STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145358	A. BUILDING _____ B. WING _____	01/16/2014

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COMMUNITY NURSING & REHAB CTR	1136 NORTH MILL STREET NAPERVILLE, IL 60563

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F 000	INITIAL COMMENTS	F 000		
F 323 SS=D	Annual Licensure and Certification 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: Based on record review and interview, the facility failed to ensure monitoring alarm devices on residents with high risk of falls were functioning. This applies to 1 of 7 residents (R19) reviewed for falls in a sample of 24. Findings include: R19's diagnosis includes Dementia, Osteoporosis and hip joint replacement. R19's post fall assessment dated 12/15/13 assessed R19 as high risk of falls with approaches to include bed alarm. Incident report dated 1/7/14 at 3:34 PM documents R19 was heard hearing yelling from R19's room. R19 was found by staff on the floor next to her bed. Facility incident investigation notes R19's bed alarm was not working at the time of finding R19 on the floor.	F 323		

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.

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F 323	Continued From page 1 Initial assessment of R19's shows R19 complained of no injury at time of incident, however R19 was sent out to hospital on 1/7/14 for evaluation after complaining of left hip pain later that afternoon of the incident and returned to facility at 10:50 PM with no injury. E2 (Director of Nursing) stated during daily status at 10:15 AM R19's battery in the bed alarm was not working on 1/7/14. E2 stated alarms are to be checked by CNA on every shift to see if the alarms are functioning. Facility policy for Resident Alarms Procedures includes: identify residents at risk for falls and those who would benefit from the use of an alarm device (confused residents, unsteady or weak in ambulation and/or rail climber. Test alarm for process functioning. Alarms should be tested by CNA/RN daily. R19's restorative Nursing Flow Record for January 2014 states batteries should be checked daily to be sure alarm is working properly for bed and /or chair every shift. There is inconsistent documentation that the bed alarm for R19 is being checked every shift as required per R19's care plan.	F 323		
F 431 SS=E	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	F 431		

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F 431	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that expired medications and biologicals were not available for residents' use. The facility also failed to ensure that supplies and employee's personal property were not stored in the cabinet under the sink. This applies to 8 residents (R2, R3, R4, R7, R8, R19, R20 and R23) in the sample of 24 and 51 residents (R25 to R74) in the supplemental sample.	F 431		

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The findings include:
1) During observation of 2 North/South Medication Room and Crash Cart on 1/15/14 between 10:00 AM with E4 (2nd Floor ADON - Assistant Director of Nursing), the following were found:
1 plastic container of Slow Iron tablets with 44 pills- labeled with expiration date of 12/2013, kept in the medication cabinet.
2 tubes of saline injection (10 milliliter each) - labeled with expiration date of 7/2013, kept in the crash cart drawer.
2 plastic tubes of Insta Glucose - labeled with expiration date of 4/2013, kept in the crash cart drawer.
There was no log that the crash cart was being checked.
E4 said that 11-7 staff nurse was responsible to check medication expiration dates in the medication cabinet and crash cart.

Surveyor: Soyemi, Caroline
2) During observation of Homeward Bound Unit Medication Room on 1/15/14 at 9:30 AM with E5 (Registered Nurse), the following was noted:
There were several tubes of plastic medication cups stored underneath the sink co mingling with unidentified employee ' s lunch bag.

3) On 1/15/14 at 3:30 PM, during an inspection of the facility's first floor medication room located between the North and South units an open multi-dose vial of Purified Protein Derivity (PPD) was found with the date 11/22/13.

The Assistant Director of Nursing (E3) responsible for 1 north and 1 South units present during the observation stated that it is the policy of the facility that PDD solution be discarded 30

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F 431	Continued From page 4 days after opening. The facility's Injectable Vial and Ampules policy (12/12) states that multi-dose vials are to be discarded when empty, when suspected or visible contamination occurs or when the manufacturer's stated expiration date is reached, provided the manufacturer' storage conditions have been maintained. Expiration dating not specifically referenced in the the manufacturer's package insert should not exceed 28 days once the vial has been opened.	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	F 441		

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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 its isolation policy for contact isolation for one resident (R1) out of 9 residents reviewed for infection control and failed to perform proper hand hygiene during wound care for one resident (R7) out of 7 residents reviewed for pressure ulcers from a total sample of 23.

Findings include the following:

1. R1 is a 75 year old resident admitted to the facility on 7/10/13. Admitting diagnoses include Osteoarthritis, Colitis, Obsessive compulsive disorder, depression, chronic abdominal pain, lumbar stenosis, Gastroesophagial reflux disease, frequent urinary tract infections, hypothyroidism, anxiety, and dementia.

On 1/13/14 at approximately 10:45 AM, during the initial tour of the facility R1 was reported by the facility's Transitional Care Coordinator (E10) to be on isolation precautions for a Methicillin Resistant

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Staph Aureus (MRSA) infection.

At the time of the observation there was no sign posted at R1's door or outside of her room indicating that the resident was on isolation precautions or to see the nurse prior to entering the resident's room.

There Were also two Certified Nurse's Aides (E11, E12) observed in R1's room. E11 was observed walking out of R1's room wearing a pair of gloves and entering another resident's room. E12 was observed making R1's bed and getting her ready to leave the room. Both E11 and E12 did not wear gowns while in R1's room.

On 1/15/14 at approximately 1:45 PM one of the facility's staff nurses (E13) was asked if R1 was on isolation precaution. E13 stated that she wasn't sure and that she would have to ask her supervisor. E13 returned several moments later and stated that R1 was not on isolation precautions. The Assistant Director of Nursing supervising (E3) the unit (1 North) confirmed E13's statement that R1 was not on isolation precautions.

Review of a physician order sheet located in R1's medical record dated 1/11/14 showed that R1 was ordered to be placed on contact isolation on 1/11/14. Laboratory reports drawn on 1/8/14 and reported on 1/11/14 indicated that R1 was positive for MRSA.

The the facility's Transmission -Based Precautions (effective 9/15/12) states that when a resident is place on isolation a sign is placed on the door directing visitors to see the nurse prior to entering the resident's room. The information is

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placed on the 24 hour report and other departments are informed. In addition the policy states that Gown and gloves are required and are applied upon entry to the room and discarded before exiting.

On 1/16/14 at 9:39 AM, the facility Director of Nursing (E2) confirmed that R1 was on contact isolation. She stated that to her knowledge facility staff were not required to wear gowns when entering the room of a resident on contact isolation. E2 stated that she was unaware of why a sign indicated R1 infectious status was not placed outside her room.

Review of R1's care plan did not show that interventions to address her isolation status was initiated. A care plan wasn't initiated to address R1's infected wound until two days after her diagnosis of MRSA.

2) On 01/15/14 at 2:10 PM,, R7's wound dressing was observed with E6 (Nurse). E6 put on clean gloves and took a saline soaked clean gauze and cleansed the wound on R7's buttocks. R7's wound was observed with small amount of drainage. E6 took another clean dry gauze and wiped R7's buttocks with same dirty gloves. E6 removed her dirty gloves and applied Vasolex ointment then washed her hands for 8 seconds. E6 put on clean gloves and cut the elastic gauze dressing on R7's left leg then soaked the remaining dressing that was stucked on R7's wound with normal saline. E6 removed the soaked dressing and cleansed the wound with normal saline with the same dirty gloves. E6 then washed her hands for 8 seconds after removing the dirty gloves.

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E6 proceeded to put on clean gloves, applied the aquacel alginate, put gauze over it and wrapped the leg with elastic gauze. E6 removed her gloves went to get a tape outside the room in the treatment cart but there was no tape in the treatment. E6 then went to the nursing station to get a tape without washing her hands.

E6 was asked what was the policy for hand washing. E6 said the hand washing should be done for 15 seconds. E6 was informed that she did not washed her hands for 15 seconds. E6 said he was kind of nervous.

The facility's policy entitled, "Hand Hygiene," dated 5/25/12, required:
"Hand hygiene is performed :
- after removing gloves
Procedure:
- Wash all areas of the hands and fingers vigorously for 15- 20 seconds to aid in the mechanical removal of bacteria."