

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0009258		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/25/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2130 HARRISON STREET , QUINCY, Illinois, 62301			
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S0000	Initial Comments		S0000			03/11/2026	
	Annual Licensure						
S9999	Final Observations		S9999			03/11/2026	
	Statement of Licensure Violations:						
	1 of 2						
	300.610a)						
	300.1210b)						
	300.1210d)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 nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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 an initial care plan on admission to prevent pressure ulcers, failed to implement pressure relieving interventions to prevent the development of pressure ulcers, failed to initiate a pressure ulcer care plan as soon as a pressure ulcer was identified, and failed to obtain a treatment as soon as a pressure ulcer was identified for one resident of four residents (R79) reviewed for pressure ulcers in the sample of 37. These failures resulted in R79 developing two stage two facility acquired pressure ulcers. Findings include: The Skin Care Protocol: Prevention and Treatment policy dated 2/14/2025 documents "The facility will ensure that a resident who enters the facility without pressure injury does not develop a pressure injury unless the individual's clinical condition demonstrates that the pressure injury was unavoidable. The facility will further ensure that a resident having pressure injury receives necessary treatment and services which promote healing, prevent infection, and prevent new injury from developing. Procedure 1. Upon admission/readmission, the charged nurse will document the presence of all marks, scars, rashes, pressure injuries, moles, bruises, etc.(etcetera) in the designated space in the Admission Assessment under observations in (computer program). 3. Upon admission/readmission, the charged nurse will complete the Braden Pressure Ulcer Risk Assessment under observations in (computer program). Based on the risk category indicated, the charged nurse will implement the respective risk protocol. 4. Within seventy-two hours following admission/readmission the Resident Care Coordinator will review the Admission Assessment and Braden Pressure Ulcer Risk Assessment for implementation of risk protocol, review treatment orders, and refer to the Nursing Program Coordinator or start Initial Pressure Sore event in (computer			S9999			

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S9999	Continued from page 2 program). 6. The Resident Care Coordinator or Nursing Program Coordinator will review and update the Braden Pressure Ulcer Risk Assessment quarterly and upon finding of new pressure injury. Risk Assessment Process 1. Risk Assessment Definitions a. Braden Scale for Prediction of Pressure Sore Risk will be used to identify residents who are at increasing risk for acquiring a pressure injury. The Braden Scale will be completed upon admission, quarterly and upon identification of a new pressure injury. b. If the resident has a new or existing pressure injury, including stage I, the resident shall be considered High Risk. 3. At Risk Protocol (Braden Score 15-18) b. If using wheelchair for mobility, obtain cushion from the therapy department. c. Obtain order for house barrier cream to be applied during incontinence care to minimize the effects of urine and feces. d. Repositioning of residents who are unable or not inclined to self-reposition every 2 (two) hours in lying position and every hour when in seated position." The Initial Care Plan policy dated 5/23/2022 documents "The initial care plan will be used to communicate the resident care needs on admission. This form will be completed and placed in the care plan book until the admission care plan is developed following completion of the MDS (Minimum Data Set Assessment) and care plan meeting." The Resident Care Planning policy dated 3/21/19 documents "Each resident has a Resident Care Plan that is current, individualized, and consistent with the medical regimen. The plan of care is initiated within 48 hours after admission by using the Initial Care Plan. A care plan will be initiated at the time a pressure injury or skin alteration is identified and will include prevention strategies as well as treatment plans." R79's Face Sheet documents that R79 is an 82-year-old that was admitted to the facility on 1/30/26 with diagnoses which included Chronic Obstructive Pulmonary Disease/COPD, and Pneumonia. R79's Braden Scale Pressure Risk Assessment dated 1/30/26 at 3:48 PM, documents that R79 scored a 17 indicating R79 was at risk for the development of pressure ulcers. R79's Admission Evaluation dated 1/30/26 at 4:40 PM, documents that R79's cognition level was independent with decision making, R79 made herself understood, and R79 required a one person assist for activities of daily living, bed mobility, and transfers. The same			S9999			

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S9999	Continued from page 3 Evaluation documents R79 was continent of bladder/bowel, R79 had no redness, rashes, lesions, or excoriations, R79 had no verbal complaints of pain, and R79 had no pressure ulcers. R79's Initial Care Plan dated 1/30/26 does not include any pressure relieving interventions to prevent R79 from developing pressure ulcers. R79's Skin Integrity Report printed 2/24/26 at 3:16 PM documents that a stage two pressure ulcer was discovered on R79's right buttock on 2/6/26 at 1:30 PM. The wound measured 3 centimeters (cm) by 3 cm x 0.1 cm with a scant amount of serous drainage causing mild pain. R79's Skin Integrity Report printed 2/24/26 at 3:16 PM documents that a stage two pressure ulcer was discovered on R79's left buttock on 2/6/26 at 1:30 PM. The wound measured 2.5 cm by 3.5 cm with blistered skin still intact causing mild pain. R79's Nursing Note dated 2/6/26 at 1:38 PM written by V16/Infection Preventionist/Registered Nurse/RN documents that R79's buttock was assessed and R79 had a stage two ruptured blister observed to R79s right buttocks that measures 3 cm by 3 cm by 0.1 cm and R79 had a stage two partial thickness wound to her left buttocks that measured 2.5 cm by 3.5 cm. R79's Treatment Administration Record documents to cleanse with soap and water the stage two "deroofed blister" and apply Xeroform (medicated wound dressing) dressing to the wound bed, cover with sacral optifoam (foam dressing) and change on shower days and as needed (if it starts draining start Calcium Alginate). If stage two intact blister opens apply the same treatment once a day on Wednesday and Saturday. Start Date 2/8/26. On 2/25/26 R79 was sent to the hospital for respiratory issues and was not in the facility for the wounds to be observed by this surveyor. R79's current Care Plan was not updated with documentation of R79's pressure ulcers or pressure ulcer interventions until 2/9/26. On 2/23/26 at 10:30 AM, R79 was sitting in her wheelchair next to her bed with her eyes closed. R79 was sitting with direct pressure on her buttocks with no offloading of pressure. R79 stated that she has a couple of sores on her bottom that she got since coming to the facility.			S9999			

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S9999	Continued from page 4 On 2/23/26 at 11:57 AM, V28/R79's Family Member stated that she got a call from the facility that R79 had developed a wound on her buttock. V28 also stated "(R79) has had to wait up to 45 minutes for (R79's) call light to be answered and that is a long time when you have to use the bathroom. I'm sure that is not good for getting sores if your left sitting in a wet (disposable brief)." On 2/24/26 at 11:43 AM, R79 was sitting in her wheelchair next to her bed visiting with V29/R79's Family Member. V29 stated "I don't know what to think about (R79's) care. (R79) came to the facility three weeks ago for therapy and (R79's) health has been steadily declining." On 2/24/26 at 1:59 PM, V3/Assistant Director of Nursing verified that R79 was admitted to the facility on 1/30/26 and did not have a pressure ulcer but now has two stage two pressure ulcers on R79's buttocks. V3 also verified that R79 scored a 17 on the Braden Scale meaning R79 was at risk for developing a pressure ulcer. V3 stated that there were no pressure relieving interventions on R79's baseline care plan and there should have been. V3 also stated that the pressure ulcers were identified on 2/6/26 and a pressure ulcer care plan was not initiated with interventions until 2/9/26. On 2/25/26 at 12:55 PM V25 (Nurse Practitioner) stated R79's wounds to the buttock were caused by pressure. V25 also verified she is not sure if the facility implemented pressure relieving interventions prior to the development of pressure ulcers. On 2/25/26 at 9:38 AM, V16/Infection Preventionist/RN stated that R79 has two stage two ulcers that were caused by pressure. The wounds were identified on 2/6/26 and treatment was not started until 2/8/26. (B) 2 of 2 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies		S9999				

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S9999	Continued from page 5 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 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 requirements are not met as evidenced by: Based on Observation, Interview and Record Review, the facility failed to provide a resident with adequate supervision and assistance with footwear to prevent a fall and conduct a thorough investigation with staff interviews after a resident suffered a fall with fracture for one of two residents (R7). This failure resulted in R7's footwear being worn unsafely, and R7 suffering an unwitnessed fall, experiencing swelling and pain in her right wrist and resulting in a distal radius bone fracture requiring cast application. Findings include: The facility's Program for Reduction of Falls Risk policy, dated 4/9/25, documents "As part of the program			S9999			

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S9999	Continued from page 6 for the prevention of falls, all newly admitted residents and those residents experiencing a change in function will be assessed for the risk of falls. The care plan will indicate that the resident is at risk for falls and provide interventions for fall prevention. Purpose: to enable staff to recognize those residents who have been found to be at increased risk for falls, implement interventions to reduce the risk of resident falls and ultimately prevent resident falls. If the resident is found to be at risk, the individual who has completed the assessment will initiate a care plan for prevention of falls or update the existing care plan. The appropriate fall prevention interventions will be selected on the basis of the individualized needs of the resident." R7's current Care Plan, dated 12/30/25, documents R7 is 93 years old and has diagnoses including Alzheimer's disease, Anxiety, Chronic Respiratory failure and Age-related Macular Degeneration. This care plan documents "I require varying levels of assist due to Alzheimer's disease, COPD (Chronic Obstructive Pulmonary Disease), chronic respiratory failure and macular degeneration. Approach: Observe frequently and place in supervised area when I am out of bed and restless (start date 7/8/25)." This care plan also documents "I am at risk for falls due to Dementia, Alzheimer's, COPD, Chronic hypoxia, and Nonexecutive age related macular degeneration. Approach: I wear non-skid shoes/socks, increased staff supervision with intensity based on my needs (both started 7/8/25)." This same care plan also documents "I am limited in my ability to dress/undress self, related to macular degeneration, weakness and COPD. Approach: provide me consistent amount of oversight and encouragement with occasional cueing and physical assistance, provide me step by step instructions during dressing (both started 7/8/25)." On 2/23/26 at 10:50 AM, R7 was sitting in a wheelchair in front of the 600 hall nurses' station. R7 was pleasantly confused with conversation and denied any history of falling. On 2/25/26 at 11:05 AM, R7 was sitting in a wheelchair in front of the 600 hall nurses' station with her eyes closed. R7's Minimum Data Set assessment, dated 7/3/25, documents R7 has moderately impaired cognition and requires supervision/touching assistance with putting on and taking off footwear. R7's Safety Fall Event, dated 8/26/25, documents on		S9999				

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S9999	Continued from page 7 8/25/25 at 9:13 PM R7 suffered an unwitnessed fall in her room. This event documents the last time R7 was seen prior to falling, was at 7:30 PM while headed to her room after an activity (1 hour and 45 minutes prior to the fall). This event also documents R7's shoes were not worn properly, "the backs of the shoe were pressed down as if they had been slipped on" and R7 exhibited pain and swelling in her right wrist. This same event form also documents measures put in place after the fall: "educated resident to no longer slide her shoes on with the backs flat to the sole. We (staff) can assist with putting on her shoes properly, so her feet stay in the shoes." R7's nursing progress note, dated 8/26/25 at 7:51 AM, documents "Right wrist swollen, warm to the touch, blue/black bruising present with deformity. (R7) states pain level four out of ten while positioning to elevate with ice." R7's nursing progress note, dated 8/26/25 at 12:40 PM, documents R7 returned from the orthopedic walk-in clinic with a diagnosis of a right distal radius fracture requiring a cast that was applied in the office. On 2/25/26 at 11:29 AM, V2 (Director of Nursing) stated "I do not have a complete fall investigation with witness statements for (R7's) fall on 8/25/25. I know she went to get an x-ray of her wrist the next day and had a wrist fracture. (R7) is forgetful, she can be conversated with, but she may not remember what was discussed. I know (R7's) shoes were not on correctly at the time she fell, and she does have confusion off and on. Educating her would not be very effective." V2 confirmed staff should always assist R7 with applying and removing her shoes and that R7 requires frequent supervision as part of her fall prevention plan. (B)		S9999				