STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146130	A. BUILDING _____ B. WING _____	09/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST RETIREMENT VILLAGE	1740 NORTH CIRCUIT DRIVE ROUND LAKE BEACH, IL 60073

(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 520	Continued From page 18 evaluate and educate. This will e helpful in efforts to reduce the number of infections at the facility."	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.696a) 300.696b) 300.696c)2)6)7) 300.3240a) 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): 2) Guideline for Hand Hygiene in Health-Care Settings	F9999		

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F9999	Continued From page 19 6) Guideline for Isolation Precautions in Hospitals 7) Guidelines for Infection Control in Health Care Personnel Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to monitor facility-acquired infections (requiring isolation). The facility currently has 8 residents on isolation and had 25 acquired infections from 3/10 through 8/10. The facility failed to have disposable/paper towels available for residents and staff in all rooms (including isolation rooms) to wash hands. The facility failed to transport clean and dirty linens in a sanitary manner. This failure to have an ongoing infection control policy to investigate, control, and prevent infections, the lack of handwashing paper towels, and the practice of cohorting infected and non infected residents in the same room sharing bathroom facilities, resulted in a system failure in the prevention of transmission of disease causing organisms. These failures have the potential to affect all 131 residents residing at the facility. Findings include During the initial tour of the facility on 9/7/10 between 10:00 and 10:30 AM it was noted that there were no disposable or paper towels in the bathrooms of resident rooms, including resident	F9999		

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F9999	Continued From page 20	F9999		

isolation rooms. Two residents in rooms 105 and 402 are on isolation precautions for Clostridium difficile (C-diff). Four residents in rooms 207, 309, 512 and 515 are on isolation precautions for Extended Spectrum Beta-Lactamases (ESBL). Two residents in rooms 405 and 500 are on isolation for Methicillin Resistant Staphylococcus Aureus (MRSA). The eight residents in isolation rooms 105, 207, 309, 405, 512 and 515 share their 2 bedroom room and their bathrooms with the other resident in the room who does not have infections, or share the common bathroom with another adjoining room with compromised but uninfected residents..

On 9/8/10 between 8:45 AM and 9:35 AM the following observations were made during the dressing change of R8's MRSA infected wounds: At 8:45 AM E8 (Wound Care Nurse) removed the soiled dressings from R8's infected wounds and then used R8's bathroom to wash her soiled hands. At 8:50 AM E7 (Housekeeper) entered R8's bathroom and washed her hands. E7 left the bathroom with her hands noted wet. When interviewed at 9:00 AM, E7 confirmed that she touched the faucet handles with her wet bare hands after washing her hands and that she did not dry her hands prior to leaving the bathroom. At 9:15 AM, E8 returned to R8's room to remove the wet guaze that she placed in the infected wounds to soak. E8 washed her soiled hands in the bathroom without drying. At 9:30, AM R34 (who lives in the next room and shares the common bathroom with R8) entered the bathroom to use the toilet. At 9:33 AM R34 was interviewed about washing her hands. R34 confirmed that she used her bare hands to turn off the faucet after washing her hands. R34 said that she then shook her hands in the air and

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F9999	Continued From page 21 wiped them on her pants to dry them as she usually does. The facility's Employee Hand Washing Policy (undated) states, "Turn off faucet with used paper towel or wipe. Be careful not to contaminate hands with faucet." The facility currently has 8 residents on isolation precautions for various infections according to the list provided by E3 (ADON) on 9/7/10. There were 25 new facility acquired infections requiring isolation between March 2010 and August 2010 according to documentation on the "Line Listing of Resident Infections" provided by E3 on 9/7/10. E3 was interviewed on 9/7/10 and 9/8/10 regarding analysis and interpretation of facility acquired infections. E3 (ADON) confirmed that she does not analyze the data collected on facility acquired infections to determine possible transmission trends caused by facility practice. E3 stated that there have been no recent changes made to employee practice guidelines related to infection control. E3 stated that residents on isolation are provided with 1 cloth towel everyday to dry their hands, that many are kept not in the bathroom but in the drawer limiting immediate access. On 9/8/10 at 11:10 AM E1 (Administrator) confirmed that there are no paper/disposable towels in any of the resident bathrooms and that it has been that way for some time. The decision was mmade to remove paper towels as a precaution to prevent plumbing issues when they were being flushed in the toilet. On 9/9/10 at 9:23 AM, Z1 (Medical Director) stated that she was not aware of the number of	F9999		

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F9999	Continued From page 22 facility acquired infections. Z1 stated that she periodically has input into the infection control program but stated that lately she has not looked at the percent of acquired infections. Z1 said that she was not aware that there were no paper towels in resident bathrooms and agreed that paper towels should be readily available for proper handwashing. On 9/7 and 9/8/10 the following observations were made: On 09/07/10 at 2:00 PM on the 100 wing E5 (CNA) was observed carrying bags of both soiled linen and clean linen. On 9/7/10 at 2:00 PM in isolation room 207 there were no gloves available in the room. Two cloth hand towels were hanging on hooks located on the bathroom wall. There were no paper towels available in the bathroom. On 09/08/10 at 9:10 AM E6 (Housekeeper) was carrying a bag of soiled linen while pushing a clean linen cart. She emptied the soiled linen bag into a linen chute, and continued to push the cart directly to the 500 wing (the opposite end of the building) without washing her hands. When interviewed, E6 stated that she was not supposed handle both clean and soiled items at the same time. (A)	F9999		