

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

PRINTED: 11/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145483	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER MONTGOMERY NURSING & REHAB CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 9086 IL ROUTE 127, P O BOX 309 HILLSBORO, IL 62049		
(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 Annual Licensure and Certification Survey	F 000			
F 371 SS=F	Licensure Survey for Subpart S: SMI 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide an air gap on the ice machine between the ice storage bin and the floor sewage drain in the Main Kitchen. This has the potential to affect 97 residents living in the facility. Findings include: 1. On 11/17/2015 at 10:00 AM, the main kitchen, the drain from the ice machine bin protruded one half inch into the floor sewage drain, leaving no air gap with the potential for back flow of sewage into the ice machine storage bin contaminating the ice served to residents. On 11/17/15 at 10:15 AM, E13, Certified Dietary Manager (CDM), stated, "We use ice from this ice machine for water pitchers in all patient rooms	F 371			

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

TITLE

(X6) DATE

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.

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F 371	Continued From page 1 and in beverages for all meals." On 11/17/15 at 12:08 PM, E13 stated, "The ice machine drain should not go into the floor drain like that. That needs to be up out of the drain." 2. The Resident Census and Conditions of Residents, CMS 672, dated 11/16/15, documents that the facility has 97 residents living in the facility.	F 371			