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	146051	A. BUILDING _____ B. WING _____	11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRY COMMUNITY CARE CENTER	1313 PRATT STREET BARRY, IL 62312

(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 431 SS=F	Annual Certification Survey 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		11/21/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/08/2014

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 431	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to store medications in locked storage areas/carts. This has the potential to affect all of the 48 residents living in the facility. Findings include: 1. On 11/16/14 at 12:15 PM medication carts for the 200 Hall and the 300 Hall were located outside the dining hall entrance unlocked and unattended. Keys attached to a green bungee cord were observed placed on the top of the 200 Hall medication cart. On 11/16/14 at 12:15 PM, R17 ambulated past the unlocked and unattended medication carts. On 11/20/14 at 8:45 AM, E4, Licensed Practical Nurse (LPN), stated "I lock the cart and close the MAR (medication administration record) when I walk away from the medication cart. Keys are always with me. The set of keys with the green bungee attached to them, unlock the medication cart, the controlled medication box, medication room, storage room, treatment cart, and some general offices." On 11/20/14 at 8:55 AM, E17, LPN, stated "I worked on the 100 hall Sunday. I lock the medication cart when I walk away from the cart. I keep the keys with me." On 11/20/14 at 9:00 AM, E3, LPN, stated "I worked the 200 Hall on Sunday. The keys with the green bungee cord are the keys for the 200	F 431		

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F 431	Continued From page 2 Hall medication cart. I lock the cart when I walk away from the cart. I don't know why the keys were on top of the cart unless someone borrowed them from me and put them there." On 11/20/14 at 11:05 AM, E2, Director of Nurses (DON), stated "The keys the nurses have, unlock the medication cart, controlled substance box, medication room, storage room, treatment cart, and some general offices." Facility policy on Storage and Expiration of Medications, Biologicals, Syringes, and Needles dated 1/1/13, documents "Procedure: 1. Facility should ensure that only authorized Facility staff, as defined by Facility should have possession of the keys, access card, electronic codes, or combinations which open medication storage areas. 3.3 Facility should ensure that all medications and Biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors." 2. The Resident Census and Condition of Residents, CMS 672, dated 11/16/14 documents that the facility has 48 residents living in the facility.	F 431		
F 441 SS=F	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	F 441		11/21/14

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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, interview and record review, the facility failed to follow standard and contact isolation precautions/protocols when caring for residents with infections, failed to implement ongoing surveillance of employee isolation practices for residents with Clostridium difficile (C-diff). This has the potential to affect all

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of the 48 residents living in the facility.

Findings include:

On 11/16/14 at 1:30 PM, during the initial tour of the facility, E3 Licensed Practical Nurse (LPN), stated R1 has C-Diff. When asked if R1 was in isolation, E3 said, "No, but we do contact isolation when cleaning up loose stools." E3 said R1 has had one loose stool in three days. E3 was asked why no sign was posted on the door to notify staff and visitors of the isolation, and no isolation cart was outside R1's room. E3 said "Everyone knows she has C-diff. They have been told." During the initial tour, eight visitors were observed in R1's room without gowns or gloves on.

R1 was readmitted to this facility on 11/12/14 from the hospital with diagnoses, per Hospital Discharge Orders including gastrointestinal bleed and Clostridium difficile, status active. Transfer orders dated 11/12/14, from the hospital include Vancomycin 125 milligrams (mg), 1 capsule by mouth every 6 hours for 10 days. R1's Medication Administration Record (MAR) for November 2014, documented Vancomycin was discontinued on 11/17/14. The MAR showed no documentation of Vancomycin being given from 11/12/14 to 11/17/14.

On 11/18/14 at 9:45 AM, E13 LPN, when asked why the Vancomycin was not started as ordered. E13 stated "I don't no why the Vancomycin was never started it was just missed and all of (R1's) medications except for comfort medications were stopped on 11/17/14."

On 11/17/14 at 3:10 PM, E2, Director of Nurse's

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(DON), was asked for a copy of the policy and procedure for contact isolation for C-diff. E2 said the facility follows "Standard Precautions" for any resident in isolation. E2 said the Facility "does not have a specific C-diff contact isolation policy". E2 stated that no other residents in the facility currently had C-diff.

On 11/18/14 at 10:00 AM, E2 was asked again for a copy of the facility's policy and procedure for contact isolation and for C-diff. E2 provided a copy of the facility's policy and procedure, not dated for "INFECTION CONTROL (ALSO SEE UNIVERSAL PRECAUTIONS)." The policy documented "RESPONSIBILITY: ALL STAFF Under PURPOSE: To follow the most current recommendations of the Center for Disease Control regarding Universal Precautions."

The Centers for Disease Control CDC guidelines, dated May 2010, documented:

A. Measures for Healthcare Workers, Patients, and Visitors

Healthcare workers and visitors must use gloves (A-I) and gowns (B-III) on entry to a room of a patient with Clostridium difficile Infection (CDI). Emphasize compliance with the practice of hand hygiene (A-II).
In a setting in which there is an outbreak or an increased CDI rate, instruct visitors and healthcare workers to wash hands with soap (or antimicrobial soap) and water after caring for or contacting patients with CDI (B-III).
Accommodate patients with CDI in a private room with contact precautions (B-III). If single rooms are not available, cohort patients, providing a dedicated commode for each patient (C-III).

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F 441	Continued From page 6 Maintain contact precautions for the duration of diarrhea (C-III). Routine identification of asymptomatic carriers (patients or healthcare workers) for infection control purposes is not recommended (A-III) and treatment of such identified patients is not effective (B-I). B. Environmental Cleaning and Disinfection Identification and removal of environmental sources of C. difficile, including replacement of electronic rectal thermometers with disposables, can reduce the incidence of CDI (B-II). Use chlorine-containing cleaning agents or other sporicidal agents to address environmental contamination in areas associated with increased rates of CDI (B-II). Routine environmental screening for C. difficile is not recommended (C-III). The Center for Disease Control, CDC, guidelines documented under 11.1 Environmental Measures "Certain pathogens (e.g.....C. difficile) may be resistant to some routinely used hospital disinfectants. Also, since C. difficile may display increased levels of spore production when exposed to non-chlorine based cleaning agents, and the spores are more resistant than vegetative cells to commonly used surface disinfectants, some investigators have recommended the use of 1:10 dilution of 5/25%...hypochlorite (household bleach) and water for routine environmental disinfection of rooms and with patients with C. difficile when there is continued transmission." On 11/17/14 at 12:10 PM, E5 Certified Nurse Aide (CNA), was observed bringing R1 into the dining room per R1's wheelchair. E5 did not have gloves	F 441		

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on. R1 was placed at a dining table with 3 other residents and the dining room was observed to be full with 44 residents eating their noon meal.

On 11/18/14 at 10:50 AM, E12 (CNA) was interviewed regarding how many residents in this facility were on isolation, E12 said, "Only R1." When asked when she would gown and glove when caring for R1, E12 said, "I gown and glove when I am going to clean her up after she is incontinent of bowel movement."

On 11/18/14 at 10.52 AM, E5 (CNA) was interviewed and asked when she would gown and glove when caring for R1. E5 said "I would gown and glove to clean up stool, but I don't put a gown on for anything else."

On 11/18/14 at 10:55 AM, E8, Registered Nurse (RN) was interviewed, and asked what precautions she would take when caring for R1. E8 said she "Would use contact precautions if she were going to be in contact with stool."

On 11/18/14 at 10:58 AM, E9, RN Supervisor, when asked what precautions she would use when caring for R1. E9 said she would use gloves for all personal care, for cleaning up stool would use gloves, gown and hand washing, but no gown or gloves if not helping with bathroom privileges."

On 11/18/14 at 10:55 AM, E6 (CNA) was interviewed and asked when she would gown and glove when caring for R1. E6 said "I don't usually go in (R1's) room, this is my first pregnancy. If I would go in there I would gown and glove when I was cleaning up her stool."

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On 11/18/14 at 10:45 AM, E4 (LPN) stated, "I would use gown and gloves when (R1) is incontinent of bowel and urine."

On 11/18/14 at 11:00 AM, interview with E3 (LPN) about R1's loose stools, E3 said prior to R1's last hospital visit, R1 had issues at dialysis with loose stools. E3 said R1 "was diagnosed with C-diff at the hospital and does not know how long it has been going on."

Record review of lab work collected at the hospital on 11/9/14, documented R1 is Positive for C-difficile.

On 11/17/14 at 5:00 AM, Nurses notes documented, "Had loose foul stools times two." On 11/17/14 at 10:00 PM, Nurses notes documented "loose stools, watery. Continue with contact precautions." Review of the bowel movement list dated November 2014, documented, on 11/13/14, 11/14/14, 11/15/14, 11/16/14 and 11/17/14, R1 had moderate to large stools.

The Minimum Data Set (MDS) dated 10/14/14 for R1, documented R1 needs extensive assist with transfers and is incontinent of bowel and bladder. Care Plan for R1, dated 11/5/14, documented R1 is max assist with transfers using the hoyer lift and two caregivers.

On 11/16/14, 11/17/14 and 11/18/14, while observing R1's room, no designated hoyer lift was in R1's room.

On 11/19/14 at 1:30 PM, E13 (LPN) provided a list of residents on Hall 2 who require the hoyer lift for transfer, these residents are R1, R6 and R13.

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E13 said the facility has 3 hoyer lifts, but one of them is broke and is being fixed. One hoyer is used for the residents on Hall 3, and the other hoyer is used for the residents on Hall 2.

Housekeeping staff were interviewed on 11/18/2014. At 10:45 AM, E10 (housekeeper) stated that they have one resident (R1) with isolation precautions and they are aware that it was for a Clostridium Difficile infection. She stated that she uses the same chemicals with R1's room as they do with all the other rooms. E10 also stated that they use the similar routines to clean R1's room as they do with other rooms, except that they would make sure they washed their hands with running water before and after entering R1's room. E10 stated "They wash their hands, or use pocket hand cleaner, for standard rooms. In both cases they use gloves but no gowns or masks. " E10 also stated that they use the same chemicals for all the rooms as follows. E10 stated they wipe down furniture and other non-floor surfaces with Swisher Turquois 3 Disinfectant; and wipe down bathroom non-floor surfaces with Swisher Bathroom Cleaner or Spic & Span Disinfectant, they clean the floors with Swisher Neutral General Purpose Cleaner. E10 stated she would use extra precautions by making sure she washed her hands thoroughly after cleaning R1's room."

At 10:10 AM, E11 (Housekeeper) stated that she was aware of R1's isolation precautions due to Clostridium Difficile, also. She stated she uses the same above-mentioned procedures in regard to handwashing and chemicals used except she would use a gown in addition to gloves when entering R1's room.

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The housekeeping carts used by R10 and R11 were observed on 11/18/2014 at the time of the above interviews. Four cleaner containers were noted both these carts: Swisher Turquois 3 Disinfectant, Swisher Bathroom Cleaner, Spic & Span Disinfectant and Swisher General Purpose Cleaner. The label on the Spic & Span Disinfectant container documented that Dimethel Ammonium Chloride was the active ingredient. The labels on the Swisher Turquois 3 and the Swisher Bathroom Cleaner documented that the active ingredients were Quaternary Ammonium Compounds. There was no ingredient statements on the Swisher Neutral General Purpose Cleaner; however the Safety Data Sheet for this product, dated 10/20/2013, documented that the active ingredients are D-Limonene and Dipropylene glycol monomethyl ether. Bleach was not listed as part of the ingredients on any of these chemical cleaners.

On 11/18/2014, at 2:15 PM, numerous gallon containers of bleach were noted in the housekeeping storage room. E10 and E11 were interviewed at this same time about how they use this bleach product. They both stated that this bleach was not used much. They stated they use it for visible blood clean-up situations only.

The facility's Housekeeping policy/procedures, which had no date, outlined details of how the housekeepers are to clean rooms. This document had no procedures in regard to how staff are to clean a room where a resident with C-diff resides in nor did it have specific chemical use specifications. On 11/19/2014, at 2:00 PM, E1 (Administrator) stated that this was the housekeeping policy in use when R1 was admitted.

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F 441	Continued From page 11 The Resident Census and Conditions of Residents, CMS 672, dated 11/16/14, documented the facility has 48 residents living in the facility.	F 441		