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 _____	08/20/2015

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 000	INITIAL COMMENTS	F 000		
F 225 SS=D	Annual Certification Survey 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have 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	F 225		

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

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.

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F 225	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to report an allegation of physical abuse to the State Agency and failed to investigate this allegation for one of five residents (R31) reviewed for abuse in the sample of 27. Findings include: Current computer generated diagnosis list documents R31 has a diagnosis of Dementia. R31's Nurses Notes dated 8/15/15 AM document R31 alleged a large man (Unidentified) had used an orange gait belt on R31 and had pulled it too tight and hurt R31. R31 then alleged that when this man stood R31 up, the man rubbed himself up against R31 and touched R31's breasts. R31's nurses notes document E1(Administrator) was notified at the time the allegation was made. E1 (Administrator) stated on 8/19/15 at 3:13 PM, E1 was aware of the allegation of abuse made by R31 on 8/15/15. E1 stated the allegation had not been reported to the State Agency and E31 had not started an investigation into the allegation made by R31. E1 stated male staff do occasionally work R31's living area.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written	F 226		

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F 226	Continued From page 2	F 226		

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 follow the facility Abuse Policy for reporting and investigating allegations of physical abuse for one of five residents (R31) reviewed for abuse in the sample of 27.

Findings include:

The Facility Policy titled "Abuse Prevention Program Facility Policy" dated 10/02/14 documents upon learning of a report of potential mistreatment the administrator shall initiate an incident investigation and notify the State Agency Immediately.

Current computer generated diagnosis list documents R31 has a diagnosis of Dementia.

R31's initial Health Care Plan dated 8/11/15 documents R31 is confused.

R31's Nurses Notes dated 8/15/15 at 5:25 AM document R31 alleged a large man (Unidentified) had used an orange gait belt on R31 and had pulled it too tight and hurt R31. R31 then alleged that when this man stood R31 up, the man rubbed himself up against R31 and touched R31's breasts. R31's nurses notes document E1(Administrator) was notified at the time the allegation was made.

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F 226	Continued From page 3 E1 stated on 8/19/15 at 3:13 PM E1 was aware of the allegation of physical abuse made by R31 on 8/15/15. E1 stated E1 had not reported the allegation to the State Agency or initiated an investigation.	F 226		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to revise resident care plans after changes in resident activities for three of 27 residents (R25, R27, and R28) reviewed for care plans in the sample of 27.	F 280		

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F 280	Continued From page 4 Findings Include: The Facility's Resident Care Planning Policy dated 2/23/04 documents that, "Between Interdisciplinary Conferences, each discipline adds activities to the Resident Care Plan when initiated and discontinues activities when completed. 1. R25's Physician's Order Sheet documents a 7/28/15 order for "heel protectors when in bed or recliner, legs elevated." R25's Pressure Area Care Plan dated 7/21/15 documents an intervention for "heel protectors when in bed." On 8/20/15 at 9:28 AM, E4 Assistant Director of Nursing stated that R25's order for "heel protectors in bed or recliner, legs elevated" should be documented on R25's Care Plan. E4 confirmed that the order was not documented on R25's care plan. 2. R27's Physician's Order Sheet documents a 2/13/15 order for "leave shoes off unless working with therapy, wear heel protectors." R27's 6/25/15 Comprehensive Care Plan does not contain this order. On 8/20/15 at 9:28 AM, E4 Assistant Director of Nursing stated that R27's order for "leave shoes off unless working with therapy, wear heel protectors" should be documented on R27's care plan. E4 confirmed that the order was not documented on R27's care plan. 3. R28's Nurse's Note documents that R28's transfer status is being changed from a weight bearing (sit to stand) mechanical lift to a non weight bearing mechanical lift. R27's Care Plan	F 280		

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F 280	Continued From page 5 documents an intervention dated 3/31/15 that documents, "Assist me using the sit to stand (non weight bearing mechanical lift) lift and 2 staff members for transfers. On 8/19/1014 at 11:35 AM, E3 Director of Nursing stated that R28's transfer status as a non weight bearing mechanical lift. E3 stated that R28's transfer status should be documented on R28's care plan. E3 confirmed that R28's care plan does not document the correct transfer status.	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to apply physician ordered pressure relieving devices for two of seven residents (R25 and R27) reviewed for pressure ulcers in the sample of 27. Findings include: 1. R25's Physician Order Report dated 8/1/15 through 8/31/15 documents a diagnosis of a left heel pressure ulcer. The Report also documents	F 314		

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a 7/28/15 order for "heel protectors when in bed or recliner, legs elevated" for a diagnosis of a heel pressure ulcer. R25's skin risk assessment dated 6/24/15 documents that R25 is at risk for pressure ulcers.

On 8/19/15 at 10:40 AM, E10 Certified Nurse's Assistant (CNA) and E 11 CNA transferred R25 into a recliner. R25 was sitting up right in the recliner and R25's feet rested on the foot rest. R25 was wearing nonskid socks. On 8/19/15 at 1:15 PM, R25 was sitting in the recliner, R25's feet were resting on the foot rest. R25 was wearing nonskid socks. At that time, the recliner was in the upright position and not reclined.

On 8/19/15 at 1:40 PM, E 12 Registered Nurse, Resident Care Coordinator confirmed that R25 was not wearing heel protectors and confirmed that R25's legs were not elevated. E 12 stated that R25's heel protectors should be on and that R25's legs should be elevated.

2. R27's Physician Order Report dated 7/19/15 though 8/19/15 documents a 2/13/15 order to "leave shoes off unless working with therapy, wear heel protectors." R27's Physician Order Report documents that R27 has a pressure ulcer to the left foot. R27's pressure ulcer assessment dated 7/21/15 documents that R27 is at risk for pressure ulcers.

On 8/19/15 at 1:40 PM, R27 was sitting in a recliner. R27 was wearing a shoe on the right foot.

On 8/19/15 at 2:00 PM, E 13 Registered Nurse confirmed that R27 was wearing a shoe on the right foot. R27 stated that R27's shoe was not

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F 314	Continued From page 7 suppose to be on and that R27 was suppose to be wearing a heel protector to prevent her right heel from breaking down.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain R19's indwelling urinary catheter drainage bag below the level of the bladder, to prevent back flow of urine, for one resident (R19) of seven residents reviewed for indwelling urinary catheters in the sample of 27. Findings include: The facility's Urinary Catheter Insertion and Removal Policy, dated, 8/19/14, documents "Drainage bags are always kept below the level of the bladder and off the floor." The facility's Nursing Policy and Procedure Lifting and Transferring Residents, dated 12/15/08, documents, "During the move, consider where and when equipment, such as catheter, or oxygen tubing, will be transferred, comply with	F 315		

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F 315	Continued From page 8 method of lifting and transferring as indicated in Resident Care Plan." R19's POS (Physician's Order Sheet) dated 8-1-15 to 8-19-15 documents an order for an indwelling urinary catheter 14 French/10 milliliters. R19's Indwelling urinary catheter plan of care dated, 5-21-15, documents, "Position (urinary catheter bag) below level of bladder." On 8-18-15 at 9:45 a.m., E5 (CNA/Certified Nursing Assistant) and E6 CNA transferred R19 from R19's wheelchair to R19's bed with a mechanical lift. During the transfer, E5 held R19's indwelling catheter drainage bag at E5's waist level, above R19's bladder, with pale yellow urine backflowing through the indwelling urinary catheter tubing towards the bladder. On 8-18-15-15 at 10:25 a.m., E5 stated, "(R19's) urinary catheter bag is suppose to be held below (R19's) bladder at all times." On 8-18-15 at 11:01 a.m., E4 (ADON/Assistant Director of Nursing) stated, "(I) would expect during a transfer with a urinary catheter that the urinary bag would not be held above the level of the bladder and below the level of the bladder at all times."	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		

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prevent accidents.

This REQUIREMENT is not met as evidenced by:
Surveyor: Stell, Tonya

Based on observation, interview, and record review the facility failed to implement fall related interventions which resulted in subsequent falls for one of seven residents (R15) reviewed for falls in the sample of 27.

Findings include:

The facility's Program For Reduction of Falls Risk Policy, dated, 8/24/12, documents "If the resident is found to be at risk, the individual who has completed the assessment will initiate a care plan for prevention of falls...the appropriate fall prevention interventions will be selected on the basis of the individualized needs of the resident...All resident Care Coordinators, Director of Nursing and/ or Assistant Director of Nursing, Coordinator will meet to evaluate all residents who have fallen two times or more in a 30 day period...this meeting will be held to discuss circumstances of the falls and individualized interventions."

A Minimum Data Set dated 1/20/15, documents R15 scored four out of fifteen on the Brief Interview for Mental Status, indicating severe impaired cognitive skills.
A Fall Log dated 3/2015 through 8/2015, documents R15 fell on 3/5/15, 4/8/15, 5/19/15,

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F 323	Continued From page 10 5/22/15, 6/25/15, 6/26/15, 6/30/15, 7/5/15, 7/11/15, and 7/17/15. R15's Post Fall Evaluation dated 3/6/15 (resident sent to emergency room and admitted with facial fractures), documents, Immediate actions to prevent future falls as, "remind resident to ask for help." R15's Post Fall Evaluation dated 4/9/15, documents, Immediate actions to prevent falls as, "continue with current intervention." R15's Fall Interventions Care Plan reviewed 5/23/15 documents, New Interventions as, "re-directed resident to ask for assistant in ambulating." R15's Post Fall Evaluation dated, 6/28/15 (Fall on 6/25/15), documents, New Interventions as, " re-educate resident to use call light for assist." R15's Post Fall Evaluation dated, 6/28/15 (Fall on 6/26/15), documents, "New Interventions, "continue with current interventions." R15's Post Fall Evaluation dated, 7/1/15 documents, New Interventions as "re-educate resident and staff." R15's Post Fall Evaluation dated, 7/15/15 documents, New Interventions as "re-education for resident." R15's Post Fall Evaluation dated, 7/21/15 documents, New Interventions as "continue with current interventions." On 8/19/15 at 11:29 a.m., E3 (DON/Director of Nursing) verified R15 had impaired cognitive skills and a fall intervention of "educating resident" or "continue with current interventions" is not appropriate for R15.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record

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review, the facility failed to prevent cross contamination during incontinence care for one of one resident (R23) reviewed for isolation precautions in the sample of 27.

Findings include:

An Incontinence/Perineal Care policy dated 10/16/14, documents ...Remove soiled gloves, wash hands, and don clean gloves.

A Care Plan for R23 dated 7/21/15 documents that resident is to be in contact isolation for colonization of MRSA, Methicillin Resistant Staph Aureus, and VRE, Vancomycin-resistant Enterocci.

On 8/18/15 at 1:00p.m., E8 Certified Nurse Aide, (CNA) and E9 (CNA) provided incontinence and pericare to R23. After completion of pericare and incontinence care for R23 for an incontinent bowel movement, E8 removed soiled gloves and did not wash her hands. E8, then reached under protective isolation gown, into her uniform pocket for clean gloves and applied these to continue incontinent care. E8 then continued to perform incontinence care and the removal of soiled linens. E8 removed soiled gloves again, did not wash hands, and again reached into her uniform pocket for clean gloves to continue care. Upon completion of incontinence care, E9 removed soiled gloves, washed hands, then reached under protective isolation gown, into her uniform pocket for clean gloves.

On 8/18/15 at 1:25p.m., E8 (CNA) stated she has been instructed when providing incontinence care, to change soiled gloves and wash hands

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prior to donning clean gloves. E8 acknowledged that she did not wash her hands between glove changes. E8 further stated she was unaware she could not reach under a protective isolation gown to retrieve gloves out of her uniform pocket.

On 8/18/15 at 1:30p.m., E9 (CNA), stated ..she was unaware that she was not to reach under isolation gown to get clean gloves out of her uniform pocket.

On 8/20/15 at 9:45a.m., when asked regarding facility policy for hand washing during incontinent/ pericare, E3, Director of Nursing stated... staff are to wash hands prior to donning gloves, change soiled gloves, wash their hands again prior to applying clean gloves, to complete care. Then remove gloves and wash hands upon completion of task. E3 further stated it is not acceptable practice for staff to reach under a protective isolation gown, to retrieve items from their uniform pockets.