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	145719	A. BUILDING ______ B. WING ______	03/16/2012

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MAPLE RIDGE CARE CENTRE	**2202 NORTH KICKAPOO STREET** **LINCOLN, IL 62656**

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F 520	Continued From page 38 the QA process. On 03/13/12 at 10:00AM E5 (LPN/Licensed Practical Nurse/Wound Nurse/Infectionist) stated, "I have only been to two meetings in the six years I have had this position. I never have any issues so I don't present anything." On 03/13/12 at 3:00PM E23 (Senior Administrator) stated, "We just need to have all department managers attend QA so they know what is going on. That's what we do in other facilities." The Resident Census and Conditions of Residents completed on 3-6-12 by E25, (Licensed Practical Nurse) documents the facility census as 102.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.696a) 300.696b) 300.696c) 300.696c)2) 300.696c)7) 300.1020a) 300.1020b) 300.1210a) 300.1210b) 300.1210c) 300.3240a) 300.3240b) 300.3240c) 300.3240d)	F9999		

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Section 300.696 Infection Control

a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed.
b) A group, i.e., an infection control committee, quality assurance committee, or other facility entity, shall periodically review the results of investigations and activities to control infections.
c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340):
2) Guideline for Hand Hygiene in Health-Care Settings
7) Guidelines for Infection Control in Health Care Personnel

Section 300.1020 Communicable Disease Policies

a) The facility shall comply with the Control of Communicable Diseases Code (77 Ill. Adm. Code 690).
b) A resident who is suspected of or diagnosed as having any communicable, contagious or

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F9999	Continued From page 40 infectious disease, as defined in the Control of Communicable Diseases Code, shall be placed in isolation, if required, in accordance with the Control of Communicable Diseases Code. If the facility believes that it cannot provide the necessary infection control measures, it must initiate an involuntary transfer and discharge pursuant to Article III, Part 4 of the Act and Section 300.620 of this Part. In determining whether a transfer or discharge is necessary, the burden of proof rests on the facility. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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	F9999		

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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.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)
b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)
c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act)
d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)

A. Based on observation, record review, and interview, the facility failed to ensure a resident infected with MRSA (Methicillin Resistant Staphylococcus Aureus) of the nose and sputum maintained a covered airway while amongst other staff/residents, failed to educate family on proper precautions to take for Respiratory Isolation, failed to perform handwashing after coming in

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contact with body secretions, and failed to remain up to date on current standards of Infection Control practices, for one of seven residents (R4) reviewed on Isolation Precautions, in a sample of 23.
On 3/07/12, R4, who has MRSA of the sputum and nose, was ambulating freely throughout the facility with his airways uncovered, openly coughing, touching his tracheostomy opening and then touching handrails and the Nurses Station Desk. R4 has Severe Mental Retardation and can roam freely throughout the facility. The lack of infection control measures and lack of knowledge regarding current recommended standards of infection control has the potential to effect all residents in the facility, including 25 residents (R5, R6, R7, R16, R17, R25, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, R43, R44, R45) which were identified as being immunocompromised.

Findings Include:

A Physician's Order Sheet, dated 2/01/12, documents R4 has the current diagnoses of Downs Syndrome, Aspiration Pneumonia, MRSA of the Sputum and Blood, and Respiratory Failure and was admitted on 6/15/11. Microbiology Reports dated 1/05/12 document R4 was positive for MRSA infection of the nares and sputum. Follow up Microbiology Reports dated 2/13/12 document R4 continued to be positive for MRSA infection of the nares. A Plan of Care, dated 6/15/11, indicates R4 has "severe (Mental Retardation) and Downs Syndrome and has decreased safety awareness. He pulls at his (tracheostomy), (ventilator) tubing ." The Plan of

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F9999	Continued From page 43 Care further identifies that R4 has MRSA of the sputum and requires isolation, but did not identify specific precautions to take for covering R4's airways. The Facility Policy and Procedure, titled "Universal Precautions/Infection Control", indicates for "Airborne Precautions" that respiratory precautions are to be used and that patient transport in the facility is to be limited. The Facility Policy and Procedure, titled "Handwashing/Cleansing", indicates "Handwashing/Cleansing is done before and after resident contact, before and after any procedure, after using a Kleenex or the restroom, before eating or handling food, when hands are obviously soiled and regardless of glove use." The Facility Policy and Procedure, titled "Protocol for the Care of Residents with MDRO'S (Multi-Drug Resistant Organisms)", identifies MRSA as a MDRO and indicates that "Residents are permitted out of their room as long as precautions are maintained to contain secretions and excretions." The Facility Policy and Procedure, titled "Infection Control Guidelines", indicates "A resident who is infected with MRSA in the respiratory tract, such as pneumonia or bronchitis, should wear a mask when leaving the room ....Those residents who are colonized with MRSA in their sputum and who have a chronic, uncontrollable cough should wear a mask when leaving the room." On 3/06/12 at 9:05 a.m., while touring the facility, the door to R4's room had a sign indicating the resident is currently on Respiratory Isolation. On 3/07/12 at 8:40 a.m., R4 was ambulating through the facility independently and unsupervised by staff, with only a mask on the opening to his	F9999		

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F9999	Continued From page 44 trachea and no mask on his face. R4 wandered into the Conference Room and had mouth secretions expelling from his bottom lip. At 9:42 a.m., R4 continued to wander the facility independently and unsupervised and was coughing in the main hallway with his mouth uncovered. On 3/07/12 at 1:30 p.m., R4 was at the Respiratory Nurses Station openly coughing and secretions could be heard rattling. R4 was not wearing a mask over his mouth and nose. On 3/08/12 at 8:15 a.m. R4 was walking down the hallway with E21 (Respiratory Therapist), with the opening to his trachea, mouth and nose uncovered. R4 touched the opening to his trachea multiple times and then touched the handrail and the counter at the Nurses Station. While standing at the Nurses Station, E21 wiped eye secretions from R4's face with her bare hand and did not perform handwashing. E21 then walked R4 back to his room, went to the kitchen to obtain a sugar packet and gave that sugar packet to another resident. At 9:22 a.m., R4 had a mask on his trachea opening while sitting in his private room. E21 was sitting next to R4, when R4 started to take the mask off of the trachea opening. E21 told R4, if he removed his mask, she would need to put a mask on herself. On 3/08/12 at 12:55 p.m., R4 was being pushed in a wheelchair up and down the hallway by Z2 (Family). R4 did not have a mask covering the opening to his trachea or his mouth and nose. At 2:05 p.m., Z2 stated he frequently takes R4 for walks throughout and outside the building. Z2 stated R4's trachea opening is usually not covered, "because he's (R4) picky and doesn't like to wear a mask." Z2 stated staff have not discussed with him under which circumstances	F9999		

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F9999	Continued From page 45 R4's airways are to be covered. On 3/08/12 at 1:15 p.m., E2 (Director of Nursing) stated R4 does like to wander the facility and trade books with people. E2 stated "they have discussed" the fact that R4 is out among the general population with an open airway and MRSA infection, but R4 wouldn't "tolerate a mask on his face." E2 further sated, "He (R4) is a problem. The only other choice they would have is to put him in a four point restraint." E2 confirmed that the facility currently had 25 residents that would be considered immunocompromised due to their medical condition (R5, R6, R7, R16, R17, R25, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, R43, R44, R45). On 3/13/12 at 9:30 a.m., E5 (Infection Control Coordinator) stated R4 has been on isolation for MRSA since he was admitted in June 2011. E5 stated R4 initially stayed in his room most of the time. E5 stated R4 eventually became more likely to leave his room and staff would just have R4 cover the opening to his trachea. E5 stated the facility failed to address the fact that R4 was out amongst the general population and MRSA positive. E5 stated R4 does not have the cognitive ability to understand the importance of handwashing or covering his airway. E5 stated she has been the Infection Control Coordinator for the last six years and has never had any special training on Infection Control Prevention/Interventions. E5 stated she had not stayed current with what the CDC (Centers for Disease Control) recommends for infection control in the Long Term Care Setting. On 3/12/11 at 11:07 a.m., Z1 (Infectious Disease Physician) stated, his recommendations regarding R4 would be that the facility "control	F9999		

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F9999	Continued From page 46 respiratory secretions as much as possible, with either a mask or room isolation, and use diligent handwashing." The facility also failed to ensure proper personal protective equipment was worn by staff when providing cares, failed to ensure the dedication of non-critical medical equipment (gait belt), and failed to properly disinfect multi-resident use equipment for residents on Isolation Precautions for a MRSA infection, for four of seven (R17, R14, R16 and R11) residents reviewed on Isolation Precautions, in a sample of 23 and one additional resident (R23) in the supplemental sample. Findings include: 1. An Admission Summary, dated 1/18/12, documents R17 has the current diagnoses of Anoxic Brain Damage, MRSA, and Acute Respiratory Failure. A Plan of Care, dated 12/19/11, documents R17 is on Isolation for MRSA of the nares. Microbiology reports, dated 12/14/11 and 2/14/12, document R17 as positive for a MRSA infection in the gastrostomy tube site. On 3/06/12 at 9:10 a.m., while touring the facility, the door to R17's room had a sign, which indicated "everyone who enters must wear gloves" and "wear a gown if contamination is possible." On 3/08/12, at 11:30 a.m., E9 (Respiratory Therapy Nurse) was wearing only gloves and verified the placement of R17's gastrostomy tube and administered medication and water through	F9999		

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the gastrostomy tube, while leaning against the resident's bed and sheets. E9 lifted R17's gown to observe the gastrostomy tube insertion site, which was open to air. E9 stated R17 had a MRSA infection of the nares and a drug resistant proteus of the urine and a gown was not necessary when handling R17's gastrostomy tube, because the infection was contained.

The facility Policy and Procedure, titled "Universal Precautions/Infection Control", indicates for "Contact Precautions" that staff are to "(4.) Wear a gown when entering the room if contamination is at all possible" and "(6.) Dedicate the use of personal, noncritical medical equipment to a single patient."

The facility Policy and Procedure, titled "Infection Control - Equipment and Supplies Used During Isolation Policy", indicates "(4.) Nursing Services will notify environmental services staff regarding equipment that needs sanitizing after use in the care of an individual with isolation precautions" and "(6.) Environmental services staff or designee shall be responsible for cleaning and sanitizing such equipment before it is returned to Central Supply or to designated storage areas."

2. A Physician's Order Sheet, dated 2/01/12, documents R14 has diagnoses which include quadriplegia, methicillin resistant staphylococcus aureus (MRSA) in the urine, and vancomycin resistant enterococcus (VRE) in the urine. A facility Universal Precautions/Infection Control Policy dated 7-15-02, indicates that residents with MRSA, VRE, or clostridium difficile (C-Dif) infections be placed in contact isolation. The facility policy also indicates that anyone entering a

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F9999	Continued From page 48 contact isolation room must wear gloves "upon entrance to the room and at all times" and to wear an isolation gown "when entering the room if contamination is at all possible." On 3-06-12 at 12:55 p.m. E6 (CNA) and E7 (CNA) applied gloves and entered R14's room to transfer R14 from the wheelchair to the bed and to provide R14 with incontinence care. Neither E6 or E7 (CNAs) wore isolation gowns while providing incontinence care to R14 or while touching R14's soiled linens. On 3-06-12 at 3:15 p.m., E13 (CNA) and E14 (CNA) entered R14's room after applying only gloves then provided R14 with incontinence care. E13 and E14 then lifted R14 from the bed using a mechanical lift device and transported him into the hall onto shower stretcher. E13 and E14 left the mechanical lift in the hall outside of R14's room without sanitizing it. E13 stated that R14 is "only in contact isolation and gowns don't need to be worn." On 3-06-12 at 3:30 p.m. E14 transported R14 by stretcher to the "Redwood" shower room. E14 removed R14's gown and placed it on a second bath stretcher located in the shower room. E14 stated that she was going to place R14's gown into one of the soiled linen barrels in the shower room but did not indicate the gown would be doubled bagged or separated from the non isolation soiled linen. On 3-08-12 at 2:15 p.m. E18 (Housekeeping Supervisor) stated that the staff are suppose to keep isolation linens separate from regular soiled linens by putting the isolation linens in a double bag before placing them in a biohazard (red) barrel. 3. A Physician's Order Sheet, dated 2/01/12, indicates R16 has diagnoses which include	F9999		

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F9999	Continued From page 49 MRSA septicemia and C-Dif. On 3-08-12 at 1:30p.m., R16 had an isolation sign posted on the door frame of R16's room but R16 did not have isolation supplies readily available outside the room. E15 (CNA) entered R16's room without wearing gloves or a gown and raised R16's bed rail. E15 then walked out of R16's room without washing her hands and stated that she did not know what kind of isolation R16 was in. On 3-08-12 at 1:40p.m. E15 and E16(CNA) transferred R16 from the wheelchair to the bed using a mechanical lift. E16 removed the mechanical lift from R16's room and without first sanitizing the mechanical lift and placed it into another resident's room. E16 stated that he did not know under what circumstances the mechanical lift should be cleaned, stating, " I don't know, I just pushed it here." On 3-07-12 at 11:00 a.m. E2 (Director of Nursing) stated that "contact isolation does not necessarily mean that staff need to wear gowns when entering an isolation room unless the staff member is sure they will get contaminated." E2 also stated that staff would not necessarily wear a gown in a resident's room who has MRSA or VRE in the urine even if staff are performing incontinence care unless there was urine "spilled all over the floor." E2 also stated that even though the facility policy indicates to "wear a gown when entering the room if contamination is at all possible," that "still means," that staff " don't necessarily need a gown for incontinence care for residents with MRSA in their urine." 4. On 3-9-12 at 2:00 pm R23 was in bed and incontinent of stool. E11 and E22 (CNAs/Certified Nursing Assistants) starting cleaning R23. While cleaning R23's stool, E11	F9999		

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ran out of washcloths, went to the door of R23's room and opened the door placing her dirty gloved hand on the door latch to ask someone for more linens. E11 and E22 finished cleaning R23 and transferred him with E11's gait belt from the bed to the wheelchair. E11 then removed her gait belt from around R23's chest and put it back on her own waist, finished in the room, washing her hands and then leaving the room.

R23's care plan dated 2-19-12 states R23 has MRSA (Methicillin Resistant Staphylococcus Aureus) of the gastrostomy tube (G-tube). R23's care plan states to "follow facility isolation protocol."

On 3-9-12 at 2:10 pm, E11 (CNA) stated she didn't realize she had touched the door handle with her dirty gloved hand. E11 also stated the staff use their own gait belts to transfer R23 instead of keeping one in the room for transfers. At 2:20 pm, E11 stated she talked with E2 (Director of Nursing) and was instructed to place a gait belt dedicated to R23's room to use for transfers. E11 also stated they cleaned the door handle to R23's room.

5. The sputum culture laboratory report for R11 dated 11/04/11 documents the following: "Moderate growth of MRSA (Methicillin Resistant Staph Aureus)". Facility policy on Contact Isolation (undated) documents that contact isolation precautions include wearing gloves upon entering the room and to wear gowns if physical contact with the resident will occur.

On 03/06/12 at 9:30AM R11 was sitting in the room in the wheelchair. R11 was wearing a face

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145719	A. BUILDING ______ B. WING ______	03/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE RIDGE CARE CENTRE	**2202 NORTH KICKAPOO STREET LINCOLN, IL 62656**

(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
F9999	Continued From page 51 mask. There was no isolation set up outside R11's room. On 03/07/12 at 10:00AM E2 (DON/Director of Nursing) stated. "Oh, there isn't an isolation set up outside (R11's) door? There should be one there, so the staff can put on the right protective equipment." 6. On 3-7-12 at 2:40 pm, E5 (Infection Control Coordinator) described the infection control program as follows: E5 gets a house report of who has started on antibiotics and logs those residents. E5 also gets a monthly log from the pharmacy for antibiotic use. E5 then attempts to determine what organism causes the infection. When asked how she monitors for trends or clusters, E5 stated she looks back from year to year. E5 verified there are 11 residents on her isolation log for 3-6-12. The facility provided a log for 2011 that listed only the number of nosocomial infections, urinary tract infections and upper respiratory infections by month. There is no indication of what organisms or other form of infections have been in the facility. E5 stated she does not track employee illness or have knowledge that employee illnesses are being tracked in the facility. E5 (Infection Control Coordinator) stated she has been in charge of the infection control program for approximately six years. E5 stated she has only recently started attending quality assurance meetings and has attended only two. E5 stated she takes her wound and infection reports to the meetings but states they have not really discussed anything related to infection control.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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
F9999	Continued From page 52 On 3-9-12 at 11:00 am, E2 (DON/Director of Nursing) stated that when staff call in with an illness, the Department heads take the information and then E2 logs it on a form. E2 stated she does not necessarily share/correlate this information with E5 (Infection Control Coordinator). (B)	F9999		