STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G037	A. BUILDING _____ B. WING _____	R-C 01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	**2150 EAST MCCORD, PO BOX 568 CENTRALIA, IL 62801**

(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
{W 000}	INITIAL COMMENTS 45 DAY COMPLAINT FOLLOW-UP TO THE SURVEY OF 11/24/15. W318 CORRECTED. W331 REPEATED.	{W 000}		
{W 331}	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: REPEAT Based on observation, interview and review of the facility's policy on Enteral Medication Administration, nursing staff failed to flush the enteral tubing prior to medication administration as per the facility's policy for 5 of 5 individuals (R5, R6, R7, R8 and R9) observed on 01/13/16 during the 1:00 P.M. enteral medication administration. Findings include: The facility's policy and procedures for Enteral Medication Administration dated 11/25/15 states that after the nurse has checked tube for proper placement, the nurse will "7. Flush the tube with 20-30 ml (millimeters) of water prior to administering the individual's crushed medications mixed with water..." E4 (LPN/Licensed Practical Nurse) was observed on 01/13/16 to prepare for and administer the enteral medication(s) for R5 - R9. E4 did not flush the individuals tubes with 20-30 ml (milliliters) of water as per the facility's Enteral Medication Administration policy.	{W 331}		2/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/22/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{W 331}	Continued From page 1	{W 331}		

a) At 1:02 P.M., E4 was observed administering R5's medication (Baclofen 20 mg) via enteral tube after checking for proper placement. E4 poured approximately 20-30 cc's (cubic centimeters) of water into the tube. E4 did not flush R5's tube prior to medication administration. When E4 was asked, she stated that she flushes with a total of 100cc's of water. E4 did not state that she was to flush R5's tube prior to medication administration as per facility policy. After flushing R5's tube, the surveyor noted that there was still medication residual within the syringe. E4 recapped R5's tube and did not attempt to re flush R5's tube to ensure that he received all of his medication as physician ordered.

b) At 1:15 P.M., E4 was observed administering Keppra, Phenobarbital, Provastatin and Senna S via R6's enteral tube after verifying proper placement. E4 did not flush R6's tube prior to the administration of her medications.

c) At 1:25 P.M. E4 was observed administering Tylenol, Levedopa, OsCal with Vitamin D and Valporic Acid liquid via R7's enteral tube after verifying proper placement. E4 did not flush R7's enteral tube prior tot he administration of her medications.

d) At 1:35 P.M., E4 was observed administering Tums and Valporic Acid (liquid) to R8 along with his Fiber Bolus via enteral tube after verifying proper placement. E4 did not flush R8's tube prior to the administration of his medication and/or his Bolus feeding.

e) At 1:56, E4 was observed administering

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{W 331}	Continued From page 2 Acidophilus, Diazepam, OsCal and Theophyeline (liquid) to R9 via enteral tube after verifying placement. E4 did not flush R9's tube prior to the administration of his medications. E2 (DON/Director of Nursing) was interviewed on 01/14/16 at 11:30 A.M. and observations of the medication administration for 01/13/16 were reviewed with her. E2 stated that nursing staff are to flush the individual's enteral tube prior to and after the final medication as per the facility's policy. E2 stated that E4 did not follow the facility's policy for enteral medication administration when she failed to flush each individual's tube prior to administering their (R5's, R6's, R7's R8's and R9's) medications.	{W 331}		