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 _____	C 04/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - PONTIAC	1225 SOUTH EWING DRIVE PONTIAC, IL 61764

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S 000	Initial Comments Complaint # 2262923/IL145803 Investigation of Facility Reported Incident 4/4/22/IL145871	S 000		
S9999	Final Observations Complaint # 2262923/IL145803 Investigation of Facility Reported Incident 4/4/22/IL145871 Statement of Licensure Violations: 1/2 300.698e) 300.698f) Section 300.698 COVID-19 Vaccination of Facility Staff Emergency e) Each facility shall post conspicuous signage throughout the facility notifying staff that the facility makes available opportunities for staff to be up to date on COVID-19 vaccinations. The signs shall be on 8.5 by 11-inch white paper, with text in Calibri (body) font and 26-point type in black letters. Section 300.698 COVID-19 Vaccination of Facility Staff Emergency f) Each facility shall provide its unvaccinated staff a minimum of 90 minutes of clear and accurate instruction covering vaccine education, effectiveness, benefits, risks, common reactions, hesitancy, and misinformation. Records of training shall be made available to the Department upon request.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 These regulations are not met as evidenced by: Based on observation and interview, the facility did not post signage on white paper with text in Calibri, throughout the facility indicating the facility makes opportunities available for staff to be up to date on the COVID-19 vaccinations, or provide the unvaccinated staff with 90 minutes of education regarding the COVID-19 vaccination. This failure has the potential to affect all 56 residents who reside at the facility. Findings Include: On 4/19/22 from 5:15 am - 3:15 pm, and 4/20/22 from 7:15 am - 3:00 pm there were no signs posted indicating the facility makes opportunities for staff to become up to date on their COVID-19 vaccination. On 4/19/22 between 5:15 am - 3:15 pm, V1 did not provide the requested 90 minutes of education for unvaccinated staff. On 4/20/22 at 9:12 am, V1 Administrator stated V1 was not aware of the new state requirements for the 90 minutes of education for unvaccinated staff or the required mandated signage regarding staff vaccinations. On 4/20/20 at 10:20 am, V26 CNA (Certified Nursing Assistant) confirmed V26 has not received the COVID-19 vaccination due to having a religious exemption. V26 stated the facility encouraged V26 to get it but did not provide a 90 minute education/instruction session regarding getting the vaccination. The facility Resident List Report dated 4/19/22	S9999		

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S9999	Continued From page 2 documents 56 residents reside at the facility. (A) 2/2 300.610a) 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 300.1210 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	S9999		

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S9999	Continued From page 3 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: Based on observation, interview and record review, the facility failed to thoroughly assess a resident's risk for falls, implement appropriate safety interventions to prevent further falls, provide a safe, non-hazardous shower environment, failed to follow the facility policy for bathing, and failed to use an appropriate chair for transporting/moving a resident from one location to another for one of six residents (R2) reviewed for falls on the sample list of six. Theses facility failures resulted in R2 falling out of a shower chair while being relocated, while in the shower chair, to a dry/non-slick environment. This fall resulted in R2 sustaining a closed displaced fracture of the posterior arch of the first and second cervical vertebra, an open fracture of the nasal bone, bilateral closed fractures of the maxilla and a traumatic epidural hematoma. R2 passed away seven days later from a traumatic head injury and fall, as documented on R2's death certificate. Findings Include: R2's April 2022 Physician Orders document the following Diagnoses: Brief Psychotic Disorder, Psychotic Disorder with Hallucinations, Adult Failure to Thrive, Dementia with Behavioral	S9999		

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S9999	Continued From page 4	S9999		

Disturbances, and History of Falls. These orders also document PT (Physical Therapy) and OT (Occupational Therapy) as indicated.

R2's MDS (Minimum Data Set) dated 3/9/22 documents R2 has severe impaired cognition, has physical and verbal behaviors 4-6 days a week, is totally dependent of staff for bathing, and has a history of falls.

R2's Care Plan dated 3/17/22 documents R2 is at risk for falls due to confusion, gait/balance problems, impaired safety awareness and a history of falls. This Care Plan also documents R2 has 'repetitive physical movements."

R2's Progress Notes document the following falls:
2/15/22 - R2 "lunged forward" while sitting in R2's wheelchair and landed on the floor.
2/18/22 - CNA (Certified Nursing Assistant) was propelling R2 in a wheelchair when R2 "lifted (R2's) feet, tucked {the} top half of {R2's} body in a forward motion and fell to floor."
4/4/22 - CNA was wheeling R2 in a shower chair, out of door of shower room into an open area to transfer R2 into a wheel chair when R2 "leaned forward and fell out of shower chair" and hit R2's head on the door frame of the bathroom, landing on the floor on R2's right side. R2 was noted to be bleeding from the bridge of the nose and nostrils.

R2's Hospital History and Physical dated 4/4/22 by V28 Hospital ER (Emergency Room) Physician documents R2 presented to the ER after a fall at the nursing home. R2 was sitting in a shower chair while taking a shower and R2 moved and slipped forward onto R2's face. R2 has a large frontal contusion with a puncture wound laceration to the upper bridge of the nose

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S9999	Continued From page 5	S9999		

with mild bleeding, and superficial abrasions to the left knuckles between the 4th and 5th digit as well as the lateral aspect of the 2nd digit. V28 documents X-rays and a CT (Computerized Tomography) was preformed and revealed the following: closed displaced fracture of the posterior arch of first cervical vertebra, closed nondisplaced fracture of the second cervical vertebra and traumatic epidural hematoma without loss of consciousness, open fracture of the nasal bone, and bilateral closed fracture of the maxilla. R2 was then sent to a Trauma Center due to the extent of R2's injuries.

R2's Hospital Discharge Summary from the Trauma Center dated 4/11/22 by V29 Trauma Center Physician documents, R2 was found deceased on 4/11/22 {7 days after the fall} at 1:26 am after being brought in to be evaluated by the Trauma Team after sustaining a ground level fall at a skilled nursing facility. R2 was found to have bilateral maxillary sinus fractures, nasal bone fractures, C2 odontoid fracture, epidural hematoma of C3, T1, T8, T11 and compression fractures.

R2's Death Certificate 4/18/22 documents R2's cause of death as Traumatic Head Injury and Fall.

On 4/19/22 at 5:30 am, V6 CNA stated V6 was at the nurses station on 4/4/22 when V9 CNA was giving R2 a shower. V6 stated V6 responded to the shower room call light to find R2 "had slid sideways in the shower chair." V6 explained V6 helped V9 readjust R2 in the shower chair and then stayed with V9 to help finish up R2's shower. V6 stated V9 was sliding on the wet shower room floor so V6 and V9 removed R2, in the shower chair to the middle of the room, got R2 dried off

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S9999	Continued From page 6	S9999		

and R2's gown on. V6 explained the floor was slick because it was wet so they were moving R2 into another room, attached to the shower room, which was approximately 20 ft away to transfer R2 from the shower chair into R2's wheelchair. V6 stated V6 opened the door and then turned away to grab the wheelchair as V9 was pushing R2 in shower chair and then heard V9 say "ugh", "as I heard a "thud"." V6 stated V6 turned around to see R2 lying on the floor, with R2's nose bleeding. V6 and V9 summoned the nurse, V10 LPN (Licensed Practical Nurse), who then called V7 RN (Registered Nurse) to also come and assist. V6 stated facility staff left R2 on the floor until the ambulance arrived, applied ice to R2's forehead due to the immediate swelling, then R2 left for the hospital. V6 explained the wall that R2 hit R2's head on was concrete with tile over it. V6 stated R2 was "hollering out in pain." V6 explained R2 "had issues with lunging forward when up in the wheelchair", so staff always kept a close eye on R2. V6 stated the shower chair did not have any safety belt or lap bar on it. V6 also stated "we {staff} don't transport residents in the shower chair typically but we will move them in the chair from the shower to the pre-shower room due to the floor being wet."

On 4/19/22 at 5:48 am, V7 RN confirmed V7 had been called over to assist with R2's fall on 4/4/22. V7 stated when V7 responded, V7 found R2 lying on R2's right side in the pre-shower room with "a nasty 3 cm (centimeter) x (by) 3 cm bump to (R2's) forehead and a cut/puncture area to the bridge of (R2's) nose." V7 explained that R2 moved to try and straighten R2's self out and then yelled out in pain. V7 stated the staff reported that R2 had slipped out of the shower chair but (R2) "does have a tendency to lean forward." V7 stated the shower chairs do not have a safety belt

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S9999	Continued From page 7 but that is actually one of the things V7 suggested to the DON (Director of Nursing) and Administrator, because V7 thinks that would have helped. On 4/19/22 at 5:55 am, V8 CNA stated R2 has a known behavior of rocking back and forth when sitting up in a chair. On 4/19/22 at 7:41 am, V1 Administrator provided a list of additional parts that could be purchased for the facility shower chairs, that included a seatbelt and lap bar but stated the shower chairs do not have those. "I (V1) don't think they were ever purchased." R2's medical record contained a PT screening from 2/18/22 with recommendations for foot pedals on the wheelchair when propelling R2 and dumping the back of the wheelchair to keep R2's shoulders over hips "to reduce (R2) lunging forward" out of the chair. There is no screening from OT in R2's medical record. On 4/19/22 at 11:50 pm, V19 PT confirmed V19 screened R2 in February after R2 had fallen from R2's wheelchair. V19 stated V19 recommended dumping the wheelchair which means lowering the back of the wheelchair by a couple of inches to ensure R2's shoulders aren't in front of R2's hips so that R2 sits in good alignment. V19 stated V19 doesn't assess for shower safety, that is something OT would do. On 4/19/22 at 12:50 pm, V20 OT stated V20 has never evaluated R2 so V20 can't make any recommendations or suggestions of what V20 would have recommended to keep R2 safe in the shower.	S9999		

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S9999	Continued From page 8 On 4/19/22 at 1:40 pm, V1 stated the facility policy says to refer to therapy after the second fall so "if we ordered PT to screen (R2), OT would have been ordered too" The facility Fall Policy dated 3/20/18 documents, 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. Any ambulatory resident who has had two falls within the last 30 days or less will be screened by therapy. On 4/19/22 at 2:03 pm, V10 LPN confirmed V10 was R2's assigned nurse on 4/4/22 when R2 fell out of the wheelchair, hitting R2's head on the wall. V10 stated staff had brought R2 into the open room before the shower room to transfer R2 from the shower chair to the wheelchair when R2 "reportedly stiffened up, leaned forward and fell out of it." V10 explained, that was a known behavior R2 had, and R2 had done it often in the last couple of months, which resulted in R2's previous falls. On 4/19/22 at 2:34 pm, V1 stated even though R2 had behaviors of lunging forward when up in a wheelchair, R2 never had those behaviors while in the shower chair. R2 had always used the upright/standard shower chair, without incident so V1 didn't think to use any additional safety attachments for the shower chair, plus those recommendations would have come from OT after OT screened R2 {which did not happen}. The facility Bath, Shower/Tub Policy dated February 2018 documents that after the bath/shower is given, staff are to dry the resident off from head to waist, then assist them out of the	S9999		

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S9999	Continued From page 9 shower chair, apply a towel to the shower chair seat then have the resident sit back down, and finish drying the resident bottom half of the body. On 4/20/22 at 9:04 am, V9 CNA stated V9 CNA was showering R2 on 4/4/22 and that the shower floor and shower room floor were both very slick, due to being soaking wet with water since this was the third shower that was given that night. V9 stated V9 did not dry the floor between showers. V9 explained that after R2's shower, V9 dried R2 off and placed a gown on R2 before moving R2, in the shower chair, but did not place a dry towel on the shower seat for R2 to sit on. V9 stated V9 was sliding "all over the place" so V9 and V6 were moving R2, in shower chair, to the room that was attached to the shower room, before transferring R2 from the shower chair to the wheelchair. V9 stated V9 was "pushing the chair with both hands and had (V9's) foot holding the door open for (V6) to bring the wheelchair through when (R2) lunged forward and fell, hitting hard. (R2) had immediate swelling to (R2's) face." V9 stated R2 "leans and lunges all the time." On 4/20/22 at 12:36 pm, V9 stated V9 and V6 had dried R2 off and placed a gown on R2 prior to moving R2 into the room next to the shower room but had not placed a towel under R2 per the facility Bath, Shower/Tub Policy. V9 stated that not just the shower floor gets slick but so does the entire shower room floor, that is why V9 was relocating R2 to a dry area. On 4/20/22 at 1:40 pm, the shower room in the spa has a shower with a plastic bottom with built in grips. On the shower rail, there were 3 extra shower anti-slip grips. The shower floor when dry is not slick but after turning the water on, it was slick. Water ran out of the shower into the shower	S9999		

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S9999	Continued From page 10 room causing the shower room floor to become slick as well. On 4/20/22 at 2:10 pm, V22 Maintenance Director confirmed the shower floor and shower room floor both can get slick when they are wet, which was reported to V22 after R2's accident. On 4/20/22 at 2:35 pm, V31 Director of Sales and Marketing/Supplier stated shower chairs are not intended to be used as a transport chair. (AA)	S9999		