STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145524	A. BUILDING _____ B. WING _____	C 03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF RIVERVIEW	**500 CENTENNIAL DRIVE EAST PEORIA, IL 61611**

(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 Complaint Investigation 1120527/IL51866	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		

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

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F 441	Continued From page 1 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 implement their "Cleaning Policy and Procedure when there is evidence of Clostridium difficile," failed to practice hand hygiene, and failed to handle linens and keep dirty linens off the floor to reduce the spread of infection and prevent cross-contamination for 3 of 3 residents on the sample who have active Clostridium difficile infections (R1, R2, and R3). This failure has the potential to effect all sixty-seven residents residing in the facility. Findings as follows: R1's current care plan indicates R1 was admitted on 1/24/11 without a diagnosis of Enteritis/Clostridium Difficile. On 03/15/11 at 8:50 am, E2 (DON/Director of Nursing/Facility Infection Preventionist) stated that a laboratory test on R1's fecal sample dated 01/27/11 had a positive result for Clostridium Difficile. E2 stated R1's Clostridium Difficile infection was facility acquired not hospital acquired as the 2/11 infection control records reflect. On 03/14/11 at 9:45 am, E16 (Care Plan Coordinator) stated R1 is residing in a private room and that contact isolation precautions are being utilized when care is being provided by staff. E4 (CNA/Certified Nurse Aide) stated at 10:10 am on 03/15/11 that R1 was ambulatory and disoriented at times, requiring assistance with daily living because of	F 441		

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F 441	Continued From page 2 some non-compliance with isolation precautions. An interview with R1 was limited due to R1's level of cognition and her medical condition. According to their current care plans, R2 and R3 were admitted from a hospital stay with diagnoses of Enteritis/Clostridium Difficile. R2 was originally admitted 2/23/11 and readmitted 3/8/2011 with a care plan for "Gastrointestinal distress regards to Clostridium difficile" initiated 3/14/11. R2's MDS (Minimum Data Set) dated 03/03/11 indicated R2 was confused, disoriented, and unable to complete activities of daily living without extensive assistance of staff. R3 was admitted 2/4/2011 with a care plan for "Infection of gastrointestinal tract" initiated 2/7/11. R3's MDS of 02/11/11 indicated R3 was confused, disoriented, and unable to complete activities of daily living without extensive staff assistance. On 03/14/11 at 9:45 am, E16 (Care Plan Coordinator) stated R2 and R3 are sharing a room with contact isolation precautions to be followed when staff provide care. R2 and R3 were confused and unable to converse when interviewed. The facility's "Infectious Process" practice guidelines dated 6/2/06 state: "A two-tiered precautions system is utilized: standard precautions and transmission-based precautions. The first tier, standard precautions, is applied to all patients and designed to reduce the risk of transmission of infectious agents in moist body secretions. Standard precautions emphasize:	F 441		

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F 441	Continued From page 3 hand hygiene practices, uses of gloves when touching body fluids, utilize mask, eye protection and gown when splashing of body fluids is likely and avoid needle sticks and sharps injuries. The second tier, transmission-based precautions, is used for patients with documented or suspected contagious pathogens and includes: airborne precautions, droplet precautions, and contact precautions... Soiled linen has been shown to be a source of large number of pathogenic organisms. Techniques minimizing potential nosocomial and occupational risks associated with soiled linen handling include: consider all soiled linen contaminated, handle soiled linen as little as possible, use containers for wet laundry collection made of impervious material to prevent soaking or leakage of fluid to exterior, do not drop soiled items on the floor unprotected." The ""Patient room/Bathroom, High Touch Disinfection policy of the March 2009 Housekeeping Manual states: "Housekeeping staff will maintain high standards of sanitary conditions. When evidence of ongoing transmission of Clostridium difficile is noted, a second disinfection procedure in addition to daily cleaning is performed in the rooms of infected patients. This second disinfection of "High Touch" areas is performed on a different shift than the normal cleaning schedule. Supplies used to provide a clean and sanitary room and bathroom for each patient includes, "wet disinfecting with 10% Sodium Hypochlorite solution, and large sani-cloth wipes with bleach. The disinfection procedure is to begin cleaning using a 10% sodium hypochlorite solution and wipe door frame paying close attention to frequently touched areas. Working right to left, around the room continue to wipe "High Touch"	F 441		

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F 441	Continued From page 4 surfaces, including door knobs, light switches, faucets, hand gel dispensers, towel and glove dispensers,bed controls, call lights, chair handles and seats " During facility tour on 3/14/11 at 8:30 am, E5 (CNA/Certified Nursing Assistant) dropped used gloves and linens on the floor of R14 and R15's room. E5's stated, "They were dirty." E2 (Director of Nurses) reminded E5 that soiled linens needed to be placed in a bag not on the floor. E5 (CNA) dropped bed linens again on the floor after being reminded by E2. E2 then again directed E5 not to violate the facility rules by dropping dirty/soiled linens and trash on the floor. Other observations of poor infection control practices made on the North hall were: Room of R4 and R5-soiled wipes and gloves on the random spotted/stained floor, Room of R6 and R7-soiled diaper hanging out of the garbage can in the resident's bathroom, Room of R8 and R9-garbage can sitting in the middle of the bed linens on the bed, linens found on floor, Room of R10 and R11-pillow and papers on floor, Room of R12 and R13-exelon patch (medication for dementia) found on floor dated 3/13/11 near the room ventilation system, large foam appliance on floor used to position lower extremities, and 3 uncovered 4 X 4s and small tampon like rolled bandages on top of the resident's candy box, empty medicine cup on floor, and a pillow trapped between the mattress and wire foundation of the bed, Room of R2 and R3-had a small sign on the border of the room stating "See nurse before entering." There were 9 towels in the sink in the bathroom and a large soaked roll of toilet paper laying on the shower floor. At 9:05 am , E4 (CNA)	F 441		

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F 441	Continued From page 5 entered the room neither washing hands nor putting on gloves. E4 picked up the call light and bed control from the floor and placed them on the bed of R3. R3 then requested a blanket, and E4 left the room to go get the blanket without washing E4's hands. E4 then went to the North wing linen cart touching the clean linen with her unwashed hands. E4 went back to R3's room and placed the blanket on the resident's bed. E4 again left the resident's room without washing her hands. E4 (CNA) stated at this time, E4 was not aware of any infection control precautions to be taken when caring for the two residents in the room. The West hall room of R1 at 1:30 pm on 3/14/11, had a small sign on the border of the room stating "See nurse before entering." The toilet had brownish yellow fecal smears on the toilet riser. E14 (Certified Nurse Assistant) stated on 3/15/11 at 10:08 am that E14 is assigned to care for R1 and is not aware of any isolation precautions needed to be taken when caring for R1. At 10:08 am on 3/15/11, the toilet riser in R1's room was still smeared with fecal matter in the bathroom as noted on 3/14/11. E1 (Administrator) verified at 1:15 pm on 3/15/11 that the toilet riser in R1's room was the same as it had been on the prior day. On 3/15/11 at 10:17 am, E15 (maintenance staff) entered and exited R1's room without washing his hands or wearing gloves. E15 stated, "It's my fault. I should know better and I did not pay attention. I did not take note of any isolation precautions. I guess I should have worn a mask." E15 stated that he went into every room in the	F 441		

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F 441	Continued From page 6 facility without washing his hands to shore up any hanging wires under the beds. On 3/15/11, 8:24 am, E11 (LPN/Licensed Practical Nurse) was in R1's room comforting R1 who was nauseous and vomiting into her garbage can at the bedside. E11 (LPN) was not wearing any protective equipment other than a pair of gloves to protect her clothing. E9 and E10 (Housekeeping Staff for the North and West halls) stated on 3/15/11 at 8:00 am (E9) and on 03/15/11 at 8:20 am (E10) that there is no one in isolation in the facility and that there is no particular order to when the resident rooms are cleaned on a daily basis unless there is a request for immediate cleaning from staff. E9 and E10 stated the wash water used contained a premeasured ammonia-based disinfectant mixture found in the housekeeping closet (but not a 1:10 bleach solution). E9 and E10 agreed that they are not using the Clostridium Difficile protocol found on their carts because no one has such an infection requiring isolation precautions. Both E9 and E10 (housekeeping staff) verified during this interview, that their daily lists of duties to do in each assigned room does not address any specific isolation precautions or protocols to use if required. E8 (Housekeeping Supervisor) on 3/14/11 at 1:40 pm stated that their is a new system of cleaning using an ammonia chlorite disinfectant and a 1:10 bleach spray bottle/or cloth for surface cleaning. E8 (Housekeeping Supervisor) commented that the isolation rooms are to be done last and done at least once a day or two times if possible using the corporate issued cleaning policy and procedure when there is	F 441		

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F 441	Continued From page 7 evidence of Clostridium difficile with a Level one and Level two tiered approach. When R2 and R3's room was cleaned on 3/15/11 at approximately 10:15 am, the saniwipes were not used, nor was the mop water a 1:10 bleach solution. The dry mop was used for all resident rooms on the north end, and the wet mop was used in R2 and R3's room without being changed before using the same wet mop on another room being prepared for a new admission. While cleaning R2 and R3's room, the dry mop collected debris from the floor. E9 (Housekeeping staff) brushed the debris out into the main hallway before using the dust pan and hand broom from the cart to collect it all before putting the debris into the collective garbage bin on the cart. E9 did not wash her hands or use a sanitizing gel before and after leaving the room of R2 and R3. Daily Census sheets provided by the facility on 03/14/11 indicates there are thirty-five residents residing on the North hall and thirty-two residents residing on the West hall for a total of sixty-seven residents residing in the facility. Census sheets indicate R1 resides on the West hall and R2 and R3 reside on the North hall.	F 441		