

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/31/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>146000</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/22/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>WAY-FAIR NURSING &amp; REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>305 N.W. 11TH STREET</b> <b>FAIRFIELD, IL 62837</b>		
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F 323	Continued From page 3  According to the Medical Examiner/Coroner's Certificate of Death Worksheet, R2 expired on May 19, 2013 at home with the cause of death stated as Pneumonia.  2. R1's facility Accident Incident report dated 04-17-13 at 9:00 am documents that E4, (Registered Nurse), heard R1's body alarm sounding and went in the room. R1 was standing up with the wheeled walker, walking toward the bath room. E4 assisted R1 to the bath room, placed R1 on the toilet, and instructed R1 to pull call light. E4 went to the hallway to pull resident medications and a few seconds later heard R1 yelling for help. E4 ran to the bath room and saw R1 laying face down on the floor. R1 stood up, lost his balance and fell on the floor. R1 sustained a skin tear to the left elbow measuring 2 cm by 0.1 cm, bloody in color per the 04-17-13 Accident Incident report. The interventions given to prevent the reoccurrence were to counsel R1 on factors that affect his safety and need to use the call light for assistance and "re-educated E4 to never leave an assist resident alone in the bathroom. Res (resident) should have had supervision."	F 323			
F9999	FINAL OBSERVATIONS  Licensure Violations:	F9999			

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F9999	<p>Continued From page 4</p> <p>300.610a) 300.1210b)5) 300.1210d)6) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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</p>	F9999			

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F9999	<p>Continued From page 5</p> <p>care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:</p> <p>5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based upon observation, interview, and record review, the facility failed to adequately identify, implement and evaluate safety hazards to prevent falls for 2 residents (R1 &amp; R2). These failures resulted in 1 resident, R2, being</p>	F9999			

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F9999	<p>Continued From page 6</p> <p>hospitalized after sustaining a compression fracture.</p> <p>1. The shower room where R2 fell was observed to have 1 inch by 1 inch tile flooring and a tiled wall partition that has been removed. According to E1, (Administrator), the shower room is being repaired after R2's fall to remove the hump that was in front of the shower stall and the half wall partition to allow more room in the shower area for movement of the residents in the shower chairs.</p> <p>An interview with E1, on 05-21-13 at 1:15 pm and E2, (Certified Nurses Aide/Shower Aide) on May 21, 2013 at 2:40 pm verified R2 fell in the shower room and that 4 - one inch by one inch tiles were missing in the floor of the shower at that time. R2 was in the shower chair when the shower chair fell backward causing R2's head to hit the floor. During an interview with E2 on May 21, 2013 at 1:40 P.M., E2 said she was pushing R2 in a shower chair backwards in the shower to get the chair over the raised hump in front of the shower and into the shower area when the shower chair wheel went down in the missing tile area and a black rubber mat on the shower area floor wrapped around the wheel causing the chair to stop moving. The chair went backwards with R2 in the chair causing R2's head to hit the floor of the shower.</p> <p>An interview with E3, (Shower Aide) on May 22, 2013 at 10:42 A.M., verified R3 has been a shower aide at Way Fair for 1.5 to 2 years. R3 stated she had received no training by the facility on giving showers or for maneuvering the shower chair over the tile hump. E3 stated that when placing residents in the shower she picks up the</p>	F9999			

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F9999	<p>Continued From page 7</p> <p>matts and hangs them on the handrail, pushes the shower chair with the resident in it backward into the shower area over the tile hump by standing in front of the shower chair and resident and pushing the shower chair backward into the shower area. Once the resident is in the area, the matts are placed on the floor in front of and on the side of the shower chair for the resident to stand on, due to the floor being slick, for dressing and self bathing if needed.</p> <p>The nursing notes in R2's medical record dated May 1, 2013 at 10:45 A.M. indicates R2 was sent to the Emergency Room (ER) for evaluation and treatment of a head hematoma and returned from the ER at 2:15 P.M.</p> <p>The radiology report on R2 for a x-ray computed tomography (CT scan) of the Head with Intervenuous contrast, date examined May 1, 2013, has findings of "no significant change since February 12, 2013."</p> <p>Nursing note on May 2, 2013 at 10:45 A.M., indicates R2's family requested R2 be transferred to an out of town hospital for another work up due to back pain, and non medical transportation was called, upon arrival due to R2's low oxygen saturation the Emergency Medical Technician's (EMT) made the decision to take R2 back to the local hospital.</p> <p>Radiology reports for a CT chest with a date examined as May 2, 2013 documents "several bilateral rib fractures of varying ages", CT of the head without intervenous (IV)contrast indicates "left posterior scalp swelling, and no fracture" and CT of the lumbar spine without contrast states "Mild to moderate compression deformity of L2,</p>	F9999			

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F9999	<p>Continued From page 8 new since July 2011 of uncertain acuity."</p> <p>An interview with Z1 attending physician, on May 22, 2013 at 2:45 P.M., reports R2 was hurting all over from the fall, the x-ray report reviewed indicated R2 had a mass in the lung, R2's family wanted R2 to be transferred to an out of town hospital on May 2, 2013 as they did not like the radiology department at the local hospital, and the fall did not lead to R2's death.</p> <p>Upon review of the Discharge Summary from the out of town hospital, R2 was discharged from the out of town hospital on May 14, 2013 to her daughters home and referred to a hospice provider to receive services.</p> <p>According to the Medical Examiner/Coroner's Certificate of Death Worksheet, R2 expired on May 19, 2013 at home with the cause of death stated as Pneumonia.</p> <p>2. R1's facility Accident Incident report dated 04-17-13 at 9:00 am documents that E4, (Registered Nurse), heard R1's body alarm sounding and went in the room. R1 was standing up with the wheeled walker, walking toward the bath room. E4 assisted R1 to the bath room, placed R1 on the toilet, and instructed R1 to pull call light. E4 went to the hallway to pull resident medications and a few seconds later heard R1 yelling for help. E4 ran to the bath room and saw R1 laying face down on the floor. R1 stood up, lost his balance and fell on the floor. R1 sustained a skin tear to the left elbow measuring 2 cm by 0.1 cm, bloody in color per the 04-17-13 Accident Incident report. The interventions given to prevent the reoccurrence were to counsel R1 on factors that affect his safety and need to use</p>	F9999			

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F9999	<p>Continued From page 9</p> <p>the call light for assistance and "re-educated E4 to never leave an assist resident alone in the bathroom. Res (resident) should have had supervision."</p> <p>According to the 02-26-13 quarterly Minimum Data Set dated 02-26-13, R1 needs supervision for transfers, ambulation, dressing and eating. R1's Resident Flow Records for 04-10-13 through 04-27-13 documents that R1 had general weakness present on those days.</p> <p>(B)</p>			F9999			