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HOLY FAMILY VILLA	12220 SOUTH WILL COOK ROAD PALOS PARK, IL 60464

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F 514	Continued From page 54 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to keep accurate medical records of one resident, (R5) list of allergies in a sample of 19 residents. R5's current MAR (Medication Administration Record) for December 2011, list an allergy to Bactrim. The POS (Physician Order Sheet) for December 1-31, 2011 also list Bactrim as an allergy. The physician progress notes of Z1, Physician, for August 8, 2011, September 28, 2011 and December 14, 2011 documents that R5 has "No known drug allergies except ACE inhibitors." According to the POS, on December 23, 2011, ZI prescribed Bactrim DS for R5 to take for 7 days. On December 29, 2011 at 11:15am E12, (Licensed Practical Nurse) stated that R5 is allergic to Bactrim, so she got an order for a different medication.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION 300.610a) 300.1210b) 300.1220b)8)	F9999		

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F9999	Continued From page 55 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and 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 b) The facility shall 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 resident care plan. 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and	F9999		

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restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These regulations are not met, as evidenced by the following:

Based on observation, interview and record review, the facility failed to:
1) Practice Standard Precautions associated with hand washing before and after resident care involving 5 sampled residents(R5,R6,R7,R8,R11) of 19 total residents, 5 residents from the supplemental sample(R23,R31,R32,R39,R42) and medication administration involving 1 resident(R43). 2) Practice Specialized Precautions associated with wearing of Personal Protective Equipment during care of two residents (R2, R8) requiring Contact Isolations. 3) Provide Staff Education regarding Infection Control. 4) Establish an ongoing Infection Control Program to comprehensively analyze trends of Infection and develop Policies and Procedures with addressing Nosocomial Infections. 5) Clean and disinfect the Glucometer machine involving 1 sampled resident(R5) of a sample of 19 and 2 residents from the supplemental sample(R36,R45) per manufacturer guidelines. 6) Sanitize rooms of residents with Clostridium Difficile (C-Diff)

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F9999	Continued From page 57 Infections per CDC (Center for Disease Control) guidelines involving 2 residents (R2,R8) . 7) Follow the facility's policy regarding Infection Control practices. These failures resulted in residents increased risk of being exposed to pathogens associated with infections. These failures has the potential to affect all medically compromised residents. Findings Include: 1. On December 27, 2011 at 9:25am at the 1st floor nursing station, the surveyor supervisor observed R39 dropped her hearing aid on the floor, E15 (Registered Nurse) picked the hearing aid off the floor, changed the battery, then placed the hearing aid back into R39's ear. E15 did not wipe the contaminated hearing aid before giving it back to to R39. On December 27, 2011 at 12:10pm, during meal observation in the 1st floor dining room, E10 started serving coffee and water to the residents at various tables without performing any hand hygiene. At 12:38pm, E10 then began feeding R5, still with no handwashing. At 12:45pm E10 then left the table and started feeding R11, with no hand washing in between feeding residents. E14, then took over feeding R5 without performing hand hygiene. At 12:50pm E10, stopped feeding R11 went to assist another resident out of the dining room, E10 helped her up out of the seat, touch the walker and then resumed feeding R11 without performing hygiene before re-touching R11's utensils and tray.	F9999		

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F9999	Continued From page 58 On December 28, 2011 at 1:15Ppm, E2 (Director of Nursing) stated she is the Infection Control Nurse but does not track infections of residents. There is no record of if infections are community acquired or Noscomial and the outcome of antibiotic therapy. On December 29, 2011 at 9:35am E2, Director of Nursing, stated " If we washed our hands after caring for each resident, we would be washing our hands 24/7, and that's just not necessary." On December 29, 2011 at 9:45am E2 stated that she does not have to wear an isolation gown to protect her clothing when giving direct bedside care to a resident in isolation for C-Diff and ESBL (Extended Spectrum Beta Lactamase). According to the facility's policy for Infection Control dated July 2009 denotes: Handwashing is to take place "between resident contact.". Additionally when resident is in Contact Precautions: "wear a gown, as you will have contact with the resident, environmental surfaces, or items in residents room." 2. On 12/27/11 at 9:30am, during initial tour of the facility with E18 (Registered Nurse) R2 was lying in bed. E18 stated that R2 was on contact isolation precautions for clostridium difficile (C diff) and ESBL (Extended Spectrum Beta Lactamase). There was no sign located outside of the room informing staff and visitors of isolation precautions. There was a sign inside the room posted to the wardrobe cabinet which read as follows: Special Handling Required! Remember that Good Hand Washing is Required	F9999		

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Before & After Caregiving! Very Important Procedure! The sign did not indicate personal protective equipment (PPE) to be worn when providing care to residents on isolation precautions. E18 stated there are no other signs used by the facility for isolation precautions.

On 12/27/11 at 3:00pm, E18 (Registered Nurse) and E26 (Certified Nursing Assistant) repositioned R6 in the reclining chair located in the dining room. E18 and E26 each placed one hand under R6 ' s leg, and the other hand behind R6 ' s back. After repositioning R6, E26 proceeded to reposition R23 ' s feet onto the foot rest of R23 ' s wheel chair. E26 did not perform hand washing between residents.

On 12/27/11 at 3:55pm (in the resident ' s room), E21 (Licensed Practical Nurse) administered an Albuterol nebulizer (breathing) treatment to R43. The medication chamber contained a liquid substance. E21 identified the liquid as medication from the previous treatment. E21 emptied the chamber and poured a new vial of medication into the chamber. E21 then administered the nebulizer treatment to R43. E21 did not cleanse the chamber prior to administering the nebulizer treatment.

On 12/27/11 at 4:05pm, E21 performed a finger stick blood glucose reading on R36. After obtaining the blood sample, E21 wiped the glucometer with a CaviWipes Towelette and placed the glucometer on the medication cart.

On 12/27/11 at 4:44pm, E6 (Registered Nurse) performed a finger stick blood glucose reading on R45. After obtaining the blood sample, E6 wiped

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the glucometer with a CaviWipes towelette and placed the glucometer on the medication cart.

On 12/28/11 at 11:48am, E12 (Licensed Practical Nurse) performed a finger stick blood glucose reading on R5. After performing the BGM check, E12 placed the glucometer in the top drawer of the medication cart and locked the cart. E12 did not cleanse the glucometer prior to placing it on the medication cart.

The facility ' s policy for the blood Glucose Monitoring System documents: To prevent the spread of infectious disease the following procedure will be used-
Procedure: all blood should be removed from the lancing device after each testing. After testing clean with CaviWipes supplied in each med cart.

The manufacturer ' s cleaning instructions on the CaviWipes towelette container documents the following:
Use one CaviWipes towelette to completely pre-clean surface of all gross debris. Use a second CaviWipes towelette to thoroughly wet the surface. Repeated use of the produce may be required to ensure that the surface remains visibly wet for 2 minutes at room temperature.

On 12/28/11 at 11:40am (in the resident room) E2 (Director of Nursing) and E15 (MDS coordinator) were providing wound care to R2. R2 was on contact isolation precautions for clostridium difficile (C Diff) and (ESBL) in the urine. R2 was totally undressed during the procedure. E2 was holding R2 ' s legs against E2 ' s clothing as E15 wiped the open wound to R2 ' s buttocks. Neither staff was wearing an isolation gown.

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On 12/28/11 at 4:00pm E20 exited R2 ' s room. R2 is on contact isolation for Cdiff and ESBL in the urine. E20 was wearing gloves and carrying the glucometer upon exiting the room. The glucometer contained a testing strip with visible blood on it. E20 sat the glucometer on top of the medication cart. E20 removed the testing strip and threw it into the trash can attached to the medication cart. E20 then disposed of the gloves and placed the glucometer in the top drawer of the medication cart. E20 did not cleanse the glucometer prior to placing it on the medication cart. E20 pushed the medication cart to the other side of the nursing station and locked the drawer. E20 then entered the medication room and opened the refrigerator. E20 reached into the refrigerator (It is unclear as to what E20 was placing in the refrigerator), then exited the medication room. E20 then entered the clean utility room and performed hand hygiene.

On 12/29/11 at 8:50am (location - resident room) (E15, MDS Coordinator) performed wound care for R2 along with assistance form E16, (Licensed Practical Nurse) and E17 (Registered Nurse, RN). R2 is on contact isolation for Cdiff and ESBL. The staff did not wear isolation gowns. There were no isolation gowns on the isolation cart in R2 ' s room. At 9:57am E23 entered the room and began giving R2 a complete bed bath, along with assistance from E17. E23 did not wash R2 ' s legs or right foot, nor did E23 remove the heel protectors from R2 ' s feet. The heel protectors became wet during the bath. R2 ' s indwelling catheter tubing had white substances on it. E23 did not cleanse the catheter tubing. E15 performed wound care for R2 and E15 ' s

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shirt and skin was in contact with R2 ' s skin. The four side rails remained up during the procedure. The staff were all leaning against the side rails at different times during the procedure. E15 cleansed the wound to R2 ' s foot and applied hydrogel ointment. E15 did not perform hand washing between cleansing the wound and applying the Hydrogel. After providing wound care to R2 ' s feet, E15 performed wound care to R2 ' s buttock. E15 did not perform hand washing between treatments. R2 ' s feeding tube remained connected during the procedure. E16 and E17 pulled R2 up in bed and were stretching the feeding tube. The feeding tube was also stretched between R2 ' s feet and legs during the bath and wound treatment. The staff did not cleanse the feeding tube. E15 did not perform hand washing during the entire procedure. E15 stated that the facility ' s procedure for contact isolation is to wear gowns only if body fluids splash. E15 further stated that the facility has not placed gowns in R2 ' s room because there ' s no splashing.

3. During the first floor lunch observation on 12/27/2011 which started at 11:50 AM, the following were observed:

-E32 (Dietary Staff) noted donning gloves without prior handwashing observed. Started preparing tea in plastic pitchers. E32 coughed towards the direction of the sink on two episodes while preparing tea without covering her mouth did not wash hands after taking off gloves.
-E10 (CNA, Certified Nurse Aide) did not wash her hands prior to serving water and coffee.
-E 34 (CNA) observed sneezing on her hand then opened a carton of milk and handed it to a

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resident without washing her hands after sneezing.

On 12/27/2011 at 1:42 PM, E10 (CNA) and E11 (CNA) did incontinent care on R11. Both washed their hands , donned gloves, took off R11's adult incontinent briefs which was moderately wet with urine and soiled with a minimal amount of brown fecal material. After cleaning R11, E10 put clean incontinent briefs on him with E10's help and both CNAs took off gloves and washed their hands.

During dinner observation on the first floor on 12/27/2011 starting at 5:20 PM, the following were observed:
-E33(Certified Nursing Assistant) started placing soup into bowls without any hand hygiene observed and was anchoring each bowl on her chest as she tried to hold it steady. After serving soup E33 sat down and fed R42 without any hand hygiene observed. Then R42 spilled soup on to the floor and dropped a cup under the table. E33 cleaned up the mess with a towel, picked up the cup and replaced it on the table, walked to the dirty utility room with the soiled towel in hand and came back to resume feeding R42. There was no hand hygiene observed at any given time during this chain of activities.
-E7 (CNA) dropped her badge on the floor, picked it up and clipped it on her front uniform top then continued serving soup to residents without any hand hygiene observed after picking up badge from the floor.

4. On 12-28-11 at 12:13pm E25 was feeding R23 and R32 when E16 asked E25 to take R31 to the recliner or her room. E25 stop feeding R23 and R32 and proceeded to take care of R31 without

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F9999	Continued From page 64 hand hygiene. On 12-28-11 at 12:45pm E26 assisted R7 to the bathroom. E26 removed incontinent brief, soiled pants and leg boot without gloves. After R7 had a bowel movement, E26 put gloves on and wiped R7. Then E26 arranged R7's incontinent brief, put on clean pants-after searching and touching R7's closet. E26 then applied the leg boot, assisted R7 to the wheel chair, collected the dirty clothes in a plastic bag, tied the bag and placed a clean plastic bag in the bathroom waste basket. There was no removal of the contaminated gloves or hand hygiene while E26 was rendering care to R7. E26 wheeled R7 back to day room, took bag of dirty clothes to dirty utility room, remove contaminated gloves and washed his hands. E26 stated " I need to wash hands every time I touch a resident and after hands are dirty I clean them too.come over there, I am getting conscientious." 5. 12/27/11 at 12:10PM observed E11 (CNA) and E32 (Therapy staff) bring R8 into his room from the elevator. E14 (LPN) took resident out of his room (117) and pushed him to his dining room table. Residents were in the room preparing for lunch. E11 and E32 took resident out of his wheelchair and put him in the dining room chair by his legs near his buttocks area. E11 and E32 then went to assist and have contact with other residents in the dining room. E11 and E32 never washed their hands after handling R8 and going to the other residents. E14 went to other residents after pushing R8 out to the dining room without washing her hands. E14 then went into the medication room directly to the	F9999		

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medication prep cart and started preparing medications. E14 never washed her hands during the entire observation.

During the initial tour and environmental tour the facilities has two rooms 117 (R8) and 217 (R2) which are designated isolation rooms. R8 is isolated for Clostridium Difficile. R2 is isolated for Clostridium Difficle and Extended Spectrum Beta Lactamase. These rooms were observed during the initial tour on 12/27 and environmental tour 12/27 with no isolation precaution signs posted on the entrance to their rooms.

12/28/11 at 11 AM , Z2 (visitor) was observed sitting on R8s bed touching his shoulder and head. Z2 did not have a gown or gloves on. R8 is currently on isolation for Clostridium Difficle.

12/28/11 at 11:30AM , E28 (Maintenance/ Housekeeping Director) was interviewed in the conference room. E28 responded he did not have specific procedures for cleaning resident isolation rooms with Clostridium Difficle. E28 produced a label of the chemical his staff use in isolation rooms. The Chemical is a combination one step disinfectant germicidal detergent and deodorant . (active ingredient Didecyl dimethyi ammonium chloride) The label does not show that this chemical is effective againt the Clostridium difficile pathogen and spores.

12/28/11 at 11:45 AM E27(housekeeper) was interviewed on the 2nd floor in the corridor. E27 did not have specific knowledge on isolation room cleaning procedures for rooms isolated for Clostridium difficile.

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