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 ____	11/05/2021

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 Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)3) 300.1210 d)5) 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 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. d) Pursuant to subsection (a), general	S9999	Attachment A Statement of Licensure Violations	

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

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nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to implement interventions to prevent pressure ulcers, maintain pressure relieving equipment, complete and document daily skin checks, and identify pressure ulcers in a timely manner for two of four residents (R80, R111) reviewed for pressure ulcers in the sample of 49. These failures resulted in R80 developing a Stage three pressure ulcer to the right scapula and R111 developing an unstageable pressure ulcer to the right heel.

Findings include:

1. On 11/3/21 at 9:54 AM, a pressure wound was

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observed on R80's right scapula. While the dressing was being changed, R80 complained of pain. The wound was approximately the size of a quarter and was open.

R80's Minimum Data Set assessment, dated 9/28/21, documents R80 requires extensive assistance of two staff for bed mobility. R80 currently has a Stage three pressure ulcer, and did not have any pressure ulcers when admitted.

R80's current Care Plan documents R80 is at increased risk for pressure injuries related to immobility.

R80's Braden Scale, dated 4/6/21, documents R80's mobility is very limited, and R80 is at risk for developing pressure sores.

R80's Physician Progress Notes, dated 7/15/21 at 10:00 AM, written by V6 (Nurse Practitioner) documents, "Staff are working on getting a new air mattress for bed as current one seems to be deflating in certain areas. (R80) reports her back does hurt at times and repositioning helps."

R80's Physician Progress Notes, dated 7/15/21 at 10:00 AM, written by V6 (Nurse Practitioner) documents R80 has an unstageable ulcer to R80's right back/near scapula measuring 2.8 cm (centimeter) x 2.1 cm.

On 11/3/21 at 10:11 AM, V5 (Nursing Progress Coordinator/Wound Nurse) stated "(R80) has a chronic pressure ulcer on (R80's) right scapula. Unfortunately, it (the wound) was acquired here. (R80) had a low air loss mattress and it got unplugged so it was flatter than it should have been. The wound was unstageable when it was discovered because it had eschar covering it.

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When the eschar was removed it was determined to be a Stage three."

On 11/4/21 at 8:30 AM, V3 (Assistant Director of Nursing) stated, "I'm not proud of it, but (R80) acquired it (pressure ulcer) here. I thought that (R80) got the pressure ulcer because the air mattress got unplugged but I think it may have been malfunctioning. We have found it (air mattress) unplugged a few times and had to plug it back in because (R80's) roommate pushes her bed over and unplugs the air mattress for (R80)."

2. On 11/2/21 at 10:00 AM, R111 was sitting in R111's wheelchair with lift boots on. R111 was complaining of pain to R111's right heel. R111 stated, "It feels like daggers are sticking in my foot."

On 11/2/21, V10 (LPN/Licensed Practical Nurse) stated, "(R111) has an open area to his right heel that is from pressure and is unstageable."

On 11/3/21, during wound care, R111 had an open area to R111's right heel slightly larger than quarter size.

R111's MDS/Minimum Data Set Assessment, dated 7/18/21, documents R111 has a BIMS/Brief Interview for Mental Status score of 04 (cognitively impaired), requires extensive assist of two staff with bed mobility and transfers, and has an unstageable pressure ulcer.

R111's Pressure Ulcer care plan, dated 10/21/21, documents R111 is at risk for pressure ulcers related to immobility, incontinence and poor nutrition. On 7/4/21, R111's Pressure Ulcer care plan documented (R111) has an unstageable pressure area to Right heel.

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S9999	Continued From page 4 R111's Progress notes, dated 07/04/2021, documents, "CNA (Certified Nursing Assistant) reported to this nurse (V11/LPN) about right heel with an area present to it. Area has black center cover to it with edges having pink skin surrounding. Size: 4.2 cm (centimeters) x 4.5 cm." R111's Event Report (Weekly Pressure Sore Report), dated 7/4/21 and documented by (V11), documents unstageable black scab that has pulled away from edge of wound to right heel, wound has foul odor, and R111 has weight loss and ill fitting footwear. This same report documents R111's pressure wound measures 4.2 cm. x 4.5 cm. R111's Physician progress notes/written orders, dated 7/6/21 and signed by V6 (Nurse Practitioner), documents Levaquin 250 mg (milligrams) two tabs on day one, and then one tablet every 24 hours on days two through ten, for history of epididymitis and unstageable heel ulcer with odor from dead tissue. On 11/4/21 at 8:45 AM, V2 stated, "Yes the staff should have identified R111's pressure ulcer to his right heel before it was unstageable." V2 also stated, "There is no documentation of daily skin checks for R111 and daily skin checks were obviously not done or they would have found it sooner." The Facility Skin Care Protocol: Prevention and Treatment documents, "The facility will ensure that a resident who enters the facility without pressure injury does not develop pressure injury unless the individual's clinical condition	S9999		

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S9999	Continued From page 5 demonstrates that the pressure injury was unavoidable. The facility will further ensure that a resident having pressure injury receives necessary treatment and services to promote healing, prevent infection, and prevent new injury from developing. Ongoing Assessment Process: The resident's skin will be inspected daily by direct staff and any changes shall be brought immediately to the attention of the charge nurse." The National Pressure Ulcer Advisory Panel's Pressure Injury Prevention Points, dated 4/16, documents, "Inspect the skin at least daily for signs of pressure injury, especially nonblanchable erythema." (B)	S9999		