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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 Complaint #1924135/IL112860	S 000		
S9999	Final Observations Statement of Licensure Violations. 300.510 c) 300.510 e) 300.610 a) 300.650 f) 2) 300.695 b) 3) 300.695 c) 5) 300.695 d) 300.840 300.1040 b) 1) 2) 3) 4) 300.1040 c) 300.1040 d) 300.3240 a) 300.3240 c 300.3240 d 300.3240 e) Section 300.510 Administrator c) The administrator shall arrange for facility supervisory personnel to annually attend appropriate educational programs on supervision, nutrition, and other pertinent subjects. e) The licensee and the administrator shall be familiar with this Part. They shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities. Section 300.610 Resident Care Policies	S9999	Attachment A Statement of Licensure Violations	

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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 300.650 Personnel Policies

f) Orientation and In-Service Training

2) All employees, except student interns shall attend in-service training programs pertaining to their assigned duties at least annually. These in-service training programs shall include the facility's policies, skill training and ongoing education to enable all personnel to perform their duties effectively. The in-service training sessions regarding personal care, nursing and restorative services shall include information on the prevention and treatment of decubitus ulcers. In-service training concerning dietary services shall include information on the effects of diet in treatment of various diseases or medical conditions and the importance of laboratory test results in determining therapeutic diets. Written records of program content for each session and of personnel attending each session shall be kept.

Section 300.695 Contacting Local Law Enforcement

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b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations:

3) Sexual abuse of a resident by a staff member, another resident, or a visitor;

c) The facility shall develop and implement a policy concerning local law enforcement notification, including:

5) Facility investigation of the situation.

d) Facility staff shall be trained in implementing the policy developed pursuant to subsection (c).

Section 300.840 Personnel Policies

The personnel policies required in Section 300.650, Section 300.651, and other personnel policies established by the facility, shall be followed in the operation of the facility.

Section 300.1040 Care and Treatment of Sexual Assault Survivors

b) The facility shall adhere to the following protocol for the care and treatment of residents who are suspected of having been sexually assaulted in a long term care facility or elsewhere (Section 3-808 of the Act):

1) Notify local law enforcement pursuant to the requirements of Section 300.695;

2) Call an ambulance provider if medical care is needed;

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3) Move the survivor, as quickly as reasonably possible, to a closed environment to ensure privacy while waiting for emergency or law enforcement personnel to arrive. The facility shall ensure the welfare and privacy of the survivor, including the use of incident code to avoid embarrassment; and

4) Offer to call a friend or family member and a sexual assault crisis advocate, when available, to accompany the survivor.

c) The facility shall take all reasonable steps to preserve evidence of the alleged sexual assault, and not to launder or dispose of the resident's clothing or bed linens until local law enforcement can determine whether they have evidentiary value, including encouraging the survivor not to change clothes or bathe, if he or she has not done so since the sexual assault.

d) The facility shall notify the Department and draft a descriptive summary of the alleged sexual assault pursuant to the requirements of Section 300.690.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act)

d) A facility administrator, employee, or

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agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

These regulations are not met as evidenced by:

Based on observation, record review, and interview the facility failed to protect a resident (R1) from being sexually abused by a staff member (V5/Chaplain) for one of four abuse allegations reviewed. This failure resulted in R1 suffering ineffective coping and emotional distress following the sexual abuse.

Based on observation, interview, and record review the facility failed to implement their abuse policy and remove an alleged perpetrator (V5/Chaplain) from direct contact with residents after an allegation of abuse was made, failed to identify a pattern of allegations involving the alleged perpetrator (V5), failed to interview other residents that had contact with the alleged perpetrator (V5), failed to evaluate/assess the residents for safety following the abuse allegations, and failed to prevent further abuse from occurring for one of four residents (R1) reviewed for sexual abuse allegations in the sample of seven. These failures resulted in V5 having continued access to all residents in the

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facility following several allegations of abuse, resulting in V5 sexually assaulting R1 on 5-31-19, causing R1 ineffective coping and emotional distress.

Findings include:

1. On 6-10-19 at 11:05 AM, R1 was sitting in a chair in her room. R1 knew the day of the week, her name, and that she resided in a nursing facility. R1 stated with tears in her eyes, "Last week (V5/Chaplain) came into my room to ask me questions. When I stood up, (V5) grabbed my left breast under my shirt and shook it. I am very upset about it. (V5) touched my breast for about two minutes and then left the room." During this time, R1 raised her shirt and shook her own left breast, demonstrating what V5 had done to her.

R1's Clinical Record includes a Spiritual Care Assessment that was done on 5-31-19 and signed by V5 as the staff member that completed the assessment.

V2's (Director Of Nursing) written statement dated 6-6-19, documents, "(I) went with (V4/Police Detective) to speak with (R1). (V4) asked (R1) what had happened. (R1) was tearful. (R1) stated they (R1 and V5) stood up and (V5) lifted (R1's) shirt and grabbed (R1's) breast for about two minutes. (R1) reported that (V5) was the person that did it." (V5) was suspended." V2's Abuse investigation regarding R1's allegation does not include other resident or employee interviews to determine if any other residents experienced or witnessed abuse in regards to V5 or any other staff member.

R1's Progress Note/Assessment dated 6-6-19

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and signed by V6 (Nurse Practitioner) documents, "(R1) is an 88 year old female who is seen today at the request of staff for concerns expressed to them by another resident indicating that (R1) had an encounter last week that (R1) described as being a sexual assault in nature. When asked about the encounter, (R1) drops her head into her hands and begins crying. (R1) states she was in her room with the individual (V5). (R1) stood up and when (R1) was standing, (V5) reached under (R1's) shirt touching (R1's) left breast for what (R1) described at that time as being for two minutes. (R1) then shoved (V5) away. (R1) does have a history of Dementia and a recent BIMS (Brief Interview of Mental Status) was reviewed. (R1's) description in all accounts remained the same and (R1's) obvious distress illustrated by tearfulness and comments that (R1) would never forget the incident were noted. (R1) states that she had never had an encounter with a male in the past. Primary diagnosis for visit: Suspected Elder Abuse. New orders to consult with (outside facility) behavioral health for assistance with coping due to ineffective coping."

On 6-10-19 at 10:05 AM V4 (Police Detective) stated, "I was informed on Thursday (6-6-19) that (R1) had made an allegation of sexual abuse against (V5/Chaplain). I went to the facility that day to do my investigation. I was informed on Thursday (6-6-19) that (R1) had made an allegation of sexual abuse against (V5/Chaplain). I am pretty confident that abuse occurred because (R1's) statements were consistent. (R1) was pretty shaken up and crying when talking to me. (R1) also lifted her shirt and demonstrated (V5) grabbing her breast. I am turning over my report to the State's Attorney. The facility has not contacted me in the past about any other allegations of sexual abuse regarding (V5)."

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On 6-10-19 at 1:40 PM V6 (Nurse Practitioner) stated, "When I met with (R1) on Thursday (6-6-19), (R1) burst into tears and said a preacher came into (R1's) room. (R1) informed me that (V5) had lifted up her shirt and rubbed her breast. The abuse officer and V2 met with her with me also. R1 was consistent. I believe that what (R1) reported to me was factual and the allegation had occurred. No prior history of her making allegations. I have been coming to the facility since October, 2018 and my nurse had heard of something like this occurring before with V5, but I am not exactly sure what that was. I referred (R1) to a licensed clinical worker because (R1) had a diagnosis of ineffective coping due to the amount of distress (R1) was exhibiting."

On 6-11-19 at 12:30 PM V17 (R1's Power of Attorney) stated, "(R1) reported to me that the preacher (V5) felt her up and raised her blouse and felt her breast. (R1) is of sound mind to know if someone would do this to (R1). (R1) has a good mind and would not make it up that (V5) pulled up her blouse and felt her breast. (R1) would have known who did that to her. (R1) was crying when she told me. I hated it that (R1) needed to stay at the facility. (R1) has been very upset over this. I have been told that (V5) no longer works at the facility, so I am glad about that. I lived with (R1) for 55 years and (R1) had never made up any accusations against anyone else. (R1) was admitted to the facility because she could no longer drive due to her atrial fibrillation."

On 6-12-19 at 10:15 AM, V2 (Director Of Nursing) stated, "(V1/Administrator) assigned me as the primary staff member to do the investigation into

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(R1's) allegation of abuse that occurred from (V5). After investigating this allegation, I am substantiating this allegations as probable sexual abuse. I did not interview any other residents during this investigation to determine if they had experienced or witnessed abuse of any type. I only interviewed the staff/residents that reported the alleged abuse of (R1)."

2. On 6-12-19 at 2:35, PM V2 (Director of Nursing) stated that allegations of sexual abuse have been made against V5 from three other residents (R5, R6, R7) and that V2 and V1 (Administrator) did not identify a pattern of sexual allegations made against V5 until after R1 had already been sexually abused.

On 6-11-19 at 10:15 AM V15 (Social Service Director) stated, "Sometime last summer (2018), (R5) had reported that a guy came in her room with a mask on (like one for an isolation room) that sounded and looked like (V5/Chaplain). (R5) reported that (V5) was grabbing her breasts. I know (V1/Administrator) and (V2/Director of Nursing) were made aware of the situation. (V5) had drove the van for the youth volunteers at night late the week that (R5) had made the allegation. (V5) had came back after midnight the night he drove the volunteers which I thought was very suspicious."

On 6-11-19 at 12:00 PM V16 (LPN/Licensed Practical Nurse) stated, "Sometime around August 2nd or 3rd, 2018 (R5) was very uncomfortable and upset and told me that (V5) came into her room at night and something happened. (R5) would not tell me what happened because she did not want to get (V5) in trouble and said she did not want me to look at (V5) any different. I immediately reported (R5) feeling

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uncomfortable to (V2) and (V1). I was scared to leave (R5) alone because she lived on the sheltered care unit where there are no staff unless one of the resident's use their call light. (V5) enters and exits the door of the sheltered care unit to get to his office. I also knew that (V5) had driven a bus one of the nights of the same week (R5) had stated (V5) had came into her room. (V5) did not get back from that bus trip until the middle of night."

On 6-11-19 at 11:20 AM V1 (Administrator) stated, "(R5) kept telling me (unsure of the date) that (V5) came into her room and sat on her bed and attempted to kiss her. She kept saying I hope it is just a dream. I did not do an abuse investigation or report the allegation to the police or state agency. I know (V5) drove a group of volunteers in our van and am not sure of when they returned. I know now that I should have reported and investigated this allegation. (V5) was not suspended pending investigation after this allegation, no investigation was completed and no report was sent to the state agency. There is no documentation about (R5's) allegation. (R5) is expired now."

On 6-11-19 at 10:45 AM V2 (Director Of Nursing) stated, "(R5) reported a masked man had touched her breasts and the voice sounded familiar. We looked into it. This was late at night. We did not do an abuse investigation at that time. (R5) reported this sometime last summer. Was not on isolation. (R5) knew it was (V5) by the voice. (V5) was the Chaplain and had access to all residents that reside in the nursing facility, sheltered care facility, and the assisted living facility. (V5) was not suspended pending investigation. (R5's) allegations are not documented in (R5's) record."

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R5's Medical Record and the facility's abuse investigation records do not include any documentation of the allegation of sexual abuse R5 had made against V5, or an evaluation of R5's condition to determine the most suitable therapy, care approaches, and placement, considering placement, considering his or her safety, as well as the safety of other residents and employees of the facility (as stated in the facility's abuse policy).

R5's Transfer Form dated 7-7-19 documents R5 was alert, orientated, and follows instructions. R5's Progress Notes documents R5 passed away while in skilled care at the facility on 2-18-19.

3. Additional allegation on typed statement written by V22/LPN (Licensed Practical Nurse) dated 11-10-16 documents that R6 (residing in Sheltered Care at that time) reported that on 11-9-16 V5 had touched her shoulder and neck and started touching her breasts above her bra.

R6's Final Abuse Investigation dated 11-11-16 and signed by V2 documents R6's allegation was unsubstantiated based on V5 stating that he had only met with R6 in the hallway on 11-9-19 and not in R6's room. V2's abuse investigations regarding R6 does not include other resident or employee interviews to determine if any other residents experienced or witnessed abuse in regards to V5 and do not include interviews to determine if staff witnessed V5 with R6 during the time of the allegation. This investigation only includes interviews from staff that R6 had reported the allegation to and V5.

4. Additional allegation documented in R7's progress note dated 11-3-13 documents R7 reported that V5 raped her.

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V2's Final Abuse Investigation documents R7's allegations of abuse was unsubstantiated due to allegation having no supporting evidence. V2's abuse investigations regarding R7 does not include other resident or employee interviews to determine if any other residents experienced or witnessed abuse in regards to V5 and do not include interviews to determine if staff witnessed V5 with R7 during the time of the allegation. This investigation only includes interviews from staff that R7 reported the allegation to and V5.

On 6-12-19 at 2:35 PM, V2 stated that she and the Administrator did not identify a pattern of allegations made against V5 until this last (fourth) allegation was made regarding R1. V2 also stated, "I think we (facility staff) trusted him (V5) too much."

The facility's Abuse Prevention Program Policy dated 3-25-13 documents, "The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect, or abuse of our residents. This facility is committed to protecting our residents from abuse by anyone including facility staff. The facility will take steps to prevent mistreatment while the investigation is underway. Residents who allegedly mistreated another resident will be removed from contact with that resident during the course of the investigation. The resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering placement, considering his or her safety, as well as the safety of other residents and employees of the facility. Employees of this facility who have been accused of mistreatment will be removed from resident contact immediately until the results

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of the investigation have been reviewed by the Administrator. Once notified, the Administrator will begin an investigation or appoint a person to take charge of the investigation. The investigator will follow the Resident Protection Investigation Procedures that contain specific investigation paths depending on the nature of the allegation, and procedures for investigation, interview parameters, and reporting requirement. Upon receipt of an allegation, the Administrator will notify the following agencies immediately: Illinois Department of Public Health (IDPH) and the Elder Services Office/Local Police Department. Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation will be sent to IDPH."

The facility's Resident Protection Investigation Procedure dated 10-16-14 documents, "Investigation Procedures include interviews with the residents, interviews with staff members having direct contact with the resident and accused individual, interviews with the resident's roommate, family members, visitors or others within the vicinity of the incident, interviews with other residents that have regular contact with the accused, and interviews with other employees that have regular contact with the accused. Obtain written interviews for all statements."

V5's Director of Pastoral Services Job Description Dated 2-22-18 and signed by V5 on 2-27-18 documents, "The primary purpose of your job position is to provide pastoral care, religious support and services to residents, family members, and employees. Working Conditions: Works throughout the facility. Moves intermittently during working hours. Works beyond normal working hours and on weekends

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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) COMPLETE DATE
S9999	Continued From page 13 and holidays, when necessary." The facility's Centers for Medicare and Medicaid Services Form 802 Matrix for Providers dated 6-10-19 and signed by V2 (Director of Nursing) documents 148 residents reside in the facility. V5's Employee Counseling Record dated 6-7-19 documents, "You (V5) have the option of resigning or being terminated effective immediately based on the fact the investigation of the allegation is being referred to the State Attorney's Office to review for possible charges and that Illinois Department of Public Health will be conducting an investigation." This same record documents V5 signed to resign immediately on 6-7-19. V5's Employee Separation Report dated 6-7-19 documents V5 was hired on 6-28-10 and was terminated from employment on 6-7-19. 5. The Administrator/Chief Executive Officer's Job Description dated 12-12-18 documents, "The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with all current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality care is provided to residents at all times. Administrative Functions: Assist staff in maintaining the residents right to quality of life and care. Staff Development: Meet with department directors on a regularly scheduled basis, and conduct/participate in in-service classes and supervisory level training programs. Attend and participate in workshops, seminars, etc., to keep abreast of current changes in the long-term care field, as well as maintain professional status."	S9999		

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 06/20/2019

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S9999	Continued From page 14	S9999		

The facility's Abuse Prevention Program Facility policy dated 3-25-13 documents, "On a periodic basis, staff will receive training on their obligation under law when receiving an allegation of abuse, neglect, or theft, and how to monitor and correct inappropriate or insensitive staff actions word, or body language. On a periodic basis, staff will receive a review on staff obligations to prevent and report abuse, neglect and theft without fear of reprisal."

The facility's Annual In-service List documents Resident Rights/Elder Abuse in-servicing should be done yearly.

The Yearly Resident Rights/Elder Abuse Mandatory Whole House In-service Log presented by V1 and V15 (Social Service Director) dated 7-25-18, documents V5 did not attend the annual mandatory abuse training on this date. The facility's in-service logs indicate V5 had not received abuse training since 11-15-17.

On 6-11-19 at 11:20 AM V1 (Administrator) stated that V1 had received an allegation sometime last summer, 2018 that V5 went into R5's room, sat on R5's bed, and attempted to kiss R5. V1 stated that himself nor the facility did an investigation into R5's abuse allegation and did not report R5's allegation to the police or state agency. V1 also stated that "V5 was not suspended pending investigation after this allegation was made."

On 6-13-19 at 10:45 AM V1 (Administrator) stated, "I am the Abuse Coordinator. I have never been trained on abuse since I have been here in 30 years. I am responsible to obtain my own abuse training. I do not have a job description for Abuse Coordinator."

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 06/20/2019

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S9999	Continued From page 15 On 6-13-19 at 12:50 PM V1 stated, "It is mandatory that all employees are to attend the annual abuse training in-services. (V2/Director of Nursing) informed me today that (V5) did not attend the mandatory abuse in-service that I presented on 7-25-18. I did not identify a pattern of abuse allegations that had been made against (V5) over time)from R1, R5, R6, and R7)." On 6-13-19 at 1:30 PM, V5 (Chaplain) stated, "I was never told that I can recall that supervisors (including self) had to attend yearly in-services on abuse." (A)	S9999		