STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145964	A. BUILDING _____ B. WING _____	04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEANSBORO REHABILITATION & HCC	405 WEST CARPENTER MCLEANSBORO, IL 62859

(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/Certification Survey 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	F 225		

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

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
	145964	A. BUILDING _____ B. WING _____	04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEANSBORO REHABILITATION & HCC	405 WEST CARPENTER MCLEANSBORO, IL 62859

(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 days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure staff immediately report to their administrator and Illinois Department of Public Health (IDPH) a possible resident abuse as required by State law for 1 of 8 residents (R1) reviewed for abuse in the sample of 8. Findings include: An incident report dated 2-24-13 by E1, Administrator, documented R1 was noted to have upper right eyelid bruising at 2:45AM on 2-23-13. Page one of two of the Facility's Five Day Alleged Abuse/Neglect IDPH Report completed by E1 on 2-25-13, indicated E1, (Administrator, Abuse Coordinator), became aware of the bruise at 10:26PM on 2-23-13. (7 hours and 51 minutes later) This report indicates during a routine bed check at approximately 2:45AM on 2-23-13, a CNA (E6, Certified Nurse Aide), observed a bruise on the right upper eyelid of the resident (R1) who was lying in her bed. The reports states, " She advised the charge nurse, (E7, Licensed Practical Nurse), who initiated the investigative report. The MD (Medical Doctor) and POA (Power of Attorney)were notified, as well as the DON (Director of Nursing) and Administrator. After interviewing witnesses, it was determined that the bruise was not caused	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145964	A. BUILDING _____ B. WING _____	04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEANSBORO REHABILITATION & HCC	405 WEST CARPENTER MCLEANSBORO, IL 62859

(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 from willful act of physical abuse, but rather from contact with a surface." On page two of two of the Alleged Abuse/Neglect IDPH Report, E1 notes E2, (Director of Nursing) was informed at 10:07PM on 2-23-13 (7 hours and 32 minutes after the observation by E5) and IDPH was faxed at 4:07PM on 2-24-13. (37 hours and 22 minutes after the observation by E5) The Facility's failure to ensure staff immediately report suspicious bruising was confirmed with E1 at 4PM on 4-9-13.	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 record review and interview the facility failed to follow their policy by reporting immediately to their Administrator and Illinois Department of Public Health (IDPH) a possible resident abuse for 1 of 8 residents (R1) reviewed for abuse in the sample of 8. Findings include: 1. An incident report dated 2-24-13 by E1, (Administrator), indicated R1 was noted to have upper right eyelid bruising at 2:45AM on 2-23-13.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145964	A. BUILDING _____ B. WING _____	04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEANSBORO REHABILITATION & HCC	405 WEST CARPENTER MCLEANSBORO, IL 62859

(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 Page one of two of the facility's Five Day Alleged Abuse/Neglect IDPH Report completed by E1 on 2-25-13, indicated E1, (Administrator, Abuse Coordinator), became aware of the bruise at 10:26PM on 2-23-13. (7 hours and 51 minutes later) This report indicates during a routine bed check at approximately 2:45AM on 2-23-13, a CNA (E6, Certified Nurse Aide), observed a bruise on the right upper eyelid of the resident (R1) who was lying in her bed. The reports states, " She advised the charge nurse, (E7, Licensed Practical Nurse), who initiated the investigative report. The MD (Medical Doctor) and POA (Power of Attorney)were notified, as well as the DON (Director of Nursing) and Administrator. After interviewing witnesses, it was determined that the bruise was not caused from willful act of physical abuse, but rather from contact with a surface." On page two of two of the Alleged Abuse/Neglect IDPH Report, E1 notes E2, (Director of Nursing) was informed at 10:07PM on 2-23-13 (7 hours and 32 minutes after the observation by E5) and IDPH was faxed at 4:07PM on 2-24-13. (37 hours and 22 minutes after the observation by E5) The Facility's Abuse Prevention Program Policy dated 11-11-11 includes on page 5 paragraph 1, employees are required to immediately report any occurrences of potential/alleged mistreatment of residents they observe, hear about or suspect to a supervisor and the administrator. Page 5, paragraph 4 states supervisors shall immediately inform the administrator or his/her designated	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145964	A. BUILDING _____ B. WING _____	04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEANSBORO REHABILITATION & HCC	405 WEST CARPENTER MCLEANSBORO, IL 62859

(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 representative (specified by the administrator in the case of a a planned absence) of all reports of potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property. The Facility's failure to ensure staff immediately report suspicious bruising as noted in their policy was confirmed with E1 at 4PM on 4-9-13.	F 226		
F 332 SS=D	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 administer medications at the right times ordered by the Physician, and did not dispense one medication in the appropriate form. There were 42 opportunities with 3 errors resulting in a 7.14% medication error rate. The errors involved 1 (R1) in the sample of 8 and two residents (R9 and R10) in the supplemental sample. Findings include: 1. On 04/08/13 at 12:00 noon, E9 Licensed Practical Nurse (LPN) gave R9 Reglan 5 mg (milligram) tablet 1 po (by mouth) ac (before meals) while R9 was eating lunch. The Physician Orders dated 04/2013 document that R9 is to get Reglan 5 mg 1 po ac.	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145964	A. BUILDING _____ B. WING _____	04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEANSBORO REHABILITATION & HCC	405 WEST CARPENTER MCLEANSBORO, IL 62859

(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 2. On 04/09/2013 at 3:53 PM, E9 gave R10 Calcium Carbonate 600 mg/Vitamin D 400 IU (International Units) 1 po in R10's room. The Physician Orders dated 04/2013 document that R10 is to get Calcium Carbonate 600 mg/Vitamin D 400 IU 1 by mouth twice a day with meals. 3. On 04/08/2013 at 2:55 PM, E10 Registered Nurse (RN) removed the outer coating of the Phenytoin Sodium Extended 100 mg capsule and put the contents of the capsule into applesauce to "break down". E 10 stated that R1 doesn't swallow well. 4. On 04/10/2013 at 10:00 AM, E11 (Pharmacist) stated that Phenytoin Sodium Extended capsules should not be crushed or opened.	F 332		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview the facility failed to ensure milk based nutritional supplements are maintained and served at safe temperatures for 1 of 1 resident	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145964	A. BUILDING _____ B. WING _____	04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEANSBORO REHABILITATION & HCC	405 WEST CARPENTER MCLEANSBORO, IL 62859

(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 371	Continued From page 6 (R1) reviewed for a Physician ordered nutritional supplement in the sample of 8 and 2 residents (R11 and R12) in the supplemental sample. Findings include: 1. On 4-8-13 at 11:30AM, E9, Licensed Practical Nurse, LPN, obtained an unopened 32 ounce carton of Med Pass 2.0 Supplement from the refrigerator and placed it in a holding container with 2 chilled gel packs then placed it on top of the medication cart. The ingredient label on the carton noted milk protein as the third ingredient. The carton was opened around 11:37AM and 60cc poured out for R12. At 3:49PM the Med Pass Supplement was still on the med cart and the gel packs were not cool to touch. A temperature of 64.7 degrees Fahrenheit was obtained on the milk based supplement with a digital thermometer calibrated on 4-3-13. At 4PM on 4-8-13, E10, Registered Nurse, RN, placed the unused supplement back into the refrigerator. 2. The failure to ensure the supplement was maintained at a safe temperature was confirmed with E1, Administrator, at 4:10PM on 4-10-13.	F 371		
F 431 SS=C	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145964	A. BUILDING _____ B. WING _____	04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEANSBORO REHABILITATION & HCC	405 WEST CARPENTER MCLEANSBORO, IL 62859

(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 431	Continued From page 7 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to keep the Medication Cart free of loose unlabeled medications and failed to keep the Medication Cart and Treatment Cart in clean and sanitary condition. This has the potential to affect all 19 residents in the facility. Finding include: 1. On 04/08/13 at 2:00 PM, the medication cart was observed. The second and third drawers	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145964	A. BUILDING _____ B. WING _____	04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEANSBORO REHABILITATION & HCC	405 WEST CARPENTER MCLEANSBORO, IL 62859

(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 431	Continued From page 8 were observed to have multiple loose pills and capsules in the bottom of the drawers along with small foil coverings and rubber bands. The bottom of the drawers were also observed to have a large amount of loose brown and white residue. 2. On 04/08/13 at 2:15 PM, the Treatment Cart was observed. The bottom drawer was pulled out and the base of the cart was noted to have a large amount of dust and scattered brown residue. The outside base of the cart was also observed to have a moderate amount of dust and brown debris. 3. On 04/11/13 at 1:00PM, E2, Director of Nurses, stated the Medication Cart was not to have loose pills in the drawers and the Medication Cart and Treatment Cart are to be kept clean. 4. The Resident's Census and Conditions of Residents, CMS 672, dated 04/09/13 documents that the facility has 19 residents living in the facility.	F 431		
F 441 SS=E	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	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145964	A. BUILDING _____ B. WING _____	04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEANSBORO REHABILITATION & HCC	405 WEST CARPENTER MCLEANSBORO, IL 62859

(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 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 record review, observation and interview, the facility failed to use proper hand washing technique, failed to properly store and label resident's personal supplies, and failed to properly disinfect blood glucose meters for 4 residents (R1, R2, R5, R6) observed for infection control in the sample of 8 and 2 residents (R9, R13)) in the supplemental sample.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145964	A. BUILDING _____ B. WING _____	04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEANSBORO REHABILITATION & HCC	405 WEST CARPENTER MCLEANSBORO, IL 62859

(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 Finding include: 1. On 04/08/13 at 12:00PM, E9, Licensed Practical Nurse (LPN). was observed passing medications in the dining room. E9 administered R9's oral medications and then began preparing medications for R2 without washing her hands. At 12:07PM, E9 adminstered R2's crushed oral medication in applesauce with a spoon. E9 wiped R2's mouth by using his clothing protector, then returned to the medication cart, and proceeded to prepare R1's oral supplement without washing her hands. At 12:11PM, E9 administered R1's oral supplement. R1 began coughing while drinking the supplement, E9 took R1's clothing protector, and covered R1's mouth. E9 then returned to the medication cart, and prepared R4's oral medication without washing her hands. 2. On 04/08/13 at 2:55PM, E10, Registered Nurse (RN), was observed preparing R1's oral Phenytoin Sodium Extended 100 milligram capsule for administration. Without wearing gloves, E10 opened the capsule and placed the contents in applesauce. 3. On 04/08/13 at 11:20AM, a 4 ounce plastic cup filled with blue liquid was observed sitting on the floor in the west hall shower. A plastic bottle filled with a blue liquid labeled "Perineal Wash" was observed on a wire rack hanging on the shower wall along with several bottles of shampoo. Some of the bottles of shampoo had resident's names and others did not. The perineal wash was labeled with an illegible residents name and March, 2013 date. The shampoo bottles were not labeled with residents names. On 04/08/13 at 11:25AM, E12, Certified Nurse	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145964	A. BUILDING _____ B. WING _____	04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEANSBORO REHABILITATION & HCC	405 WEST CARPENTER MCLEANSBORO, IL 62859

(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 11 Aide (CNA), stated that some residents have there own personal shampoo and each resident has there own perineal wash that is stored in the Clean Utility Room. E12 stated they use a small plastic cup to transport body wash/shampoo to the shower for resident use and this is taken from a multiple use bottle that is stored in the Clean Utility Room. 4. On 04/08/13 at 11:30AM, the Clean Utility Room was observed. The top left cabinet drawer was observed to have several black combs with a small amount of white residue in the teeth. One comb was noted to have hair in the teeth. One brush was also observed in the drawer to have hair in the bristles. There were no names observed on the any of these hair supplies. E12 stated at 11:35AM that each resident has there own brush and comb and this drawer is where the new brushes and combs are stored. The top left drawer was also observed to have 2 tubes of dental paste. The paste was not labeled with a resident's name. The top right drawer was observed to have 2 tubes of dental paste and 2 tubes of toothpaste. The tubes were not labeled with a resident's name. E12 stated that the resident's dentures are cleaned in this room by the night shift staff and residents have tooth paste in their room. 5. On 04/10/13 at 3:00PM, E3 (RN) stated the perineal wash is not taken into the resident's room. E3 also states the CNA's use a cart to transport incontinent care supplies down the hall and the perineal wash is prepared for use outside the resident's room. E3 stated the CNA's place the wash back in the Clean Utility Room after it is used. On 04/10/13 at 3:05PM, the Clean Utility	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145964	A. BUILDING _____ B. WING _____	04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEANSBORO REHABILITATION & HCC	405 WEST CARPENTER MCLEANSBORO, IL 62859

(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 12 Room was observed. The top right cabinet drawer was observed to have 1 tube of toothpaste that was almost empty and 2 tubes of dental paste. The tubes were not labeled with resident's names. 6.On 04/11/13 at 9:00AM the Clean Utility Room was observed. The top right cabinet drawer was observed to have 6 tubes of dental paste and 1 tube of toothpaste that was almost empty and 1 tube of toothpaste that was almost completely full. The tubes were not labeled with resident's names. 7. On 04/11/13 at 9:05AM, E3 stated that the dentures are cleaned in the Clean Utility Room. E3 stated that only one resident uses the dental paste and it is in that resident's room. E3 stated she did not know where the dental paste came from and needed to verify what the night shift CNA is using to clean the dentures. E3 also stated that each resident is to have their own toothpaste. 8. On 04/09/13 at 11:30AM, E5 (CNA) was observed providing perineal care on R2. E5 used a bottle of "Perineal Wash" that was labeled with R2's name. This wash was carried into the resident's room. 9. On 04/09/13 at 3:20PM, E12 (CNA) was observed providing catheter care on R5. E12 used a bottle of "Perineal Wash" that was labeled with R5's name. This wash was carried into the resident's room. On 04/11/13 at 9:05AM, E3 stated the CNA's are not to carry the wash into the resident's room.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145964	A. BUILDING _____ B. WING _____	04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEANSBORO REHABILITATION & HCC	405 WEST CARPENTER MCLEANSBORO, IL 62859

(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 13 10. On 04/08/13 at 12:00PM, R6 was observed sitting in the dining room in her wheelchair. R6's lap cushion was observed sitting on the floor. 11. On 04/08/13 at 2:00PM, E9 stated that a "Sani-Cloth" is used to clean the blood glucose meters between resident use. The "PDI Sani-Cloth Bleach Wipe" was observed and the label failed to indicate it is a disinfectant. 12. On 04/10/13 at 3:30PM, E2, Director of Nurses, stated she has two types of PDI Sani-Cloths in the facility and the one that is currently being used is not the correct cloth to be used for meter disinfecting. E2 stated that R6 and R13 are the only residents currently using blood glucose monitoring in the facility.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145964	A. BUILDING _____ B. WING _____	04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEANSBORO REHABILITATION & HCC	405 WEST CARPENTER MCLEANSBORO, IL 62859

(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 514	Continued From page 14 Based on record review, and interview the facility failed to maintain complete and accurate clinical records regarding medication use for 1 resident (R5) reviewed for accuracy of medical records in the sample of 8. Findings include: The Physician's Orders dated March, 2013 and April, 2013 document that R5 can have Norco 5/mg (milligram) one tablet po (by mouth) every four hours as needed for moderate pain and Norco 5/325mg two tablets every 4 hours as needed for severe pain. The Facility's "Controlled Substances Proof Of Use" form dated March, 2013 documents that R5 was given: Norco 5/325mg one tablet po on 03/27/13 at 11:15AM. However, the Medication Administration Record (MAR) dated March, 2013 does not document the medication was administered. Norco 5/325mg one tablet po on 03/27/13 at 4:00PM. The March 2013 MAR does not document the medication was administered. Norco 5/325mg one tablet po on 04/02/13 at 1:00PM. The MAR dated April 2013 does not document Norco 5/325mg one po was given. Norco 5/325mg one tablet po on 04/03/13 at 2:00PM. The April 2013 MAR does not document the medication was administered. Norco 5/325mg one tablet po on 04/06/13 at	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145964	A. BUILDING _____ B. WING _____	04/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLEANSBORO REHABILITATION & HCC	405 WEST CARPENTER MCLEANSBORO, IL 62859

(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 514	Continued From page 15 8:00PM. The April 2013 MAR documents that Norco 5/325mg one tablet was given and Norco 5/325mg two tablets were given. On Norco 5/325mg one tablet po on 04/07/13 at 5:10AM. The April 2013 MAR does not document the medication was given. On 04/11/13 at 11:00AM, E2, Director of Nurses, stated the clinical records are not accurate. E2 stated she has reviewed the Nurse's Notes and the Pain Management Flow Sheets and they have inconsistencies, and do not accurately reflect the medication R5 received.	F 514		