STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145930	A. BUILDING ______ B. WING ______	07/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN - PONTIAC	15335 US HIGHWAY 66 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) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Survey	F 000		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to employ a Registered Nurse as Director of Nursing. This failure has the potential to affect all 15 residents who reside at the facility. Findings Include: The Facility Roster sheet dated 7/21/15 and signed by E4 Receptionist documents, "Director of Nurses (DON) - Not Applicable (NA)." On 7/20/15 at 10:30 am, E2 Licensed Practical Nurse (LPN)/Minimum Data Set (MDS) Coordinator stated, "our old DON left in February 2015 and we haven't had one since then...I have been doing most of what she did."	F 354		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 354	Continued From page 1 On 7/21/15 at 2:15 pm, E1 Administrator confirmed that the facility has not employed a DON since February 2015 and stated, "I was told that since we decreased our bed capacity down to 49 beds, which occurred June, 2015, that we did not need a DON." The Resident Census and Conditions of Residents Report dated 7/20/15 documents 15 residents in the facility.	F 354		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		

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F 441	Continued From page 2 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to maintain the oxygen concentrator humidifier in a sanitary condition to prevent potential bacterial contamination for one of two residents (R15) reviewed for oxygen use in the sample of 8. The findings include: The Physician Order Sheet dated July 2015 documents, R15 is diagnosed with Stage IV Lung Cancer and Chronic Obstructive Pulmonary Disease with CO2 (Carbon Dioxide) Retention. R15's Physician Orders include O2 (oxygen) at 6 Liters per nasal canula continuous. Progress Notes dated 5/24/15 documents "Resident remains in ICU (Intensive Care Unit) for acute respiratory failure." Progress Notes dated 5/28/15 documents, R15 was "readmitted to the facility on Hospice care." Hospice Admission Agreement dated 5/28/15 documents R15's admission to hospice care.	F 441		

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F 441	Continued From page 3	F 441		

On 7/20/15 at 10:00 am, R15 was lying in bed with oxygen running at 6 Liters/minute per nasal canula via oxygen concentrator. The oxygen concentrator at R15's bedside had a refillable humidifier reservoir bubbling with slight amber-tinged liquid that was less than half full. The oxygen humidifier and tubing were not dated.

On 7/21/15 at 9:35 am, R15 was sitting in the wheelchair with oxygen running per nasal canula. The oxygen concentrator with humidifier reservoir was unchanged. The humidifier reservoir continued to bubble the slight amber-tinged liquid. The oxygen humidifier reservoir and tubing were not dated.

On 7/21/15 at 9:40 am E3, Licensed Practical Nurse (LPN) stated that there was no date on R15's oxygen tubing. E3 stated that R15's oxygen tubing is "changed weekly on Saturday and documented on the Treatment Administration Record (TAR)."

R15's TAR dated from 5/28-7/15/15 documents the oxygen tubing and nebulizer tubing is changed once per week on Saturdays. There is no information on the humidifier bottle cleaning or changing.

On 7/21/15 at 2:00 pm the humidifier bottle at R15's bedside still had amber tinged liquid and there was visible mineral scale on the inside of the reservoir and yellow sediment in the bottle of the liquid.

On 7/21/15 at 2:05 pm an oxygen concentrator with a refillable humidifier was by the activity area in the living room. The concentrator was labeled Hospice. The humidifier bottle was less than half

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F 441	Continued From page 4 full of amber tinged liquid. There was no date on the humidifier bottle. On 7/21/15 at 2:10 pm, LPN E3 stated, "(R15) uses the bedside oxygen concentrator with humidity while in bed, and the oxygen concentrator in the living room is also for R15 to use while in activities, the concentrator equipment was provided by Hospice." E3 confirmed that E3 had switched R15's nasal canula and tubing over from the portable oxygen tank on the wheelchair to the oxygen concentrator while in the bedroom that morning. E3 stated, "We fill the humidifier with distilled water that is kept in the medication room or the kitchen." E3 stated she has not personally changed or added any water to R15's humidifier bottle. E3 stated, "any of the nurses can refill the unit and the Hospice Nurse who visits on Tuesdays and Fridays may refill the humidifier as well." E3 was unaware of any cleaning procedures or water change policies in place for the humidifier. On 7/21/15 at 2:30 pm two undated gallon jugs of "Spring water " were on the window sill in the medication room. One of the jugs had been opened. E3 stated at that time she did not know when the jug was opened. On 7/21/15 at 2:15 pm Lead Nurse, LPN E2 stated she could not find any policies for maintaining the refillable humidifier bottle in facility policy. E2 stated, "the facility uses prefilled humidifier bottles." Hospice had provided the oxygen concentrator with the refillable humidifier for R15. E2 stated, "(R15) would have been switched to the Hospice oxygen concentrator on 5/28/15 when (R15) became Hospice care." At	F 441		

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F 441	Continued From page 5 2:30 pm, E2 removed the humidifier bottle from R15's concentrator. E2 and E3 confirmed that the water was "yellow and there was sediment in the bottom of the liquid." On 7/21/15 at 3:15 pm, E2 stated she spoke with Hospice Supervisor Z3 on the phone and there is not a policy for cleaning refilling humidifier bottles. The Hospice oxygen concentrators come with the refillable bottles however, the Hospice policy is not to use the refillable bottles but to use prefilled humidifiers with sterile water. Z3 told E2 that Hospice should have sent a supply of prefilled humidifiers for the facility to use. The facility Oxygen Therapy policy dated 9/15 states: "Change oxygen tubing/nasal canula/mask weekly and prn (as needed). Change humidifier bottle prn...Humidified oxygen will be used on residents receiving more that 2 liters of oxygen..RN (Registered Nurse)/LPN provides services for administering oxygen therapy...When a resident needs to switch between a concentrator and a portable or vice a versa, a nurse must do this."	F 441		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and record review four multiple resident bedrooms do not provide 80 square feet per resident bed. This affects two	F 458		

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F 458	Continued From page 6 residents(R12, R13) in the supplemental sample. The finding includes: Historical room size waiver information dated 9/5/14 documents the facility had a waiver for thirteen multiple bed resident rooms that did not provide 80 square feet per resident bed. On 6/23/15 the facility received approval from the Department to decrease it's licensed bed capacity from from 122 beds to 49 beds. The 2015 Room/Bed/Level of Care Listing from the Department of Public Health dated 6/23/15 documents that four of the remaining bedrooms are licensed for 2 resident/ beds and do not provide 80 Square Feet per bed. This includes: B-Wing room 25 and 36 provides 78 square feet per bed and are unoccupied. These beds are Medicaid Title 19 certified. B-Wing is has been closed since December 2012. C-Wing rooms 92 and 93 are Medicaid Title 19 certified. These rooms provide 78 square feet per resident bed instead of the required 80 square feet per bed. These rooms are currently occupied by one resident each, (R12 and R13). The waivered rooms provide adequate space for resident personal belonging, equipment and nursing care. No infection control issues related to room size was identified.	F 458		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520		

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F 520	Continued From page 7	F 520		

Continued From page 7
assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to maintain a Director of Nursing as part of the facility Quality Assessment and Assurance committee. This failure has the potential to affect all 15 residents in the facility.

Findings Include:

On 7/20/15, E4 Receptionist provided the listing of Members of the Quality Assurance (QA) Committee that includes E1 Administrator, E2 Minimum Data Set Coordinator, E3 Director of Social Service, E5 Director of Dining Services, Z1 Medical Director and Z2 Pharmacist. No Director

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F 520	Continued From page 8 of Nursing (DON) was listed. The QA meeting sign in sheets dated 4/1/2015 and 7/6/2015 do not list a DON in attendance for those meetings. On 7/21/15 at 2:15 pm, E1 Administrator confirmed that the facility currently does not employee a DON, and has not since February 2015. The Resident Census and Conditions of Residents Report dated 7/20/15 documents 15 residents in the facility.	F 520		