

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

PRINTED: 08/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145580		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2012	
NAME OF PROVIDER OR SUPPLIER RICHLAND MEMORIAL HSP SK N FAC				STREET ADDRESS, CITY, STATE, ZIP CODE 800 EAST LOCUST OLNEY, IL 62450			
(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 327 SS=D	<p>Annual Certification Survey</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to assure proper hydration based on calculated fluid needs for 1 of 1 residents (R3) reviewed for dehydration in the sample of 8.</p> <p>The findings include:</p> <p>1. A review of R3's admission records find R3 is an 86 year old admitted to the facility on 7/27/12 with an admission diagnosis of Dehydration. R3's initial care plan from admission states a focus/need of : "maintain adequate fluid volume" with actions/interventions including : "monitor I and O , ... "Encourage oral intake as able". Review of An Initial Interview for Nutritional services conducted by E5 (Registered Dietitian) on 7/30/12 at 11:15am found R3's fluid needs per her current weight to be 1300ml/day. The fluid needs were not incorporated into R3's care plan.</p> <p>Review of Fluid Intake and Output records for R3 dated 7/28 through 8/1/12 were incomplete for meals and snacks and do not include all fluids taken with medication or free water at the bed side. Interview with E1 (nurse administrator) and E2 (charge nurse) on 8/2/12 at 3:45 pm</p>			F 327			

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 327	Continued From page 1		F 327				
F 441 SS=D	<p>indicated they were aware of the incomplete information related to R3's fluid needs and care plan.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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 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.</p> <p>(c) Linens Personnel must handle, store, process and</p>		F 441				

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F 441	<p>Continued From page 2</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to properly disinfect a blood glucose meter after resident use for 1 of 1 residents (R4) who required blood glucose monitoring in the sample of 8.</p> <p>Findings include:</p> <p>On 08/01/12 at 11:40AM, E4 (Registered Nurse) was observed performing a blood glucose monitoring procedure on R4. After completion of the procedure, E4 cleaned the meter with a Sani-Cloth Plus Wipe for approximately one minute. The "Precision Xceed Pro/Xtra Blood Glucose Testing" policy dated 09/01/2010 does not specify how long the monitor is to be cleaned. The "Glucose Meter Cleaning" policy dated 06/2010 states the meter is to be cleaned with an "approved EPA disinfectant."</p> <p>On 08/02/12 at 11:00AM, E5 (Registered Nurse) stated she cleans the blood glucose meter with a Sani-Cloth Plus Wipe for 1 minute. On 08/02/12 at 11:30AM, E1 (Administrator) verified the meter should be cleaned for 3 minutes with a Sani-Cloth Plus Wipe.</p> <p>On 08/02/12 at 9:15 am E1 stated that , E3 (Registered Nurse/Staff Development Coordinator) verified that at the yearly competency testing, she has the staff use a</p>			F 441			

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F 441	Continued From page 3 Sani-Cloth Plus Wipe to clean the meter. The staff is instructed to use a 3 minute contact time with a return demonstration.	F 441					