

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

PRINTED: 10/14/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145552</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/18/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>FAIRFIELD MEMORIAL HOSPITAL</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>NORTH WEST 11TH STREET FAIRFIELD, IL 62837</b>			
(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
F 000	INITIAL COMMENTS			F 000			
F 315 SS=D	<p>Annual Certification Survey 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, and record review the facility failed to prevent cross contamination by keeping urinary catheter tubing off of the floor, and during emptying of a catheter bag for one of one resident (R6) reviewed for preventing cross contamination during catheter bag care in the sample of eight.</p> <p>Findings include:</p> <p>1. R6 was observed sitting in a chair in his room on 09-16-14 at 1:15 PM . R6's urinary bladder catheter tubing was noted on the floor. At 1:30 PM, E4 (Certified Nurse Aide) was observed to place a plastic container on the floor without a barrier. E4 opened and closed the catheter port without cleaning the end of the port, both before and after emptying the urine from the catheter bag.</p>			F 315			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

10/01/2014

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.

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

PRINTED: 10/14/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145552</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/18/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FAIRFIELD MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>NORTH WEST 11TH STREET FAIRFIELD, IL 62837</b>		
(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
F 315	Continued From page 1  R6's urinalysis dated 08-18-14 indicated he had a urinary tract infection. R6's physician order sheet for August, 2014 indicates R6 was started on antibiotic therapy on 08-18-14 to treat his urinary tract infection.  The Collecting Urinary Output from Foley Catheters Policy and Procedure (Reviewed-October, 2013) states: #2. The catheter bag and tubing should never be raised above the bladder or allowed to touch the floor. #4. A barrier (Such as a paper towel) should be placed on the floor to sit the collecting container on. #5. The drain spout should be cleansed with alcohol prior to opening the drain, and should not come in contact with the collecting container.	F 315			
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT  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, interview and record review and interview the facility failed to maintain all air conditioners in a sanitary manner. This has the potential to affect all 20 residents in the facility.  The findings include:  The facility's Resident Census and Conditions of	F 465			

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

PRINTED: 10/14/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145552</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/18/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FAIRFIELD MEMORIAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>NORTH WEST 11TH STREET FAIRFIELD, IL 62837</b>		
(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	
F 465	<p>Continued From page 2</p> <p>Residents form, dated, 9/15 /14 documented the facility had a census of 20 residents.</p> <p>1. A tour on 9/16/14 beginning at 1:40 PM found the following air conditioners with a black substance clinging to the adjustable vent grates and the insulation behind the grates.</p> <p>a) Resident rooms: 303, 305 and 316</p> <p>b) Common Dining Room</p> <p>All of the units were in operation at the time of the observations.</p> <p>2. The units were rechecked on the morning of 9/18/14 at 10:00 AM, and found to be somewhat cleaner. The black substance was less noticeable. However, the black remained on some of the insulation and tiny crevices on the grates.</p> <p>3. On 09/16/14 at 2:30 PM, E1 (Nurse Manager) and E14 (Chief Nurse Executive) stated, "The Housekeeping Supervisor had cleaned the vents the evening of 09/16/14".</p>	F 465			