STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145457	A. BUILDING _____ B. WING _____	09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT'S HOME	1440 NORTH 10TH STREET QUINCY, IL 62301

(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	F 000		
F 225 SS=D	Annual Licensure and Certification 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		

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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appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to investigate and report an allegation of abuse to the State Agency for one of one resident (R26) reviewed for grievances in the supplemental sample.

Findings include:

Resident Council Meeting minutes dated 2/2/16, state: "One resident (R26)stated that he made a 'mess' in his room and that it was over dinner time and that the aides took their time to come and help and then when they did, they laughed and joked and took pictures. Did not know if it was lunch or supper but it was while other residents were at a meal."

On 9/28/16 at 9:45 a.m., E6 (Activity Director) stated R26 voiced concern during the Resident Council Meeting on 2/2/16. E6 stated that R26 reported that he had "messed himself" in his room during a meal. E6 stated R26 then reported that it took staff awhile to come help R26 and when they (staff) did, they laughed and took pictures.

On 9/28/16 at 3:00 p.m., Z1 (Ombudsman) verified attendance at the 2/2/16 Resident Council Meeting. Z1 stated "(R26) commented on the fact that he had been incontinent in his pants and he was really upset about it. (R26) seemed coherent at the time of the meeting."

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F 225	Continued From page 2 On 9/28/16 at 1:05 p.m., E1 (Administrator) verified no investigation was conducted or documented of R26's allegation of abuse. On 9/28/16 at 10:15 a.m., E2 (Director of Nurses) verified there was no written investigation and the state agency was not notified of R26's allegation of abuse on 2/2/16.	F 225		
F 226 SS=D	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 follow the facility abuse policy by not investigating and reporting an allegation of abuse to the State Agency for one of one resident (R26) reviewed for grievances in the supplemental sample. Findings include: The Facility's Abuse Investigation policy (date unknown), states "Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident...The individual conducting the investigation will, as a minimum: ...Interview any witnesses to the incident;	F 226		

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F 226	Continued From page 3 Interview staff members (on all shifts) who had contact with the resident during the period of the alleged incident...review all events leading up to the alleged incident...Each interview will be conducted separately and in a private location...Witness reports will be obtained in writing...The results of the investigation will be recorded on approved documentation forms...The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency...within five working days of the reported incident." Resident Council Meeting minutes dated 2/2/16, documents R26 reported an allegation of abuse by staff members. On 9/28/16 at 9:45 a.m., E6 (Activities Director) verified that R26 verbalized an allegation of abuse by staff during the Resident Council Meeting on 2/2/16. On 9/28/16 at 1:05 p.m., E1 (Administrator) verified there was no written evidence that R26's allegation of abuse on 2/2/16 was investigated or that the State Agency was notified.	F 226		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314		

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F 314	Continued From page 4	F 314		

prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to wear gloves when providing pressure ulcer treatment and failed to perform hand hygiene during wound care for one of two residents (R18) reviewed for pressure ulcers in the sample of 15.

Findings include:

The "Wound Care" policy dated Revised October 2010 documents to put on exam glove... use no-touch technique...use sterile tongue blades and applicators to remove ointments and creams from their containers.

The "Handwashing/ Hand Hygiene" policy dated Revised August 2014 states "Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations...Before moving from a contaminated body site to a clean body site during resident care."

On 9/27/16 at 10:10 a.m., E5, Licensed Practical Nurse (LPN) removed R18's wound dressing to R18's right heel. E5 did not perform hand hygiene. E5 put a glove on her right hand but not her left hand. E5 then applied the wound barrier cream to the wound edges of R18's right heel with her bare left index finger.

On 9/27/16 at 2:10 p.m., E5 verified E5 did not use a glove to apply barrier cream to R18's

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F 314	Continued From page 5 pressure ulcer on the right heel and did not wash E5's hands after removing R18's soiled dressing.	F 314		
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 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		

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F 441	Continued From page 6	F 441		

infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to remove soiled gloves and perform hand hygiene after incontinence care for one of four residents (R18) reviewed for incontinence care in the sample of 15.

Findings include:

The "Handwashing/ Hand Hygiene" policy revised August 2014 documents
"use an alcohol-based hand rub...before moving from a contaminated body site to a clean body site during resident care"; and also documents "single-use disposable gloves should be used when anticipating contact with blood or body fluids."

On 9/27/16 at 10:00 a.m., E4, Certified Nursing Assistant (CNA) was providing incontinence care of stool to R18. E4 applied clean gloves and used peri-wipes to clean stool off R18. E4 proceeded to change R18's shirt with same soiled gloves and then put a clean shirt on R18 with the same gloves. E4 did not remove those gloves until she finished all cares to R18. E4 also touched the side rails and picked up the peri-wipes and placed them on the nightstand with the same gloves.

On 9/27/16 at 2:00 p.m., E4 stated "Yes, we are supposed to change gloves when you go from dirty/contaminated to clean. E4 also stated, Yes, I am supposed to wash my hands after providing

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F 441	Continued From page 7 peri-care (perineal) or incontinence care to a resident."	F 441		