STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146115	A. BUILDING _____ B. WING _____	C 05/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW ATHENS HOME FOR THE AGED	203 SOUTH JOHNSON STREET NEW ATHENS, IL 62264

(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 441	Continued From page 4 notified of the Immediate Jeopardy at 2:45PM on 5/24/10. The facility took the following steps to correct the immediacy: 1. 5/14/10, 9:00 AM-6:00 PM, first report of potential procedure error for lancet usage checking blood sugar levels. Accused nurse was questioned and it was determined that protocol was not followed. Employee was terminated. Facility medical director was contacted for guidance. Started immediate monitoring of vital signs every shift for the 16 impacted residents. 2. 5/15/10, Administrator gathered data on all residents in the Facility who may have been affected by this procedure for the last year. All physician's were notified. 3. 5/16/10, Medical Director instructed staff to continue checking vital signs and ordered lab work which included Hepatitis B, Hepatitis C and HIV for all 16 residents. Facility Quality Assurance Committee met to review safety policies and procedures. Completed one-on-one inservices with all nursing staff concerning proper infection control and glucose testing.	F 441		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) Section 300.610 Resident Care Policies a) The facility shall have written policies and	F9999		

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F9999	Continued From page 5 procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. These requirements are not met as evidenced by: Based on record review and interview, the Facility failed to ensure that licensed nursing staff follow proper infection control procedures when performing blood glucose monitoring finger sticks, for 16 of 16 (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16) residents in the Facility who require glucose monitoring.	F9999		

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F9999	Continued From page 6 Findings include: Facility incident investigation, dated 5/14/10, states the following: 9:00 AM, E5, Licensed Practical Nurse (LPN), approached E2, Director of Nursing (DON) and stated that the new nurse, E4, LPN, was questioning the Facility's policy regarding blood glucose monitoring and the proper disposal of unsterile lancets and needles. E5 informed E2 that E4 witnessed the midnight nurse, E3, LPN, not utilizing proper technique when obtaining resident's blood sugars. 11:30 AM, E2 placed phone call to E3 and questioned "Do you change lancets between each resident and discard after each use?" After a long pause, E3 stated "Sometimes I do." E2 asked E3 to explain her reasoning as to why she was not following proper protocol and sterile technique. E3 stated "My husband doesn't do it." E2 informed E3 that her husband was in his own home and own environment, surrounded by his own germs and that reusing lancets was still not recommended. E2 informed E3 of possible bloodborne pathogens being passed from one resident to the next, and cross contamination. E3 stated "I guess I'm just old school." E2 informed E3 that even "old school" did not practice such improper technique. E3 had attended and was present for the entire infection control inservice that was held in-house during the month of March 2010. 5:00 PM, E2 received return call from E4 and asked her to explain the orientation she had received this morning. E4 stated "I was	F9999		

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F9999	Continued From page 7	F9999		

dumbfounded when I witnessed E3 not changing lancets between each resident during blood glucose monitoring."

On 5/24/10, E1, Administrator stated that he and E2 immediately started an investigation as soon as they became aware of what E3 was doing. E1 said that the Facility immediately contacted their medical director, physician's, resident's and/or resident's family members while they continued their investigation. E1 said that all of the 16 potentially impacted residents were tested for bloodborne pathogens on 5/18/10, and all 16 have had their vital signs checked every shift. The laboratory test for bloodborne pathogens includes Hepatitis B, Hepatitis C and HIV. All 16 resident's were found negative for bloodborne pathogens. E1 said that he had asked E3 how long she had been doing blood glucose monitoring finger sticks without changing the lancet and she stated "not long." E1 said that all potentially impacted residents from 12/09 to present were tested.

A review of E3's Facility employee file shows that she started working at the Facility on 3/2/06. E3 worked the night shift. E2 said that the night nurse performs all of the early morning blood glucose monitoring finger sticks prior to the end of the shift. E2 said that E3 worked part time, "usually only two days a week."

E3 was interviewed by telephone on 5/26/10 at 2:12 PM. When asked how long she had been doing glucose finger sticks without changing the lancet, E3 stated the following: "My best judgement is that it happened just during that orientation with the nurse. I got confused while having to orientate her, introducing her to

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F9999	Continued From page 8 resident's and doing everything else. It was just a slip - I wasn't even aware that I wasn't changing the lancet. It still boggles my mind. this is not my general way of doing things. I can't put my finger on it." E5, E6, E7 and E8, all LPN's, were all interviewed on 5/24/10 concerning proper procedures for blood glucose monitoring. All four of the nurses interviewed stated that lancets are to be changed between every resident and the machine is to be sanitized. A review of R1-R16's clinical records was conducted on 5/24 and 5/26/10. All of the resident have physician's orders for "Fingerstick glucose monitoring every morning." None of the 16 residents have diagnoses which indicate a presence of bloodborne pathogens. None of the 16 residents have diagnoses which would indicate compromised immunity. (A)	F9999		