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	145243	A. BUILDING _____ B. WING _____	03/26/2015

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NORTH LOGAN HEALTHCARE CENTER	801 NORTH LOGAN AVENUE DANVILLE, IL 61832

(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	F 000		
F 226 SS=C	Annual Licensure and Certification survey 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to operationalize its Abuse Prevention and Prohibition Policy for screening new employees by failing to complete the required fingerprint background check upon a new hire of one Housekeeper, (E5). This failure has the potential to affect all 72 residents residing in the facility. Findings include: According to the Facility's Healthcare Employee List dated 3/25/15, E5 was hired on 2/23/15 as a full time Housekeeper. On 3/25/15 the personnel file for E5 contained an Illinois Department of Public Health Health Care Worker Registry report dated 2/23/15. This report did not have documentation of a Fingerprint Based Fee Applicant Background Check (FEE AP). The Health Care Worker Background check Act (amended 08/18/09) and Administrative Rules	F 226		

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

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(amended 03/26/09) require that a Fee AP be completed within ten working days of hire. The rules specify that the consequence for not obtaining the applicant's fingerprints within ten working days is that the facility suspends the applicant from work.

The facility report titled "Employee Timecard" dated for February 16 through March 31, 2015, documents E5 working the following days after the 10 working day parameter: 3/9 through 3/11, 3/13 through 3/18, 3/20 and 3/22 through 3/25/15, totaling 14 days working as a full time housekeeper.

The Facility's Abuse Prevention and Prohibition Policy dated 8/10/11 directs staff to complete the following on new hires: "The personnel director, or other person designated by the Administrator, will conduct employment background checks, reference checks and Illinois Nurse Aide Registry Checks on persons making application for employment with this facility. Such investigation will be initiated prior to employment or offer of employment. A criminal background check will be initiated for all employees within 10 days of accepting employment."

On 3/25/15 at 10:30 am E11, Dietary Manager and the employee responsible for completing and reviewing all staff background checks, could not provide a record of a FEE AP for E5. E11 stated "I thought it had been done, but I should have known better when there was no documentation on the Health Care Worker Registry showing a FEE AP date or result. I dropped the ball."

On 3/24/15 and 3/25/15 at 10:00 am and 9:30 am respectively, E5 was on the third floor of the

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F 226	Continued From page 2 facility, cleaning resident rooms. On 3/25/15 at 2:45 pm, E11 acknowledged E5 was in the facility working, but had been sent home at 2:00 pm. On 3/26/15 at 1:00 pm, E11 confirmed that E5 had worked 14 shifts outside the 10 working day parameter. E11 also confirmed that E5 had access to all residents in the facility. The Facility's Residents Census and Conditions of Residents Report dated 3/24/15 documents a census of 72.	F 226		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A.) Based on observation, interview and record review the facility failed to implement post fall interventions (floor mats and personal safety alarms) for two (R2 and R6) of eight residents reviewed for falls in a sample of 15. Findings include: 1. The facility face sheet dated 9/23/2014 documents R6 has a diagnosis of Difficulty	F 323		

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F 323	Continued From page 3 Walking, Hypertension, Lack of Coordination, and Unspecified Disorder of Muscle Ligament and Fascia. On 3/25/2015 at 8:45 AM, R6 was lying in bed with a fall mat in place on the right side of the bed, near the middle of the room. There was no fall mat on the left side of the bed near the window. On 3/25/2015 E6 Certified Nurse Aid (CNA) stated "the only falls (R6) had were from when (R6) crawled out of bed. (R6) will crawl out of either side of the bed." On 3/25/2015 at 11:45 AM, E7 (CNA) stated " (R6) is to have a bed alarm sensor pad on the bed. The pad is under (R6), but there is no alarm box connected to the pad. The sensor pad will not alarm without the alarm box attached." On 3/25/2015 at 11:50AM, E6 (Registered Nurse) stated "yes, (R6) is to have a bed alarm on the bed. The nurses check the alarm every shift and sign the Treatment Administration Record. I have not checked (R6's) alarm yet. I will check the alarm at 2:00PM." The Minimum Data Set dated 2/11/2015 documents R6 requires extensive assistance of two staff for transfers. R6's Physicians Order dated 3/1/2015 documents the following mat on floor next to low bed and bed alarm on bed check every shift. The Fall Assessment dated 2/11/2015 documents R6 is a high risk for falls.	F 323		

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The facility Accident Log from 4/1/2014-3/25/2015 documents R6 had falls on 3/12/2015, 9/13/2014, and 4/2/2014.

2. The Admission Record, 9/23/14, documents R2 with Senile Dementia and Difficulty Walking.

On 3/24/15 at 9:45am, R2 sat in the hallway in a wheelchair without a personal fall alarm in place. On 3/25/15 at 10:05am, R2 sat in the bedroom in a wheelchair without a personal fall alarm in place. On 3/25/15 at 10:10am, E12 (Nurse), stated R2 is supposed to have a wheelchair alarm in place on the wheelchair when R2 is up.

On 3/24/15 at 2:09pm, R2 laid in bed, not against the wall, with one mat on the floor between the bed and the wall and the floor by the other side of the bed (window side) exposed. On 3/25/15 at 12:30pm, E12 stated R2's bed is supposed to be up against the wall with a mat on the exposed portion of the floor by the bed. E12 stated, "(R2's) bed probably didn't get moved against the wall when R2 changed rooms. I will have (R2's) bed moved."

The Care Plan, 11/4/14, documents R2 at risk for falls with interventions to include the bed against the wall and a chair alarm while up in the wheelchair.

The Physician Order Sheet, March 2015, documents R2 with an order to include a wheelchair alarm due to lack of safety awareness.

The Incident Report, 11/27/14, documents R2 was found on the floor by the bed.

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F 323	Continued From page 5 The facility Fall Prevention and Assessment policy, 9/2012, stated the facility will identify individuals with a history of falls and risk factors for subsequent falling. Based on the assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. B. Based on observation, record review and interview the facility failed to store potentially hazardous chemicals in locked areas that are not accessible to residents on two of two resident floors. The facility failed to ensure resident do not have key access to the linen chute room to prevent accidents. The facility failed to maintain hair dryer filters to prevent overheating. This has the potential to affect five residents (R1, R2, R4, R19, R20) in the sample of 15 and 17 residents (R21, R23- R38) in the supplemental sample. The findings include: 1. On 3/26/15 at 9:45 am a key was in the door lock of the linen chute room located on the 2nd floor, East hall -Memory Lane (dementia care area). When the chute room was entered it was noted that the linen chute door was sagging down and was ajar. The opening to the linen chute was large enough that a resident could climb into it. R4 was seated in a wheelchair in the vicinity during this observation. R4 was previously identified as cognitively impaired resident that sometimes ambulates with out assistance by Registered Nurse E12 on 3/24/15 at 10:00 am during the initial tour.	F 323		

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The linen chute room is also in close proximity to R19's room, a cognitively impaired mobile resident who wears an electronic monitoring bracelet per the undated facility (Wandering Resident) list.

2. On 3/26/15 at 9:50 am the soiled utility room on the second floor was unlocked. The push button locking mechanism was not functioning. An unlocked housekeeping cart was stored in the room. There was a spray bottle of 1:10 bleach solution, spray bottles of quaternary ammonium disinfectants, two aerosol cans of air fresheners with warnings to keep out of reach of children and with labeled precautions for avoiding eye and skin contact.

On 3/26/15 at 10:30 am the Soiled Utility room door on third floor was unlocked. The door locking mechanism did not function when checked by E14. There were spray bottles of 16 ounce (oz) aerosol multipurpose cleaner and adhesive remover in an unlocked lower cabinet. The housekeeping cart was also unlocked and there was a 1:10 bleach disinfectant spray and air sanitizer in the cart that residents could gain access to once in the unlocked utility room.

The undated facility policy "Stocking a Housekeeping Cart" states "Employees should make sure their cart is stocked at all times...The cart must be kept locked at all times and never left unattended in any work area."

On 3/26/15 at 10:20 am the Janitors closet on the 3rd floor was unlocked. The door locking mechanism did not function. There were several 2 quart containers of Concentrated Quaternary

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F 323	Continued From page 7 Ammonium disinfectant, Peroxide Cleaner, Air freshener, and heavy duty floor cleaner with warnings to keep out of reach of children and labeled precautions for avoiding eye and skin contact. There was also access to the chemical fill station in the room with a container of floor cleaner attached. Maintenance Director E14 stated at that time that no one had reported problems with the door not locking. The MSDS (Material Safety Data Sheet) dated 12/04/14 for the floor cleaner stated "Danger causes skin irritation. Causes serious eye damage. May be harmful if swallowed." The facility "Care of Equipment" policy states: "Janitor Closet: Closets must be locked at all times when housekeeping is not working in the closet." The undated facility list for second and third floor cognitively impaired residents who wander and wear electronic monitoring bracelets included (R1, R2, R19, R20, R21, R23-R32). 3. On 3/26/15 at 10:00 am the resident beauty shop had two free standing hair dryers in the room. The filters for the air intake for each dryer was thickly coated with lint and dust which could cause the dryer to overheat during use. The Beauty Shop sheet dated 3/23/15 listed nine residents (R23, R24, R30, R33-38) who had had their hair done that day.	F 323		
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	F 441		

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F 441	Continued From page 8 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 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 utilize a bleach	F 441		

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based disinfectant for floor care, failed to change soiled gloves to prevent contamination of equipment, and failed to disinfect high touch areas to prevent transmission of Clostridium difficile spores. The facility failed to ensure that sterile suction catheters stored in two of two medical storage facilities were not outdated. This failure affected one resident (R17) of two reviewed with Isolation Precautions in the sample of 15.

The findings include:

1. R17's Admission Physician's Order Sheet dated 2/26/15 list diagnoses of an intestinal infection- Clostridium difficile (C-diff), Urinary Tract Infection, and Gastroenteritis. The physician order lists "Contact Isolation for C-diff." A hospital laboratory report for R17 dated 2/23/15 listed a positive stool culture result for "C.difficile Toxin-Positive H".

R17's Care Plan dated 3/09/15 states "(R17) has diagnoses C-diff". The interventions state: "Isolation Precautions".

On 3/24/15 at 11:20 am an isolation cabinet was outside of R17's doorway. A card in the top drawer indicated that R17 was under Contact Isolation Precautions. Registered Nurse (E3) stated at 11:30 am that R17 was under contact isolation for a C. diff infection. E3 stated R17 has completed antibiotic therapy and facility is awaiting stool culture results to determine if the treatment was effective. E3 stated that the facility staff is to follow isolation precautions wearing personal protective equipment such as gowns, and gloves to enter R17's room or provide care

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F 441	Continued From page 10 to R17. On 3/24/15 at 12:20 pm Certified Nurse Aide (E4) delivered the lunch tray to R17. E4 did not don gloves or a gown prior to going into the room. E4 set up the tray for R17, who was seated in front of an over the bed table. E4 moved the residents water pitcher and other personal items to accommodate the tray. E4 exited the room with out handwashing. 2. On 3/24/15 at 2:00 pm E5 Housekeeper was outside of R17's room. E5 put on a gown and gloves and entered the room to clean. E5 touched the over the bed table, R17's soiled lunch tray and silverware, the water pitcher, eyeglasses, and hairbrush while E5 was wiping the over bed table with a bleach solution on a cloth rag. E5 did not clean the TV remote or resident cell phone with the bleach solution. E5 did not wipe down the seat or armrest of R17's wheelchair that was beside the bed. E5 wore the same gloves and rag to wipe the resident sink, faucets, and counter. E5 used a different rag for the toilet but wore the same gloves to clean the toilet. There was brown matter on the toilet seat that E5 wiped with a bleach rag. E5 did not disinfect the door handle of the bathroom door or the bedroom door and E5 did not wipe down the light switches or the grab bar at the toilet. When E5 was done cleaning in the bathroom at 2:05 pm E5 did not remove her soiled gloves and wash hands. E5 went to the housekeeping cart in the doorway and grabbed the dust pan and dust mop with her soiled gloves. E5 swept and dusted the floors then put the dust pan and broom back	F 441		

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on her housekeeping cart without disinfecting the broom handles. E5 then grabbed a clean mop off of the cart with the same soiled gloves and mopped the floors in the bedroom and bathroom. E5 placed the mop back on the housekeeping cart without disinfecting the mop handle.

E5 at 2:10 pm stated that she had mopped the floors with a floor cleaner. E5 did not know the name of the floor cleaner but stated it did not contain any bleach. E5 stated she uses the 1:10 dilution of bleach solution for disinfecting the resident isolation rooms but uses regular floor cleaner for floors.

At 2:20 pm E5 removed her soiled gloves, gown in the room and washed her hands. E5 pushed the housekeeping cart to the janitors closet, donned new gloves and removed the soiled mop head and put the soiled mop handle back on the cart with out disinfecting the handle of the mop.

At 2:30 pm E5 pushed the housekeeping cart with the dust pan, broom and mop to another resident room to clean.

On 3/25/15 at 3:45 pm Housekeeping Supervisor E9 stated that staff should clean and disinfect all resident isolation rooms with a 1:10 bleach solution. E9 stated staff should disinfect all high touch areas in the room including door knob, light switches, grab bars, faucet handles, TV remote and cell phones. E9 stated staff should be frequently changing gloves and wiping clothes while cleaning to prevent contamination and should wash hands with soap and water before leaving the room. E9 stated at that time E9 was not aware that the floors should be disinfected with bleach for isolation room for Clostridium

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F 441	Continued From page 12 difficile. On 3/25/15 at 9:30 am R17 stated having diarrhea intermittently. R17 stated " I may not go for 1 or 2 days and then it just gushes out!" R17 stated at that time, when R17 has to make a bowel movement it is "urgent" and R17 has had some recent "accidents", not getting to the bathroom on time. R17 stated washing R17's hands at the sink with soap and water but does not have any hand sanitizer or wipes to use on R17's hands when R17 is in the wheelchair or the bed. Occupational Therapy staff E13, stated on 3/25/15 at 11:40 am that R17 had been incontinent of stool the previous Friday when he was working with R17. E13 stated he cleaned R17 up in the bathroom and then the housekeeping staff cleaned the bathroom and floors. The facility "Infection Control Contact Precautions for Clostridium Difficile dated 11/2010 documents: "It is the policy of this facility to ensure measures are taken to prevent the occurrence of Clostridium Difficile Infections(CDI) among residents: and that precautions will be taken while caring for residents with confirmed CDI until testing confirms otherwise...Residents with symptoms of CDI will be placed in contact precautions and the facility will follow the guidelines below pending results of stool testing...Don gloves upon entering resident room. Change gloves immediately if visibly soiled and after touching surfaces or materials contaminated with feces. Gowns should be worn with gloves for all interactions that may involve contact with the resident, contaminated equipment , or potentially	F 441		

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contaminated areas within the residents environment. ..perform hand hygiene after removal of gowns and gloves. Wash hands with non antimicrobial or an antimicrobial soap and water.."
"Use an EPA (Environmental Protection Agency) approved germicide for routine disinfection during non outbreak situations...Disinfect high-touch surface areas such as door knobs/handles, bedrails call buttons,telephones, over the bed tables, counter tops, light switches,...arms/seats of resident chairs, bedside commode and medical equipment."

A facility fact sheet for "Clostridium Difficile dated 11/2005 documents: "Environmental sources play a major role in transmission since C. difficile has a hardy spore that may persist for many months. These spores have been found on bedding, toilets, bedpans, sinks, floors, curtains and medical devices..Person to person transmission via the hands of healthcare workers or contact with contaminated environmental surfaces is the main route of transmission in hospitals."

3. On 3/24/15 at 12:00 pm the medical supply room on the third floor had a box with multiple peel packs containing different types of sterile suction catheters. There were 24 #12 french suction catheters in peel packs that had an expiration date of 2/2013. There was also a bottle of 70% isopropyl alcohol, with a 2/2015 expiration date, a bottle of hydrogen peroxide with a 7/2014 expiration date, and a 0.9% bottle of sodium chloride with a 1/2015 expiration date.

On 3/25/15 at 1:15 am Infection Control Coordinator E10 was shown the expired suction catheters. E10 stated that E8 stocks the supply

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145243	A. BUILDING _____ B. WING _____	03/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH LOGAN HEALTHCARE CENTER	801 NORTH LOGAN AVENUE DANVILLE, IL 61832

(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 441	Continued From page 14 room and should be checking supplies for outdates. E10 stated someone must have donated the suction catheters to the facility and they were placed in the storage room. E10 stated at this time there are no residents receiving routine suctioning. E8 stated on 3/25/15 at 1:25 pm that she only checks the outdates on supplies that she stocks. E8 had not checked the suction catheters.	F 441		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that all resident accessible toilet rooms were equipped with emergency nurse call stations for five resident (R1, R2, R4, R19, R20) in the sample of 15 reviewed for safety and eleven residents (R21, R23-32) in the supplemental sample. The findings include: 1. On 3/24/15 at 12:05 pm the third floor public restroom on the long hall was locked but had a ring with the bathroom key hanging on the door knob. There was no emergency call station for the toilet or any grab bars should a resident access the bathroom with the key and need assistance. On 3/26/15 at 10:20 am the same	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145243	A. BUILDING _____ B. WING _____	03/26/2015

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F 463	Continued From page 15 third floor public restroom had the key ring hanging on the door knob. 2. On 3/24/15 at 12:15 pm the third floor public restroom on the short hall was not locked. There was no emergency nurse call station at the toilet should a resident need assistance. On 3/26/15 at 10:35 am the restroom was again unlocked. Social Service Director E15 stated at that time that the restroom should be kept locked. 3. On 3/25/15 at 12:00 pm there was a bathroom key on a ring on the second floor public toilet room doorknob. There was an emergency nurse call station beside the toilet, however the pull cord to activate the station had been cut off leaving a one inch long string. There were also no grab bars at the toilet. Registered Nurse E12 stated at that the room doesn't need a nurse call because residents don't go in there because it was locked. E12 did agree that a resident could use the key to unlock the door. The undated facility (Wandering Resident) list for second and third floor shows fifteen residents (R1, R2, R19, R20, R21, R23-R32) who are cognitively impaired and mobile who could possibly gain access to the public restrooms if left unlocked or with the key readily available.	F 463		