STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005573	A. BUILDING: _____ B. WING _____	06/04/2021

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GOOD SAMARITAN - PONTIAC	1225 SOUTH EWING DRIVE PONTIAC, IL 61764

(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 Annual Licensure Certification Survey Complaint #2163746/IL134417	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.610 c)4)a) 300.1210b) 300.1210d)6) 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 300.610 Resident Care Policies c)The written policies shall include, at a minimum the following provisions: 4) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs. 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 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. Section 300.1210 General Requirements for Nursing and Personal Care 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. These regulations were not met as evidenced by:	S9999		

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S9999	Continued From page 2 A. Based on record review and interview, the facility failed to apply foot pedals to a wheelchair, to provide a safe transport of a resident (R25) when leaving the facility in the facility van. This failure resulted in R25 sustaining a right distal femur and patella fracture, which required emergency treatment, overnight hospitalization and a leg cast. R25 is one of four residents reviewed for accidents/falls on the sample list of 35. B. Based on observation, interview and record review the facility failed to provide supervision to prevent a resident from wandering, impacting six of eight residents (R30, R38, R24, R29, R50 and R13) reviewed for resident to resident altercations on the sample list of 35 residents. Findings include: A. R25's Local Hospital Discharge Summary dated 12/12/20 documents R25 was being discharged to this skilled care facility after an episode of hyperglycemia that resulted in a fall at home which caused R25 an Iliac Wing (Pelvic) fracture. R25's Face Sheet confirms R25 was admitted to the facility on 12/12/20. R25's Minimum Data Set (MDS) to dated 2/8/21 (prior to incident of 3/30/21) documents R25's BIMS score as 14/15 (no cognitive impairment), uses a wheelchair for mobility, does not ambulate, and required physical staff assistance of one person for transfers. On 6/3/21 at 1:25 pm R25 was laying in bed. R25	S9999		

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stated " I (R25) suffered a fracture to my (R25) right leg from being pushed by (V5, Transportation Assistant) in her wheel chair." R25 pulls back the blankets on her bed to show R25's right leg. R25 had a full length, thigh high immobilizer brace on R25 right leg. R25 stated "I did not have foot peddles on my wheelchair at the time. The transportation person (V5) was pushing my wheel chair without the foot pedals on. My (R25) foot went under the wheelchair. I (R25) have to wear this brace now. My doctor says it will likely not heal completely, as I am getting a little older. I likely will never be able to walk again. I had a cast on (right leg) initially. This happened about two months ago, I don't know the actual date."

R25's "Health Status (Nursing) Note" dated 3/30/21 at 9:00 am documents R25 went out of the facility for a follow-up appointment with the dentist (unidentified).

R25's "Health Status (Nursing) Note" dated 3/30/21 at 11:13 am documents R25 returned from the dentist appointment.

The facility incident investigation includes a signed statement dated 3/31/21, signed by V5, Transportation Department Assistant documents the following: "I (V5, Transportation Department Assistant) transported (R25) to her (R25) Dentist appointment, (V6, Dentist), (local address and phone number) on March 30, 2020 at 9:00 am. As we (V5 and R25) were going into her (R25's) appointment, (R25) dropped her (R25's) foot, stopped holding her (R25's) legs up. Which stopped the wheelchair from it's forward motion, up the handicapped (wheelchair accessible) ramp. (R25) has never used foot rest in the year that I (V5, Transportation Department Assistant) I

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have been doing Transportation at (the facility name). (R25) said her leg hurt and was pointing just below her (R25) knee. She (R25) asked the receptionist (unidentified at the dentist office) for Tylenol (pain medication). I (V5, Transportation Department Assistant) said no (to R25), she (unidentified receptionist) cannot give you (R25) anything (resident first name used). Then (R25) asked and received an (elastic) bandage. I (V5, Transportation Department Assistant) left to go do another transport. Upon my (V5, Transportation Department Assistant) return to (facility name), I (V5, Transportation Department Assistant) informed Nurse (V7, Registered Nurse) of what happened and got footrest from (R25's) room. When I (V5, Transportation Department Assistant) returned to pick (R25) up at her appointment, she (R25) was in the waiting room (at the dentist office). When we (R25 and V5, Transportation Department Assistant) got back to (facility name), stopped at the nurses desk, as I (V5, Transportation Department Assistant) always do upon returning from appointments. (R25) asked (V7, Registered Nurse) for some Tylenol."

The facility investigation report, had an undated, handwritten witness statement by (V8, Certified Nursing Assistant/CNA) that documents the following: "Transport (V5, Transportation Department Assistant) took resident (R25) to (R25's) room. (R25) complained of pain in knee. Reported to nurse (V9, Licensed Practical Nurse/ LPN). (V9, LPN) told CNA (V8,CNA) to put a warm blanket on (R25's) knee. At 6:00 pm, (R25) could not bear weight, had to use (mechanical stand lift) for transfer.

R25's "Health Status (Nursing) Note" dated 3/31/21 at 05:39 am, documents the following: "Resident (R25) complained of right knee pain 10

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out of 10 (on a scale of one to ten, ten being the worst pain). Unable to bear weight on right leg. Bruising noted on knee. (V10, Nurse Practitioner) notified, awaiting orders (physician)."

R25's "Health Status (Nursing) Note" dated 3/31/21 at 09:10 am, documents the following: "X-ray ordered of right knee including distal and lateral femur AP, two views, each scheduled through (private X-ray service) for today."

R25's "Health Status (Nursing) Note" dated 3/31/21 at 1:02 pm, documents the following: "(private X-ray service) here to do X-ray."

R25's "Health Status Note" nurses note dated 3/31/21 at 1:35 pm documents the following" (V10, Nurse Practitioner) here (in facility) reviewed X-Ray results, new order to transfer to (local hospital) due to distal fracture of right femur."

R25's "ED (Emergency Department) to Hospital Admission/ Discharge Summary" Physician Progress Note dated 3/31/21-4/1/21 signed by (V11, Physician) documents the following: " Hospital course: Shows matter (?), further evaluation management of right distal femur fracture. Pain controlled, on oral antibiotics with minimal IV (intravenous) analgesics (pain medication) required. Orthopedic surgery (unidentified person) was consulted, who ordered additional CT (Commuted Tomography) imaging. Recommended non operative management. Short leg cast placed by Ortho (Orthopedic) with instructions for outpatient follow-up." The same "ED (Emergency Department) to Hospital Admission/ Discharge Summary" documents the following Right Femur X-Ray results 3/31/21: "There is a displaced and

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impacted fracture through the distal femoral metaphysis (end plate of the bone). This is likely comminuted (multiple fragments) There is approximately once centimeter posterior displacement of the distal fragment. No fracture of proximal to mid femur. Stable arthritic changes in the right hip. Diffuse vascular calcifications. Moderate to severe osteoarthritis in the knee." The same "ED (Emergency Department) to Hospital Admission/ Discharge Summary" report documents: "Impression: Acute, impacted, commuted and displaced through the distal metaphysis (end plate of the bone)." The same "ED (Emergency Department) to Hospital Admission/ Discharge Summary" documents the following results of a CT of R25's Right knee results dated 4/1/21 findings: "Twisting injury comparison to Radiograph (X-Ray) 3/31/21. The same CT documents "Injury on wheelchair. Impression: 1. Acute comminuted displaced transverse fracture of the distal femoral diaphysis as described. No intercondylar extension. 2. Acute nondisplaced vertically oriented fracture of the mid- patella (knee cap triangular bone)."

V5, Transportation Department Assistant's " Verbal Discipline Report dated 4/2/21 documents the following: " Please back patients on/off the platform for the lift in the van (facility transportation vehicle). Always use foot pedals on wheelchair for transports."

On 6/3/21 at 3:27 pm V2, Director of Nursing stated "(R25) was taken by our previous transportation staff, (V5, Transportation Department Assistant), to a dentist appointment. (V5, Transportation Department Assistant) had not put wheelchair pedals on (R25's) wheelchair before leaving. (R25) should have had foot pedals on her wheelchair before being taken out

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of the facility. Our expectations for safely transporting residents in a wheelchair, requires staff to put wheelchair foot pedals on when taken residents out." V2 confirmed "(R25's) right leg fracture could have been prevented had the facility protocol been followed."

On 6/4/21 at 9:30 am V2, DON and V1, Administrator confirmed R25 was transported without wheelchair pedals on R25's wheel chair which resulted in R25's fractures (right knee and femur. V2, DON also stated "(V5, Transportation Department Assistant) was not following safe transfer procedure when taking R25 out of the facility which caused these preventable fractures." V1, Administrator nodded in agreement. V2, DON also stated "(R25) and should have always had her foot pedals on the wheelchair. I do not have a written policy, but all staff have been educated. Moving forward, they (staff) all know residents being pushed in or outside the facility in their wheelchair should have the foot pedals on at all time. "

The Fall policy revised 3/20/18 states "The resident's environment will remain free from accidents and hazards as possible; and each resident will receive adequate supervision and assistance devices to prevent accidents."

B. The Care Plan updated 5/26/21 documents R30 has the potential to be physically, verbally and sexually aggressive with staff and that R30 has the potential to be physically aggressive with other residents related to dementia. The Care Plan also documents R30 has a history of grabbing female staff members inappropriately and that R30 is severely cognitively impaired.

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On 6/3/21 at 10:40 am V17 and V19 Certified Nurses Aides (CNAs) transferred R30 from the toilet to the wheel chair. After being assisted into the wheel chair R30 reached out and touched V17's buttock with R30's hand and then R30 propelled R30's self to the door.

The Nurses Note dated 4/27/21 states "(R30) wandering in wheelchair going into other resident's room."

The Nurses Note dated 5/7/21 states "(R30) went into another resident room inside doorway cussing at another resident. Resident was removed from the room and redirected to lounge area."

The Nurse Note dated 5/17/states "Resident (R30) up since 4:30 (am) wandering in wheelchair into unoccupied rooms, opening outside doors and setting off alarm and yelling "help me" disturbing other residents. Resident wandered up to female resident (R50) sitting in common area numerous times kicking resident's feet and upsetting other resident (R50). (V1 Administrator) contacted regarding kicking. Currently sitting in recliner with attempts to have staff member constantly supervise when not assisting other staff members."

The Nurses Note dated 5/18/21 states "(R30) Awake and up since 3:00 am. Wandering hallway in wheelchair and attempting to enter others' rooms. Cursing at staff and combative when re-directed. Hits staff and spitting on floor."

The Nurses Note dated 5/22/21 states "(R30) wandering in wheelchair into other resident's room, calling staff assholes and saying I'll kick the

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S9999	Continued From page 9 s**t out of you." Told by female resident he had pulled the covers off her feet and was touching her feet. Another female resident states "is he running around? This is ridiculous." The Nurses Note dated 5/23/21 states "(R30) wandered in wheel chair, needing very frequent redirection to not wheel himself near other residents or into other residents' rooms." The Nurses Note dated 5/25/21 states "(R30) wandering in wheelchair from beginning of night shift until put down for bed at 9:00 PM. Resident opening outside doors and setting off alarms, digging in garbage can and kicking it over, going into female resident's room and touching her feet. Resident hit this nurse in the arm as I walked by him, spitting on the floor, touching sterilizer and moving isolation carts around making it difficult for staff to get work done as he was needing constant attention." The Nurses Note dated 5/27/21 states "(R30) wandering hallways in wheelchair since (6:30 PM) and requiring constant supervision. Attempting to go into others' rooms, getting into garbage, moving furniture around in unit living room, calling staff names and making inappropriate sexual comments to staff and attempting to touch staff. Staff walked with resident in hallways, pulling (R30) out of others' rooms." The Nurses Note dated 5/28/21 states "Resident (R30) then placed in (R30's) wheelchair and roamed unit yelling "help me" and attempting to enter others' rooms." The Minimum Data Set (MDS) dated 5/6/21 documents R38 is cognitively intact. On 06/02/21 at 09:43 AM R38 stated two or three weeks ago	S9999		

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while she was sleeping in her recliner R30 came in her room and pulled her blanket and socks off and told her she had big feet. R38 stated she was startled. R38 stated R30 has tried to get into her room at other times and staff have pulled him out.

The MDS dated 3/26/21 documents R24 is cognitively intact. On 06/02/21 at 10:18 AM R24 stated R30 came into her room and she told him to leave but before he left he "tickled" her feet. R24 stated "he gets away from them every now and then."

The MDS dated 4/12/21 documents R29 is moderately cognitively impaired. On 6/3/21 at 9:00 am R29 stated R30 has been in her room three or four times. R29 stated "sometimes (R30) gets away from them." R29 stated R30 roots through her dresser drawers and the basket on her table. R29 stated she does not like it when R30 comes in her room. R29 stated her room "is supposed to be private."

The MDS dated 3/22/21 documents R13 has severe cognitive impairment. On 6/3/21 at 9:20 am R13 stated R30 has been in her room three times. R13 stated "(R30) is getting to be a problem." R13 stated she has complained to the staff two or three times and she is at the point where she just yells at him when she sees him at her door. R13 stated last night R30 tried to come in her room and she yelled at him and he left.

On 6/3/21 at 9:25 am V17 CNA stated If there is a door open (R30) will go in and if staff are with another resident they can't watch him.

On 06/03/21 09:58 AM V19 CNA stated R38 reported to V19 that R30 was in R38's room and

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touched R38's feet. V19 stated R30 used to have a one to one care giver but that ended in March or April 2021. V19 stated V19 does not understand why R30 no longer has a one to one caregiver to supervise him.

On 6/3/21 at 11:00 am V16 Registered Nurse (RN) stated they try to watch R30 but if they have to leave him to care for another resident he zooms off down the hallway.

On 6/3/21 at 12:15 PM V15 RN stated V15 has seen R30 in other residents' rooms and R30 gets angry when they try to redirect him out of other residents' rooms. V15 stated R30 has been in R13's room and other residents (R38 and R24) have also complained to V15 that R30 has pulled blankets off them and played with their feet. V15 stated R30 "has to be watched constantly but staff have other things to do." V15 stated R30 has made sexual comments to staff and has tried to touch V15's buttocks.

On 06/02/21 at 02:36 PM V2 Director of Nurses stated V2 knew R30 was wandering into other resident's rooms but V2 did not know the extent of the problem.

On 06/03/21 at 12:11 PM V1 Administrator stated R30 used to have a one to one caregiver but V1 was told by risk management that that is not a service the facility provides.

On 06/04/21 at 08:38 AM V1 Administrator stated R30's one to one caregiver was discontinued in April (2021). V1 stated V1 believes the reason for the one to one caregiver for R30 was "the way he interacts with the staff and due to his wandering into other residents rooms." V1 stated V1 does not know what

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S9999	Continued From page 12 interventions were put in place to manage R1's behaviors after the one to one caregiver was discontinued. (A)	S9999		