STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145552	A. BUILDING _____ B. WING _____	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFIELD MEMORIAL HOSPITAL	NORTH WEST 11TH STREET FAIRFIELD, IL 62837

(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 226 SS=C	Annual Certification Survey 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to develop and implement written policies for internal abuse reporting, that include immediate reporting to the Administrator. This has the potential to affect all 20 residents living in the facility. The finding includes: The Resident Census and Condition of Residents dated 10/28/13 documents the facility has a census of 20 residents. 1. A review of the facility's Reporting/Investigating Resident Abuse policy (dated as reviewed, October 2013) was reviewed on 10/29/13 and found to include on page 2 under Procedure: "1. Any individual who has a reason to believe that physical abuse, mistreatment or neglect has occurred must immediately be removed from the abusive environment and notify their immediate	F 226		

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

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F 226	Continued From page 1 Supervisor." 2. An interview with E6 (Certified Nurse Aide) conducted on 10/29/13 at 10:55am, found when asked about abuse reporting, E6 identified the Nurse Manager or Charge Nurse. Further, when asked about an abuse scenario E6 indicated that the Nurse Manager or Charge Nurse would be notified immediately. 3. An interview with E5 (Registered Nurse) conducted on 10/28/13 at 2:25pm found when asked about abuse reporting E5 indicated E1 (Nurse Manager) would be notified. E5 did not indicate the need to notify the facility Administrator during the interview. 4. An interview with E4 (Director of Organizational Development) on 10/30/13 at 1:00pm confirmed that the facility policy originally presented to the surveyors indicated in the Policy section page 1 states in part... "Any individual who has reason to believe that physical abuse, mistreatment, or neglect has occurred must immediately notify their immediate supervisor." At that time, E4 further indicated that the revised policy was corrected to include immediate notification of the Administrator.	F 226		
F 428 SS=F	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	F 428		

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F 428	Continued From page 2 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review the facility failed to provide monthly pharmacy review that include treatment medications and safe storage of medications. This has the potential to effect all of the 20 residents living in this facility. The findings include: 1. On 10/29/13 during record review for R 3's, R 5's, and R 6's past medication treatment records, it was noted the pharmacist initials indicating review, were absent. During an interview with E 3 (Pharmacist) on 10/29/13 at 1:00pm E3 stated he does not check the treatment record and does not check the medications obtained from outside sources for resident treatment use. E 3 stated it would be nice but it is not done here. 2. On 10/29/13 at 10:00AM during observation of the medication cart with E 2 (Registered Nurse) a tube of hemorrhoid cream was observed in R 9's oral medication drawer. E 2 stated the family of R 9 brought the tube of hemorrhoid cream in over the weekend. Because there is no order for the hemorrhoid cream it was placed in the oral medication drawer until they could decide what to do with it. The Resident Census and Condition of Residents	F 428		

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F 428	Continued From page 3 dated 10/28/13 documents the facility has a census of 20 residents.	F 428		
F 441 SS=E	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 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	F 441		

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F 441	Continued From page 4 infection. This REQUIREMENT is not met as evidenced by: Based on observation,interview, and record review the facility failed to properly handle and disinfect the blood glucose monitor and monitor case for 1 of 1 residents (R2) reviewed for blood glucose monitoring in the sample of 5 and 5 residents (R 9, R 10, R 11, R 12, and R 13) in the supplemental sample. The findings include: 1. On 10/29/13 at 1030 AM E 2 (Registered Nurse) took the blood glucose monitoring device case from the medication room shelf and placed it on top of the medication cart. The blood glucose monitoring device case was then taken to R 9's room and placed on the resident's overbed table without a barrier. After the blood glucose monitoring was performed the case and monitor were taken to the medication room and placed on the medication cart without a barrier. The blood glucose monitor was cleaned for 15 seconds with one germicidal disposable cloth and placed in the blood glucose monitor device case. The case was then placed on the medication room shelf. 2. During an observation on 10/29/13 at 10:53 AM, E 2 (Registered Nurse) removed the blood glucose monitoring device case from the medication room shelf and placed on top of the medication cart. The blood glucose monitoring device case was then take to R 10's room and	F 441		

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F 441	Continued From page 5 placed on the resident's overbed table without a barrier. After the blood glucose testing was performed the monitoring device and case were returned to the medication room. The case was then placed on the medication cart without a barrier. The monitor was cleaned with a germicidal disposable cloth for 15 seconds and placed in the blood glucose monitoring device case. The case was then placed on the medication room shelf. 3. The Cleaning/Disinfecting Glucometer policy, dated October 2013 documents the following procedure: To disinfect use a germicidal disposable cloth, use a second cloth to thoroughly wet surface, and allow to remain wet at least 5 minutes and allow it to air dry. 4. At 4:30 PM on 10/30/13 E1 (Nurse Manager) provided a list of all residents (R2, R 9, R10, R11, R12, and R13) recieving blood glucose monitoring in the facility. The facility has one blood glucose monitor for residents use.	F 441		