STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145651	A. BUILDING _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ALTON	3490 HUMBERT ROAD ALTON, IL 62002

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F 000	INITIAL COMMENTS	F 000		
F 226 SS=C	Annual Certification Survey 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 interview and record review, the Facility failed to obtain results of a fingerprint check to determine if an employee had a prior criminal history which would disqualify them for employment and document timeliness of obtaining healthcare worker background checks for 4 of 5 employees (E9, E10, E11, E12) reviewed for pre-employment screening. This has the potential to affect all of the 77 residents living in the facility. Findings include: 1. The facility's Abuse Prevention Policy, dated 03/2011, documents under 1. Screening Potential Employees and Resident, "The facility checks the Illinois Health Care Worker Registry for disqualifiers. The facility complies with the requirements set for in the Health Care Worker Background Check Act (225 ILCS 46)." 2. The Nurse Aide Roster, dated 1/25/16, documents, E9, Certified Nurses Aide (CNA) was hired on 12/28/16. E9's Health Care Worker	F 226		2/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/22/2016

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F 226	Continued From page 1 Registry Background Check has no documentation of the date that the background check was performed. 3. The Nurse Aide Roster, dated 1/25/16, documents, E10, CNA, was hired on 12/28/16. E10's Health Care Worker Registry Background Check has no documentation of the date that the background check was performed. The document also has no documentation of a fingerprint check being performed before the date of hire. 4. The Nurse Aide Roster, dated 1/25/16, documents, E11, CNA, was hired on 1/7/16. E11's Health Care Worker Registry Background Check has no documentation of the date that the background check was performed. 5. The Nurse Aide Roster, dated 1/25/16, documents, E12, CNA, was hired on 1/20/16. E12's Health Care Worker Registry Background Check has no documentation of the date that the background check was performed. On 1/27/2016 at 10:15 AM, E15, Bookkeeper, stated, "I run the background checks before they start to look for disqualifying offenses. I did not know the background checks should be dated as to when I did them. No, I do not keep a log or anything." On 1/27/16 at 11:10 AM, E15, stated, ""I did not realize (E10) had not had a fingerprint check." On 1/28/2016 at 11:03 AM, E16, Corporate Nurse, stated, "(E10's) first day of working the floor was 12/30/2016." 6. The Resident Census and Condition of	F 226		

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F 226	Continued From page 2 Residents, CMS 672, dated 1/26/16, documents that the facility has 77 residents living in the facility.	F 226		
F 323 SS=D	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 observation, interview and record review, the facility failed to supervise toilet use for 1 of 4 residents (R5) reviewed for falls in the sample of 16. Findings Include: On 1/27/16 at 11:20 AM, E8, Certified Nursing Assistant (CNA), approached the 600 hall nurses station. E8, stated, "(R5) is in there on the toilet I hope she doesn't try and get up." E8 returned to R5's room at 11:22 AM. E8 came out into to the hallway in front of R5's room at 11:25 AM and stated, "I know I am not supposed to leave (R5) on the toilet alone." E8 went back inside R5's room to finish assisting R5 on the toilet at 11:26 AM. On 1/28/16 at 11:10 AM, E2, Director of Nursing (DON), stated that the facility does not have a policy addressing leaving a resident alone on the	F 323		2/22/16

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F 323	Continued From page 3 toilet. R5's Incident/Accident Report, dated 1/14/16, documents, in part, "(R5) taken to the bathroom by (E14) CNA. (R5) given call light and reminded to pull it when done. (E14) stayed in room to fix bed. (E14) heard (R5) get up but she didn't reach her in time before (R5) sat down on bathroom floor. No signs of injury other than oval shaped bruise with scab at distal end noted to RUA (right upper arm). Comfort foam applied per request for padding." R5's Incident Investigation, dated 1/14/16, documents, in part, "Alarms put in place to alert staff to (R5) getting up without assistance and to prevent (R5) from being alone in bathroom. Staff to monitor closely while in bathroom." R5's Care Plan, dated 1/07/16, documents, "At risk for falls. History of falls w/in (within) 6 months, a new hip Fx (fracture). Requires assistance to ambulate and transfer. Has impaired vision, depression and confused at times. Takes diuretics, antidepressants, and Narcotics. Balance problems, weakness, joint pain/difficulties, requires a wheel chair and impaired judgement. Fall 1/14/16." R5's Fall Risk Assessment, dated 12/21/15, documents, R5 has "balance problems, weakness, joint pain/difficulties, requires a wheelchair and has impaired judgment." Also documents, R5 is "at significant risk for falls and recommendations include supervision in bathroom," The Facility's In-Service Education/Meeting Attendance record, dated 1/18/16, documents,	F 323		

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F 323	Continued From page 4 "When a patient alarm is removed-patient must be directly supervised to prevent fall."	F 323		
F 441 SS=F	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		2/22/16

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F 441	Continued From page 5 infection. This REQUIREMENT is not met as evidenced by: A. Based on interview and record review, the Facility failed to provide consistent information on the infection control log to adequately track and manage infections, analyze data, identify possible staff education needs and document resolutions of infections in order to evaluate effectiveness of treatment. This has the potential to affect all of the 77 residents living in the facility. Findings include: 1. The facility policy and procedure "INFECTION CONTROL LOG," dated 11/1998 documents, in part, "1. The ADON (Assistant Director of Nursing), the designated Infection Control Nurse, will maintain an ongoing Infection Log. 2. A separate log for each nursing wing for each month will be kept. 3. The form will be updated each day as ADON reviews the new telephone and admit orders. 4. Culture reports will be documented. 5. Communicable diseases will be noted and reported to Illinois Dept of Public Health as required. 6. Notation will be made as to if infection was facility acquired (nosocomial). 7. When the infection has subsided, the residents will be highlighted off the tracking form. 7.(8) Information from this form will be used to complete the monthly nosocomial infections reports and the for the Quality Assurance Committee's review." The Infection Surveillance Logs, dated July 2015 thru January 2016, indicated the log contains the	F 441		

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F 441	Continued From page 6	F 441		

following areas which are to be completed: room number, resident name, admit date, onset date, site, symptoms, meets infection criteria, organism, source, date of initial culture, date of follow up culture or N/A (not applicable), result of follow up culture or N/A, antibiotic/dosage, other, isolation required, facility acquired and date resolved.

2. R6's admitting Physician Order Sheet (POS), dated 12/16/15, documents, in part, was admitted with Methicillin-Resistant Staphylococcus Aureus (MRSA) infection of the nares and requires contact isolation precautions. The Infection Surveillance Logs, dated December 2015 and January 2016, do not document R6's MRSA infection. The Weekly Infection Log does not document R6's MRSA infection.

3. The Infection Surveillance Log for January 2016 documents that on 1/2/16 R11 had an infection of nits, live pediculi. This Infection Surveillance Log does not document treatment. The Weekly Infection Log does not document weekly updates.

4. The Infection Surveillance Log for January 2016 documents that on 1/2/16 R3 had an infection of live pediculi. This Infection Surveillance Log does not document treatment. The Weekly Infection Log does not document weekly updates.

5. R5's POS, dated 1/6/16, documents, in part, "Isolation for VRE (Vancomycin Resistant Enterococcus)." The Infection Surveillance Log for January 2016 documents isolation is not required. The Weekly Infection Log does not document weekly updates for the week of

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F 441	Continued From page 7 1/11/16. 6. The Infection Surveillance Log for January 2016 documents that on 1/8/16 R13 was diagnosed with an urinary tract infection (UTI). The Infection Surveillance Log does not document an organism. R13's laboratory result, dated 1/8/16, for this UTI documents the organism Klebsiella Oxytoca. 7. R15's admitting POS, dated 12/10/15, documents that R15 was admitted with a MRSA infection of the nares and requires contact isolation precautions. R15's 1/4/16 POS documents R15 was discharged from the facility. The Infection Surveillance Logs, dated December 2015 and January 2016, do not document R15's MRSA infection. On 1/27/16 at 8:45 AM, E3, ADON, stated, "I am in charge of the Infection Control Log and I have these 2 legal pads that I do weekly tracking on. I do not track and trend infections on a log. I do it in my mind." E3 further states, "I am in the process of redoing the logs a different way. I took this job over in October (2015)." On 1/27/16 at 3:00 PM, E16, Corporate Nurse, stated, "We do not do weekly logs." On 1/28/16 at 9:300 AM, E2, Director of Nurses (DON), stated, "I can't say anything about the Infection Control Logs." The Resident Census and Conditions of Residents, CMS 672, dated 1/26/16, documents that the facility has 77 residents living in the facility.	F 441		

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F 441	Continued From page 8	F 441		

B. Based on observation, interview and record review, the Facility failed to follow facility policy for isolation precautions and cleansing of blood glucose monitoring devices after resident use for 1 of 13 residents (R5) reviewed for infection control practices in the sample of 16 and 2 residents (R19, R20) in the supplemental sample.

Findings include:

1. On 1/26/16 at 11:49 AM, E4, Licensed Practical Nurse (LPN), took out 2 blood glucose monitoring devices from the 300 Hall medication cart and wiped each device with one germicidal wipe for 3 seconds and laid them on top of the medication cart.

On 1/26/16 at 11:50 AM, E4 performed blood glucose monitoring by fingerstick method to R19 on his left forefinger with a reading of 566 milligrams/deciliter (mg/dl). E4 repeated the procedure using the second device on R19's right forefinger with a reading of 533 mg/dl. E4 wiped each device with one germicidal wipe all over for 2 seconds, laid them on top of the cart and discarded the wipes.

2. On 1/26/16 at 12:00 PM, E4 performed blood glucose monitoring on R20. After the procedure, E4 wiped the machine with one germicidal wipe for 2 seconds and put it down on top of the cart.

On 1/28/16 at 9:30 AM, E2 stated the nurses are expected to follow the manufacturer's directions on the proper disinfection of the glucometer.

The Facility Policy on Blood Glucose Monitoring, dated 5/2014, documents, "12. Clean and disinfect the glucometer after each use with an

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EPA (Environmental Protection Agency) registered disinfectant. Follow the manufacturer's directions for cleaning and disinfecting: a. Use a wipe to clean the glucometer; discard wipe. b. Unfold a 2nd wipe and wrap it around the glucometer, allowing the glucometer to remain wet for a full 2 minutes. After 2 minutes remove the wipe from the glucometer and discard. c. Allow the glucometer to air dry before use on another resident."

The Germicidal Disposable Wipes Label Instructions, undated, documents, "To Disinfect and Deodorize: Thoroughly wet surface. Allow treated surface to remain wet for a full 2 minutes. Use additional wipes if needed to assure continuous 2 minute wet contact time."

3. R5's POS, dated 1/6/16, documents, "Isolation for VRE."

On 1/27/16 at 11:25 AM, E8, Certified Nursing Assistant (CNA), assisted R5 on the toilet without donning a gown.

On 1/27/16 at 12:30 PM, E17, Registered Nurse (RN) stated that R5 is still on isolation for VRE of the urine.

On 1/26/16 at 11:00 AM, E2 stated that she would expect staff to put on a gown and gloves and follow universal precautions if they were assisting a resident with VRE during activities involved with urine such as during toileting or incontinent care.

On 1/28/16 at 9:30 AM, E2 stated that she would not expect staff to put on a gown while toileting a resident with VRE.

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F 441	Continued From page 10 The Facility's Infection Control Policy for VRE, dated 6/2004, documents, in part, "2.) Staff will wear a clean, disposable, non-sterile gown when entering the room of an VRE-infected or colonized resident if substantial contact with the resident or environmental surfaces is anticipated. In addition a gown will be worn if the resident is incontinent, has diarrhea, an ileostomy, a colostomy, or wound drainage not contained."	F 441		