Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					C	
<del></del>		IL6005573			03/25/2021	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S I <b>TH EWING I</b>	STATE, ZIP CODE		
GOOD S	AMARITAN - PONTIA		, IL 61764	DINVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE COMPLETE	
S 000	Initial Comments		S 000			
	Complaint Investiga	ation 216185/IL131921				
S9999	Final Observations		S9999			
\$3 <sup>7</sup>	Complaint Investiga	ation 2161851/IL131921				
	STATEMENT OF L	ICENSURE FINDINGS:		1		
	300.610 a) 300.1010 h) 300.1210 d) 5) 300.1220 b) 3) 300.3240 a)					
	Section 300.610 R	desident Care Policies				
	procedures govern facility. The writter be formulated by a Committee consist administrator, the a medical advisory or of nursing and other policies shall comp. The written policies the facility and shall comp.	advisory physician or the committee, and representatives or services in the facility. The sly with the Act and this Part. It is shall be followed in operating the reviewed at least annually documented by written, signed				
	Section 300.1010	Medical Care Policies				
	of any accident, inj resident's condition safety or welfare of limited to, the pres	notify the resident's physician ury, or significant change in a nather threatens the health, faresident, including, but not ence of incipient or manifest a weight loss or gain of five		Attachment A Statement of Licensure Violation	•	
	tment of Public Health Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE	

STATE FORM

6899

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		IL6005573	B. WING		C 03/25/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN - PONTIA		TH 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)		
S <b>9</b> 999	Continued From pa	ge 1	S9999			
	facility shall obtain a of care for the care	hin a period of 30 days. The and record the physician's plan or treatment of such accident, condition at the time of				
	Section 300.1210 ( Nursing and Persor	General Requirements for hal Care				
	sores, heat rashes of be practiced on a 2d basis so that a residuithout pressure so pressure sores unle condition demonstrativere unavoidable, sores shall receive to	to prevent and treat pressure or other skin breakdown shall 4-hour, seven-day-a-week dent who enters the facility res does not develop ass the individual's clinical ates that the pressure sores A resident having pressure treatment and services to event infection, and prevent from developing.				
,	Section 300.1220 S Services	Supervision of Nursing				
	b)The DON shall su nursing services of	pervise and oversee the the facility, including:				
Illa a la Dan	each resident based comprehensive asso and goals to be account and personal care a Personnel, represer nursing, activities, d	essment, individual needs omplished, physician's orders,				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6005573	B. WING		03/2	; 5/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		Y	
GOOD S	AMARITAN - PONTIA	C 1225 SOU PONTIAC,	TH EWING D	PRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE	
\$9999	Continued From pa	age 2	S9999				
	plan. The plan sha reviewed and modi needed as indicate	preparation of the resident care all be in writing and shall be fied in keeping with the care d by the resident's condition. eviewed at least every three				۸	
	Section 300.3240	Abuse and Neglect					
		ee, administrator, employee or hall not abuse or neglect a 2-107 of the Act)				8.5	
	These regulations	were not met as evidenced by:					
2	review, the facility of ulcer treatments as contamination of the measure the press pressure relieving notify the Physician worsening pressuresidents (R1 and ulcers. This failure	cion, interview and record failed to complete pressure so ordered, prevent cross he pressure ulcer, assess and cure ulcer weekly, implement interventions and failed to hand Registered Dietician of the ulcers for two of three R4) reviewed for pressure resulted in R1 and R4's has a size and progressing to an ure ulcer.					
	Findings Include:		13/11				
3	flat on R1's back, of stated R1 "has a b	3:20 pm, R1 was lying in bed on a regular mattress and lister or something on (R1's) I it needs something done to it."					
	documents R1 is a	im Data Set) dated 3/8/21 alert and oriented, requires ace with bed mobility and					

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Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_\_\_\_ B. WING 03/25/2021 IL6005573 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1225 SOUTH EWING DRIVE GOOD SAMARITAN - PONTIAC** PONTIAC, IL 61764 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 3 S9999 S9999 transfers, and is at risk for pressure ulcer development. R1's Weekly Wound Tracking Worksheet dated 3/10/21 documents, R1 has a open area to R1's bottom measuring 0.5 cm (centimeters) by 0.6 cm by UTD (unable to determine) that is covered 100 percent with epithelial tissue. This note does not document the exact location, the type or description of open area. The facility Weekly Wound Tracking Worksheet dated 3/23/21 documents R1's Pressure ulcer as a stage II to the left gluteus measuring 1.2 cm by 1 cm by UTD. R1's medical record does not contain any additional wound measurements or descriptions. R1's March 2021 POS (Physician Order Sheet) documents an order to cleanse open area to bottom, apply hydrogel & border foam dressing daily until healed. On 3/23/21 at 3:25 pm, V9 LPN (Licensed Practical Nurse), R1's scheduled nurse, stated V9 does not do the treatments for V9's assigned residents. V9 stated the facility normally has a "float nurse" that does them but that there was miscommunication as to who was going to do it today, it will either be V17 RN (Registered Nurse) or V18 RN. On 3/23/21 at 3:55 pm, V9 LPN and V13 CNA (Certified Nursing Assistant) entered R1's room. R1 did not have a dressing covering R1's pressure ulcer to the left buttocks, and was incontinent of stool. R1 has two pinpoint open areas that scabbed over and a larger area underneath that is red and scabbed {measuring

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1.2 cm by 1 cm according to Weekly Wound

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
AND LEW	01 001112011011		A. BUILDING:		1	
-11		IL6005573	B. WING	\$11	03/2	5/2021
	91	12000373			1 00/2	JIZUZ (
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOODS	AMARITAN - PONTIA	C	TH EWING	DRIVE		
90000	AMARTAN - TONTIA	PONTIAC	, IL 61764			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
\$9999	Continued From pa	nge 4	S9999			!
	Tracking) V9 confi	rmed R1 did not have the				
		place and stated, it was due				
		ication earlier in the shift as to				
	who was going to o	complete it, and not sure how				
	long R1 had been v	without a dressing. V13 CNA		00		
		nt care to R1 with a disposable				
		ne entire buttocks, including		***		
		three times, with the wipe that				
		ol and contaminating the				
		at 1:30 pm when V13 provided I not have a dressing on the				
		3 adjusted R1 in bed and V9				
		18 RN would be completing				
	R1's treatment late		9			
		AR (Treatment Administration		*		
		cument R1's treatment as		70.		
	being completed or	n 3/12/21, 3/19/21, or 3/22/21.				
	On 2/24/24 at 0:30	am, R1 was lying in bed,				
	eliabily on right side	e when V24 RN and V25				
		to complete the ordered				
		R1's incontinence brief was				
		e and had stool in it. V24		1.9		
		removed the soiled dressing				
	to reveal, 2 scabbe	ed pin point open areas to the				_
		e larger pressure ulcer that is				
		overed in white slough. V24				
		it did not perform hand				
2.5		eeded to clean the pressure				
	wound cleanser. V	ling tissue with 4x4 gauze and		43		
111		24 then sat the d 4x4 used to cleanse the				
1		an surface next to the bordered				
		thout performing hand hygiene				
		s, V24 then applied hydrogel to				
		oint areas and 1 larger area				
		ough) V24 confirmed covered				!
	in slough, and not	able to see the wound bed.				
		he new foam dressing.				
	rtment of Public Health					
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMF	PLETED	
						С	
		IL6005573	B. WING		03/2	25/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
GOODS	AMARITAN - PONTIA		TH EWING	DRIVE			
		PONTIAC	IL 61764				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	.D BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 5	S9999				
	did not perform han should have brough me. I (V24) knew I (V24 also confirmed used to clean R1's next to the new stercontaminating the room of a vere using hydroge that it was deteriorated that it was deteriorated and good nutricity is getting worse, R1 pressure to the area with R1's non-compositive that whatever the R1's non-compositive that whatever the R1's non-compositive that whatever the R1's recommended would help with the nutrition Ultimately though, pressure, the wound on 3/24/21 at 1:38 in R1's notes that R1's bottom but did on the type or stage intake history, and the not feel R1 needed V29 stated, "had I (measurements, like Previous DON, Dire would have seen the stage of the previous DON, Dire would have seen the stage of the previous DON, Dire would have seen the stage of the previous DON, Dire would have seen the stage of the previous properties of the previous properties and properties of the previous propertie	A pm, V30 Physician stated a "small open area" that they el on, but had not been notified ating, and should have been. nealing wounds, is to keep the ee of infection, off load the ation. V30 stated if the wound needs to off load the atin order for it to heal, and oliance at times, an air a alternative that the facility that pressure. V30 also stated D (Registered Dietician) and have been put into place to onal needs for wound healing, if you don't get rid of the d will not heal."  pm, V29 RD stated V29 found thad a new open area on not have actual information of the wound. Based on R1's the wound being new, V29 did any extra recommendation. V29) received wound et (V29) use to get from ((V20) ector of Nursing)) I (V29) e wound was deteriorating					
	did not perform han should have brough me. I (V24) knew I (V24 also confirmed used to clean R1's next to the new stercontaminating the room of a vere using hydroge that it was deteriorated that it was deteriorated and good nutricity is getting worse, R1 pressure to the area with R1's non-compositive to the area with R1's not established with the nutrition Ultimately though, "pressure, the wound on the type or stage intake history, and the type or stage intake history and the type or stage intake his	nd hygiene and stated, "I (V24) and alcohol {hand gel} in with (V24) was missing a step."  she sat the soiled 4x4 gauze wound on the clean surface rile dressing, potentially new dressing.  4 pm, V30 Physician stated a "small open area" that they eld on, but had not been notified ating, and should have been. The healing wounds, is to keep the ee of infection, off load the eld in order for it to heal, and oliance at times, an air a alternative that the facility that pressure. V30 also stated (D) (Registered Dietician) ald have been put into place to onal needs for wound healing, if you don't get rid of the dwill not heal."  pm, V29 RD stated V29 found the and a new open area on not have actual information of the wound. Based on R1's the wound being new, V29 did any extra recommendation. V29) received wound et (V29) use to get from ((V20) ector of Nursing)) I (V29)					

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IDENTIFICATION AND PER		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		IL6005573	B. WING		1 -	, 5/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN - PONTIA	C :==:	TH EWING D	DRIVE		
3000		PONTIAC	, IL 61764	DOCUMENTO PLAN OF CORPORT		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LID BE	(X5) COMPLETE DATE
S9999	Continued From pa	age 6	S9999			
	supplements. Good contribute to wound	d nutrition will definitely d healing."				
	wounds are to me a weekly. V2 stated weekly. V2 stated weekly being done but that care plans and wor to assist with DON was not able to find	nd treatments, or on		- 17		
7.	dated 7/30/15 docu washed after remo Sanitizer Policy dat sanitizer should be	Vashing and Gloves Policy uments, hands must be val of gloves. The facility Hand ted 3/6/20 documents, hand used after contact with blood, caminated surfaces.		₩.		¥
	R4's back, on a reg	:35 pm, R4 was lying in bed on gular mattress, and stated R4 d might have an open area.				
=	3/2/21 documents measuring 0.5 cm	nd Tracking Worksheet dated R4 has a sacrum wound (centimeters) by 0.5 cm by 0.1 with 100 percent epithelial				
		d does not contain any neasurements or descriptions				
#3	3/23/21 documents has deteriorated as	nd Tracking Worksheet dated s R4's coccyx/sacral wound nd is now an unstageable asuring 2 cm by 1 cm by UTD ne).				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
	9				l c	.
		IL6005573	B. WING		03/25/2021	
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
COODS	AMARITAN - PONTIA	<u></u>	TH EWING D	PRIVE		
GOOD 3/	AMANIAN TONIA	PONTIAC	IL 61764			
(X4) ID		TEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE
TAG	REGULATORT OR L	SCIDENTIFTING INFORMATION)	TAG	DEFICIENCY)		
S9999	Continued From pa	age 7	S9999			
	On 3/24/21 at 1:22	pm, V29 RD (Registered				
		29 reviewed R4's pressure				
		d recommendations were				
		V29 was reviewing facility				
		/17/21 and when V29 asked				
		rts, V29 was informed that				
		able and hadn't been				
	completed due to \	/20 Former DON (Director of	i			
		working at the facility. V29				
		own R4's wounds were				
	worsening, V29 wo	uld have recommended				
	enhance potatoes and cereals to give R4 more					
		a liquid protein supplement				
		9 stated, "good nutrition would				
	contribute to wound	d healing."				
		MO A III DONI/Disselses				
		pm, V2 Acting DON (Director				
		wounds are to me assessed				
	and measured wee	ekly. V2 stated V2 was aware				
	that was not being	done but that V2 is trying to do				
	also trying to assis	s and working the floor, then				
	also trying to assis	t with DON duties.				
	(B)					
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