Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003685	A. BUILDING: ____ B. WING ____	C 02/26/2019

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) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of 2/20/19/IL109678 investigation	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a	S9999	**Attachment A** **Statement of Licensure Violations**	

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comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable

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 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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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.

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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 Regulations were not met as evidence by:

Based on interview and record review the facility failed to ensure supervision was provided as was instructed on the fall prevention care plan for one of three residents (R1) reviewed for falls in a sample of three. This failure resulted in R1 falling, while not being supervised, and sustaining a Subdural Hematoma and a potential Intraparenchymal Hemorrhage, requiring hospitalization.

Findings include:

A Program for Reduction of Falls Risk policy dated 7/23/15 states, " If a 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."

R1's Initial/Admission Fall Risk Assessment dated 2/5/19 documents that R1 has the fall risk factors of: disoriented to person, place, and situation, is incontinent, has a psychiatric or cognitive condition causing delirium, decline in cognitive skills, Manic Depression, Alzheimer's Disease, or other Dementia. This same assessment concludes that R1's risk factors put R1 at high risk for falls.

R1's Minimum Data Set (MDS) assessment dated 2/5/19 documents that R1 is hearing and

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vision impaired without hearing aids or glasses, is severely cognitively impaired with inattention, disorganized thinking, and requires extensive assistance of two people for transfers, walking in the corridor, and toileting. This same MDS documents that R1 is not steady and only able to stabilize herself with staff assistance while walking, moving from a seated to a standing position, turning around, and for surface-to-surface transfers, This MDS further documents that R1 has diagnoses which includes non-Alzheimer's dementia.

R1's fall investigations dated 2/7/19 to 2/20/19 document that R1 had nine falls during that time period. R1's fall investigation dated 2/17/19 documents that R1 fell from a recliner while seated in the common area and also while exhibiting the symptoms of agitation, anxiety, restlessness and resistiveness. This same fall investigation documents that after R1's fall the facility took the immediate action of providing 1:1 supervision to prevent future falls. R1's care plan intervention dated 2/17/19 also documents that the intervention of 1:1 supervision was initiated on that date. R1's fall investigation dated 2/20/19 and signed by V4 (Unit Coordinator) documents that R1 had an unwitnessed fall in the common area at 6:00a.m. on that date. This same investigation documents that when R1 was found on the floor, R1 had a, "Large golf ball (sized) bump noted on right side of temple. Area was open and bleeding. (R1) was unable to form sentences that made sense and pupils were uneven."

R1's nurse's notes dated 2/20/19 at 6:01a.m. documents that on that date, "This nurse was alerted by CNA (Certified Nurse Aide) that (R1) had gotten up from the recliner at nurses station

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and had fallen on the floor."

R1's hospital History and Physical physician's progress note dated as dictated 2/21/19 states, "(R1) has had nine falls in the last week or so. (R1) presented to the ER (emergency room) after a fall yesterday morning, on February 20. She fell while walking in the hall. Unclear as to how she fell but it appears to be a mechanical fall. When she did fall, she fell forward and suffered a right parietal scalp laceration and bleeding. After the fall, she was somewhat difficult to arouse. She was taken to the emergency room at that time. CT (Computed Tomography) scan done in the emergency room showed a Subdural hemorrhage, 7mm(millimeters) in size, with some mass effect as well. There was also high density foci noted within the right frontal lobe which could be consistent with a potential Intraparenchymal hemorrhage as well. Since her fall, (R1) has been extremely lethargic and unarousable." This same progress note documents that R1 was referred to hospice care for comfort measures.

On 2/26/19 at 11:25a.m. V4 verified that R1's fall prevention intervention implemented following R1's fall on 2/17/19 was 1:1 supervision. V4 also verified that R1 was not receiving 1:1 supervision resulting in an unwitnessed fall on 2/20/19.

(A)