STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145499	A. BUILDING _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTE COUNTY HOSPITAL	650 W TAYLOR ST VANDALIA, IL 62471

(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 157 SS=D	Annual Licensure/ Certifcation Survey 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145499	A. BUILDING _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTE COUNTY HOSPITAL	650 W TAYLOR ST VANDALIA, IL 62471

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F 157	Continued From page 1	F 157		

by:
Based on record review and interview the facility failed to notify the physician of high blood glucose readings for 1 of 2 residents (R8) reviewed for Insulin Dependent Diabetes Mellitus in the sample of 14.

The findings include:

1. R8 's admission records and current physician's orders state R8 was admitted 11/28/08 with multiple diagnoses including: Manic Depression , Diabetes Mellitus, Convulsive Disorder and Hypertension. Current June physician's orders found R8 has an order for routine blood glucose monitoring three times each day and once before bed. The orders included a sliding scale dose schedule of Humalog insulin. R8's current 6/5/14 care plan for Diabetes states "Notify MD of Accucheck over 401 or Accucheck below 50."

2. Review of nursing notes for R8 for the month of May 2014 found the following entries:

5/23/14 at 4:00pm, states "Sitting up per chair eating a snack. R- even nonlabored. . Accucheck --CR. Administered routine Levemir 25 units, refused SSI at this time. Will continue to monitor." Phone interview with E16 (Registered Nurse) on 6/19/14 at 12:15pm found the CR that she noted was a "Critical High" blood glucose value.

5/23/14 at 5:00pm, states "Sitting up per chair eating supper. Appetite fair. R even nonlabored. Rechecked BS at this time 464. Will continue to monitor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145499	A. BUILDING _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTE COUNTY HOSPITAL	650 W TAYLOR ST VANDALIA, IL 62471

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F 157	Continued From page 2 5/23/14 at 8:00pm states "Sitting up per chair. C/O nausea and headache. Accucheck---465. Agreed to SSI at this time. Humalog 10 units administered. Tylenol and Zofran given at this time. Will cont to monitor." The next nursing note available following the entries above from 5/23/14 was 6/12/14. There was no documentation to indicate that the physician was notified of the blood glucose values of critical high, 464 and 465.	F 157		
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 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145499	A. BUILDING _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTE COUNTY HOSPITAL	650 W TAYLOR ST VANDALIA, IL 62471

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F 280	Continued From page 3	F 280		

Based on observation, interview, and record review, the facility failed to review and revise care plans for two residents (R2 and ,R7) whose care plans were reviewed in the sample of fourteen.

Findings include:

1. On 06/18/14 at 1:15 pm, E3, Licensed Practical Nurse, was observed doing a skin assessment on R7's right heel. R7 was wearing foam heel protectors on both feet. The skin on R7's right heel was intact but reddened and did not blanch easily.

On 06/18/14 at 8:15 am, R7 stated, "I had a sore on one of my toes awhile ago, I guess because I have a circulation problem. It seemed like it took forever to heal."On 06/18/14 at 1:45 pm E3 stated that because R7 has arterial insufficiency and a history of skin breakdown, she gets daily skin checks.

A Nursing Admission Assessment dated 06/04/14 stated that R7's feet were reddish blue and cool to the touch.According to a Weekly Pressure Ulcer Report dated 06/12/14, R7 had a pink, intact, boggy area on her right heel, which was acquired 06/05/14, due to arterial insufficiency. R7's Braden Pressure Scale dated 06/04/14 showed that R7 has limited mobility, occasionally moist skin and a potential problem with friction and shearing of skin, all of which are indicators of potential for skin breakdown. R7's 04/10/14 Brief Interview for Mental Status score was fourteen, indicating R7 has few cognitive deficits. R7's Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145499	A. BUILDING _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTE COUNTY HOSPITAL	650 W TAYLOR ST VANDALIA, IL 62471

(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 280	Continued From page 4 Plan with an initiation date of 11/07/13 and a review date of 04/30/14 did not list a problem area, goals, or interventions to address the fact that R7 is at risk for skin breakdown. 2. The current Care Plan dated 05/22/14, notes on 06/02/14, R2 is to be in a low bed with a mat beside the bed. During intermittent observations , on 06/17/14 , at 10:40 AM and 11:40 AM, R2, did not have a mat beside the bed and the bed was not in the lowest position,	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to follow physician's orders for sliding scale insulin for 1 of 2 residents (R8) reviewed for Insulin Dependent Diabetes Mellitus in the sample of 14. The findings include: 1. R8 's admission records and current physician's orders state R8 was admitted 11/28/08 with multiple diagnoses including: Manic Depression , Diabetes Mellitus, Convulsive Disorder and Hypertension. Current June physician's orders found R8 has an order for routine blood glucose monitoring three times each day and once before bed. The orders	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145499	A. BUILDING _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTE COUNTY HOSPITAL	650 W TAYLOR ST VANDALIA, IL 62471

(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 282	Continued From page 5	F 282		

include a sliding scale dose schedule of Humalog insulin. The order read: 0 - 100 no insulin, 101-150 2 units, 151- 200 4 units, 201 - 250 6 units, 251 - 300 8 units and over 300 10 units. Review of R8's Diabetic Flow Sheet for June 2014 found the following sample entries: Examples include:

date	time	result	insulin given
6/1/14	5:25am	127	none
	11:00am	136	none
	4:00pm	138	none
	8:00pm	179	none
6/2/14	5:03	228	4 units
	10:30	critical low	none
	12:30pm	190	none
	4:00pm	386	5 units
	10:00m	348	5 units
6/3/14	5:10am	143	none
	11:00am	321	6 units
	4:00pm	225	none
	8:00pm	291	4 units
6/4/14	5:00am	100	none
	11:00am	77	none
	1:00pm	265	none
	4:00pm	332	5 units
	8:00pm	149	none

This pattern of not giving the sliding scale accurately is reflected and continued throughout the documentation for the month.

2. R8 stated on 6/18/14 at 8:50am that she is aware that the staff do not always give her the full amount of insulin ordered. R8 stated "they know I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145499	A. BUILDING _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTE COUNTY HOSPITAL	650 W TAYLOR ST VANDALIA, IL 62471

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F 282	Continued From page 6 will bottom out" if I get it all. R8 stated I trust the nurses I'm in their hands. When asked if she has talked with her doctor R8 indicated that she is afraid to talk with him about the insulin doses. 3. E2 (Chief Nursing Officer) stated on 6/19/14 at 9:30am that the administrative nursing staff was unaware that the sliding scale insulin was being adjusted by staff nurses until 6/18/14.	F 282		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review , the facility failed to dispose of expired	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145499	A. BUILDING _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTE COUNTY HOSPITAL	650 W TAYLOR ST VANDALIA, IL 62471

(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 425	Continued From page 7	F 425		

medications. This failure has the potential to affect all 53 residents living in the facility.

Findings include:

1. On 06/18/14 at 1:10 pm, the 600 hall medication cart was observed to contain a bottle of Ferrous Sulfate 325 milligram #1000 tablets with an expiration date of 09/13.
On 06/19/14 at 8:00 am E1, Administrator/Director of Nurses,stated the expired Ferrous Sulfate was disposed of on 06/19/14.

2. On 6/18/14 at 3:00 pm, the 400/500 hall medication cart contained 1 opened bottle of stock Docusate Sodium capsules, with less than twenty-five percent capacity of the medication remaining, and an expiration date of 11/2013. E8, (Registered Nurse), acknowledged that the medication was currently being received by residents during medication administration. E8 removed the expired medication bottle and placed it into a bin for return to pharmacy.

3. On 6/18/14 at 3:10 pm, the medication refrigerator's locked narcotic compartment was found to contain (2) 30 millimeter sized bottles of Lorazepam 2 milligram per millimeter liquid medication for intermuscular injection; 1 bottle was opened and 1 bottle was unopened. Both bottles expired 4/2014. The medication was stored for 1 resident, R29, and ordered for use as needed - for seizures. E8 immediately removed the 2 expired bottles and called pharmacy to report that the medication was expired and needed to be replaced.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145499	A. BUILDING _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTE COUNTY HOSPITAL	650 W TAYLOR ST VANDALIA, IL 62471

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F 425	Continued From page 8 An undated Medication Storage/Medication Security Policy stated , "Expired, damaged, and/or contaminated medications shall be removed from drug storage areas within the facility during the Pharmacy inspection and shall be returned to the Pharmacy/Provider Pharmacy for proper disposal." The Facility's Resident Census and Conditions of Residents form dated 06/17/14, documented the facility had a census of 53 residents.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145499	A. BUILDING _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTE COUNTY HOSPITAL	650 W TAYLOR ST VANDALIA, IL 62471

(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 431	Continued From page 9	F 431		

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 observation, interview, and record review, the facility failed to provide proper labeling of medications. This has the potential to affect all 53 residents living in the facility.

Findings include:

1. On 06/18/14 at 1:10 pm , the 700 hall medication cart was noted to contain a bottle of Calcium 500 milligram tablets with no expiration date. On 06/19/14 at 8:00 am, E1, Administrator/Director of Nurses, stated that the Calcium tablets had been taken from a larger stock bottle, and on 06/19/14 had been relabeled to include a date of expiration from the original packaging.

2. On 6/18/14 at 3:00 pm, the 400/500 hall medication cart drawer contained 6 loose pills observed at the bottom of the medication card drawer. E8, (Registered Nurse), acknowledges that she needs to remove all of the cards to clean out the loose pills.

3. On 6/18/14 at 3:15 pm, the storage shelf of the medication room was found to contain 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145499	A. BUILDING _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTE COUNTY HOSPITAL	650 W TAYLOR ST VANDALIA, IL 62471

(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 431	Continued From page 10 sealed packages of catherization stabilization devices, each with an expiration date of 4/2013. 20 sealed packages of intravenous tubing connectors are present, each with an expiration date of 4/2014. An undated Medication Storage/Medication Security Policy stated, "All medications and chemicals used to prepare medications shall be accurately labeled with contents, expiration dates and appropriate warnings." The Resident Census and Conditions Form dated 06/17/14 showed that 53 residents are currently living at the facility.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an 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	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145499	A. BUILDING _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTE COUNTY HOSPITAL	650 W TAYLOR ST VANDALIA, IL 62471

(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 441	Continued From page 11	F 441		

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 interview the facility failed to prevent cross contamination during perineal care and catheter care for 2 or 2 residents (R3, R4) observed for perineal/catheter care in the sample of 14.

Findings include:

1. E5 (Certified Nurse Aide-CNA) was observed performing catheter care for R4 on 06/18/14 at 1:15PM. E5 placed a basin full of water and a bottle of No-Rinse Perineal Wash on the over the bedside table without using a barrier. E5 put on gloves and placed a wash cloth into the water basin and then picked up the No-Rinse Wash and proceeded to cleanse R4's perineal area. E5 continued to cleanse R4's perineal area and catheter tubing in this same manner picking up the No-Rinse Wash two more times with the same gloved hands. After the perineal care, E5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145499	A. BUILDING _____ B. WING _____	06/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTE COUNTY HOSPITAL	650 W TAYLOR ST VANDALIA, IL 62471

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F 441	Continued From page 12	F 441		

emptied the basin of water in the sink in the bathroom which is shared with another resident. Two denture cups were sitting on the sink basin at this time and were splashed when E5 emptied the basin into the sink. The over the bedside table was not observed to be disinfected after this procedure.

The facility's (Revised 2/2012) "Perineal/Catheter Care" policy states, "The purpose of peri-care is to prevent possible urinary tract infections from bacteria spreading from the perineal area."

E4 (Infection Control Coordinator) stated on 06/18/14 at 4:15PM E5 and E6 (CNA)should not have touched the No-Rinse Perineal Wash bottle with their contaminated gloves and that E5 should not have disposed of the water in the toilet.

2. While performing incontinence care on 06/17/14 at 2:00 PM , E6 (Certified Nurse Aide), did not remove her soiled gloves, three times before touching a bottle of no rinse soap after cleaning R3's peritoneal area.