STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145827	A. BUILDING _____ B. WING _____	03/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRITISH HOME, THE	**8700 WEST 31ST STREET BROOKFIELD, IL 60513**

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F 000	INITIAL COMMENTS Annual Licensure/Certification Annual Licensure/Shelter The British Home is in compliance with the Shelter Care facilities code (77 Illinois Administration Code 330) for this survey.	F 000		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based upon observation, record review and interview the facility failed to ensure that call lights are within reach and failed to follow call light policy and procedure for two residents (R20, R21) in the sample and three residents (R24, R25, R26) in the supplemental sample reviewed for accommodation of needs. Findings include: On 3/24/14, during initial tour initiated at 10:15am, the following was observed: R21's call light was lying on the floor and not within reach. R24's call light was clipped to the siderail above her head and not within reach. R25 was sitting in a wheelchair, the call light was clipped to the bed and not within reach.	F 246		

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

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F 246	Continued From page 1 R26 was sitting in a wheelchair, the call light was clipped to the bed and not within reach. On 3/24/14 at 2:20pm, R20's call light was on the bedside table and not within reach, R20's Intravenous Pump was alarming at this time. On 3/24/14 at 2:32pm, E11, Certified Nursing Assistant (CNA) stated, the call light should be attached to the resident's clothing at chest area. Facility's Call Light Answering Policy and Procedure includes but not limited to; Purpose: To respond to the resident's requests and needs. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. The facility failed to follow their policy and procedure.	F 246		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to have a five percent (5%) or lower medication error rate. There were four medication errors out of twenty-five opportunities, resulting in a sixteen percent (16%) medication error rate. This affected one resident (R14) in the sample of 14 observed during medication pass.	F 332		

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F 332	Continued From page 2 Findings include: On 3/25/14 at 8:00am, during medication pass observation with E10 RN (Registered Nurse)administered medication to R14 who has a G-Tube (Gastrostomy Tube) and scheduled 8:00am medications that include but not limited to Diphenoxylate Atropine tab 2.5-0.025mg tablet one tablet once daily, Allopurinol 100mg (milligrams) tablet one tablet once daily, Ranitide 75mg tablet one tablet twice daily, and Vitamin B1 100mg one tablet once daily. E10 crushed the pills (tablets) into four seperate medication cups. E10 then proceeded to administer each medication through R14's G-tube by pouring each of the medications into the syringe and pouring water over the medications without letting the medications dissolve into the water. After administering the medications, E10 reconnected the feeding tube started R14's feeding pump. E10 proceeded to exit the room. E10 was asked why there was still crushed medication residue at the base of the syringe with a clump of medication residue left at the base and along the tip of the syringe, he stated, "Oh," after being made aware. The facility Medication Administration via Feeding Tubes policy presented dated revised April 2001 indicated "the purpose of the procedure is to provide residents with necessary medications via feeding tube." This policy was not followed.	F 332		
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	F 441		

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F 441	Continued From page 3	F 441		

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 infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to implement their infection control handwashing policies and procedures for one resident in the sample (R7)

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and four residents outside the sample (R20, R27, R28, R29). Staff was observed not washing hands in order to prevent cross contamination. Care equipment was not stored under sanitary conditions. Staff in the laundry failed to use protective gear (mask, apron) when processing linen through the laundry from isolation rooms. The facility failed to implement their infection control policy in the laundry area. The laundry staff processes linen from isolation rooms without all the protective gear reqiured by their infection control policy. This failure has the potential to affect all 53 residents.

Findings Include:
The facility policy on Nebulizer Use presented indicated under the procedure to "remove mask (if used) or mouth piece, clean and put in plastic bag." This procedure was not followed.
On 3/24/14 between 9:30am and 10:30am, during the initial tour R28's oxygen tubing cannula was on the concentrator at her bedside uncontained.
On 3/24/14 at 2:05pm, R7 was noted in her room with her nebulizer machine in use. E10 RN (Registered Nurse) went into the room, removed the mask and the tubing from R7 s face, put it back in the plastic bag provided to store the tubing on the side table without cleaning the mask. E10 did not wear any gloves, and after rendering care to R7 did not wash or sanitize his hands and proceeded to use the computer at the nurses ' station. When asked about it, E10 stated all he has to do for the resident is to take the pulse after getting the treatment.
On 3/24/14 at 2:23pm E11 CNA (Certified Nurse's Aide) was noted rendering care to R20 removing her shoes and adjusting her oxygen tube in her nose. E11 was noted leaving R20's room without washing or sanitizing her hands. E11 proceeded

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F 441	Continued From page 5 to R29's room to render care to her. E11 was noted wearing gloves without exercising any hand hygiene when moving from R20 to R29's room. At 2:32pm, when asked about it, E11 could not identify what she has done wrong stating "I did put on my gloves to take care of R29, and my hands were not dirty." On 3/24/14 at 2:25pm, E13 RN (Registered Nurse) was noted drawing blood from R27 with gloved hands, and after the blood draw, E13 removed the gloves threw them in the garbage and exited the room without washing or sanitizing her hands, then proceeded to use the phone. When asked about it, E13 acknowledged that she should have washed or sanitized her hands after drawing R27's blood stating, "she just got carried away." The facility policy on hand washing with no revised date indicated to staff to wash their hands " After handling items potentially contaminated with a resident's blood, body fluids, excretions or secretions." The policy further indicated that they are to wash their hands "after removing gloves." This policy was not followed. On 3/24/2014, during the Environmental tour of the facility with E5 (Environmental Services) that started at 1:30pm. A cardboard box containing hazardous waste was observed in an unlocked and unattended garage. The box was stored next to items (Decorations) that are brought back into the building and used in resident areas. E5 was interviewed, and asked if this was the area the facility uses to store infectious waste waiting to be picked up. E5 said "Yes." Both the garage door and service were open and unattended.	F 441		

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F 441	Continued From page 6 E9 (Housekeeping/Laundry) was working in the laundry at the time of the Environmental tour. E9 was asked how linen from the isolation rooms was handled in the Laundry. E9 said she only wears gloves when handling isolation linen, she does not wear a mask or apron. The facility's policy and procedure on handling isolation linen requires staff to wear a mask, gloves and apron.	F 441		