STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E288	A. BUILDING _____ B. WING _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTHAVE HOME-WHITESIDE COUNTY	408 MAPLE AVENUE MORRISON, IL 61270

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Complaint Follow up Visit 1211452/ IL#57503	F 000		
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	F 441		4/22/14

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

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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 identify and contain residents' exposure to a communicable disease. The facility failed to ensure staff handled a soiled brief to prevent cross contamination and the facility failed to assist a resident with handwashing after toilet use.

This applies to 6 of 10 residents (R10, R30 R35, R32, R29, R13) reviewed for infection control in the sample of 10 and 3 residents (R15, R20, R24) in the supplemental sample .

The findings include:

1. On 4/1/14 at 9:30 AM, an updated sign on an 8.5 x 11" piece of paper was posted on the entrance door that stated, "If you are visiting, please check with the nurses as we have had a few cases of the flu to make sure you are able to visit with the individual you came to see."

On 4/1/14 at 9:45 AM, during initial tour, E2 (Director of Nurses - DON) stated, "We have a little bit of a flu outbreak in the facility." E2 stated there were no residents in isolation. E2 provided a list of 5 residents that currently have diarrhea and vomiting symptoms.

On 4/1/14 at 11:10 AM, E7 (Cook) opened a large can of chicken noodle soup. E7 stated, "Over the

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weekend and the end of last week, we had a flu outbreak. Residents with vomiting and diarrhea.. Many don't feel like eating the regular meal so we are making light trays of soup, and toast." E7 was asked about residents eating in their room or in the dining room. E7 stated, "Residents can eat in their room if they want or don't feel like coming out. The resident decides on how they're feeling."

On 4/2/14 at 11:15 AM, E2 (Director of Nurses-DON) was asked what measures are in place to contain the spread of the vomiting and diarrhea symptoms in the facility. E2 stated we are using good hand washing and hand sanitzer is available on the units. "We have not used isolation, because the outbreak seems random. E2 stated the roommates of affected residents have not been moved. So far none of the affected resident's roommates have come down with the symptoms." E2 stated it has not yet been determined where the flu came from, but they have had staff calling off with vomiting and diarrhea symptoms. No specific trends had been identified or isolated. E2 reported both Assisted Living and Nursing (intermediate care) residents have been affected. No additional measures have been implemented to prevent the spread of the infections.

On 4/2/14 (Wednesday) at 1:15 PM, R30 was lying in bed in her room. R30 appeared fatigued and barely opened her eyes to speak. A large bowl (for emesis) was on a bedside table near the head of R30's bed. R30 stated she had vomited earlier today. R30's roommate (R20) was in the room sitting in a recliner, positioned next to the head of R30's bed. R20 explained that R30 has been ill since Sunday night/Monday morning. R20 stated she and R30 share the same

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bathroom. R20 stated she had not received any information regarding what precautions she should take to prevent acquiring R30's illness.

On 4/2/13 at 1:20 PM, E8 (Licensed Practical Nurse - LPN) stated, "R30 started Sunday night, early Monday morning with diarrhea and vomited 5 times. She had a temperature 99 degrees." E8 stated she thinks R30 is better today, she is starting to take small amounts of fluid. E8 stated there were no precautions in place to prevent the transmission of the illness to her roommate. E8 stated there are 5 residents on one wing, and 1 resident on the other wing with flu symptoms.

On 4/2/14 at 1:30 PM, E2 (DON) and E8 (LPN) reviewed the list of ill residents and concluded that the first 2 residents to start with flu sypmtoms were Z1 and Z2 (assisted living residents that live together). E2 stated that Z1 was ill first (3/29/14 Saturday) and the next day (3/30/14 Sunday) Z2 got sick. Z1 and Z2 eat with Z3 and R10 in the assisted living dining room. E2 and E8 were unsure if Z1 and Z2 ate in the dining room on Saturday and Sunday. E2 stated R10 started with symptoms on Sunday night (3/30/14). E2 explained the R10 likes to go to activities and does not like to stay in her room. R30 also likes to go to activites and is friends with R10. R30 started with vomiting and diarrhea on Sunday night/Monday morning (3/31/14). R30 shares a lunch table with R35. R35 had 2 diarrhea stools on 4/2/14. E8 reported R32 had diarrhea starting on Tuesday (4/1/14) and during the night/early AM on 4/2/14. R32 was observed participating in the group activity on 4/2/14 at 10:30 AM. R32 eats at the same table as R29. R29 started with diarrhea stools on 4/2/14.

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Of the residents documented as experiencing vomiting and diarrhea, R15's nurses' notes show he started vomiting on 3/29/14 at 2:50 PM after lunch.

On 4/2/14 at 2:15 PM, E8 (LPN) stated she had spoke with the daughter of Z1 and Z2 and she reported that she and her family had flu symptoms after visiting with her parents on Sunday (3/30/14).

The employee infection control tracking log shows from 3/16/14 - 3/29/14, three employees called off with stomach flu, 2 with temperature over 100 degrees, 4 with upper respiratory symptoms and 1 with a sick child.

The Physician Progress note dated 1/8/14 states R13 was seen with an Upper Respiratory Infection and Exacerbation of Chronic Pulmonary Disease. The reports states R13 had "Contracted the illness going around the facility".

The Physician Progress Note dated 1/22/14 states R39 had an Upper Respiratory Infection and cough. "She has the same illness that has been going through the facility".

The Monthly Infection Control Log for January 2014 shows 9 residents received antibiotic treatment for respiratory infections. 1 resident required 3 different antibiotics and a second resident required 2 different antibiotics to resolve their illness.

On 4/2/14 at 11:15 AM, E2 confirmed the facility had a respiratory illness outbreak in January 2014. E2 stated several residents and staff were ill. E2 stated she was not sure what transmission

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precautions were taken because she personally caught it and was very ill.

The employee infection control tracking log shows from 1/5/14 - 2/1/14, two employees called off with upper respiratory infection and 10 called off with the stomach flu.

2. On 4/2/14 at 2:20 PM when R13 was in the shower/tub room using the toilet, E4 (CNA) entered the room carrying a soiled brief and placed it in the trash can. The brief was not in a plastic bag and E4 was not wearing gloves. E4 (walked past the sink) and left the room without washing her hands.

On 4/12/14 at 2:30 PM, E4 (CNA) was asked why she was not wearing gloves when she brought the soiled brief into the shower/tub room. E4 responded, "That's a very good question. I'm not working as a CNA today, I was just helping out one of the residents before she left (the facility). I'm working in medical records today. I'm old school, I don't wear gloves alot of the time when I work as a CNA".

The facility policy on Standard Precautions dated 8/13/09 states handwashing is the single most important procedure for preventing cross contaimination. Handwashing is required after touching .... contaminated items and between patient contact.

3. On 4/2/14 at 2:15 PM, R13 was taken to the shower/tub room by E6 (Certified Nursing Assistant - CNA). R13 was transfered to the toilet. While R13 was seated on the toilet, he was fideting with his pants and brief. R13's indwelling catheter was attached to a leg bag and was

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draining very dark amber urine. R13 stood up from the toilet with assistance and his brief and pants were re- positioned. R13 was returned to the wheelchair and escorted out of the bathroom (past the sink) and into the hallway. R13 did not receive hand hygiene after using the toilet. E6 (CNA) stated, "I usually take the resident to the sink, I guess I was not thinking."

The Physician Order Sheet dated 3/1/14 lists R13's diagnosis to include Dementia, Prostate Cancer, Urinary Retention, History of MRSA (Methicillin Resistant Staphylococcus Aureus) and Indwelling Urinary Catheter. The MDS of 1/21/14 shows R13 requires assistance of 1 staff person for hygiene and toileting. R13's BIMS (Brief Interview of Mental Status) score is 3 (severe cognitive impairment). R13's care plan states he is at risk for urinary tract infections related to chronic indwelling urinary catheter use. The interventions specific to R13 to reduce cross contamination is not listed in his care plan. The medical record shows R13 has had urinary tract infections on 12/9/13, 2/7/14, 3/6/14 and 3/20/14 all from Escherichia Coli bacteria. (Escherichia Coli (Ecoli) bacteria is found in the intestinal tract of humans and spread through direct contact.)