STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145241	A. BUILDING _____ B. WING _____	C 07/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA SOUTHBELT HEALTHCARE	**101 SOUTH BELT WEST BELLEVILLE, IL 62220**

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F 000	INITIAL COMMENTS Complaint # 1643298/IL86265 - F315, F441 Complaint # 1643544/IL86526 - No deficiencies	F 000		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide complete catheter care and failed to provide an indication for the continued use of an indwelling catheter for 2 of 4 residents (R1 and R5) reviewed for catheter care in the sample of 14. Findings include: 1. R5's Physician Order Sheet for 6/2016 documents R5 was on contact isolation for Extended Spectrum Beta Lactamase (ESBL) of the urine and has a suprapubic catheter. On 6/29/16 at 2:51 PM, E13, Licensed Practical Nurse (LPN), provided dressing change and catheter care to R5's suprapubic catheter. E13 washed hands and put on gloves and took off the	F 315		

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

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F 315	Continued From page 1	F 315		

old dressing on R3's suprapubic catheter and discarded it. E13 took off her gloves and put on new gloves without prior hand hygiene cleansed the stoma and the juncture of the tubing from the insertion site down the catheter tubing with gauze wet with normal saline solution.

On 6/29/16 at 4:08 PM, E2, Director of Nursing (DON), stated the nurse should cleanse the suprapubic catheter with soap and water.

The Facility Policy on Suprapubic Catheter Care dated 7/2014 documents, "It is the policy of (Facility) that catheter care is provided by a licensed nurse or a certified nurse's aide, on each shift or as ordered, for resident with a suprapubic catheter. Procedure: 5. Clean area around catheter well with soap and warm water."

2. On 6/29/16 at 11:10 AM, E8 and E9 both Certified Nursing Aides (CNAs), provided catheter care to R1.

R1's Hospital General Discharge Instructions dated 6/14/16 documents, "Please leave (indwelling catheter) in until completion of Urinary Tract Infection (UTI) treatment. After completion of full course of Omnicef, pull out (indwelling catheter)."

R1's Medication Administration Record for 6/2016 documents Omnicef was completed on 6/22/16.

On 6/30/16 at 10:09 PM, Z1, R1's Physician, stated R1 returned on 6/15/16 from his most recent hospital stay with an indwelling catheter. Z1 stated R1 was treated in the hospital for UTI. Z1 stated R1's catheter should have been taken out after his antibiotic treatment was completed a

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F 315	Continued From page 2 week ago. Z1 stated there was no indication for R1's use of an indwelling catheter after that.	F 315		
F 441 SS=E	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		

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infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to follow contact precautions by not wearing proper personal protective equipment when cleaning an isolation room for Clostridium difficile (C-diff), and failed to perform proper hand washing/hand hygiene to prevent the spread of infection for 5 of 5 residents (R1, R2, R4, R5, R6) reviewed for infection control practices in the sample of 14.

Findings include:

1. R1's Physician Order Sheet (POS) dated 6/15/2015 documents R1 was readmitted to the facility with orders for Omnicef for Urinary Tract Infection and Metronidazole for C-diff and placed on contact isolation.

R1's Minimum Data Set (MDS) dated 5/27/16 documents R1 is totally dependent on staff for toilet use, dressing and personal hygiene.

On 6/28/16 at 9:41 AM, E14, Housekeeping Staff, went inside R1's room wearing gloves and holding a broom and dustpan and swept the floor. E14 came out of R1's room with the dustpan and broom, put them back in her cleaning cart. E14 replaced her gloves and brought a mop inside R1's room. E14 mopped the bathroom then the bedroom. E14 brought the mop out and remove the mophead and put it in a plastic bag and brought it to the laundry room. E14 did not wear any gown or shoe protector, only gloves. E14 did

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not wash her hands after she finished cleaning R1's room and taking off her gloves.

On 6/28/16 at 1:10 PM, E14 stated she did not think she should be wearing a gown when cleaning R1's room because she was not dealing with R1's "poop."

On 6/30/16 at 11:30 AM, E12, Housekeeping and Laundry Supervisor, stated housekeeping staff should wear gowns, gloves and shoe protectors when cleaning isolation rooms for Clostridium difficile infections like R1.

On 6/29/16 at 11:10 AM, E8 and E9 both Certified Nursing Aides (CNAs), provided perineal and catheter care to R1. E8 and E9 washed their hands, gowned and gloved before starting the procedure. E8 washed the catheter at the insertion site, then the penis, scrotum, and inner thighs. E8 changed gloves after sanitizing her hands, not washing her hands, as she moved from one area to the next in the front. R1 turned to his left side and he had a very loose bowel movement of moderate amount. E8 washed R1's rectal area, changed gloves after sanitizing her hands, not washing her hands, and finished cleaning R1's buttocks. E8 and E9 washed their hands after they were done.

2. R5's Minimum Data Set (MDS) dated 5/2/2016 documents R5 is totally dependent on staff for toileting, dressing, hygiene and bathing and is fequently incontinent of bowel and has a suprapubic catheter.

R5's Physician Order Sheet (POS) dated 6/2016 documents an order for contact isolation for Extended Spectrum Beta Lactamase (ESBL) of

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the urine.

On 6/29/2016 at 2:51 PM, E13, Licensed Practical Nurse (LPN), provided catheter dressing change to R5. E13 gowned and gloved and took off R5's old dressing to the suprapubic catheter stoma. E13 took off gloves after discarding the dressing and put on clean gloves without prior hand hygiene. E13 cleansed the insertion site and the catheter tubing from the insertion site outwards with normal saline solution one time. E13 taped a clean dressing to the insertion site, took off her gloves and sanitized her hands and stated she was done with dressing change to the catheter site.

3. R6's MDS dated 5/12/16 documents R6 is totally dependent on staff for toileting and personal hygiene, has an indwelling catheter and is frequently incontinent of bowel.

R6's POS dated 6/2016 documents isolation for Clostridium difficile of the stool and Vancomycin for 14 days.

On 6/30/16 at 2:37 PM, E16 and E17, both CNAs, provided perineal care to R6. Both E16 and E17 washed their hands and wore gloves before providing care to R6. E16 washed using no rinse periwash the penis starting from the point of insertion of the catheter, then the shaft, scrotum, inner thighs, groin area and dried. E16 and E17 turned R6 to his left side and washed him on his anal area where some fecal smear was noted on the washcloth, then under the scrotum, and buttocks. E16 changed gloves regularly when moving from one area to the next without washing her hands, only using hand sanitizer before each glove change. E16 and E17 washed their hands

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with soap and water after they were done with the procedure.

On 6/30/16 at 4:15 PM, E2, Director of Nursing (DON), stated staff should always wash their hands with soap and water everytime they take off their gloves when taking care of residents on contact isolation for C-diff of the stool.

The Facility Policy on Disease Specific Guidelines and Protocols dated 10/22/15 documents, "C-diff Precations: 1. Alcohol-based hand cleanser is not effective in killing or removing C-diff spores from the skin. Preventing contamination of the skin by glove use is the cornerstone for preventing C-diff transmission via the hands of healthcare workers. Hands should be washed with soap and water following glove removal. 3. Disposable gown and gloves will be worn by staff entering the room to provide care/interaction with any resident on active C-diff isolation. "

The CDC Guidelines on Hand Hygiene in Healthcare Settings dated 10/2002 documents, "When to Perform Hand hygiene: Before eating. Before and after direct contact with a patient's intact skin. After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressing. After contact with inanimate objects in the immediate vicinity of the patient. If hands will be moving from a contaminated body site to a clean body site during patient care. After glove removal."

4. On 6/22/16 at 12:45 PM, E4, Housekeeper, was observed in R2's room wearing gloves, E4 picked up R2's ice water pitcher, carried it out to the hallway, filled the pitcher with ice from a cooler using the ice scoop, returned the ice water

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F 441	Continued From page 7 pitcher to R2's bedside table, exited room, pushed ice chest cart to the next doorway R4's room, entered the room, obtained R4's ice water pitcher, exited the room, filled R4's ice water pitcher, returned it to R4's bedside and exited room. E4 did not change gloves during this process. The facility provide list of isolation residents dated 6/21/16 which documents R2 has Clostridium Difficile. On 6/22/16 at 12:50 PM, E2 stated, "(E4's) actions while filling the ice is inappropriate."	F 441		