STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145961	A. BUILDING _____ B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEDDINGTON OAKS	2223 WEST HEDDING AVENUE PEORIA, IL 61604

(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 441 SS=D	Annual Licensure and Certification Survey 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 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	F 441		1/22/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145961	A. BUILDING _____ B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEDDINGTON OAKS	2223 WEST HEDDING AVENUE PEORIA, IL 61604

(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 1	F 441		

infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to follow infection control measures regarding handwashing and wound care for three of eleven residents (R4, R8, R28) reviewed for infection control in the sample of 27.

Findings include:

According to the facility's wound care policy revised January 2002, a disposable cloth/item is to be used to establish a clean field. The policy also documents that hands are to be washed thoroughly after removing a dressing.

According to the facility's handwashing/hand hygiene policy dated March 2004, employees are to either wash their hands or apply alcohol-based hand rub before direct contact with the residents, before donning gloves and after removing gloves.

1. On 1-7-12 at 11:05 a.m., E13 (Certified Nursing Aide) entered R4's room to assist R4 with toileting. E13 did not wash his hands before applying gloves. E13 then wiped R4's buttock clean after a bowel movement. E13 threw away his soiled gloves and did not wash his hands or apply hand sanitizer. E13 then touched R4's doorknob and wheelchair handles. E13 then left R4's room and entered R28's room. A sign on R28's door documents that R28 is in contact precautions for isolation. E13 did not wash his hands or apply hand sanitizer when entering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145961	A. BUILDING _____ B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEDDINGTON OAKS	2223 WEST HEDDING AVENUE PEORIA, IL 61604

(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 2	F 441		

R28's room. E13 then touched R28's wheelchair handles and call light. E13 applied gloves and assisted E13 with a transfer. E13 did not wash his hands or apply hand sanitizer prior to applying the gloves.

On 1-7-12 at 1 p.m., E13 verified that he did not wash his hands or apply hand sanitizer before caring for R4 and R28 or between cares of R4 and R28.

2. On 1-8-13 at 10 a.m., E12 (Licensed Practical Nurse) entered R8's room to perform a dressing change to R8's left lower buttock wound and right heel wound. E12 entered R8's room with gloves on and a dressing in her hand. E12 did not wash her hands when entering R8's room or prior to doing R8's dressing changes. E12 removed R8's dressing, soiled with red drainage, from R8's left lower buttock wound. E12 then carried the soiled dressing to the hallway and disposed of it. E12 then re-entered the room and applied new gloves. E12 did not wash her hands or apply hand sanitizer between glove changes. E12 cleansed R8's wound to the left lower buttock with wound cleanser and gauze. E12 place the soiled gauze on a glove sitting on the side table next to the bed. E12 placed the wound cleanser bottle on R8's bed. E12 applied a new dressing to R8's left lower buttock wound. E12 changed her gloves and preceded to remove a dressing from R8's right heel wound. E12 did not wash her hands or apply hand sanitizer between dressing changes. E12 took the wound cleanser bottle that was placed on R8's bed and placed it on top of the treatment cart. E12 did not set up a clean field to do the dressing changes to R8's left lower buttock and right heel.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145961	A. BUILDING _____ B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEDDINGTON OAKS	2223 WEST HEDDING AVENUE PEORIA, IL 61604

(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 3 On 1-8-12 at 1:30 p.m., E12 acknowledged that she did not wash her hands before doing the dressing changes to R8's left lower buttock wounds and R8's right heel wound. E12 also acknowledged that she did not wash her hands between removing the soiled dressing to R8's left lower buttock wound and placing a new dressing. E12 verified that she placed the wound cleanser bottle on R8's bed and then set it on top of the treatment cart after use. E12 verified that after removing the soiled dressing to R8's left lower buttock, she placed the soiled dressing on top of a clean glove that was on top of a side table.	F 441		