STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146086	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCOLA HEALTH CARE CENTER	1203 EGYPTIAN TRAIL TUSCOLA, IL 61953

(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 Annual Certification Survey Licensure/Bed Level Change Survey-Upgrade 52 Intermediate Care beds to Skilled Care beds Recommend upgrade of rooms 104 (1 bed), 108 (1 bed), 111 (3 beds), 112 (2 beds), 113 (3 beds), 116 (2 beds), 119 (3 beds), 208 (2 beds), 209 (3 beds), 212 (2 beds), 214 (2 beds), 215 (3 beds), 218 (2 beds), 307 (1 bed), 503 (2 beds), 504 (3 beds), 505 (2 beds), 509 (2 beds), 511 (2 beds), 512 (3 beds), 514 (3 beds), 515 (2 beds) and 520 (3 beds) effective 2-9-12.	F 000		
F 226 SS=C	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 operationalize its policy regarding screening of potential employees by not checking the Illinois Health Care Worker Registry for four of eight employees reviewed. This failure has the potential to affect all 53 residents residing in the facility. Findings include: On 02/08/12 at 10:00am the Pre-Employment Screening records for E2, Registered Nurse (RN), E3, RN, E6, Licensed Practical Nurse (LPN) and E7, LPN did not include documented evidence of a check of the Illinois Health Care	F 226		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146086	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCOLA HEALTH CARE CENTER	1203 EGYPTIAN TRAIL TUSCOLA, IL 61953

(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 226	Continued From page 1 Worker Registry. On 02/08/12 at 1:30pm, E1, Administrator, stated that he did not check the Illinois Health Care Worker Registry for E2, E3, E6, and E7. On 02/08/12 at 1:30pm E8, Regional Corporate Director, also confirmed that the Illinois Health Care Worker Registry was not checked for E2, E3, E6, and E7. The Facility Abuse Prevention Program policy directs the Facility to "Check the Illinois Health Care Worker Registry on all individuals being hired for a position" (revised 11/11/11). The Resident Census and Condition Report dated 02/07/12 documents the facility census is 53.	F 226		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide range of motion services for R4, one of two residents reviewed for range of motion and contractures, on the sample of 14. Findings include: R4's Range of Motion Assessment dated 1-18-12	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146086	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCOLA HEALTH CARE CENTER	1203 EGYPTIAN TRAIL TUSCOLA, IL 61953

(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 318	Continued From page 2	F 318		

states that R4 is at high risk for contractures and has contractures of bilateral shoulders and elbows and minimal limitations in range of motion of bilateral wrists, fingers, hips, knees, ankles, and toes.

R4's February 2012 Physician Order Sheet reflects that R4 has diagnoses including Degenerative Joint Disease, Pain, Trigeminal Neuralgia, and Multiple Sclerosis.

R4's 1-18-12 Minimum Data Set reflects that R4 is totally cognitively intact, has upper and lower extremity range of motion limitations on both sides, and is totally dependent on staff for all activities of daily living.

R4's Physician Order Sheet includes an order initiated on 7-9-11 for "Therapy-APROM BID (Active Passive Range of Motion twice daily) all extremities". R4's 1-25-12 Care Plan includes a problem statement that states "...requires total assist for all adl's (activities of daily living) r/t (related to) dx (diagnosis) of multiple sclerosis and progression of..." An approach/intervention includes "...Aprom bid..."

R4 stated on 2-7-12 at 2:30 p.m. that she has contractures of her hands and other joints. R4 stated that she does not participate in any range of motion or exercise program related to repetitious movement of her joints. R4 stated that she would attempt to participate in such activity but that such movement can be uncomfortable and painful. At this time R4 demonstrated the limited range of motion and contractures of her hands and fingers including the handroll placed in the palm of her right hand

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146086	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCOLA HEALTH CARE CENTER	1203 EGYPTIAN TRAIL TUSCOLA, IL 61953

(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 318	Continued From page 3 by staff. E4, Licensed Practical Nurse and Assessment Coordinator stated on 2-7-12 at 3:30 p.m. that R4 scored high on the range of motion assessment and should have a plan to address her range of motion to prevent or reduce contractures. According to E4 such program should include assisting R4 with range of motion with repetitious joint movements. E4 further stated that there was no documentation indicative that such range of motion was being completed.	F 318		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the medication error rate did not exceed five percent. The medication pass consisted of 45 opportunities of medications administered with five medication errors involving 4 residents (R7, R15, R16 and R17) resulting in a 11.11% medication error rate. R7 is one of 14 sampled residents. R15, R16, and R17 are supplemental residents. Findings include: 1. On 2/7/12 at 11:20 AM during medication pass E5, Licensed Practical Nurse (LPN), administered medications to R15 omitting ordered Natural Balance Tear Drops, one drop in	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146086	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCOLA HEALTH CARE CENTER	1203 EGYPTIAN TRAIL TUSCOLA, IL 61953

(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 332	Continued From page 4	F 332		

each eye four times daily.

2. On 2/7/12 at 11:32 AM during the medication pass E5 administered R16 Mi-Acid Liquid 30 ml (milliliters) before the noon meal. Physician's Orders Sheet (POS) dated 2/2012 states the medication Mi-Acid Liquid 30 ml to be taken three times daily 30 - 60 minutes after meals.

3. On 2/7/12 at 11:35 AM a blood glucose reading was done for R7 which read 226 mg/dl (milligram per deciliter.) The POS dated 2/2012 states R7 is to receive Humalog 100 u/ml (units per milliliter) per sliding scale. Per the order, for a glucose reading of 201 to 250 R7 is to receive 5 units of Humalog insulin. At 11:40 am on 2/7/12 E5 administered to R7 4 units of Humalog insulin.

4. The POS dated 2/2012 states R7 is to receive a scheduled dose of 14 units of Humalog 100 u/ml Insulin every day at 11 AM. E5 did not administer this medication during the medication pass.

5. On 2/8/12 at 11:05 AM E5 administered to R17 Dilantin 100 mg two capsules to equal 200 mg. The POS for R17 dated 2/2012 states R17 is to receive Dilantin 100 mg two capsules to equal 200 mg by mouth at 8 AM and 1 PM. R17 received this medication 55 minutes too soon per physician's orders.

On 2/7/12 at 3:55 PM E3, ADON (Assistant Director of Nurses) confirmed that R7 did have an order to receive 14 units of Humalog Insulin in addition to the sliding scale order of Humalog insulin. E3 also confirmed that R7 should received 5 units of Humalog Insulin for the sliding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146086	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCOLA HEALTH CARE CENTER	1203 EGYPTIAN TRAIL TUSCOLA, IL 61953

(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 332	Continued From page 5 scale reading of 226 mg/dl instead of 4 units. On 2/8/12 at 8:55 AM E5 confirmed that R15 did not receive her Natural Balance Tear Drops as ordered. E5 confirmed that E5 did give R16 his Mi-Acid before the meal instead of after the meal. E5 stated that she read the sliding scale wrong and administered the wrong amount of Humalog to R7 and R7 did not receive the 14 units of Humalog insulin as ordered by the Physician everyday at 12 Noon.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to administer a diabetes medication to R7, one of 14 sampled residents, resulting in a significant medication error. Findings include: The Physician's Order Sheet (POS) dated February 2012 for R7 includes the diagnosis, Diabetes Mellitus Type II. The 2/2012 POS states that R7 is to receive Humalog Insulin 100 u/ml (units / milliliter) SQ (subcutaneous) per sliding scale four times a day in the following amounts: Blood Glucose reading of 175 to 200 mg/dl (milligrams per deciliters) to receive 3 units, 201 to 250 to receive 5 units, 251	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146086	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCOLA HEALTH CARE CENTER	1203 EGYPTIAN TRAIL TUSCOLA, IL 61953

(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 333	Continued From page 6 to 300 to receive 7 units, 301 to 350 to receive 8 units and 351 to 400 to receive 10 units of Humalog Insulin. The POS also states R7 is to receive scheduled dosages of Humalog Insulin at the following times: 7 AM 8 units of Humalog Insulin, 12 Noon 14 units of Humalog Insulin and 5 PM 12 units of Humalog Insulin . On 2/7/12 at 11:35 AM a blood glucose reading was done for R7 which read 226 mg/dl (milligram per deciliter.) The POS dated 2/2012 states R7 receives Humalog 100 u/ml (units per milliliter) per sliding scale for the glucose reading of 201 to 250 to receive 5 units of Humalog insulin. At 11:40 a.m. on 2-7-12 E5 administered 4 units of Humalog insulin to R7. No additional Humalog Insulin was given at that time. On 2/7/12 at 3:55 PM E3, ADON (Assistant Director of Nurses) confirmed that R7 did have an order to receive 14 units of Humalog Insulin in addition to the sliding scale order of Humalog insulin. E3 also confirmed that R7 should have received 5 units of Humalog Insulin for the sliding scale reading of 226 mg/dl instead of 4 units. On 2/8/12 at 8:55 AM E5 stated that she read the sliding scale wrong and administered the wrong amount of Humalog to R7 and R7 did not receive the 14 units of Humalog insulin ordered by the Physician everyday at 12 Noon.	F 333		
F 441 SS=D	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	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146086	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCOLA HEALTH CARE CENTER	1203 EGYPTIAN TRAIL TUSCOLA, IL 61953

(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 441	Continued From page 7 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 infection. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that the environment, potentially contaminated with Clostridium difficile (C. diff)	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146086	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCOLA HEALTH CARE CENTER	1203 EGYPTIAN TRAIL TUSCOLA, IL 61953

(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 441	Continued From page 8	F 441		

organisms and spores, was effectively decontaminated and disinfected. This failure involved rooms occupied by residents R4 and R6, two of two residents reviewed for infection control on the sample of 14.

Findings include:

During the initial tour on 2-7-12 at 9:30 a.m. E4, Licensed Practical Nurse stated R6 was in contact isolation while being treated for a diarrheal illness diagnosed as Clostridium difficile. R6's Nurse's Notes dated 2-2-12 through 2-6-12 reflect documentation stating that R6 had loose, watery stools.

R6's most recent quarterly minimum data set dated 6-24-11 reflects that R6 is incontinent of bowel and bladder, is severely cognitively impaired, and is dependent on staff for all activities of daily living. A Clostridium difficile Toxin Assay dated 2-4-12 reflects "Positive for Clostridium difficile toxin A & B".

E2, Director of Nursing stated on 2-8-12 at 2:45 p.m. that R6 was moved to a private room and placed on isolation precautions on 2-4-12. E2 stated on 2-8-12 at 1:20 p.m. that it is facility policy to disinfect rooms with Clostridium difficile cases with a 1:10 bleach solution. E2 stated that the housekeeping department was notified of R6's C. diff status on 2-5-12.

E9, Housekeeping Supervisor stated on 2-8-12 at 11:55 a.m. that he was informed of R6's C. diff status on 2-7-12. E9 stated at this time that he had not yet implemented decontamination procedures using a chlorine (bleach) based

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146086	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCOLA HEALTH CARE CENTER	1203 EGYPTIAN TRAIL TUSCOLA, IL 61953

(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 441	Continued From page 9	F 441		

disinfectant. E9 stated he was aware of the need to use a bleach based disinfectant to eradicate C. diff (spores) and that he had been supplied written operating procedures specific to this. E9 stated that housekeepers were currently using a quaternary ammonia-based disinfectant cleaning agent for R6's bedroom. The quaternary ammonia compound manufacturer's labeling yielded no claim that this disinfectant was formulated to be effective against C. difficile spores.

E10, Housekeeper stated on 2-8-12 at 11:45 a.m. that she was aware that R6 was under isolation precautions but stated she did not know what for. E10 stated she decontaminates R6's bedroom with a quaternary ammonia based disinfectant cleaner. E10 stated she has not been using any chlorine based disinfectant in R6's bedroom or in R4's bedroom (who was just placed under isolation precautions on 2-8-12 for suspected C. diff infection).

E3, Assistant Director of Nursing stated on 2-8-12 at 12 noon that R4 was presenting with loose watery stools and was placed on contact precautions on 2-8-12. E2, Director of Nursing stated on 2-9-12 at 10 a.m. that R4 was having loose foul smelling stools and was being treated for suspected C. diff infection.

An operating policy dated 10-17-11 and titled "Clostridium Difficile (C-Diff) Infection" states "To help prevent the transmission of Clostridium Difficile (C-Diff) spores. The following precautions are to be used...Use contact precautions for residents with known or suspected C-Diff infection...Implement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146086	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUSCOLA HEALTH CARE CENTER	1203 EGYPTIAN TRAIL TUSCOLA, IL 61953

(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 441	Continued From page 10 Environmental Cleaning using a 1:10 bleach solution (1 part bleach to 9 parts water), to be completed daily, paying special attention to the bathroom area, handwashing areas, mattresses, floor and other hard surfaces....continue these precautions for 72 hours after cessation of diarrhea..."	F 441		