## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/17/2016 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|--|--|--|-----|---|-------------------------------|----------------------------|
|   |  | 146002   | B. WING                                |     |   |                               | C<br><b>16/2016</b>        |
| NAME OF PROVIDER OR SUPPLIER                        |  |  |  |     | STREET ADDRESS, CITY, STATE, ZIP CODE   | 03/                           | 10/2010                    |
| DAYSTAR NURSING & REHAB CENTER                      |  |  |  | :   | 2001 CEDAR STREET<br>CAIRO, IL 62914  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREFI<br>TAG                     |     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINE DEFICIENCY) | D BE                          | (X5)<br>COMPLETION<br>DATE |
| F 000   | INITIAL COMMENTS   |  | F 000                                  |     |   |                               |                            |
| F 465<br>SS=D                                       | Complaint Investigation 1651372 / IL 84010.<br>483.70(h)<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABL<br>E ENVIRON   |  | F۷                                     | 165 | 5   |                               |                            |
|   |  | ovide a safe, functional, ortable environment for the public.  |  |     |   |                               |                            |
|   | by: Based on observate review, the facility for the toilet, maintal clean and failed to cigarette butts for ordining room exit in Alzheimer's Unit. The findings included During initial tour of at 8:15 AM, the Alzebathroom was note not connected to the and forth on the toil streaks on the tile at and brown, yellowist toilet. Black dust ar left of the toilet in froown and grayish | ition, interview and record ailed to secure the toilet seat in the tile, keep the bathroom keep the smoking area free of one of one bathroom and the garden area on the e:  If the facility on March 15, 2016 theimer's Unit community d to have the toilet seat was e toilet and was moving back let easily. There were brown above the toilet paper holder sh orange stains around the aid dirt was in the corners to the ont and behind the toilet, material was noted on a wire ectrical outlet the bathroom |  |     |   |                               |                            |
| ADODATOS  | heater is plugged in<br>that touch the floor<br>right of the toilet se<br>On March 15, 2016<br>was noticed in the a<br>cleaning, and the b   | n, and there was broken tile<br>on the wall behind and to the<br>at.<br>at 10:45 AM, a housekeeper<br>above mentioned bathroom<br>rown streaks on the wall to the  | MATURE                                 |     | TITLE   |                               | (Ve) DATE                  |
| FAROKATOK,  | Y DIRECTOR'S OR PROVID   | DER/SUPPLIER REPRESENTATIVE'S SIGI   | NATURE                                 |     | 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.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/17/2016 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |         | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|--|---|---------|-------------------------------|--|
|  |  |  |  |   |         | С                             |  |
|  |  | 146002   | B. WING                                |   |         | /16/2016                      |  |
| NAME OF PROVIDER OR SUPPLIER  DAYSTAR NURSING & REHAB CENTER |  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE 2001 CEDAR STREET CAIRO, IL 62914                             | Ē       |                               |  |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  |  | IX (EACH CORRECTIVE ACTION SH   | OULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 465  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  | F 4                                    | ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUTH TAG CROSS-REFERENCED TO THE APP |         | ILD BE COMPLÉTION             |  |

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/17/2016 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (X3) DAT | (X3) DATE SURVEY<br>COMPLETED |  |
|---|----------------------|--|--|--|----------|-------------------------------|--|
|   |                      | 146002   | B. WING                                |  |          | С                             |  |
| NAME OF F   | PROVIDER OR SUPPLIER |  | b. Wild                                | STREET ADDRESS, CITY, STATE, ZIP CODI  |          | /16/2016                      |  |
| NAME OF F   | THOUDER OR SUPPLIER  |  |  | 2001 CEDAR STREET                      | =        |                               |  |
| DAYSTAI   | R NURSING & REHA     | B CENTER   |  | CAIRO, IL 62914                        |          |                               |  |
| (X4) ID   | SUMMARY ST           | ATEMENT OF DEFICIENCIES                                    | ID                                     | PROVIDER'S PLAN OF CORRE               | CTION    | (X5)                          |  |
| PREFIX<br>TAG                                       | (EACH DEFICIENC      | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFI<br>TAG                           | EFIX (EACH CORRECTIVE ACTION SHOULD BE |          | COMPLETION<br>DATE            |  |
|   |                      |  | ı                                      |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |
|   |                      |  |  |  |          |                               |  |