentation that R1's family or physician had been notified. E2 stated, "the physician and family were not notified of the abuse allegation, or the bruise on the hand last week after it was noticed."

2. R2's Minimum Data Set (MDS) dated 1/31/16 documents that R2 has severe cognitive impairments.

On 4/6/16 at 9:05 am, R2 was asleep in R2's

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F 157	Continued From page 3	F 157		

recliner, with feet elevated. R2 had a yellow/green/purple bruise to the backside of the left hand.

There was no documentation of a bruise or family/physician notification in R2's Nursing Notes or skin assessment's.

On 4/6/16 at 9:40 am, E2 DON stated, R2 was part of that same abuse allegation last week {3/30/16, which also involved R1)}. I did an assessment of (R1) on 3/31/16 and there was no bruising at that time." After doing a new assessment of R2, E2 confirmed that R2 does have bruising on backside of R2's hand and stated, "nobody reported this." E2 stated, "this looks like an older bruise, it is already turning but it wasn't there on 3/31/16.

On 4/6/16 at 9:45 am, E10 CNA stated, "I noticed that bruise on (R2's) hand sometime over the weekend. I'm not sure if I told the nurse or not but I did chart it."

R2's Nursing Progress Notes dated 3/16 - 4/6/2016 does not document any allegation of abuse, bruises or that R1's family or physician had been notified of the allegation of abuse or the bruise.

On 4/6/16 at 10:00 am, E2 provided the abuse file which contained R2's abuse investigation and report. E2 stated, "the investigation started on 3/31/16 and we just finished it yesterday {4/4/16}." There was no documentation that R2's family or physician had been notified. E2 stated, "the physician and family were not notified of the abuse allegation, or the bruise on the hand last week after it was noticed."

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F 157	Continued From page 4 On 4/7/16 at 8:45 am, E1 Administrator stated, "anytime there is a change in residents condition or an allegation of abuse, the family and physician must be notified. They should also be notified anytime there is an injury of unknown origin, that is what the policy says." The facility's Injury of Unknown Origin Policy dated 2/1/16 documents, "1. Should a resident be observed with unexplained injuries (including bruises...), the Nurse Supervisor on duty must report to the DON. 2. Injury of Unknown Source is defined as an injury that meets both of the following conditions: a)the source of the injury was not observed by any person or the source of the injury could not be explained by the resident, and b) the injury is suspicious because of the location of the injury....4. The nursing staff shall discuss the situation with the Attending Physician or Medical Director to consider whether medical conditions or other risk factors could account for the finding. 5. The investigation will follow the protocols set forth in our facility's established abuse investigation guidelines. The facility's Physician Notification for Resident Condition Change dated 4/8/09 documents, "Nursing staff...will notify the resident, attending physician and/or legal representative of changes in resident condition...A criterion for physician notification includes but is not necessarily limited to:....presence of bruising."	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have	F 225		

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F 225	Continued From page 5 been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to immediately report an allegation of	F 225		

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F 225	Continued From page 6	F 225		

abuse to the Administrator/Abuse Coordinator and failed to provide protection for two of three residents (R1 and R2) reviewed for abuse in the sample of three.

Findings Include:

The Resident Abuse Report Form dated 3/31/16 by E2 Director of Nursing (DON) and E3 Quality Assurance Nurse (QAN) documents, "incident occurred on 3/30/16 at 7:00 pm and was reported at 8:00 pm by E8 Licensed Practical Nurse (LPN)...(E5) attempting to administer medication. (R1 and R2) spitting out meds numerous times. (E5) asked (E6 Certified Nursing Assistant (CNA)) to hold residents hand while (E5) gave medication. (E6) witnessed (E5) "pinching" (R1 and R2's) nose closed, in an effort to have (R1 and R2) swallow meds. Investigation ongoing. (E5) notified not to return to work pending investigation outcome."

On 4/6/16 at 9:15 am, E2 Director of Nursing (DON) stated, "about 10:00 pm on 3/30/16, (E2) received a call from (E8 LPN). (E8) stated that (E6) had told (E8) that (E5 LPN) had (E6) hold a resident's hands down while giving medications and that (E6) didn't feel right about it."
E2 stated that she did not call (E1 Administrator/Abuse Coordinator) to report an allegation of abuse. The next morning when (E2) came to work, she assessed (R1) for any bruising to the hands and face and (R1) didn't have any. (E2) told (E1) about the phone call and started an investigation.

On 04/06/16 at 9:15AM E2 stated, "We called E6 (on 03/31/16) and that is when we found out that there was two resident involved (R1 and R2) and

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F 225	Continued From page 7	F 225		

that not only did (E5) request (E6) to hold down the hands of (R1 and R2) but that (E5) was holding onto (R1 and R2's) head and pinching their noses while giving them their medications. That is when we called and suspended (E5) due to the allegation of abuse." E2 then stated that she asked (E8) if (E8) had reported pinching of the nose the night before because (E2) didn't recall that part of the conversation but that (E8) couldn't remember telling E2 anything about pinching of the nose.

On 4/6/16 at 12:05 pm, E5 stated, "(E5) was trying to give (R1 and R2) their medication and they kept shaking their head and spitting it out, so I held my hand on their forehead, with my fingers across the bridge of their noses to hold them still, that way I could scoop up the spit out medicine and give it back to them. They were trying to hit me, so that's when I asked (E6) to hold their hands down. (E6) held (R1's) hand like (E6) would when shaking hands with someone, but then let go because (R1) kept trying to hit and was spitting the medications out." (E5) stated he continued to need help so he asked (E7 CNA) to help."

On 4/6/16 at 2:10 pm, E6 stated, "I was walking down the hall when (E5) began yelling for help. (E5) asked me to hold down (R1's) hands so he could give meds to (R1) because (R1) wasn't taking them. I held (R1's) left hand between my hands to comfort (R1). While I was talking to (R1), (E5) proceeded to plug (R1's) nose by pinching it with his thumb and index finger on the outside of each nostril. (R1's) right hand was flailing around trying to hit (E5). (E5) continued to shove pills into (R1's) mouth so I let go of her hand and stated, 'I can't do this', and walked

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F 225	Continued From page 8	F 225		

away. It wasn't right, (R1) didn't want them {pills}. That's when (E5) asked (E7 CNA) to help, which (E7) did. (E5) continued to shove the pills into (R1) while (E7) held (E5's) hand. Once they were done with (R1), they moved onto (R2), and did the same thing. I didn't feel comfortable about what was happening so I sent a text to (E9 LPN) asking if what I just witnessed was wrong. (E9) confirmed that it was not right and told me to report it. That is when I went to the other side of the facility and told (E8) what just happened to (R1 and R2). (E8) really didn't know what to do either so (E8) told me that she would call (E2) and report it. Later that night before (E8) left, (E8) whispered to me that she had called (E2). (E8) didn't say anything about the conversation other than (E2) was notified."

On 4/6/16 at 2:45 pm, E7 stated, "I came up on (R1) having medication shoved in (R1's) mouth by (E5), around 7:30 - 8:00 pm. (E5) was pinching (R1's) nose closed."E7 verified that E5 was pinching R1's nose shut while administering R1's medications. E7 then stated, "(R1) would spit the medicine out and (E5) would scoop it up and shove it back into (R1's) mouth, (E6) was standing near (R1 and E5). I didn't see (E6) touching (R1), and I never touched (R1). (E5) then stated he needed help with holding (R2's) hands down. E6 and I just look at each other like, "I'm not doing that." When I turned around, (E5) was pinching (R2's) nose. I grabbed (R2's) hand to comfort (R2) and stated, "(E5) isn't trying to hurt you, (E5) is just giving you your medicine." (R2) was pushing (R2's) hands at (E5) trying to get (E5) to stop. (E5) did the same thing to (R2) that (E5) had done to (R1)...(E5) just kept shoving the medicine in their mouth, while (E5) was pinching their nose..neither resident could say

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F 225	Continued From page 9	F 225		

anything but both kept trying to hit (E5) away. I thought (E5) was being abusive but I was afraid to report the situation. I was scared of what might happen. (E5) kept saying, (E5) didn't know why the resident's couldn't just take their medication like they were suppose to. (E5) was still working when I left the facility on the evening of 3/30/16 and was still at the facility working the morning of 3/31/16 when I got to work."

On 4/6/16 at 3:10 pm, E8 stated, "I came to (E8) after supper, around 8:00 pm and told (E8) what had just happened...(E5) pinching the nose of (R1) while holding (R1's) heads, and asking us (E 7 and I) to hold (R1's) hands down. I was whispering so that nobody else overheard us talking. I might have mentioned (R2) at that time, but (E8) don't recall. (E8) called (E2) and told (E2) about the pinching of the nose and holding down of hands. (E2) said she would work on it in the morning. (E8) told (E5) about the allegation and that (E8) had notified (E2). (E5) felt like (E5) needed to get the medications down (R1), that's all (E5) really said."

On 4/6/16 at 3:30 pm, E2 confirmed E5 was still in the facility after the allegation of abuse was made against E5 and stated, "(E5) came into work at 6:00 pm on 3/30/16 and (E5) works 12 hour shifts. E2 said she talked to (E5) a few more times on the phone, later that night {3/30/16} and (E5) seemed fine. E2 said she didn't mention anything about the allegation on the phone, since (E5) seemed calm. (E2) then stated, "I didn't want to get anything going again." Trust me, I have learned a lot from this investigation and from this point forward, any time I gets a call that someone is feeling uneasy and uncomfortable about something, I will come in to check it out and

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F 225	Continued From page 10 report it to (E1 Administrator). (E12 Chief Executive Officer (CEO)) told me yesterday, that any time an allegation of abuse is reported that I needed to report it to (E1) immediately." On 4/7/16 at 8:15 am, E1 stated, "I am the Abuse Coordinator and (E2) is an abuse designee. I was not made aware of the abuse allegation until the morning of 3/31/16. (E2) should have notified me the day before, after (E2) received the allegation and that (E5) would have been suspended immediately. Resident's have the right to refuse medications and cares and through training, the staff should know that if a resident is refusing care, to walk away and come back later. You don't force the issue." The facility Abuse Prevention Policy dated 1/20/16 documents, "...the right of our resident to be free from abuse...the facility therefore prohibits mistreatment, neglect, or abuse of it's resident's and has attempted to establish a resident sensitive and resident secure environment. This will be done by...implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively, and making necessary changes to prevent future occurrences....Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish...Physical Abuse includes hitting, slapping, pinching, kicking...Employees are required to report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the administrator. Supervisors shall immediately inform the administrator of all reports of potential mistreatment...Employees of this facility who have been accused of mistreatment will be	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - FLANAGAN	205 NORTH ADAMS FLANAGAN, IL 61740

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F 225	Continued From page 11 removed from resident contact immediately until the results of the investigation have been reviewed by the administrator or designee. Employees accused of possible mistreatment shall not complete the shift as a direct care provider to residents.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to operationalize their abuse policy by failing to notify the Administrator of an allegation of abuse and failing to remove an alleged perpetrator for two of three residents (R1, R2) reviewed for abuse in the sample of three. Findings Include: The facility Abuse Prevention Policy dated 1/20/16 documents, "...the right of our resident to be free from abuse...the facility therefore prohibits mistreatment, neglect, or abuse of it's resident's and has attempted to establish a resident sensitive and resident secure environment. This will be done by...implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively, and making necessary changes to prevent future occurrences....Abuse is the willful infliction of	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	C 04/07/2016

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(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 226	Continued From page 12	F 226		

injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish...Physical Abuse includes hitting, slapping, pinching, kicking...Employees are required to report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the administrator. Supervisors shall immediately inform the administrator of all reports of potential mistreatment...Employees of this facility who have been accused of mistreatment will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator or designee. Employees accused of possible mistreatment shall not complete the shift as a direct care provider to residents.

On 04/06/16 at 9:15PM E2/Director of Nursing stated that at about 10PM on 03/30/16 she received a call from E8/LPN (Licensed Practical Nurse) telling her that E6 C.N.A. (Certified Nurse Aid) had told E8 that E5/LPN had E6 hold down R1 ' s hands while E5 gave R1 medications and the E6 didn ' t feel right about it. E8 went on to tell E2 that E6 witnessed E5 pinching R1 ' s nose shut while administering medications so R1 would swallow the meds instead of spitting them out. The Resident Abuse Report Form dated 3/31/16 by E2 Director of Nursing (DON) and E3 Quality Assurance Nurse (QAN) documents, "incident occurred on 3/30/16 at 7:00 pm and was reported at 8:00 pm by E8 Licensed Practical Nurse (LPN)...(E5) attempting to administer medication. (R1 and R2) spitting out meds numerous times. (E5) asked (E6 Certified Nursing Assistant (CNA) to hold residents hand while (E5) gave medication. (E6) witnessed (E5) "pinching" (R1 and R2's) nose closed, in an effort to have (R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146089	A. BUILDING _____ B. WING _____	C 04/07/2016

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F 226	Continued From page 13 and R2) swallow meds. Investigation ongoing." On 4/6/16 at 3:30 pm, E2 confirmed E5 was still in the facility after the allegation of abuse was made against E5 and continued to work through the night until removed from duty and suspended on 03/31/16 after E2 told E1/Administrator of the allegation that occurred the evening before. On 4/7/16 at 8:15 am, E1 stated, "I am the Abuse Coordinator and (E2) is an abuse designee. I was not made aware of the abuse allegation until the morning of 3/31/16. (E2) should have notified me the day before, after (E2) received the allegation and (E5) should have been suspended immediately. Residents have the right to refuse medications and cares and through training the staff should know that if a resident is refusing care, to walk away and come back later. You don't force the issue."	F 226		