STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145918	A. BUILDING _____ B. WING _____	C 09/06/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE COMMUNITY HLTHCR CTR	**900 EAST CORPORATION BRIDGEPORT, IL 62417**

(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 443	Continued From page 10 the Administrator and the Director of Nursing to monitor infection control procedures and nursing care. On-going process.	F 443		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.696a)b)c) Section 300.696 Infection Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. b) A group, i.e., an infection control committee, quality assurance committee, or other facility entity, shall periodically review the results of investigations and activities to control infections. c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340): 1) Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2) Guideline for Hand Hygiene in Health-Care	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145918	A. BUILDING _____ B. WING _____	C 09/06/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE COMMUNITY HLTHCR CTR	**900 EAST CORPORATION BRIDGEPORT, IL 62417**

(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
F9999	Continued From page 11 Settings 3) Guidelines for Prevention of Intravascular Catheter-Related Infections 4) Guideline for Prevention of Surgical Site Infection 5) Guideline for Prevention of Nosocomial Pneumonia 6) Guideline for Isolation Precautions in Hospitals 7) Guidelines for Infection Control in Health Care Personnel This REGULATION is not met as evidenced by: Based on interviews, facility infection control records, observations, and facility policy review, the facility failed to prohibit a food service employee, E5, from working who had nausea and diarrhea before and during her shift on 08-30-06 and also failed to prohibit a housekeeping employee (E4) who was still showing symptoms after becoming ill with nausea, diarrhea, and vomiting from working. This occurred during an out break of gastrointestinal illnesses which affected 45 facility residents and at least 10 facility staff. The facility also failed to ensure that ice is protected from possible contamination and that it is dispensed to residents in a sanitary manner. These failures resulted in all 77 in-house residents being put at risk for contracting the same pathogenic microorganism that caused these symptoms. The findings include:	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145918	A. BUILDING _____ B. WING _____	C 09/06/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE COMMUNITY HLTHCR CTR	**900 EAST CORPORATION BRIDGEPORT, IL 62417**

(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
F9999	Continued From page 12 1. Review of the facility infection control records on 08-31-06 documents that the facility was experiencing an outbreak of gastrointestinal illnesses in residents and facility staff. E1, Administrator, stated on 08-31-06 at 2:00 pm, that R1, who was a re-admission to the facility on 8-23-06 from an out of state hospital, developed symptoms of nausea, vomiting, and diarrhea on 08-23-06. E1 also stated that R1's roommate (R2) contracted these same symptoms two days later on 08-25-06. The on-set of other facility residents with the gastrointestinal illness is as follows: On 08-28-06, one more resident, R3, was affected. Thirty-six residents had on-set date of 08-29-06. On 08-30-06, five residents became ill with the gastrointestinal illness. One resident became ill with nausea, vomiting, and diarrhea on 08-31-06. As of 08-31-06 at 3:00 pm, forty-five of the 77 in-house residents were ill with the gastrointestinal illness. Norwalk Virus RT-PCR Reports dated 09-05-06 document that stool specimens collected from residents on 08-30-06 indicate the Norovirus was the pathogenic microorganism. 2. E3, Dietary Manager, stated during an interview on 08-31-06 at 11:00 am that E5, Cook, came to work on 08-30-06 at 12:00 pm with diarrhea and not feeling well. E3 stated that E5's symptoms were gone by 4:00 pm and that E5 cooked the evening meal preparing the grilled cheese sandwiches which were served to the residents. E5 was interviewed on 08-31-06 at 1:55 pm by	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145918	A. BUILDING _____ B. WING _____	C 09/06/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE COMMUNITY HLTHCR CTR	900 EAST CORPORATION BRIDGEPORT, IL 62417

(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
F9999	Continued From page 13	F9999		

telephone. During the interview, E5 stated that she became ill on the morning of 08-30-06 with diarrhea and started taking an over-the-counter medication for the diarrhea. E5 stated she went to work and was still having diarrhea with everything she ate going "right through" her but by 3:00 pm the diarrhea had stopped.

E1 was interviewed at 2:00 pm on 08-31-06 and stated that he did not know that E5 had worked her entire shift on 08-30-06 despite being ill and would have expected E3 to have sent E5 home if she was having diarrhea. E1 also stated that the employee handbook documents that employees are not to work if they have a communicable disease.

3. E4, Housekeeping and Laundry Supervisor, was interviewed at 9:45 am on 08-31-06. E4 stated that he was affected by the gastrointestinal illness on the evening of 08-29-06 and did not work on 08-30-06 due to being ill. He stated on 08-31-06 that he still was not feeling well but came to work because the facility was short-handed. E4 stated, "Normally we have one housekeeper per hall but today we have 2 housekeepers each cleaning 2 halls."

E1 was told about E4 working on 08-31-06 at 10:15 am and stated he did not know E4 was working. E1 later that morning stated that he sent E4 home.

4. During observations in the dietary areas on 08-31-06 at 10:00 am and 11:30 am, the ice machine was observed to be in an enclosed area outside the kitchen. Various staff from outside the dietary department were observed to lift the lid of the ice machine, take the scoop, and scoop

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145918	A. BUILDING _____ B. WING _____	C 09/06/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE COMMUNITY HLTHCR CTR	**900 EAST CORPORATION BRIDGEPORT, IL 62417**

(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
F9999	Continued From page 14 ice into a glass for personal use. No handwashing was observed during these random observations. E2, Assistant Director of Nurses, stated during an interview on 08-31-06 at 11:15 am that the certified nurses aides go to the ice machine and get the ice they need to take to resident rooms and fill the individual water pitchers. E2 stated that staff can go get ice for personal use at the facility ice machine also. E1 verified this information at 2:45 pm on 08-31-06 and also verified that there are no preventive measures in place to ensure that the ice scoop and ice are handled in a way to prevent contamination of the ice. (A)	F9999		