STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145827	A. BUILDING _____ B. WING _____	02/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITISH HOME, THE	8700 WEST 31ST STREET BROOKFIELD, IL 60513

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F 000	INITIAL COMMENTS Annual Licensure and Certification Sheltered Care Survey The British Home is in compliance with the Sheltered Care Facilities Code (77 Illinois Administrative Code 330) for this survey.	F 000		
F 226 SS=C	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, interview and record review, the facility failed to include the following in its abuse policy: notifying the administrator immediately with an allegation of abuse and reporting reasonable suspicion of a crime/Elder Justice Act. The facility also failed to post information relating to the Elder Justice Act and failed to follow their abuse policy for conducting admission background investigations for seven residents (R12, R15, R16, R17, R18, R19, R20) reviewed for back ground checks on the supplemental sample. These failures have the potential to affect all 49 residents in the facility. Findings include: Facility's Abuse Prevention Program policy, dated 8/2006, states "Encouraging all personnel, residents, family members, visitors, etc., to report	F 226		

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

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any signs or suspected incidents of abuse to facility management immediately." This policy also includes, "Conducting background investigations to avoid...admitting new residents who have been found guilty (by court of law) of abusing, neglecting, or mistreating individuals or those who have had a finding of such action entered into the...state sex offender registry."

1. Policy on abuse does not include that the Administrator has to be immediately informed of an allegation of abuse and not just the management. The policy also does not include the Elder Justice Act and Reporting of Reasonable Suspicion of a Crime information.

On 2-16-15 at 10:30 am, E1 (Administrator) confirmed the abuse policy does not state to report suspected abuse immediately to the Administrator. E1 also stated the policy does not contain the information relating to the Elder Justice Act.

During tour of the facility on 2-25-15 at 1:05 pm and on 2-26-15 at 10:40 am, the Elder Justice Act poster was not present in the facility.

On 2-16-15 at 10:45 am, E1 (Administrator) stated the facility does not have the Elder Justice Act information posted.

2. R12's face sheet indicates R12 was admitted to the facility on 2/11/15.

3. R15's face sheet indicates R15 was admitted to the facility on 2/13/15.

4. R16's face sheet indicates R16 was admitted to the facility on 2/16/15.

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F 226	Continued From page 2 5. R17's face sheet indicates R17 was admitted to the facility on 2/13/15. 6. R18's face sheet indicates R18 was admitted to the facility on 2/14/15. . 7. R19's face sheet indicates R19 was admitted to the facility on 2/15/15. 8. R20's face sheet indicates R20 was admitted to the facility on 2/16/15. On 2/25/15 at 9:10am. E4 (Admissions Coordinator) was unable to provide any documentation that E4 had compared the names of R12, R15, R16, R17, R18, R19, or R20 with the Illinois State Police Sex Offender website or the Illinois Department of Corrections website. At that time, E4 verified E4 did not compare the names of R12, R15, R16, R17, R18, R19, R20 against the Illinois State Police Sex Offender Registry or The Illinois Department of Corrections website. The Resident's Census and Conditions of Residents Report completed 2-24-15 and signed by E5 (Minimum Data Set Coordinator) states the resident census is 49.	F 226		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279		

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objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to develop a care plan for advance directives for four residents (R11, R13, R9 and R6) of 13 residents reviewed for care plans in a sample of 13.

Findings include:

1. R11's POS (Physician's Order Sheet) for February 2015 states R11 has a DNR (Do Not Resuscitate) order.

R11's current care plan dated 2-16-15 does not contain any information related to R11's Advance Directive wishes.

2. R13's POS for February 2015 states R13 has a DNR order.

R13's current care plan dated 2-21-15 does not contain any information related to R13's Advance

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F 279	Continued From page 4 Directive wishes. 3. R9's POS for February 2015 states R9 has a DNR order. R9's current care plan dated 2-11-15 does not contain any information related to R9's Advance Directive wishes. 4. R6's POS for February 2015 states R6 has a DNR order. R6's current care plan dated 1-24-15 does not contain any information related to R6's Advance Directive wishes. On 2-25-15 at 2:00 pm, E6 (Social Service Director) verified E6 does not add Advance Directives to resident's care plans.	F 279		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to contain refuse and prevent the harborage and feeding of pests from the garbage/recycling dumpsters which has the potential to affect all 49 residents in the facility. Findings include: On 2/25/15 at 2:00p.m. E11 (Maintenance Director) was standing next to the facility's	F 372		

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F 372	Continued From page 5 garbage and recycling dumpsters. A squirrel poked it's front paws and head out of a hole in the lid of the dumpster and had a piece of discarded food from the dumpster in it's mouth. E11 explained squirrels had been in the dumpster before when, "Sometimes people throw things in there (the dumpster) that they shouldn't." A Housekeeping and Pest Control policy (undated) and a Maintenance Policies and Procedures dated 1997 do not address pest control for the facility's dumpsters. A Resident Census and Conditions of Residents report dated 2/24/15 and signed by E5 (Minimum Data Set Coordinator) documents that at the time of the survey 49 residents resided in the facility.	F 372		
F 431 SS=F	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	F 431		

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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.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to prevent unauthorized staff from having access to medication storage rooms. This failure has the potential to affect all 49 residents in the facility.

On 2/25/15 at 10:40a.m. E7 (Housekeeper) was delivering supplies to the first floor medication room. E7 removed keys from E7's pocket then proceeded to insert keys into the medication room lock.

On 2/25/15 at 10:45a.m. E7 verified having a key to the medication room. E7 stated the key is a "master key" which is able to open the first and second floor medication rooms. E7 stated the medication rooms are also used to store resident care supplies stating, "There's five of us (housekeepers) who do central supply and have med room and supply room keys."

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F 431	Continued From page 7 On 2/26/15 E2 (Director of Nurses) stated the facility's policy is, "Only nurses can access the medication room..." A Resident Census and Conditions of Residents report dated 2/24/15 and signed by E5 (Minimum Data Set Coordinator) documents that at the time of the survey, 49 residents resided in the facility.	F 431		
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 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441		

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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 prevent cross contamination during incontinence care for one of six residents (R10) reviewed for incontinence care in a sample of 13.

Findings include:

On 2/25/15 at 10:45a.m. E8 (Wound Nurse), E9 (Registered Nurse), and E10 (Certified Nurse Aide) applied isolation gowns/gloves then entered R10's room to perform incontinence care. E8 and E9 assisted R10 to the bathroom to perform perineal cleansing while E10 removed R10's soiled linens from the bed. E10 cleaned bowel movement (BM) from R10's mattress then removed the isolation gown and soiled gloves E10 was wearing. Without performing hand hygiene, E10 left R10's room to retrieve additional supplies. Meanwhile, E9 used cleansing wipes to cleanse BM from R10's perineal area. Without removing the soiled gloves or performing hand hygiene, E9 assisted E8 to apply a clean incontinence pad to R10. E9 pulled R10's wheelchair into the bathroom then held onto R10's arm while transferring R10 into the wheelchair.

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F 441	Continued From page 9 A facility Infection Control, Standard Precautions policy dated 4/2001 states, "Standard Precautions will be used in the care of all residents regardless of their diagnosis or presumed infection status...Wash hands immediately after gloves are removed, between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents. Wash hands between tasks and procedures on the same resident to prevent cross-contamination of different body parts." On 2/26/15 at 1:45p.m. E2 (Director of Nurses) stated staff should, "Wash hands after removing gloves and after any resident contact."	F 441		
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to have procedures in place to calculate the amount of water needed in the event of the loss of water supply. This failure has the potential to affect all 49 residents. Findings include: The facility policy and procedure for Emergency Water Supply, dated 2010, does not include a	F 466		

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F 466	Continued From page 10 written protocol as to potable and non-potable water needs, storage or distribution. On 2/24/15 at 2:00 pm, E1 Administrator stated the facility does not currently have and is not currently using any formula to calculate the facility's water needs. The Resident Census and Conditions of Residents, dated 2/24/15, signed by E5 Minimum Data Set Coordinator, documents the facility census at 49.	F 466		