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	146000	A. BUILDING _____ B. WING _____	07/11/2016

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WAY-FAIR NURSING & REHAB CENTER	**305 N.W. 11TH STREET FAIRFIELD, IL 62837**

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey An extended survey was conducted.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by:	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 164	Continued From page 1 Based on observation and interview, the facility failed to provide privacy for 1 resident (R17) reviewed for privacy in the supplemental sample. Findings include: On 06-28-2016 at 10:25 AM, E20 (Certified Nurse Aide) was observed giving R17 a shower with the shower door open. E20 had a tri-fold privacy screen in front of the door that had a large space between the screen curtains. R17 was visible from the hallway as R9 wheeled her wheelchair past the shower, and E35 (Maintenance) also walked past the shower room door while R17 was in the shower. On 06-28-2016 at 4:30 PM, E1 (Administrator) stated that the door was open because it is hot in the shower with the door closed, but the staff need to make sure the resident isn't visible from the hall.	F 164		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to allow residents to choose waking times that are consistent with their past and	F 242		

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current daily schedules for 2 of 16 residents (R10 and R11) reviewed for residents rights in the sample of 16 and 3 residents (R20, R27 and R28) in the supplemental sample.

The findings include:

1. On 6/28/16 at 2:00pm during the resident Quality of Life Assessment Group Interview, the residents in attendance were questioned about what time they get up in the mornings . The residents indicated they are awakened by staff beginning at 5:00am. The residents indicated that they are unable to choose what time they get up and ready in the morning. R28 stated she is awakened at 6:00am and would choose 7:30am to 8:00am if she could. R20 stated she is awakened at 5:00am and would choose 6:30am to 7:00am if he could. R27 stated she gets up early by choice but no one has ever asked what time she would like to get up.

2. On 6/30/16 at 3:00pm R10 stated that she is often awake when staff come to help her in the mornings but, no one has ever asked her what time she prefers to be awakened or would like to get out of bed in the mornings.

3. On 7/5/16 at 1:15pm R11 stated that she is awakened too early. She is dressed and put in a chair and must wait for breakfast. R11 stated she has told the nursing staff that she does not want to get up early and has never been given a reason why she must be up so early. E29 (Certified Nurse Aide) who works day shift (6AM-2PM) stated she usually gets R11 up for the day but at times R11 is already up when the day shift reports to work at 6:00am. E29 indicated R11 has told her she does not want to be up that

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F 242	Continued From page 3 early. 4. On 06/28/16 at 3:00PM, E1 (Administrator) was asked how residents are asked about personal preferences. E1 indicated E12 (Activities) and E19 (Marketing) should have a process. On 6/30/16 at 9:45AM, E12 stated she assesses the residents on the Minimum Data Set (MDS) but there is no action taken on the preferences expressed on the assessment. E2 (Director of Nurses) presented a list of residents on 6/29/16 that indicates for each hall the bed checks and residents who need to be up and dressed. The list notes the residents begin getting up at 5:00am. On 6/29/16 at 4:00pm, E2 stated that the residents choices are not reviewed when making the lists. E19 stated on 6/30/16 at 1:35pm that there is no information gathered about resident preference in the admission paperwork.	F 242		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280		

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F 280	Continued From page 4 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to update the care plan with new orders for 1 of 16 residents (R1) reviewed for care plans in the sample of 16. Findings Include: 1. R1's Care Plan, dated 6/20/16, documents the problem of fluid volume related to edema. "Unna Boots" were ordered 06/21/16, as documented on the Physician's Order dated 06/01/16 through 6/30/16. On 6/28/16 there is no update to the care plan to document the new order of "Unna Boots" or the interventions needed to care for the "Unna Boots." On 6/27/16 at 10:00 AM E22 (Minimum Data Set/ Care Plan Coordinator) stated "the Unna Boots order and interventions for Unna Boots is not included on the care plan."	F 280		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312		

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by:
Based on observation and record review the facility failed to provide assistance with grooming and personal hygiene regarding facial hair, fingernails, hair, eyeglasses and/or clothing for 3 of 13 residents (R6, R8, R9) reviewed for grooming and hygiene in the sample of 16 and 3 residents (R18, R19, R25) in the supplemental sample.

Findings include:

1. On 6/27/16 at 1:55pm R25 was observed to be in the Physical Therapy area and was noted to have long fingernails with chipped polish. The long nails were packed with gray / brown material under the nails. R25 was observed again on 6/29/16 at 10:15am with the nails in the same condition. R25's Minimum Data Set dated 5/9/16 documents that R25 requires extensive assistance of 1 person for grooming.

2. On 06/28/16 at 11:05AM, R8 was observed resting in bed in her room. Dark brown dried debris was observed under R8's finger nails. R8's eye glasses were observed sitting on a shelf in the room. The lens of the glasses were observed to be dirty and smudged with a thick clear substance. On 06/29/16 at 12:10PM, R8 was observed in the dining room with her eye glasses and nails observed in the same condition. Also, at this time R8 was observed wearing a white back corset. The front of the corset had dried light brown and light red stains. R8's Minimum Data Set dated 5/2/16 documents that R8 is totally dependent of 1 person for grooming and dressing.

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3. On 6/27/16 at 2:15 PM, R6 was lying in his bed asleep. R6 had long fingernails with a brown substance underneath them, and R6 was not shaved and his hair was very messy. On 6/28/16 at 9:30 AM, R6 was up in his wheelchair sitting in front of a bedside table at the nurses station eating his lunch. R6 was not shaved, his hair was very messy and uncombed, and his fingernails were long and dirty. R6's Care Plan dated 5/16/16 documents that R6 requires extensive assistance of 2 for grooming and dressing.

4. On 6/27/16 at 2:00 PM, R9 was up in her wheelchair in front of her bedroom door. R9's eye glasses were covered with a white, flaky substance and her hair was very messy and uncombed. R9's fingernails were tattered, long, and had a brown substance underneath them. On 6/28/16 at 10:30 AM, R9 was in her wheelchair and was wearing a mis-matched blouse and slacks that had dried food and stains on them. R9's Care Plan dated 4/11/16 documents that R9 requires extensive assistance of one person for grooming and dressing.

5. On 6/28/16 at 11:40 AM, R18 and R19 were sitting in their wheelchairs in the sitting area in front of the nurse's station. R18's hair was very messy and uncombed, her fingernails were long and had a brown substance underneath. R18's clothing had stains on her slacks. R19's face was unshaved, his hair was very messy and his clothes were soiled. R18's Minimum Data Set dated 6/13/16 documents that R18 is limited assist of one person for hygiene and totally dependent and requires assistance of one person for dressing. R19's Minimum Data Set dated 6/28/16 documents that R19 is limited assist for dressing and requires assist of one person and

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F 312	Continued From page 7 requires supervision for grooming.	F 312		
F 322 SS=J	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide nursing services to aid in prevention of aspiration pneumonia: these failures include failing to follow the facility policy for reporting a change in a tube fed residents, not reporting a change in condition to the physician, including vomiting and failing to stop infusion of the enteral feeding formula when directed by the care plan and maintaining the head of bed elevated at least 30 degrees for 2 of 2 residents	F 322		

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(R5, R14) reviewed for gastric tube feeding in the sample of 16 and one resident (R30) in the supplemental sample.

These failures led to the hospitalization and diagnoses of aspiration with early aspiration pneumonitis for R14 on 04/27/16. R14 returned from the hospital on comfort care only, all IV (Intravenous) fluids, PEG (Percutaneous Endoscopic Gastrostomy) tube feedings and IV antibiotics discontinued. R14 expired on 5/1/16. The failures were repeated on 5/11/16 and 5/17/16 with R5's emesis not being reported to the physician and failing to suspend the tube feeding infusion as required. The continued lack of assessment, notification and failure to follow procedures places residents (R5 and R30) currently fed by enteral feedings, as per July 2016 physician's orders are at risk for harm including aspiration. Although the facility had identified the failure of E11 on 4/27/16, investigated, and implemented corrective measures the facility failed to re-evaluate to ensure that all nurses and nursing staff were educated on gastric tube care and standards of practice and these failures were repeated on 5/11/16 by E11 (Licensed Practical Nurse) and on 5/17/16 by E16 (Registered Nurse).

These failures resulted in an Immediate Jeopardy.

While the immediacy was removed on 07/11/16, the facility remains out of compliance at Severity Level 2 as the facility continues to educate and monitor staff on abuse policies and procedures.

The findings include:

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1. The Physician Order Sheet dated 04/01/16 notes R14 was admitted to the facility on 2/26/16 with multiple diagnoses including: Quadriplegic, Contractions of hands and feet, Urine retention, Sepsis, History of Pneumonia Traumatic Brain Injury.

R14's care plan dated 3/1/16 states Resident is dependent on Percutaneous Endoscopic Gastrostomy (PEG) tube feeding for all nutrition and hydration. R14 does not receive any medication or nutrition by mouth. The approaches related to this need included: "Hold feeding if diarrhea or emesis, notify MD (Medical Doctor)" and "Keep head of bed elevated at 30 degrees", "Observe for signs and symptoms of aspiration."

The facility presented policy's dated 8/1/15 regarding Tube Feedings for: Gastrostomy Tube Replacement, Verifying Placement of Feeding Tubes, Checking Gastric Residual, Gastrostomy/Jejunostomy Skin Care, Continuous Tube Feeding, Administering Medications and Flushing Feeding Tubes; none of these policies included using a Foley catheter instead of gastrostomy tube, or any emergency procedures to follow. The Policy and Procedure Change in Condition dated 8/1/15 states in part: Procedure: 1. The physician and Durable Power of Attorney/responsible party will be notified when there has been a change that is sudden onset, a change that is a marked difference in usual sign/symptoms and/or the signs/symptoms are unrelieved by measures already prescribed: 2. Specific information that requires prompt notification include..... b. Prolonged/unresolved emesis.... o. A need to transfer the resident to a hospital/treatment center; r. Instructions to notify

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the physician of changes in the resident's condition.

Nursing notes dated 4/27/16 at midnight state: "This nurse went to flush res (resident) G-tube and G-tube had come out. MD notified and gave order to replace with F/C (indwelling catheter) and to consult Z1 (Surgeon). F/C inserted without difficulty. No s/s (signs or symptoms) of distress." A further nursing note dated 4/27/16 at 6:30am states: "Given in report that resident had 2 emesis since putting Foley - no x-ray had been gotten to check placement nor had 2 emesis been reported to on call. This nurse answered call light to residents room - roommate had put light on to let someone know about roommate - resident had a dried towel full of brown emesis on lap, on face and chest - res starts profuse vomiting out mouth and trachea site - Gurgles noted ??? - on call called - number out of service - attempted to call E14 (Physician/ Medical Director) twice - call Z2 (Doctor)- gave order to send to ER - O2 (oxygen) applied O2 sat 78 - 80 % - Blood Pressure 110/58 - Pusle 97 - Temp.100, Resp. 18-22. Resident to ER via gurney, and nurse report called to ER nurse."

The hospital discharge summary dated 4/30/16 for R14 documents admission diagnoses: 1. Aspiration with early aspiration pneumonitis. 2. Urinary tract infection with urosepsis with elevated lactic acid and markedly elevated pyuria. 3. Quadriplegia with aphasia secondary to prior accident. 4. Hypernatremia.
The discharge plan : At this point, the patient will be transferred back to facility on comfort care only. We will discontinue IV fluids, PEG tube feedings and IV antibiotics. We will continue IV

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morphine and Lorazepam PRN (as needed). We will add scopolamine patch . Continue oxygen, and we will do our best to keep him comfortable.

The hospital Patient Discharge Summary Report dated 4/30/16 states as Diagnosis: Pneumonitits due to inhalation of food.

The death certificate for R14 dated 5/10/16 documents R14 died on 5/1/16 and the cause of death is noted as: Aspiration Pneumonia.

An undated Investigation summary regarding R14 documents nurses will receive education on documentation for change of condition, when to notify physician. Also, they will receive disciplinary action for failure to perform job safely, satisfactorily and efficiently. Continuing Education was documented for nursing staff dated 4/29/16 related to Enteral Tube: Checking placement residual and Care of. A Performance Correction Notice for E11(LPN) dated 05/05/16 was written for failing to chart vital signs for a resident with signs and symptoms of distress. A second Performance Correction Notice for E 11 dated 05/05/16 was written for Neglecting to provide care. The notation states "tube placement wasn't charted with insertion of catheter with g tube removal. Did not clarify order, resume/hold tube feeding . Did not call MD with change of condition/ vomiting.

There was no documentation available for review that the facility reevaluated the nursing staff on following the policy and procedures reviewed 4/29/16 continuing education course. The 4/29/16 inservice documentation has 10 nurse's signatures. The facility provided a list of the 14

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nurses employed. The inservice documentation did not include: E11 or E16. (Registered Nurse) There was no documentation to confirm that these nurses were initially reeducated. E16 stated on 7/5/16 at 9:45am that she has had no inservice education regarding enteral feeding or physician's notification. No evidence that Certified Nurse Aides received inservice education regarding care of residents with enteral feedings.

E14 (Physician/Medical Director) stated via telephone on 6/29/16 at 3:50pm that he had been informed in the early morning of 4/27/16 that R14's PEG tube had become dislodged. E14 told E11 to replace the tube with an indwelling catheter tube. E14 stated this was done to keep it open until the surgeon could replace it. E14 indicated he believed he had a standing order not to continue the feeding while using the indwelling catheter tube. E14 stated I don't know if that contributed to R14's change in condition. E14 indicated he was not aware of R14's vomiting until later in the morning of 4/27/16 while performing hospital rounds. E14 said if I had been informed of the vomiting earlier we might have known to stop the tube feeding. R14 is high risk for aspiration and has had his head elevated when I have seen him in the nursing home. It only takes one time to vomit to aspirate. We would have watched him more closely if they had told me E14 was vomiting. Usually aspiration doesn't show up until the next day. If I remember right we admitted E14 because his sodium level was high. Review of physician standing orders for the facility on 6/30/16 found no reference to enteral feeding.

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E17 (Certified Nurse Aide) stated via phone on 6/29/16 at 2:30pm that she had reported to work at 10:00pm and was the float aide for the night. E17 stated that early in the night R14 had looked at them when R14's name was called but later appeared sick and would not look at them. E17 stated that E11(License Practical Nurse) had put a catheter tube in for R14's PEG tube and restarted the feeding. E17 indicated that R14 began projectile vomiting at sometime after their lunch time and she had cleaned R14 up. E17 stated the nurse did not know what to do and gave R14 a breathing treatment. E17 stated that E11 did not contact the physician. At the end of the shift E17 stated R14 had increased vomiting that was coming from the nose, trachea opening (stoma from a discontinued tracheostomy) and mouth. E17 indicated the vomit was brownish - reddish and no bright red blood was seen.

E11 stated on 6/30/16 at 9:00am, that around midnight on 4/27/16, R14's Gastric tube was out. E11 stated that she called E14 (Medical Director) and reported the Gastric tube was out and he gave orders to put in a 14 French catheter. E11 stated that she started the tube feeding after she checked for placement of R14's Gastric tube by checking residual and E11 stated she also checked for placement by auscultation. E11 stated that R14 vomited one time and she checked R14's lung sounds for gurgling and crackles and did not hear any unusual lung sounds. E11 stated that R14 vomited one more time before she gave E9 (Registered Nurse) report. E11 also stated that she did not contact E14 about the emesis or get an X-ray to verify placement of the 14 French catheter, nor did E11

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review the facility policies regarding Gastric tubes. E11 stated that the head of R14's bed was elevated and she elevated R14's bed higher when he started vomiting. E11 stated that she can't remember Certified Nurse Aides (CNA) names that were working that morning, but they had cleaned vomit from R14's face and clothing. E11 also stated that she was inserviced about not calling R14's doctor concerning the Gastric tube.

On 06/29/2016 at 6:15 PM, E9 (Registered Nurse) stated that E11 told her in shift change report that R14's Gastric tube came out and E11 notified E14 and she received an order to insert a 14 French catheter which she did. E11 reported to E9 that R14 vomited one time and she waited a little while then started the G-tube feeding. E9 stated that she asked E11 if she had notified R14's doctor about the emesis and if E11 got an X-ray to verify placement of the G-tube, and E11 stated, "no." E9 stated that she went down the South and East halls to answer call lights and noticed that R14's call light was on and E9 stated that she knew R14 hadn't turned it on, so E9 hurriedly went to his room. E9 stated that R14 was lying almost completely flat and was gurgling and she immediately elevated R14 to a complete sitting position and when E9 elevated R14's bed, he began to projectile vomit, had feeding formula coming out of his nose, mouth, and an old tracheostomy stoma that was not being used. E9 also stated that when she entered into R14's room there was a towel lying over him that had dried, coffee ground colored emesis. E9 stated she immediately notified the Emergency room doctor, (couldn't remember his name) because she couldn't reach E14 by phone. On 06/30/2016 at 9:50 AM, E9 stated that she couldn't remember an inservice being given about Gastric or

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F 322	Continued From page 15 Nasogastric tubes. 2. The June, 2016 Physician's Orders state R5 has a diagnosis of Left Hemiplegia with Aphasia and Dysphasia. The orders state R5 has a gastric feeding tube with orders for Jevity 1.5 Calories of Liquid to run at 60 centimeters (cc's)/hour per the GT for 20 hours everyday. On 05/10/16 at 0345 Nurse's Note signed by E11 stated, "Res (Resident) had emesis x 1. Res cleaned up and had no further emesis. Tolerated feeding and meds well. No signs/symptoms of distress. (E1 stated on 06/30/16 at 11:00AM, the note should be dated 05/11/16.) A 05/17/16 10PM-6AM Nurse's Note signed by E16 stated, "Resident had one episode of emesis at 0130-no further episodes." The Nurse's Notes do not state if the tube feeding was stopped during the episodes of emesis, if tube placement was checked or if the physician was notified. R5's 09/22/15 Gastric Tube Resident Care Plan (Reviewed 03/14/16) states, "Hold feeding if diarrhea or emesis, notify MD (Medical Doctor)." 3. E1 (Administrator) was notified of the Immediate Jeopardy on 07/06/16 at 10:20 AM. The Immediate Jeopardy was determined to have begun on 4/27/16 at midnight when R14's PEG tube had been dislodged and replaced with an indwelling catheter tube and the feeding was resumed. R14 developed profuse vomiting after this event and the physician was not notified until 6:30am. The facility failed to provide care and treatment of R14's PEG tube feeding, ensure nurse education to prevent re-occurrence, and follow-up to assure the tube fed residents receive	F 322		

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appropriate care and treatment.

The surveyor confirmed through interview, observation and record review that the facility took the following actions to remove the Immediate Jeopardy.

A. The Facility maintains that residents who are fed by naso- gastric or gastrostomy tube receive appropriate treatments and services to prevent aspiration pneumonia , diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal pharyngeal ulcers and to restore, if possible, normal eating.

Education to all nurses on Gastrostomy Policies began on 06/30/16 concluding on 07/10/16; included the following:
Administering Medications
Checking Gastric Residual
GTube/J Tube Skin Care
GTube Replacement
Continuous Tube Feeding
Flushing Tube Feeding
Verifying Placement of Feeding Tubes
Change in Condition
Care Path GI Symptoms
Signs and Symptoms of Aspiration
Keeping the Head of the Bed elevated 30 degrees or greater at all times.
E11 (Licensed Practical Nurse) identified for not receiving education on prior incident was educated prior to starting her shift the evening of 06/30/16 and again on 7/8/16.

Education provided to nurses by E2(Director of Nursing), E8 (Assistant Director of Nursng), E22 (Minimum Data Set/Care Plan Coordinator) and E1 (Administrator).

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Effective 7/3/16 no nurse returned to work without receiving the above education. Additional education on Gastrostomy tubes was provided again on 7/8/16, 7/9/16 and 7/10/16.

Education to all Certified Nurse Aides began on 06/30/16 concluding on 07/06/16 included the following: Signs /Symptoms of Aspiration
Keep head of bed elevated 30 degrees or greater at all times.

Education provided to Certified Nurse Aides by E2, E8, and E22.
Effective 7/6/16, no Certified Nurse Aide returned to work without receiving the above education.

Documentation on residents with gastric tubes each shift began effective 7/2/16 and will continue.
Review of residents with gastric tubes charts, Medication Administration Record and Treatment Record, by Nurse Manager or designee effective 7/5/16 and will continue.

Effective 07/06/16 any non-compliance with policy will be addressed upon identification with employee through continued education, return demonstrations and /or disciplines up to termination where appropriate.

B. R5 and R30 were observed during the survey on 06/30/16 at 3:00PM, 07/05/16 at 10:00 AM, 07/07/16 at 1:45 PM, with the head of their beds elevated, between 30 and 45 degrees. They were alert, calm and quiet. They were not vomiting. Their breathing was not labored. Their skin color was pink. On 07/05/16 at 2:00 PM, E 20 (RN) cleaned R5's gastric tube. R5 was alert and comfortable. The gastric tube was intact.

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F 322	Continued From page 18 The enteral feeding was infusing. R5's skin was clear. C. R5 and R30's Nurses Notes had entries each shift, each day starting on 07/02/16. D. During interviews on 07/07/16 from 1:20 PM to 2:30 PM , the following Certified Nurse Aides stated they received training last week regarding elevating the head of the bed and signs of aspiration for residents who are tube fed. E4, E20 and E37 who work day shift. E4 and E31 who work evening shift and E33 who works night shift. Between 1:20 PM and 2:30 PM, on 07/07/16 the following nurses could identify signs and symptoms of aspiration, how to care for a resident with a gastric feeding and when to notify the doctor of changes in residents condition. The nurses knew to elevate the head of residents beds at least 30 degrees if they are receiving enteral feedings. E30 night shift nurse and E10 day/evening shift nurse stated that they received training on Gastronomy tubes and could identify signs of aspiration, a change in condition and when to notify the doctor, and knew to elevate the head of the bed at least 30 degrees if a resident is receiving enteral feedings. On 7/11/16 at 9:00 AM, E1 stated that all Registered nurses and Licensed Practical nurses received additional training on Gastronomy tubes from 7/8/16 through 7/10/16 and that included a Pre-test and Post-test to ensure they know the signs of aspiration, what constitutes a change in resident condition, and when to notify the residents physician.	F 322		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	Continued From page 19 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident did not receive additional psychotropic medication without documented justification and adequate monitoring for 1 of 3 residents (R3) reviewed for receiving psychotropic medications in the sample of 16. Findings include:	F 329		

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F 329	Continued From page 20 1. The Physician Order Sheet dated 06/01/16 notes R3 was admitted to the facility on 05/04/16 with an indwelling urinary catheter and an order for Lorazepam 0.5 milligrams every six hours as needed for agitation. The Medication Administration Record (MAR) notes R3 was agitated and received Lorazepam on 05/07/16 at 4:00 PM, 05/09/16 at 4:45 PM and 05/10/16 at 11:15 AM. The MAR notes the Lorazepam was effective, R3 was better and calm. Nurses notes state on 05/09/16 the family was notified that R3 was having an increase in agitation. There was no "Behavior Tracking" initiated to assess how often R3's episodes of agitation were occuring before Z3 (Doctor) was notified on 05/10/16 at 9:30 AM that R3 was having increased agitation and confusion, or that R3 was being treated for a urinary tract infection by Z4 (Doctor). Z3 ordered Risperdal 0.5 milligrams twice a day. Nurses notes dated 05/09/16 at 3:30 PM state Z4 (Doctor) was notified of the results from a urinalysis for R3. Z4 ordered Rocephin One Shot Intramuscularly and Cipro twice a day orally for seven days to treat R3's urinary tract infection. On 05/13/16 at 2:00 PM the Nurses Notes indicate Risperdal was decreased to one time a day because R3 was sedated, and there was no documentation that Z3 was informed of R3 having a urinary tract infection. On 06/27/16 at 1:40 PM , R3 was sitting up in bed, alert talking to family. At 10:20 AM on 06/30/16, E1 (Administrator) said she could not give a reason why R3 was taking Risperdal, or if staff took into account that R3's increase in confusion may have resulted from the urinary tract infection.	F 329		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 21 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and observation the facility failed to stored medications in a safe manner and keep	F 431		

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medications under the direct observation of the nurse. This has the potential to effect all the residents living in the facility.

The findings include:

1. On 06/28/16 at 8:30 AM the Tulip Medication Refrigerator and the Daisy Medication Refrigerator temperature has not been logged since 06/04/16, and the Rose Medication Refrigerator temperature has not been logged since 06/16/16. The Daisy Medication Refrigerator is 58 degrees. The Daisy Medication Refrigerator contains Insulin, Performist, Lorazepam and Tuberculin Purified Protein Derivative. E16 (Registered Nurse) is with the surveyor during observations of the Tulip and Daisy Medication Room and Medication Carts. On 06/28/16 at 4:15 PM, E1 (Administrator), E2 (Director of Nurses) and E8(Assistant Director of Nurses) , were notified of the above stated issues. On 6/30/16 at 1:25 PM, E18 (Facility's Pharmacist) stated Lorazepam and Tuberculin Purified Protein Derivative is problematic at this temperature for any length of time and should be discarded. On 6/30/16 at 1:35 PM, E1 (Administrator) and E2 (Director of Nurses) were notified of the conversation with the Pharmacist and was told to call the Facility's Pharmacist to verify. At 1:45 PM E1, E2, and E8 (Assistant Director of Nurses) went to the Medication Room to dispose of the Lorazepam and the Tuberculin Purified Protein Derivative.

2. On 06/28/16 at 8:30 AM in the Daisy Medication Refrigerator is thickened water, prune juice, and Resource 2.0 being stored with Insulin, Performist, Lorazepam and Tuberculin Purified Protein Derivative. E16 (registered nurse) stated

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F 431	Continued From page 23 at this time the water and juice should be kept in the resident's fluid refrigerator in the storage room. 3. On 06/28/16 at 9:30 AM 2 bottles of Vancomycin belonging to R3 and R29 is sitting in a plastic container of ice water on top of the medication cart. E15 (Licensed Practical Nurse) is at the medication cart by the nurses station and walked away from the cart to administer medications to another resident in his room down the Tulip Hallway. R13 is a known wanderer as verified by E10 (Registered Nurse) on 6/28/16 at 10:00 AM. R13 was 4 feet away from the medication cart at the time E15 walked away. On 6/28/16 at 10:00 AM E15 stated he works all the units in this facility. 4. On 06/28/16 at 8:30AM in the Daisy/Tulip Medication Room, the Daisy Medication Cart in the bottom large drawer is sticky with spilled liquids. The small top drawer in this cart is in disarray with pens, syringes, opened dressings, stethoscope, and trash from medications and syringe packets. In the floor of the Tulip Refrigerator is dirty with spilled liquids and the door of the refrigerator has one shelf and it is dirty with multiple spilled liquids. The rail to the shelf is made with multiple layers of tape and the tape is dingy and has splashes of dried liquids on it. 5. The Resident Census and Condition of Residents, dated 06/27/16, documents the facility has a census of 77 residents.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 24 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 441		

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interview the facility failed to prevent cross contamination during resident care. This has the potential to affect all 77 residents in the facility.

Findings include:

The Resident Census and Conditions of Residents dated 06/27/16 states there are 77 residents in the facility.

E21 (Registered Nurse) was observed on 06/28/16 at 11:20AM performing a blood glucose test on R11. E21 entered R11's room and placed the meter on the over the bedside table without using a barrier. After the procedure, E21 placed the meter on top of the medication cart again without a barrier. During this observation, a bedpan was observed sitting on the floor of the shared bathroom. The bedpan was not in a bag or sitting on a barrier. On 06/28/16 at 11:54AM, E21 was observed performing a blood glucose test on R31. After E21 performed the test, E21 wiped the meter with a alcohol wipe. E21 stated she has only worked at the facility for a few weeks and this is how she was told to clean the meter.

E23 (Registered Nurse) was observed on 06/29/16 at 12:30PM performing a gastrostomy tube (GT) dressing change on R5. E23 entered the room and placed a bottle of 0.9% Normal Saline (NS) on the bedside table without using a barrier. E23 stated the NS is stock. After performing the procedure, E23 left the room without washing her hands and opened the medication room door and placed the NS in the room.

E13 (Regional Director of Operations) stated on

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	146000	A. BUILDING _____ B. WING _____	07/11/2016

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WAY-FAIR NURSING & REHAB CENTER	305 N.W. 11TH STREET FAIRFIELD, IL 62837

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F 441	Continued From page 26 07/05/16 at 3:20PM the nurses are to use disinfectant wipes to clean the blood glucose meters and follow the label directions. E13 also stated E23 should not have placed the NS on the table without a barrier and should have washed her hands after resident care.	F 441		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain all wall material, floor material, air conditioning units, water fountains, medication carts and resident care equipment for the residents, staff and visitors during the survey. This has the potential to affect all 77 residents in the facility. The findings include: The facility's Resident Census and Conditions of Residents form, dated 6/27/16, documented the facility had a census of 77 residents. 1. The following resident room air conditioning wall units were noted to have cracked paint, rust and black material over the top grates Room 135 at 10:00am on 6/26/16 Room 110 at 11:00am on 6/29/16	F 465		

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F 465	Continued From page 27 Room 131 at 3:30pm on 6/27/16 Ice room from Tulip and Daisy at 10:10am on 6/29/16. 2. On 6/28/16 and 6/29/16 the following wooden entrance doors to the resident room hallways were noted to have rough wooden edges and were cracked and exposed splintered wood: The entrance doors to Tulip South and the Tulip side entrance to the sunroom 11:25 am on 6/28/16. The entrance doors to the South Daisy hall and the doors to Sunroom from the Daisy hall at 10:00am on 6/29/16. The entrance doors to Tulip West at 10:10am on 6/29/16. 3. The wallpaper in all of the facility resident room hallways was noted to be torn and tattered throughout the facility on all days of the survey. Several halls were noted have dried orange splash running down the walls. The Tulip hall was partially painted and had spackle over the seams of the wallpaper. Review of the survey results from 2015 that were posted outside the business office found that the wallpaper was documented as in need of repair. Review of the related Plan of Correction dated 6/10/16 states : " 1. Regarding the wallpaper surfaces in the facility: we are requesting a 6 month extension due to the monetary hardship to properly resolve the issue. Facility has contacted a remodeling company to assess and bid to repair, replace or cover all effected wallpaper areas." E13 (Regional Director of Operations) stated on 6/29/16 at approximately 1:30pm that due to financial	F 465		

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F 465	Continued From page 28	F 465		

restraints the facility has not had the wallpaper replaced and are in the process of painting but have not completed the work.

4. The ceiling material in the food preparation area was noted to be peeling and blistered paint in a 4 foot diameter around the ceiling vent on 6/26/16 at 10:00am. The cove mop board was missing behind the handsink in the food preparation area in a 6 foot and 10 foot area. The fan covers in the cooler were noted to be covered with a black substance.

5. On 06/28/16 at 10:45AM, Room 139 bed 2 was observed to have scratched and marred walls at the head of the bed and a floor mat was observed on the floor beside the bed with rips and tears. The air conditioning unit was also observed to be rusty.

6. On 6/27/16 at 10:50 AM, R9's seat belt was soiled with dried debris and food and her seat belt continued to be soiled on 06/28/16.

7. On 6/28/16 at 11:30 AM, the linen cart on the 100 hall near room 112 was dirty and covered with a dried substance in several places.

8. On 06/29/16 at 10:00 AM in R2's room, there is a straight back chair sitting in the recliner with the feet of the straight back chair on the seat of the recliner.

9. On 6/28/16 at 3:00PM R20's armrest of his wheelchair is cracked and tattered.

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F 497	Continued From page 29	F 497		
F 497 SS=C	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE	F 497		

The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to provide and document Certified Nurse Aide , in-service training. This failure has the potential to affect all 77 residents living in the facility.

Findings Include:

There is no documentation of the Certified Nurse Aides (CNA) receiving 12 hours per year of inservice. On 7/6/16 at 12:00PM E2 (Director of Nurses) stated there is no record of the CNAs receiving the required education. She went on to say that this is something she is working on.

The Resident Census and Condition of Residents, dated 06/27/16, documents the facility has a census of 77 residents.

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