STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001234	A. BUILDING: _____ B. WING _____	R 01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRYAN MANOR	2150 EAST MCCORD, PO BOX 568 CENTRALIA, IL 62801

(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) COMPLETE DATE
{Z9999}	FINDINGS STATEMENT OF LICENSURE VIOLATIONS: Conditional Licensure Follow-up to the survey of 11/24/15 Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These requirements are not met as evidenced by: Based on observation, interview and record review the facility has failed to ensure that nursing staff implement policy and procedures and proper nursing technique during enteral medication administration as evidenced by: 1) Nursing staff failed to flush the enteral tubing prior to medication administration as per the facility's policy for 5 of 5 individuals (R5, R6, R7, R8 and R9) observed on 01/13/16 during the 1:00 P.M. enteral medication administration; and 2) Nursing staff failed to administer medications as physician ordered for 1 of 5 individuals (R5) having residual medication remaining in the syringe after the syringe and tube were rinsed/flushed during the enteral medication	{Z9999}	Attachment A Statement of Licensure Violations	

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{Z9999}	Continued From page 1 administration on 01/13/16 from 1:00 - 2:00 P.M. Findings include: 1) The facility's policy and procedures for Enteral Medication Administration dated 11/25/15 states that after the nurse has checked tube for proper placement, the nurse will "7. Flush the tube with 20-30 ml (millimeters) of water prior to administering the individual's crushed medications mixed with water..." E4 (LPN/Licensed Practical Nurse) was observed on 01/13/16 to prepare for and administer the enteral medication(s) for R5 - R9. E4 did not flush the individuals tubes with 20-30 ml (milliliters) of water as per the facility's Enteral Medication Administration policy. a) At 1:02 P.M., E4 was observed administering R5's medication (Baclofen 20 mg) via enteral tube after checking for proper placement. E4 poured approximately 20-30 cc's (cubic centimeters) of water into the tube. E4 did not flush R5's tube prior to medication administration. When E4 was asked, she stated that she flushes with a total of 100cc's of water. E4 did not state that she was to flush R5's tube prior to medication administration as per facility policy. After flushing R5's tube, the surveyor noted that there was still medication residual within the syringe. E4 recapped R5's tube and did not attempt to re flush R5's tube to ensure that he received all of his medication as physician ordered. b) At 1:15 P.M., E4 was observed administering Keppra, Phenobarbital, Provastatin and Senna S via R6's enteral tube after verifying proper placement. E4 did not flush R6's tube prior to the	{Z9999}		

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{Z9999}	Continued From page 2 administration of her medications. c) At 1:25 P.M. E4 was observed administering Tylenol, Levedopa, OsCal with Vitamin D and Valporic Acid liquid via R7's enteral tube after verifying proper placement. E4 did not flush R7's enteral tube prior tot he administration of her medications. d) At 1:35 P.M., E4 was observed administering Tums and Valporic Acid (liquid) to R8 along with his Fiber Bolus via enteral tube after verifying proper placement. E4 did not flush R8's tube prior to the administration of his medication and/or his Bolus feeding. e) At 1:56, E4 was observed administering Acidophilus, Diazepam, OsCal and Theophyeline (liquid) to R9 via enteral tube after verifying placement. E4 did not flush R9's tube prior to the administration of his medications. E2 (DON/Director of Nursing) was interviewed on 01/14/16 at 11:30 A.M. and observations of the medication administration for 01/13/16 were reviewed with her. E2 stated that nursing staff are to flush the individual's enteral tube prior to and after the final medication as per the facility's policy. E2 stated that E4 did not follow the facility's policy for enteral medication administration when she failed to flush each individual's tube prior to administering their (R5's, R6's, R7's R8's and R9's) medications. 2) Review of the Physician's Orders and corresponding Medication Administration Record for January 1-31, 2016 R5 has orders for Baclofen 20 mg (milligrams) tablet via G-tube (Gastrostomy tube).	{Z9999}		

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{Z9999}	Continued From page 3 On 01/13/16 at 1:02 P.M., E4 (LPN/Licensed Practical Nurse) was observed administering R5's medication (Baclofen 20 mg) via G-tube after checking for proper placement. E4 poured approximately 20-30 cc's (cubic centimeters) of water into the tube. After flushing R5's tube, the surveyor noted that there was still medication residual within the syringe. E4 recapped R5's tube and did not attempt to re flush the tube to ensure that he received all of his medication as physician ordered. E2 (DON/Director of Nursing was interviewed on 01/14/16 at 11:30 A.M. and stated, "Nursing is to flush the individuals tube after the last medication to make sure that all meds (medications) are given. If there is medication residual remaining in the syringe, nursing should flush again". When E2 was asked if she considered residual medication remaining within the syringe a medication error, she stated, "Yes". (B)	{Z9999}		