STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145990	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLE CREST CARE CENTRE	**4452 SQUAW PRAIRIE ROAD BELVIDERE, IL 61008**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a gait belt was used during transfers for one of three residents (R3) reviewed for safety in the sample of four. The findings include: R3's face sheet dated 9/1/20 showed [DIAGNOSES REDACTED]. R3's facility assessment dated [DATE] showed no cognitive impairment and no memory problems. The facility assessment also showed R3 requires staff assistance moving on and off the toilet. R3's fall risk assessment dated [DATE] showed a moderate risk for falls. On 9/1/20 at 11:00 AM, V4 (CNA-Certified Nurse Aide) pushed R3's wheelchair into the bathroom. V4 instructed R3 to hold onto the wall and stand while she pulled his pants down. V4 removed the wheelchair and placed a bedside commode under R3. V4 then instructed R3 to sit down. R3 was wearing a left leg prosthesis and the right leg was heavily wrapped in a compression dressing. R3 was unsteady and swayed while standing. V4 did not utilize a gait belt during the transfer. V4 then exited the bathroom. R3 stated staff never use a gait belt when he is being transferred on or off the toilet. R3 said they do not use a gait belt during transfers in or out of bed either. R3 said a gait belt is only used during walking sessions with the therapists and never by the aides (CNAs). At 11:15 AM, V8 (CNA) assisted R3 up from the commode to a standing position. V8 performed pericare and pulled up R3's pants. V8 removed the commode from under R3 and place the wheelchair under him. Again, R3 was unsteady and held onto the wall for support. V8 did not utilize a gait belt during the transfer. On 9/1/20 at 1:45 PM, V4 (CNA) stated she did not use a gait belt while transferring R3 because she did not have one with her at that time. V4 said aides are required to have a gait belt available for use at all times and should be carrying it with them as part of their uniform. At 1:50 PM, V8 (CNA) stated she did not know if the facility had a gait belt that is the correct size for R3. V8 said she never uses a gait belt to transfer R3 because he seems pretty steady to her at transfers. On 9/1/20 at 12:55 PM, V2 (Director of Nurses) stated staff should be using gait belts during resident transfers. Gait belts are important for fall prevention because they add stability and safety. V2 said gait belts are required during every transfer. The facility's gait belt policy review dated 9/1/20 states under the general section: Gait belts are used to help prevent injury of staff or residents during transfers and ambulation. The policy states under the guideline section: 1. Gait belts should be used by all staff when ambulating or transferring a resident.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review the facility failed to ensure gloves were changed during pericare for one of four residents (R2) reviewed for infection control in the sample for four. The findings include: On 9/1/20 at 10:00 AM, V5 and V6 (CNAs-Certified Nurse Aides) entered R2's room. R2 was lying on the bed with her back facing the doorway. R2's pants were saturated with urine from her buttocks down to her mid-thighs. V5 stated R2 is confused and will remove her own incontinence brief at times. V5 and V6 rolled R2 from side to side to remove her wet pants and wet bed linens. V5 and V6 wore gloves while cleansing R2's perineal area, buttock, and thighs. V5 and V6 continued wearing the same dirty gloves and touched R2's clean brief, pillow, bed rails, fresh pants, and shirt. On 9/1/20 at 1:30 PM, V5 (CNA) stated she should have changed her dirty gloves before putting on the clean briefs and pants. V5 said gloves should be changed after touching any body fluids, including urine. At 1:40 PM, V6 (CNA) stated she forgot to change her gloves during the pericare. V6 said she should have changed her gloves between the dirty and clean areas. On 9/1/20 at 12:55 PM, V2 (Director of Nurses) stated gloves should be changed when pericare is complete and before touching anything else. There is the potential to contaminate other objects if it is not done and it is a breach in infection control. On 9/1/20 at 1:05 PM, V3 (Infection Control Coordinator) stated proper glove use is important to reduce the spread of infection between areas and between residents. The facility's glove use policy revision dated 9/1/20 states under the guideline section: 2. Gloves must be changed between residents and between contact with different body sites of the same resident. The facility's perineal care policy review dated 9/1/20 states under the guideline section: 8. When complete, remove gloves and cleanse hands.

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.