STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003420	A. BUILDING: _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE REHAB & HC	5533 NORTH GALENA ROAD PEORIA HEIGHTS, IL 61614

(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigations: 2328809/IL165796 2328927/IL165931	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1230c) 300.1230d) Section 300.1230 Direct Care Staffing c) A minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. (Section 3-202.05(e) of the Act) d) The minimum staffing ratios shall be increased to 3.8 hours of nursing and personal care each day for a resident needing skilled care and 2.5 hours of nursing and personal care each day for a resident needing intermediate care. (Section 3-202.05(d) of the Act) These requirements were not met as evidenced by: Based on interview and record review, the facility failed to meet the minimum required Registered	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003420	A. BUILDING _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE REHAB & HC	5533 NORTH GALENA ROAD PEORIA HEIGHTS, IL 61614

(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) COMPLETE DATE
S9999	Continued From page 1 Nursing, Licensed Nursing and direct care staffing hours for two of three selected days. This has the potential to affect all 54 residents in the facility. Findings include: The facility's Nurse Staffing policy (undated) documents the following: "It is the policy of (facility) to provide sufficient licensed and unlicensed nursing staff on each shift of the day to attain or maintain the highest practical physical, mental and psychosocial well-being of each resident. Nursing staff shall be based upon resident evaluation by the Administrator and Director of Nursing as specified by the (State Agency). Each skilled care resident shall receive at least 3.8 hours of nursing and personal care each day, and 2.5 hours of nursing and personal care each day for a resident needing intermediate care. A minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time by Registered Nurses. Registered Nurses and Licensed Practical Nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. The division of nursing needs by shift will be calculated based on resident census and needs". On 10/30/23, V1 (Administrator in Training) provided copies of the facility's Daily Staffing Assignment sheets (dated 10/01/23 - 10/25/23), which indicate the length of time and location of the staff members working for each day. V1 noted the facility's census with a breakdown of the census into skilled and intermediate residents. V1 stated the facility determines their minimum requirements based on the numbers	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003420	A. BUILDING: _____ B. WING _____	C 10/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE REHAB & HC	5533 NORTH GALENA ROAD PEORIA HEIGHTS, IL 61614

(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) COMPLETE DATE
S9999	Continued From page 2 stated in their staffing policy. The Daily Staffing Assignment Sheets (dated 10/15/23 and 10/16/23) both document a census of 56, with four residents determined to be skilled care, and 52 residents determined to be intermediate care. Based on the calculations in the facility's staffing policy, the facility should have had 142.5 hours of total direct care hours, 36.3 hours of licensed nurses working, and 14.5 hours of Registered Nursing hours. The Daily Staffing Assignment Sheets (dated 10/15/23 and 10/16/23) both document the following: the facility had a total of 132 total direct care hours, 36 hours of licensed nurses, and 12 hours of Registered Nursing hours. On 10/31/23 at 11:45 AM, V1 (Administrator in Training) confirmed the facility was short on their minimum staffing requirements noted in their Nurse Staffing policy for 10/15/23 and 10/16/23. The facility's Resident Census and Conditions of Residents form, provided by V1 on 10/30/23, indicates that 54 residents are currently residing in the facility. (C)	S9999		