PRINTED: 07/11/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR  COLONIAL MANOR  DISCUSSION OF COLORIAL MANOR  COLONIAL MANOR  COLORIAL MANOR  CO		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION IG	(X3) DATE SU COMPLE	
NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR  STREET ADDRESS, CITY, STATE, ZIP CODE 300 CHURCH STREET  ZEGLER, IL. 62999  Deprove Provider of Provider of Precipional Properties of Precipional Properti			14G048	B. WIN	WING			
PREFIX TAG  REGULATORY OR ISO IDENTIFYING INFORMATION)  W 455  Continued From page 29 with the person(s) suspected to have a rash suggestive of scabies. This process will be completed by 02/15/12 and on an ongoing, as needed basis. The Medical Director (Z7) will monitor for compliance.  * Clients with itching, open sores, lesions or drainage will have precautions initiated as per CDC guidelines. All staff to be trained by 02/10/12. E2 (DON) will monitor for compliance.  *Any client that has suspect rash suggestive of scabies will be placed on Contact Precautions and a skin scraping will be done. The client will remain on contact precautions until they have been treated and retreated as ordered by the physician. E2 (DON) will monitor for compliance.  *Any client attending an off site or in house day training program with suspect rash, lesion, and or drainage will remain at home and Contact precautions started. Day Training will initiate Contact Precautions and notily the facility and arrangements made for the client to return home. All day training staff will be trained by 02/15/12. E2 (DON) will monitor for compliance.  * Cleaning, laundry and deinfestation procedures was completed on 02/08, 02/09 and 02/10/12 and will be done on an as needed basis per CDC guidelines.  Although the Immediate Jeopardy is removed, noncompliance continues at the time of the exit since the facility has not had sufficient time to evaluate the effectiveness of this plan.					3	000 CHURCH STREET	OZ/Z	3/2312
with the person(s) suspected to have a rash suggestive of scabies. This process will be completed by 02/15/12 and on an ongoing, as needed basis. The Medical Director (Z7) will monitor for compliance.  * Clients with itching, open sores, lesions or drainage will have precautions initiated as per CDC guidelines. All staff to be trained by 02/10/12. E2 (DON) will monitor for compliance.  *Any client that has suspect rash suggestive of scabies will be placed on Contact Precautions and a skin scraping will be done. The client will remain on contact precautions until they have been treated and retreated as ordered by the physician. E2 (DON) will monitor for compliance.  *Any client attending an off site or in house day training program with suspect rash, lesion, and or drainage will remain at home and Contact precautions started. Day Training will initiate Contact Precautions and notify the facility and arrangements made for the client to return home. All day training staff will be trained by 02/15/12. E2 (DON) will monitor for compliance.  * Cleaning, laundry and deinfestation procedures was completed on 02/08, 02/09 and 02/10/12 and will be done on an as needed basis per CDC guidelines.  Although the Immediate Jeopardy is removed, noncompliance continues at the time of the exit since the facility has not had sufficient time to evaluate the effectiveness of this plan.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLÉTION
		with the person(s) s suggestive of scabi completed by 02/15 needed basis. The monitor for complia.  * Clients with itching drainage will have p CDC guidelines. Al 02/10/12. E2 (DON *Any client that has scabies will be plac and a skin scraping remain on contact p been treated and rephysician. E2 (DON *Any client attendir training program wirdrainage will remain precautions started Contact Precaution arrangements made All day training staff E2 (DON) will moni * Cleaning, laundry was completed on 0 will be done on an a guidelines.  Although the Immediate on consince the facility has evaluate the effective started that the started	suspected to have a rash es. This process will be 5/12 and on an ongoing, as Medical Director (Z7) will nce.  g, open sores, lesions or orecautions initiated as per 1/2 staff to be trained by will monitor for compliance.  suspect rash suggestive of ed on Contact Precautions will be done. The client will precautions until they have extreated as ordered by the N) will monitor for compliance.  In g an off site or in house day the suspect rash, lesion, and or at home and Contact. Day Training will initiate is and notify the facility and e for the client to return home. If will be trained by 02/15/12, tor for compliance.  and deinfestation procedures 02/08, 02/09 and 02/10/12 and as needed basis per CDC diate Jeopardy is removed, attinues at the time of the exit is not had sufficient time to weness of this plan.					

Facility ID: IL6010151

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \		LE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUIL	DING	<u> </u>		c
		14G048	B. WING 02			3/2012	
	ROVIDER OR SUPPLIER			30	EET ADDRESS, CITY, STATE, ZIP CODE O CHURCH STREET EIGLER, IL 62999		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	Continued From pa LICENSURE VIOL	_	W99	99			
	350.620a) 350.760a) 350.760b) 350.1210 350.1220j) 350.1223a) 350.1223b) 350.1223c) 350.1223c) 350.1230d)1) 350.1420a) 350.3220f) 350.3240a)						
	Section 350.620 Re	esident Care Policies					
	procedures governi facility which shall be involvement of the a shall be available to public. These writte	have written policies and ng all services provided by the performulated with the administrator. The policies of the staff, residents and the n policies shall be followed in and shall be reviewed at					
	controlling, and pre- shall be established and procedures sha include the requiren Communicable Disc	dection Control cedures for investigating, eventing infections in the facility of and followed. The policies all be consistent with and ments of the Control of eases Code (77 III. Adm. Code Sexually Transmissible					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		A. BUILDIN	G		c
	14G048	B. WING 02			3/2012
NAME OF PROVIDER OR SUPPLIE	R	3	REET ADDRESS, CITY, STATE, ZIP CODE 00 CHURCH STREET ZEIGLER, IL 62999		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
shall be monitored and procedures are section 350.1220 and procedures and procedures are section 350.1220 and procedures are section 350.1220 and procedures are section 350.1220 and procedures and procedures and procedures and procedures and procedures are section 350.1220 and procedures are section 35	77 III. Adm. Code 693). Activities and to ensure that these policies are followed.  In infection control committee, a committee, or other facility dically review the results of diactivities to control infections.  O Health Services  Provide all services necessary to sident in good physical health.  O Physician Services  Il notify the resident's physician njury, or change in a resident's eatens the health, safety or lent, including, but not limited to, ncipient or manifest decubitus t loss or gain of five percent or	W9999	DEFICIENCY		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  IG	(X3) DATE SU COMPLE	TED
		14G048	B. WIN	1G _	·····		3/ <b>2012</b>
	ROVIDER OR SUPPLIER		l	3	REET ADDRESS, CITY, STATE, ZIP CODE 00 CHURCH STREET ZEIGLER, IL 62999	UZ/Z	0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	allowed in subsection resident who is sus having any such disciplation, if required Control of Communifacility believes that necessary infection initiate an involuntal pursuant to Article I Section 350.630 of whether a transfer of burden of proof resident of Communication of Communication of Sexually (77 III. Adm. Code 6 immediately to the I the Department. The pertinent information occurrences. In additional subsection of the subsection of the I the Department.	on (d) of this Section. A pected of or diagnosed as sease shall be placed in I, in accordance with the sicable Diseases Code. If the control measures, it must ry transfer and discharge II, Part 4 of the Act and this Part. In determining or discharge is necessary, the ts on the facility.  ired to be reported under the sicable Diseases Code and Transmissible Diseases Code and Transmissible Diseases Code ocal health department and to be facility shall furnish all in relating to such dition, the facility shall also ent of all incidents of scabies	W99	999			
	are not limited to, the 1) Detecting signs of	onnel shall be trained in, but ne following: of illness, dysfunction or or that warrant medical,					
	Prescriber's Orders	compliance with Licensed shall be given only upon the					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPI IER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION  G	(X3) DATE SU COMPLE	TED
		14G048	B. WIN	IG			3/ <b>2012</b>
	ROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 00 CHURCH STREET (EIGLER, IL 62999	OZ/Z	5/2512
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	prescriber. The fact licensed prescriber accordance with Seconders shall have the unique identifier) of (Rubber stamp sign These medications ordered by the licendesignated time.  Section 350.3220 M  f) All medical treatmadministered as ordered as ordered by the licendesignated time.  Section 350.3220 M  f) All medical treatmadministered as ordered by the licendesignated time.  Section 350.3220 M  a) An owner after issued to assure factorders. (Section 2-1)  Section 350.3240 A  a) An owner, licensagent of a facility shresident. (Section 2-1)  These requirement by:	relectronic order of a licensed simile or electronic order of a shall be authenticated by the within 10 calendar days, in ection 350.1610. All such he handwritten signature (or the licensed prescriber. natures are not acceptable.) shall be administered as need prescriber and at the ment and procedures shall be dered by a physician. All new hall be reviewed by the facility's or charge nurse designee er such orders have been cility compliance with such 104(b) of the Act)  Abuse and Neglect ee, administrator, employee or hall not abuse or neglect a	W99	999			
	review, the facility fa	ailed to protect individuals contagious diseases when					

PRINTED: 07/11/2012 FORM APPROVED OMB NO. 0938-0391

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION  NG	COMPLE	TED
		14G048	B. WIN	NG _			3/ <b>2012</b>
	ROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 300 CHURCH STREET ZEIGLER, IL 62999	OZ/Z	3/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	they failed to develor procedures for the rashes with sympto based on guidelines. Disease Control and Department of Public recommendations of Scabies in Illinois Hacilities," for 2 of 2 in the facility who won 01/24/12. After the remaining 39 in the facility, an unknat the facility and at number of individual visitors to the facilities at local clinics and/owho have had direct individuals living at to:  * Have reproducible the management of with symptoms sugscabies and have rethat these policies a implemented;  * Determine the etic and/or symptoms sugscabies and that the symptoms of the workshop and individuals of the fascabies and that the have been exposed.	op and implement policies and management of suspicious ms suggestive of scabies as by the CDC (Centers for d Prevention ) and the Illinois	W99	999			

Facility ID: IL6010151

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION NG	(X3) DATE SU COMPLE	
		14G048	B. WIN	NG _			3/ <b>2012</b>
	ROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 300 CHURCH STREET ZEIGLER, IL 62999	OZ/Z	3/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	spread of scabies to members of their hot.  * Decrease the risk facilities or communithe local County He local hospitals and that individuals who admitted to their clip possibly been expo.  * Prevent transmiss individuals living in and the workshop a facility by failing to and/or Isolation Preper CDC guidelines symptoms suggesti.  * Implement environ procedures for launclothing worn by the within the bedrooms items that are share walking belts, crear the time the individual treatments;  * Treat all individuals as 02/01/12;  * Treat individuals as workshop with a scaleliminate infectivity asymptomatic individuals as symptomatic individuals individuals as symptomatic individualsymptomatic individuals as symptomatic individuals as symptomatic	of transmission to other nities when they failed to notify ealth Department, local clinics, a hospital in Peoria county have been seen and/or nic and/or the hospital(s) have sed to scabies; sion of scabies to other the facility, staff of the facility and visitors and others to the use Contact Precautions cautions as recommended for the individuals showing we of scabies; mmental deinfestation dering bed linens, towels and endividuals, cleaning furniture is used by the individuals, and end within the facility such as an slotions and ointments at uals receive their scabicide.  Is (R1 - 12 and R14 - R41) ordered by the physician on and staff of the facility and the abicide on the same day to in both symptomatic and	W98	9999			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		14G048	B. WII	NG			3/ <b>2012</b>
	ROVIDER OR SUPPLIER			30	EET ADDRESS, CITY, STATE, ZIP CODE 00 CHURCH STREET EIGLER, IL 62999		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	identifying suspicion symptoms suggestive being treated for so symptoms and the individuals.  Findings include:	ge 36 us rashes and/or signs and ive of scabies, the individuals tables, the date of onset of the treatment(s) provided to these cility received orders from the	W9	999			
	physician to treat R After this treatment facility contacted th Health Department R1's and R2's room nine individuals (R3 staff of the facility a recommended by C not notify staff of th direct care staff at t the facility of possib precautions were in environments to pre rashes, suggestive implement environ procedures for the for R1 and R2's bec Licensed Practical 01/26/12 that the w individuals from oth unidentified staff we individuals ((R1-R3 that these four unid rashes, suggestive had not been notifie	1 and R2 with a scabicide.  , the is no evidence that the e physician and/or the local for recommendations to treat mate, any of the other thirty 3 - R42) living in the facility and nd/or staff at the workshop as CDC guidelines. The facility did e facility, nursing staff and he workshop, nor visitors to ble exposure to scabies. No nplemented across all event the spread of suspicious of scabies. The facility did not mental deinfestation entire facility, but rather only droom. Z1 (Workshop Nurse/LPN) stated on orkshop has four unidentified					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		14G048	B WING			C <b>3/2012</b>	
	PROVIDER OR SUPPLIER		•	3	REET ADDRESS, CITY, STATE, ZIP CODE 00 CHURCH STREET EIGLER, IL 62999		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	R13 was sent to a I 01/26/12 and then a The facility did not rhospital that other is currently being trea had possibly been was admitted to a lothen transferred to the facility did not not that R42 had possibly been seen as a different to the facility did not not that R42 had possibly been seen as a different to the facility did not not the facility did not the facility of the facility. On 02/01/12 and as regulated in the facilities and IDPI infectivity. On 02/01/12 and as regulated individuals workshop and that facilities have similar scabies. Z1 stated separate CILAs (Contamination of 02/02/12 at 10:00 the facility of 02/02/12 at 10:00 treated the remaining living in the facility (10.00 the facility).	ocal after hour clinic on admitted to a local hospital. notify the clinic and/or the individuals in the facility were sted for scabies and that R13 exposed. Additionally, R42 ocal hospital on 11/30/11 and a hospital in Peoria county and otify either of the two hospitals oly been exposed to scabies.  In other individuals (R3, R6, so) living in the facility began suggestive of scabies and ere treated with a scabicide. The remaining twenty and in the facility (R4, R5, R7, R15, R27 - R41) with a sed by the physician on commended by CDC of the recommendations to reduce 02/12, R11 was sent to work on her back and R7 was sent with round, flat markings. Z1 ated that the facility continues with contagious rashes to the more individuals from other ar rashes, suggestive of that other individuals from six ommunity Living r separate group homes and ng at home with their families	W9	999			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		14G048	B. WI				C <b>3/2012</b>
	PROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 00 CHURCH STREET EIGLER, IL 62999	<i>02/2</i>	0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	them to the various twenty three individ R12, R14, R15, R2 a scabicide as orde 02/01/12. The facilit any staff of the facilit staff at the workshot scabicide as recom The facility did not it deinfestation procedures environment as recommended by reinfestation. The facility of scabing maintained an active control and investig.	day training programs. These uals (R4, R5, R7, R9, R11, 7 - R41) were not treated with red by the physician on ty had not notified, nor treated lity and had not ensured that up had been treated with a mended per CDC guidelines. Implement environmental dures for the entire facility and ts as per CDC guidelines and lity IDPH to prevent acility does not have policy and loies and/or contagious rashes es, nor has the facility re program for the prevention, ation of contagious rashes.	W9	999			
	suggested guideline parasitic diseases is have occurred amo institutions such as care facilities and hitching and rash of spersons, leading to delayed or inadequatransmission. Scalauntil it begins to appatients at the instit infested person, tre for household mem treated at the same reinfestation Scalascabies) should be body from the neck	es for institutional settings for states, "Scabies outbreaks ing patients visitors and staff in nursing homes, long term ospitals The characteristic scabies can be absent in such frequent misdiagnosis and ate treatment and continued bies often is not recognized bear among staff and other aution In addition to the atment also is recommended bers All persons should be					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		14G048	B. WI		·····		3/ <b>2012</b>
	PROVIDER OR SUPPLIER		ı	30	REET ADDRESS, CITY, STATE, ZIP CODE 00 CHURCH STREET (EIGLER, IL 62999	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	to a clean, body and time before washing be worn after treath towels used by infe household anytim treatment should be in hot water and dry cleaning, or by seal 72 hours. If itching 4 weeks after treatr pimple like rash les retreatment may be state health departr guidelines for preve outbreaks"  At the time of entra at 2:00 P.M., E1 (Arfacility has forty one in the facility. E1 st discharged from the admission to a loca complications and verifications and verifications. Whindividuals had any was present in the R2." E1 went on to and R2) were curre scabicide, but had rescabies.  On 01/25/12 at 3:00 Control Log for Jan log is entitled, "Antillogs and/or informal individuals with sus symptoms suggesti	ge 39 d left on for the recommended git off. Clean clothing should nent. Bedding, clothing and sted persons or their e during the three days before e decontaminated by washing ring in a hot dryer, by dry ing in a plastic bag for at least still is present more than 2 to ment or if new burrows or ions continue to appear, e necessary Local and/or ments may be able to provide enting and controlling scabies ince to the facility on 01/25/12 dministrator) stated that the e individuals (R1 - R41) living ated that R42 had been e facility on 01/24/12. After his I hospital, R42 developed was transferred to a hospital in en E1 was asked if any of the suspicious rashes when R42 facility, she stated, "R1 and say that these individuals (R1 ntly being treated with a not been diagnosed with	W99	666			

W9999 Continued From page 40 names of the two individuals (R1 and R2) who are presently being treated for scabies, the date of onset of the symptoms and the treatment(s) provided to these individuals.  a) On 01/25/12 at 3:10 P.M., R2 was observed in the bedroom of the facility with E1 (Administrator). R2 had multiple raised areas to her abdomen and back. The areas on her back were scabbed and other areas had been scratched open. E1 stated that R2 had been seen by the doctor twice and has been treated for scabies twice. E1 stated that she could not		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION  NG	COMPLE	TED
NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR  SUMMARY STATEMENT OF DEFICIENCIES ZEIGLER, IL 62999  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W9999  Continued From page 40  names of the two individuals (R1 and R2) who are presently being treated for scabies, the date of onset of the symptoms and the treatment(s) provided to these individuals.  a) On 01/25/12 at 3:10 P.M., R2 was observed in the bedroom of the facility with E1 (Administrator). R2 had multiple raised areas to her abdomen and back. The areas on her back were scabbed and other areas had been scen by the doctor twice and has been treated for scabies twice. E1 stated that she could not			14G048	B. WIN	NG _			
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W9999  Continued From page 40 names of the two individuals (R1 and R2) who are presently being treated for scabies, the date of onset of the symptoms and the treatment(s) provided to these individuals.  a) On 01/25/12 at 3:10 P.M., R2 was observed in the bedroom of the facility with E1 (Administrator). R2 had multiple raised areas to her abdomen and back. The areas on her back were scabbed and other areas had been scratched open. E1 stated that R2 had been seen by the doctor twice and has been treated for scabies twice. E1 stated that she could not					3	300 CHURCH STREET	J OZ/Z	5/2512
names of the two individuals (R1 and R2) who are presently being treated for scabies, the date of onset of the symptoms and the treatment(s) provided to these individuals.  a) On 01/25/12 at 3:10 P.M., R2 was observed in the bedroom of the facility with E1 (Administrator). R2 had multiple raised areas to her abdomen and back. The areas on her back were scabbed and other areas had been scratched open. E1 stated that R2 had been seen by the doctor twice and has been treated for scabies twice. E1 stated that she could not	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
remember the first time R2 had been treated for scables, but thought it had been in October or November of 2011 with the Triaminolone cream (topical corticosteroid cream which can be used to relieve itching).  Review of the Medication Administration Records and the Treatment Records for the months of September, October, November and December of 2011 does not identify that nursing documented that R2 was ever treated with any type of medication used to treat parasitic infections.  R2's Nurse's Notes for December 2011 identifies the following nursing entries regarding the suspicious rash to her body:  12/19/11 Skin assessed. Intact. Rash on trunk and BUE (bilateral upper extremities) scabbed over. No itching noted.  12/28/11 Reported rash, received telephone order for Triaminolone cream 0.035%. Apply to rash BID (twice daily) x 7 days. Pharmacy notified.	W9999	names of the two in are presently being of onset of the symprovided to these in a) On 01/25/12 at 3 the bedroom of the (Administrator). R2 her abdomen and be were scabbed and scratched open. Escabies twice. Et scabies twice. Et scabies, but though November of 2011 (topical corticostero to relieve itching).  Review of the Mediand the Treatment September, Octobe of 2011 does not ide documented that Ritype of medication infections.  R2's Nurse's Notes the following nursin suspicious rash to her 12/19/11 Skin asset and BUE (bilateral cover. No itching not 12/28/11 Reported for Triaminolone creations are presented in the same and BUE (bilateral cover. No itching not 12/28/11 Reported for Triaminolone creations in the same are presented for Triaminolone creations.	idividuals (R1 and R2) who treated for scabies, the date ptoms and the treatment(s) idividuals.  :10 P.M., R2 was observed in facility with E1 had multiple raised areas to eack. The areas on her back other areas had been twice and has been treated for stated that R2 had been twice and has been treated for stated that she could not time R2 had been treated for with the Triaminolone cream with the Triaminolone cream which can be used cation Administration Records Records for the months of er, November and December entify that nursing 2 was ever treated with any used to treat parasitic  for December 2011 identifies g entries regarding the ner body:  ssed. Intact. Rash on trunk upper extremities) scabbed ed.  rash, received telephone order eam 0.035%. Apply to rash	W99	999			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION IG	(X3) DATE SU COMPLE	
		14G048	B. WI	NG _			C <b>3/2012</b>
	PROVIDER OR SUPPLIER		•	3	REET ADDRESS, CITY, STATE, ZIP CODE 800 CHURCH STREET ZEIGLER, IL 62999		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W9999	from 01/01 -01/04/1 Triaminolone cream improvement. The istates, "Skin asset Triaminolone cream further entries were rash until 01/10/12 "rash remains on be documented that R the facility and requirement of facility and the facility and the facility and the facility that (physician) that the facility that the facility and facil	for January 2012 states that 2 she continued to receive 10.035% to her rash without nursing entry for 01/05/12 essed no improvement noted. In completed on 01/04/12. No made regarding R2's skin when nursing documented, ody." On 01/12/12, nursing 2's guardian was present at ested that she be seen by a 10 the rash on her skin. It is a seen by a 10 the rash on her skin. It is a seen by a 10 the rash on her skin. It is a seen by a 11 the rash on her guardian are gress Notes sheet dated and that R2 was seen by the 11 the rash was due to the new 12 the rash was due to the new 13 the rash was due to the new 14 the rash had not 15 the rash had not 16 the rash had not 17 the physician's 17 the rash had not 18 the rash had not 18 the rash had not 19 the rash on R2's arms and trunk on the body since early 19 the received that six days after being 19 the rash being 19 that six days after being 19 that six days afte	W9:	999			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		14G048	B. WI				C <b>3/2012</b>
	ROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 00 CHURCH STREET EIGLER, IL 62999	, J2/2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	seen by the Z7 (phy were received on 0 (scabicide lotion us itching). No docum R2's Nursing Notes that she was placed and/or placed in iso recommended by the Precautions in Hosk known or suspected. There is no docume reports identifying the completed on R2. on 01/26/12 at 3:20 have policy and procontagious rashes as b) R1 was observed his bedroom of the noted to R1's chest sides of his thighs centire buttock area. R1's Nurse's Notes reviewed. Docume identifies that Triam applied to the rash documentation doe	ysician) on 01/18/12, orders 1/24/12 to treat R2 with Eurax ed to treat scabies and reduce entation is contained within for January 2012 identifying d on Contact Precautions plation prior to 01/18/12 (as the CDC Guideline for Isolation poitals (1996) for patients d to be infested with scabies). Entation and or laboratory that a skin scraping was E1 (Administrator) confirmed P.M. that the facility does not recedures for scabies and or suggestive of scabies.  In on 01/25/12 at 3:20 P.M. in facility. A raised rash was and own his abdomen, on both down to his knees and over his for January 2012 were not interested to 1/20/1/12 recinolone cream is being the has on his body. This is not specify where the rash is	W9	999			
	documented that the cream (topical corticused to relieve itching 01/04/12 and that the On 01/06/12 nursing "drying up" and R1 date. The next entities.	dy. On 01/05/12 nursing e order for the Triamcinolone costeroid cream which can be ng) was completed on ne rash remained on his body. g wrote that his rash was returned to workshop on this ry was made by nursing on s that the rash is still present					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		\ , ,	IULTIF ILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14G048	B. WI	NG			3/ <b>2012</b>
	PROVIDER OR SUPPLIER			30	EET ADDRESS, CITY, STATE, ZIP CODE 00 CHURCH STREET EIGLER, IL 62999		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	on R1's body. On 0 that R1's guardian or requesting an appodue to the skin rash. The Physician's Pro 01/18/12 states that associated with itch legs. This report stapapular rash (rash of and small raised but excoriated over his note identifies that the unknown and that the treaction to the new or the rash could be ordered Ivermectin parasitic infections mg (milligram) 1 tail days. R1 was also to a dermatologist, Notes for January a identify that R1 was dermatologist.  No documentation in Nursing Notes for January a identify that R1 was dermatologist.  No documentation in Nursing Notes for January a identify that R1 was dermatologist.  No documentation in Nursing Notes for January a identify that R1 was dermatologist.  No documentation in Nursing Notes for January a identify that R1 was dermatologist.	o1/12/12 documentation states (Z6) was at the facility and is intment with the dermatologist in.  ogress Notes sheet dated the R1 was seen due to a rashing on his arms, trunk and ates that he (R1) has macular characterized by flat red spots arms, legs and trunk. This the etiology of the rash is he rash could be an allergic soap being used by the facility escabies. The physician (medication used to treat including lice and scabies) 3 or q (every) day for R1 for three recommended to be referred however review of his Nurses and February 2012 does not	W9	999			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		14G048	B. WI	۱G _			C <b>3/2012</b>
	ROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 300 CHURCH STREET ZEIGLER, IL 62999	, , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W9999	was interviewed on Z2 (Workshop Qual Professional/QMRF interview. During the R2, R3, R5, R6, R7 and/or have had surthese individuals a attending workshop several times and taked the facility's individual's rashes at that it is, "not scabile ongoing problem sin 2011." When Z1 was from other facilities rashes and itching, clients in the room R5-R10) and two statese individuals whare scratching." Workshop was addrand/or itching she scomfort measures, water and applying keep them from scratching." When the facility had notifi suspicious rashes a provided to any of the R5-R10), she state if the facility had cal anyone else at workshop else at worksh	nsed Practical Nurse/LPN) 01/26/12 at 11:15 A.M. and lified Mental Retardation P) was present during this nis interview Z1 stated, "R1, R8, R9 and R10 all have spicious rashes with itching. The all in the same room when I have called the facility alked with E1 (Administrator), (LPN) about the individuals tashes on their bodies. I have staff several times about the and I've been told point blank tes." This has been an the Coctober or November of as asked if any individuals have similar symptoms of she stated, "I have four other with these individuals (R1-R3, aff members working with the all have similar rashes and then Z1 was asked how the essing the individual's rashes tated, "We are providing basic like keeping their hands in cool rags to their hands to	W99	999			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPI IER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION  NG	COMPLE	TED
		14G048	B. WIN	۱G _		02/23	C <b>3/2012</b>
	PROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 300 CHURCH STREET ZEIGLER, IL 62999	02/20	5/2512
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	on 01/31/12 at 9:00 R6, R11 and R12 in rashes all over his be attendance for awhistomach is covered constantly itching he about the rashes ar individuals. No one are or what we are relieve them from it.  As a result of this in were observed in the 01/31/12 with E1(Ac (LPN/Licensed Practof Nursing/DON).  R1 was observed as assessment, R1 ha and scratch marks of his fingers on both spots and a fine rasstomach area and oboth of his legs to hine of small, scabberight leg.  R6 was observed as was noted all over heach is attributed to her (R6's) legs were (R6) always has ski from excoriation. ((LPN) informed the R6 was in the activities.	was interviewed by phone A.M. and stated, "I have R1, my room. R1 has had body. He has not been in ide. R6 is here at work and her with a rash. She is er stomach. I told Z1 (LPN) and she has examined the has told me what the rashes supposed to be doing to ching."  terview, R1, R6, R11 and R12 e bathroom of the facility on dministrator), E5 ctical Nurse) and E2 (Director	W98	999			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		NG	COMPLE	TED
		14G048	B. WIN	۱G _			C <b>3/2012</b>
	ROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 300 CHURCH STREET ZEIGLER, IL 62999	02,20	3/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	any visible areas or she had been itchin R12 was observed have one small sca pinpoint lines on his linear, pinpoint lines attributed these are she had received a that he had slipped Z3 (Workshop Staff on 01/31/12 at 9:07 R7, R8, R9, R13 are is in my room but sl When she (R2) was were covered with a time. R9 complains scratching his back but he did show the and raised bumps to She also was scratch when I help with to that R5, R6 and R1 areas on their bodic hands and stomach to her arms. R6 ha of drawing blood. Howevered and I feel sasked if anyone from had informed her reashes and/or what itching, she stated, about the rash. I had	at 4:10 P.M. and did not have her body. R11 stated that	W98	999			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) N A. BU		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		14G048	B. WII	NG			C <b>3/2012</b>
	PROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 100 CHURCH STREET L'EIGLER, IL 62999	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	be an allergic react facility. They told us when especially wo rashes. I now have sent to the (Workm the workshop. The dermatitis, but my rand my partner now on medication for the rash is not going aw They did not do a socabies. There are here at workshop with mine and the individe knew contact dermation.  As a result of the instaff), R2, R5, R7, observed in the bat 01/31/12 with E1(Ac(LPN/Licensed Pracof Nursing/DON).  R2 was observed a circular raised area sides and to both or accompanied with a were dark and scalathese areas resulte scratching herself, the webbing of her her hands. R2 attemultiple times durin.  R5 was observed a pinpoint red marks.	ion to a new soap used by the is to use standard precautions rking with the individuals with a rashes on my body and was an's Compensation) doctor by doctor says I have contact ash has spread down my legs a laso has a rash. I have been ne past four weeks and the way and is getting worse. It is scraping and test me for also three staff (unnamed) who have rashes similar to duals from the facility. I never atitis was contagious"  It terview with Z3 (Workshop R8, R9 and R15 were hroom of the facility on dministrator), E5 ctical Nurse) and E2 (Director the 4:02 P.M. to have flat, as all over her chest, back, as all over her chest, back, af her arms and legs a fine rash. Some of the areas obed over. E1 stated that d from R2 digging and Sores were noted between (R2's) fingers and to the top of mpted to scratch her body and the top of mpted to scratch her body and the top of mpted to scratch her body and the top of mpted to scratch her body and the pack. Multiple scratch on her upper and on her left	W9	999			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14G048	B. WIN	NG _			3/ <b>2012</b>
	ROVIDER OR SUPPLIER		<u> </u>	;	REET ADDRESS, CITY, STATE, ZIP CODE 300 CHURCH STREET ZEIGLER, IL 62999	OZ/Z	3/2312
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	N SHOULD BE E APPROPRIATE	
W9999	Continued From pa	ge 48	W99	999			
	linear, pinpoint mar	t 4:23 P.M. to have small ks similar to track marks ks to the left side of her					
	R8 was observed a circular raised area	t 4:11 P.M. to have flat, s to his chest.					
	pinpoint marks to th	t 3:50 P.M. to have linear, ne left side of his leg similar to scratch marks. R9 stated that n itching.					
	R15 was observed area to the left side	at 4:00 P.M. to have a raised of her face.					
	were also observed on 01/31/12 with E1	tion, R12, R3, R4 and R10 In the bathroom at the facility (Administrator), E5 ctical Nurse) and E2 (Director					
	small scabbed area to his right knee. He	at 3:58 P.M. to have one and two linear, pinpoint areas also had two linear, pinpoint his left knee similar to track the marks.					
	customized wheelch raised areas on her and on both sides of marks were noted of (Administrator) state the rash was but R3	t 4:30 P.M. sitting in her hair. She had flat, circular arms, back, stomach, chest of her neck and face. Scratch on the left side of her face. E1 ed that they did not know what 3 was currently being treated costeroid which can be used to lammation.)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTII LDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G048	B. WI				C <b>3/2012</b>
	PROVIDER OR SUPPLIER		I	3	REET ADDRESS, CITY, STATE, ZIP CODE 000 CHURCH STREET ZEIGLER, IL 62999	UZ/Z	0/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	customized wheelch both hands and was linear, pinpoint mar were similar to track E1 (Administrator) scontractures, she is scratching herself.  R10 was observed raised and scabbed and on the tops of histates that he (R10) hospital with these that he had been itche states his should was noted to have a right shoulder measinches long and about pieces of dead skin scratch marks were was also noted to histate to histate that he had been itches long and about the states his should was noted to have a right shoulder measinches long and about the states his should was noted to have a right shoulder measinches long and about the states his should was noted to have a raised bum.  E1 (Administrator) at 3:20 P.M. and stresponded to anyth surveyor why R1 arbeing treated for schas been treated the two times for scabied diagnosed with scal why the suspicious these rashes had neadility's Infection Chaven't documenter.	ge 49  It 4:20 P.M. sitting in her hair. R4 has contractures of a noted to have three separate ks on her right hand which a marks and/or scratch marks. States that due to R4's not physically capable of at 4:28 P.M. to have multiple areas on both of his arms his hands. E1 (Administrator) returned home from the marks on his arm. R10 states thing and when asked where, der. Upon examination, R10 a large, dry, open area to his suring approximately four but three inches wide. Dry hung from this area and anoted on his shoulder. R10 ave a small area of flat, ps on both of his legs.  Was interviewed on 01/26/12 ated, "They have not ing else," when asked by the had R2 had and were currently abies. E1 then stated, "R1 vice and R2 has been treated es. No one has been formally bies." When E1 was asked rashes and treatments for ot been documented in the ontrol Log, she stated, "I dyet, but I have my notes." e surveyor handwritten notes	W99	9999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTII	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		14G048	B. WI				C <b>3/2012</b>
	PROVIDER OR SUPPLIER			30	REET ADDRESS, CITY, STATE, ZIP CODE 00 CHURCH STREET EIGLER, IL 62999		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	identifying time lines was asked if she had and at the workshop treated for scabies, was asked if she had workshop staff about rashes, she stated, Z1's (Workshop's Lawith E1 at this time (Physician Assistant be viral and will only Several of the indivimeasles and/or shift the facility actually brashes are scabies. When E1 was asked procedures regarding scabies, she stated procedures after young of 1/25/12 and discommissing. I can't find them out of the boothe policy for contact. The facility's (undate Precautions states will be used for the infectious agents sy contact Contact per who are actively infectious including 3. Skin it contagious (scabies Herpes Simplex, Zo Z4 (Physician Assistelephone on 01/27.)	s for R1 and R2. When E1 ad notified staff at the facility p that R1 and R2 had been she stated, "No." When E1 ad been contacted by ut their concern with the "I was contacted on 11/28/11." PN) interview was reviewed and she stated, "Z4 t/PA) thinks the rashes may y last about seven to ten days. idual's rashes looks like ngles." When E1 was asked if knows whether or not the she stated, "I don't know." d if the facility had policy and ng suspicious rashes and/or, "I went to pull the policy and u entered the facility on wered that these policies were them. I think someone took k. At this time we are using at precautions."  ed) Policy for Contact that contact precautions, " care of all clients with pread by direct or indirect recautions apply to clients ected or colonized with aportant organisms, nfections that are highly s, major abscesses, impetigo,	W99	999			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		14G048	B. WII	NG			3/ <b>2012</b>
	PROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 00 CHURCH STREET EIGLER, IL 62999		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	determine if the ras the assumption that go away." When Zof the facility's policithe prevention and facility, she stated, pull the policy and pyou entered the facility were showing similitiching, she stated, out if the rashes are Z7 (facility's Medicatelephone on 02/01 that he was not awafacilities and works symptoms like the istated, "I received ris a confirmed case scabies. This form quickly. The facility On this date (02/01 Director) ordered the Elimite to all patient treatment. Apply perepeat in 7-10 days. The off site workshat 9:10 A.M. with Zinno," when asked if about any confirme scabies treatments individuals of the fare R11 were sent to with the state of the site workshat 9:10 A.M. with Zinno," when asked if about any confirme scabies treatments individuals of the fare R11 were sent to with the state of the site workshat 9:10 A.M. with Zinno," when asked if about any confirme scabies treatments individuals of the fare R11 were sent to with the site of the	hes are scabies. I am under it is is viral and will eventually 4 was asked if she was aware y and procedures regarding control of scabies within the "E1 (Administrator) went to procedures on 01/25/12 after ility and discovered that these ing." When Z4 was informed as and staff at the workshop ar symptoms of rashes and "I guess we will need to rule excabies or not."  Al Director) was interviewed by 12 at 12:25 P.M. and stated are that individuals of other nop staff are having similar individuals at the facility. Z7 notice this morning that there is of Norwegian Crusted of scabies spreads very will need to treat everyone."  (12), Z7 (facility's Medical ite facility to, "Please apply is as needed for scabies er package directions and	W9	999			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION NG	(X3) DATE SU COMPLE	
		14G048	B. WI	۷G _			C <b>3/2012</b>
	ROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 300 CHURCH STREET ZEIGLER, IL 62999	, , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	can't believe the factor morning. The facility regarding isolation what treatments has residents. I now has similar symptoms of scabies. I contacte already been treated. R7 was observed at at workshop with R6 facility and five other LPN) stated, "I have and other individual (Center for Independance of the LPN) and other individual (Center for Independance of the LPN) and other individual (Center for Independance of the LPN) and other individual (Center for Independance of LPN) and other facility workshop and had scabicide.)  R11 was observed Room at workshop living at other facility potentially exposed with their families at four separate CILAs confirmed on 02/02 was sent to workshow with a scabicide.)  R27, R5, R15, R28 other classrooms at individuals from oth (R27, R5, R15, R28 and had not been the service of the scale of t	rack marks down her back. I cility sent them to work this y has not contacted us precautions or anything about we been given to their we other individuals showing f rashes which looks like d my doctor and I have	W9	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED  C 02/23/2012	
	14G048		B. WII	NG			
NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR			•	30	REET ADDRESS, CITY, STATE, ZIP CODE 00 CHURCH STREET EIGLER, IL 62999		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	on 02/02/12 at 10:1 R27 was observed seven individuals. Zif R27 has been exproming to work her individuals living at four individuals living homes; and R5, R15, R28 and R Salmon Room with (Workshop LPN) st have been exposed when the facility sepotentially expose i group homes. On 02/02/12 at 9:50 gave the surveyor areceived from Z7 (findated 02/01/12. This Elimite to all patient treatment. Apply perepeat in 7-10 days the surveyor that expressed yesterday and finding lice and sithe names of these R10, R3, R16, R18 R21." E1 stated that and R26 are rooming were also treated yethis interview, E1 contention which is interview, E1 contention which is the results of the service individing facility had not been served seven individing facility had not been served seven individuals living at four indiv		W9	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED  C 02/23/2012	
	14G048		B. WII	NG			
NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR				30	REET ADDRESS, CITY, STATE, ZIP CODE 00 CHURCH STREET EIGLER, IL 62999		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		JLD BE	(X5) COMPLETION DATE
W9999	recommended by II the facility does not procedures for scale suggestive of scabi maintained an active control and investig  The Illinois Departn	ge 54 CDC guidelines and as DPH. E1 also confirmed that presently have policy and bies and/or contagious rashes es, nor has the facility re program for the prevention, ation of contagious rashes.  nent of Public Health (IDPH) or the "Management of	W9	666			
	Scabies in Illinois Healthcare and Residential Facilities," recommends the following actions with the following rationale for preventing the transmission of scabies in healthcare and residential facilities:						
	asymptomatic) should asymptomatic in and asymptomatic it is recommended in * When patients or transferred to anoth should be notified thave been exposed risk of transmission community; * All employees should as the residents in the incubation persource of transmission recommended in 7- * Household contact evaluated by a physical patients in the incubation and the incubation persource of transmission recommended in 7- * Household contact evaluated by a physical patients in the incubation persource of transmission recommended in 7- * Household contact evaluated by a physical patients in the incubation person recommended in 7- * Household contact evaluated by a physical patients in the incubation person recommended in 7- * Household contact evaluated by a physical patients in the incubation person recommended in 7- * Household contact evaluated by a physical patients in the incubation person recommended in 7- * Household contact evaluated by a physical patients in the incubation person recommended in 7- * Household contact evaluated by a physical patients in the incubation person recommended in 7- * Household contact evaluated by a physical patients in the incubation person recommended in 7- * Household contact evaluated by a physical patients in the incubation person recommended in 7- * Household contact evaluated by a physical patients in the incubation person recommended in 7- * Household contact evaluated by a physical patients in the incubation person recommended in 7- * Household contact evaluated by a physical patients in the incubation person recommended in 7- * Household contact evaluated by a physical patients in the incubation person recommended in 7- * Household contact evaluated by a physical patients in the incubation recommended in 7- * Household contact evaluated by a physical patients in the incubation recommended in 7- * Household contact evaluated by a physical patients in the incubation recommended in 7- * Household contact evaluated by a physical patients in the incubation recommended in 7- *	residents are discharged or her facility, their physicians hat the patient or resident may do to scabies to decrease the to other facilities or the hould be treated on the same so due to the employees being period, asymptomatic and a sion. A second treatment is to days; ets of employees should be sician if they develop a skin bout itching due to the fact that asmit scabies to their					

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		14G048	14G048 B. WING _			C <b>02/23/2012</b>	
NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR				3	REET ADDRESS, CITY, STATE, ZIP CODE 300 CHURCH STREET ZEIGLER, IL 62999	<u> </u>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W9999	* Visitors should be treatment and for 2 decrease the risk or decrease the risk or may in turn reinfest scabies to their fam * In addition to Stanuse Contact Precauresidents for 24 houdecrease the risk at transmission of scat *Treatment with a sparasitic infections; * All clothing, linens in hot water (above and dried in the hot the mites and their washed should be sealed plastic bag f * All environmental rugs, mattresses, p should be vacuume the following day to environment that cothe employees.  During the interview stated, "No" when a three individuals (R have been treated vinefectivity in both sasymptomatic resid asked if staff workin workshop had been scabicide. E1 said, facility had been defacility had cleaned	restricted on the day of 4 hours after treatment to f transmission. This action will f transmission to visitors who the resident or introduce illy or the community; idard/Universal Precautions, utions for all patients or ars after treatments to and prevent further bies to other residents or staff; cabicide to treat and kill and towels should be washed 122 degrees for 10 minutes) cycle of the dryer to eliminate eggs. Items which cannot be dry cleaned or placed in a or one week; and surfaces (floors, carpeting, illows, upholstered furniture) and on the day of treatment and eliminate viable mites in the build reinfest the residents and and of 02/02/12 at 9:50 A.M., E1 asked if the remaining twenty 27 - R41) living in the facility with a scabicide to eliminate	W99	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  14G048		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		B. WI	۱G		C <b>02/23/2012</b>			
NAME OF PROVIDER OR SUPPLIER  COLONIAL MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 300 CHURCH STREET ZEIGLER, IL 62999				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W9999	Z1 was asked if nur a local clinic and ho hospital and/or visit have been exposed facility have been n	ge 56 rsing staff at workshop, staff at pspital, staff at a Peoria county ors or other individuals that I to individuals living in the otified that the facility was for scabies, she stated, "No."  (A)	W9	999				