STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146000	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAY-FAIR NURSING & REHAB CENTER	**305 N.W. 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 323	Continued From page 3 understood, and has good recall. R4's Fall Risk Assessment dated 07-13-2013 states that R4 is high risk for falls. R4's Care Plan dated 04-11-13 states that R4 is potential risk for injury secondary to use of a walker for mobility, blind in left eye, generalized weakness and she doesn't always wait for assistance. R4's Care Plan states in "Approaches" that R4 is to be assisted with transfers and ambulation. The Incident Report-IDPH Notification with date of incident of 7-17-13, dated 07-18-2013 in the description of what happened states, CNA (Certified Nurses Aide) walked past R4's room and saw the door shut and the call light on. The CNA went into the room and found R4 sitting on the floor leaning on her right elbow up against the bedside nightstand. R4 told the staff that she closed the door because she needed to go to the bathroom. The Incident Report also indicates that R4 is alert and oriented and was complaining of right hip pain and right elbow pain. This report indicates that R4 was hospitalized on 7-17-13. The Radiology Report dated 7-17-13 indicates that R4 sustained an Acute Intertrochanteric Right Femur Fracture and a Left Parasymphyseal Pubic Ramus Fracture. R4's Care Plan with a date of 7-25-13 states "Re-entry S/P (status post) right hip IM nailing."	F 323		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.1210b)5) 300.1210c) 300.1210d)6)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146000	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAY-FAIR NURSING & REHAB CENTER	**305 N.W. 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
F9999	Continued From page 4 300.3240a)	F9999		

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146000	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAY-FAIR NURSING & REHAB CENTER	**305 N.W. 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
F9999	Continued From page 5 that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on interview and record review the facility failed to answer a call light timely for 1 (R4) resident reviewed for the answering of call lights timely. This failure resulted in R4 requiring surgical intervention after falling and fracturing her right hip and pelvis. On 09-26-2013 at 10:30 AM, R4 was alert and oriented, R4 stated during interview that she fell on 07-17-2013 because the staff did not answer her call light within an hour, to help her get to the bathroom and she tried to get to the bathroom on her own, fell and broke her right hip and pelvis. R4 further stated that she had to have surgery to repair the hip. R4 stated that she timed the staff on several occasions and it takes over an hour for the staff to answer her call light. Z1 (family member) was visiting R4 and stated that she has witnessed on several occasions the staff walking past a call light that had been on for a long time.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146000	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAY-FAIR NURSING & REHAB CENTER	**305 N.W. 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
F9999	Continued From page 6	F9999		

Z1 also stated that R4 is alert and knows what is going on and she was sure that her R4 fell on 07-17-2013 because she was trying to get to the bathroom before she urinated on herself. E4 (MDS/ Care Plan Coordinator) stated that R4 is alert and oriented. E4 also stated that R4 needed assistance with ambulation because she was unsteady and would not wait for assistance.

R4's MDS dated 04-26-2013, Section B; States that R4 understands and is able to make self understood, and has good recall. R4's Fall Risk Assessment dated 07-13-2013 states that R4 is high risk for falls. R4's Care Plan dated 04-11-13 states that R4 is potential risk for injury secondary to use of a walker for mobility, blind in left eye, generalized weakness and she doesn't always wait for assistance. R4's Care Plan states in "Approaches" that R4 is to be assisted with transfers and ambulation. The Incident Report-IDPH Notification with date of incident of 7-17-13, dated 07-18-2013 in the description of what happened states, CNA (Certified Nurses Aide) walked past R4's room and saw the door shut and the call light on. The CNA went into the room and found R4 sitting on the floor leaning on her right elbow up against the bedside nightstand. R4 told the staff that she closed the door because she needed to go to the bathroom. The Incident Report also indicates that R4 is alert and oriented and was complaining of right hip pain and right elbow pain. This report indicates that R4 was hospitalized on 7-17-13.

The Radiology Report dated 7-17-13 indicates that R4 sustained an Acute Intertrochanteric Right Femur Fracture and a Left Parasymphyseal Pubic Ramus Fracture. R4's Care Plan with a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146000	A. BUILDING _____ B. WING _____	C 09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAY-FAIR NURSING & REHAB CENTER	**305 N.W. 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
F9999	Continued From page 7 date of 7-25-13 states "Re-entry S/P (status post) right hip IM nailing." (B)	F9999		