STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145978	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE ROSE CARE CENTER	1000 WEST SLOAN STREET HARRISBURG, IL 62946

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	Annual Licensure and Certification. 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		3/19/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/15/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145978	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE ROSE CARE CENTER	1000 WEST SLOAN STREET HARRISBURG, IL 62946

(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 225	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and record review the facility failed to investigate and report an allegation of abuse for 1 of 6 residents (R11) reviewed for abuse in the sample of 11. Findings include: An Abuse Investigation Questionnaire completed on 11-5 -15 by E1, (Administrator) and E6, (Housekeeping) as part of an abuse allegation investigation involving a resident no longer at the facility includes the question, " Do you know of any other residents who have experienced a similar problem or injury? " E6 ' s response is documented as " R11, E5 (Licensed Practical Nurse) kind of rough with talk, jerk shirt, and pull arm. " On 2/17/16 at 9:38 am E1 verified that he had documented this response by E6 on the above mentioned questionnaire. On 2/17/2016 at 3:35pm, E6 stated that during the completion of this questionnaire, E6 informed E1 that E6 had witnessed R11 walking into the nurse ' s station, and E5 was telling R11 that R11 should not be in this area, and R11 kept repeatedly asking " Why?". E6 further stated that E5 spoke loudly and close to R11 ' s face and said , because it ' s the damn nurse ' s station, also jerked R11 ' s shirt and pulled R11 ' s arm forcibly to lead her away from the nurse ' s station. During an interview on 2/18/2016 at 9:54 am, both E1, and E2, Director of Nursing, stated they did not consider E6 ' s comments as an abuse allegation because it was made while they were investigating another incident and also confirmed	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145978	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE ROSE CARE CENTER	1000 WEST SLOAN STREET HARRISBURG, IL 62946

(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 225	Continued From page 2 that they did not report it to Illinois Department of Public Health. At this same time, E2 stated that E2 did not believe E5 would willfully hurt anyone. When asked if E5 was interviewed about the alleged incident with R11, E2 stated, she believed she did and would locate the interview. On 2/18/2015 at 2:45pm, E2 stated that documentation could not be found of the above mentioned interview. On 2/18/2016 at 11:26 am per phone interview, E5 stated that she was not aware of any abuse allegations made concerning E5 and R11 and was not interviewed by anyone regarding such an allegation. On 2/19/2016 at 12:10 pm, E1 stated that a report has been sent to the Illinois Dept of Public Health regarding the allegation involving R11 that the investigation is in progress, and that E5 , who only works on Saturdays and Sundays, has been suspended until investigation completed.	F 225		
F 226 SS=D	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 interview and record review the facility failed to implement its Abuse Prevention Program policy for investigating and reporting allegations of abuse, for 1 of 6 residents (R11) reviewed for abuse in the sample of 11. Findings Include:	F 226		3/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145978	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE ROSE CARE CENTER	1000 WEST SLOAN STREET HARRISBURG, IL 62946

(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 3	F 226		

An , Abuse Investigation Questionnaire completed on 11-5 -15 by E1, (Administrator) and E6, (Housekeeping) as part of an abuse allegation investigation involving a resident no longer at the facility includes the question, " Do you know of any other residents who have experienced a similar problem or injury? " E6 ' s response is documented as " R11, E5, (Licensed Practical Nurse) kind of rough with talk, jerk shirt, and pull arm. " On 2/17/16 at 9:38 am, E1 verified that he had documented this response by E6 on the above mentioned questionnaire. On 2/17/2016 at 3:35pm, E6 stated that during the completion of this questionnaire, E6 informed E1 that E6 had witnessed R11 walking into the nurse's station, and E5 was telling R11 that R11 should not be in this area, and R11 kept repeatedly asking " Why?". E6 further stated that E5 spoke loudly and close to R11's face and said , because it's the damn nurse' s station, also jerked R11's shirt and pulled R11's arm forcibly to lead her away from the nurse's station.

During an interview on 2/18/2016 at 9:54 am, both E1 and E2, (Director of Nursing) stated they did not consider E6's comments as an abuse allegation because it was made while they were investigating another incident and also confirmed that they did not report it to Illinois Department of Public Health. At this same time, E2 stated that E2 did not believe E5 would willfully hurt anyone. When asked if E5 was interviewed about the alleged incident with R11, E2 stated, she was sure she did and would locate the interview. On 2/18/2015 at 2:45pm, E2 stated that documentation could not be found of the above mentioned interview.

On 2/18/2016 at 11:26 am per phone interview, E5 stated that she was not aware of any abuse allegations made concerning E5 and R11 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145978	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE ROSE CARE CENTER	1000 WEST SLOAN STREET HARRISBURG, IL 62946

(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 4 was not interviewed by anyone regarding such an allegation. On 2/19/2016 at 12:10 pm, E1 stated that a report has been sent to the Illinois Department of Public Health regarding the allegation involving R11 and that the investigation is in progress, and that E5 , who only works on Saturdays and Sundays, has been suspended until the investigation is completed. A document titled Abuse Prevention Program , Facility Policy, revised 11/11/11, includes on page 6, Section V1. Appointing an Investigator. Once the administrator or designee receives an allegation of mistreatment of, neglect or abuse, including injuries of unknown source and misappropriation of property; the administrator will appoint a person to take charge of the investigation. This same document includes on page 7, V11. External Reporting of Potential Abuse 1. Initial Reporting of Allegations. The facility must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, misappropriation of resident property, and reasonable suspicion of a crime reported immediately to the administrator of the facility and to other officials in accordance with the State Law through established procedures.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279		3/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145978	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE ROSE CARE CENTER	1000 WEST SLOAN STREET HARRISBURG, IL 62946

(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 279	Continued From page 5	F 279		

medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on interview, observation and record review, the facility failed to include care plan interventions for pressure relief, and an anchoring device for an indwelling catheter, for one of eleven residents (R5) reviewed for care plans in the sample of 11.
Findings include:
The pressure ulcer log with measurements for October, 2015, lists R5 as having an unstageable vascular ulcer to right heel, measuring 3.0 cm length, by 3.0 cm width dated October 16, 2015, and according to the care plan on 10/16/2015, R5 has an un-stageable vascular ulcer to right heel due to poor circulatory status, and that same care plan lists a diagnosis of " Bullous Pemphigold " on October 28, 2015.
Wound physician notes dated December 28, 2015, January 25, 2016, and February 15, 2016 for R5 states under " Off-Loading - Other - heels floating when in bed, pressure off of wound site. "
Observations on February 16, 2016 at 11:09 AM, February 17, 2016 at 8:05 AM, and February 18,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145978	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE ROSE CARE CENTER	1000 WEST SLOAN STREET HARRISBURG, IL 62946

(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 279	Continued From page 6	F 279		

2016 at 11:00 AM R5 ' s heels were touching the geriatric chair and there were no pillows under her legs, to keep her heels from touching the foot rest of the geriatric chair.
On February 19, 2016 at 11:20 AM, E7, Certified Nurse ' s Aide states " Her heel is not suppose to touch this (pointing to the leg support dad on the geriatric chair), she is to have a pillow under her leg to float her heel. "
R5 ' s undated care plan has no interventions regarding floating, off loading or preventing R5 ' s heels from having pressure on them.

Based on R5's admission note, R5 was readmitted from a local hospital on December 13,2015 with an indwelling urinary catheter.
On February 17, 2016 at 9:25 AM during a catheter care observation, R5 did not have an anchor for the indwelling urinary catheter tubing, which would prevent excess tension on the catheter tubing.
During a catheter care observation on February 17, 2016 at 9:25 AM, prior to catheter care beginning, R5 moaned, as if in pain, while being rolled on her right side to remove a mechanical lift sling and E8, Certified Nurses Aide, quickly adjusted the catheter tubing and R5 stopped moaning.
During an interview on February 17, 2016 at 9:25 AM, E9, Certified Nurse ' s Aide states " She is suppose to have a leg strap, she probably got it dirty, I need to go get one. "
The facility Catheter Care policy dated January, 2002 does not include anchoring devices as part of the facility catheter care.
On February 18, 2016 at 3:00 PM E2 states " Our policy does not include an anchor for catheters. "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145978	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE ROSE CARE CENTER	1000 WEST SLOAN STREET HARRISBURG, IL 62946

(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 315	Continued From page 7	F 315		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent excess tension and anchor an indwelling urinary catheter for one of three residents (R5) reviewed for catheters in a sample of 11. The findings include: Based on the Admission Record, R5 is 94 years old, admitted from a local hospital on December 13, 2015 with an indwelling urinary catheter. The Minimum Data Sets (MDS) dated December 28, 2015, lists R5 with a Brief Interview for Mental Status (BIMS) score of 04, which indicates R5 has severe cognitive impairment. The pressure ulcer log with measurements for February 12, 2016, lists R5 as having a stage III vascular ulcer to right heel, measuring 7.6 cm length, by 7.4 cm width by 0.4 depth and according to the care plan, a diagnosis of " Bullous Pemphigold " was added on October 28, 2015. On February 17, 2016 at 9:25 AM during a catheter care observation, R5 did not have an anchor for the indwelling urinary catheter tubing,	F 315		3/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145978	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE ROSE CARE CENTER	1000 WEST SLOAN STREET HARRISBURG, IL 62946

(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 315	Continued From page 8 which would prevent excess tension on the catheter tubing. During a catheter care observation on February 17, 2016 at 9:25 AM, prior to catheter care beginning, R5 moaned, as if in pain, while being rolled on her right side to remove a mechanical lift sling and E8, Certified Nurses Aide, quickly adjusted the catheter tubing and R5 stopped moaning. During an interview on February 17, 2016 at 9:25 AM, E9, Certified Nurse ' s Aide states " She is suppose to have a leg strap, she probably got it dirty, I need to go get one. " The facility Catheter Care policy dated January, 2002 does not include anchoring devices as part of the facility catheter care. On February 18, 2016 at 3:00 PM E2 (Director of Nurses) states " Our policy does not include an anchor for catheters. "	F 315		
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 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.	F 441		3/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145978	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE ROSE CARE CENTER	1000 WEST SLOAN STREET HARRISBURG, IL 62946

(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 (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 observation, and interview the facility failed to properly protect themselves from indirect transmission of clostridium difficile (C-diff) and to post a notice with instructions to report to nurses station prior to entering isolation room for one of two residents (R6) reviewed for infections in a sample of 11. The findings include: On February 16, 2016 at 10:10 AM during initial tour, E3 (Licensed Practical Nurse) reported R6 was on contact isolation for C-diff. and stated this surveyor could "enter the room without protective covering as long as I did not touch anything in the room." On 2/17/2016 at 10:30 am, E2, Director of Nursing, stated if a resident needs isolation	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145978	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE ROSE CARE CENTER	1000 WEST SLOAN STREET HARRISBURG, IL 62946

(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	F 441		

precautions there should be a sign on the door of the resident's room instructing visitors to report to the Nurses Station before entering the room. On 2/16/2016 at 11:41 am and on 2/17/2016 at 9:50 am, no such sign was noted on the door or near the entrance to R6's room.

On February 16, 2016 at 12:45 PM E3, entered R6's room to provide " Artificial Tears 1.4% " eye drops. E3 entered R6's room, put on a paper gown located on the empty bed in the room, put on gloves, placed a tissue on the overbed table, placed the drops on top of the tissue, and then placed the drops into R6's eyes as prescribed. E3 then removed picked up the tissue, eye drop container, and removed her gloves, and placed the tissue, and gloves into the trash located on the side of the medication cart, leaving the residents room without washing hands. E3 then obtained an alcohol based hand sanitizer from E3's pocket and rubbed onto each hand, and continued medication pass.

On February 16, 2016 at 4:05 PM E4, Licensed Practical Nurse entered R6's to place eye drops into R6's eyes, entered R6's room without a gown, took gloves into the room, put the eye drop box containing the eye drops on the overbed table while putting down a towel barrier, picked up the eye drop container and placed the eye drop container onto the towel, put on gloves, opened the eye drop container placed the eye drops into R6 ' s eyes then put the eye drop bottle on the over bed table off the towel barrier. Removed the gloves, put the eye drop bottle into E4's uniform pocket, picked up the barrier, and placed it into the resident's linen container in the room, washed her hands, left the room and took the eye drop bottle from her uniform pocket and placed it into the medication cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145978	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE ROSE CARE CENTER	1000 WEST SLOAN STREET HARRISBURG, IL 62946

(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 458	Continued From page 11	F 458		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to provide at least 80 square feet of floor space in 12 of 13 four bed resident bedrooms, with 1 of the rooms being used for Therapy, but could be used as a four bed resident bedroom in the facility. This had the potential to affect 7 of 7 residents (R1, R3, R4, R5, R7, R8, R10) reviewed for undersized rooms in a the sample of 11, and 14 residents (R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R33, R34, R35)in the supplemental sample. Findings Include: 1. Review of these rooms on 2/17/16 at 11:45 am to 12:15 pm, documents that room 213 is used as a therapy room. All other rooms are four bed resident rooms. 2. E1, (Administrator) verified the information during interview on 2/17/16 at 1:00 pm, R7 and R12 stated that they had enough room for their personal belongings, and no complaints regarding space. 3. Observations on 2/17/16 at 11.45 am to 12:15 pm indicated these rooms provide space for personal items and care items. 4. Residents in these rooms according to the facility ' s Resident Rooms List provided 2/17/16 are R1, R3, R4, R5, R7, R8, R10, R12, R13, R14,	F 458		3/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145978	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE ROSE CARE CENTER	**1000 WEST SLOAN STREET HARRISBURG, IL 62946**

(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 458	Continued From page 12 R15, R16, R17, R18, R19, R20, R21, R22, R33, R34, R35.	F 458		