PRINTED: 09/09/2015 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING IL6012157 08/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 509 SOUTH BUCK ROAD, PO BOX 149 **LEROY MANOR** LE ROY, IL 61752 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) \$9999 Final Observations S9999 STATEMENT OF LICENSURE VIOLATIONS: 300.670 Disaster Preparedness c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other that fire shall be held twice annually for each shift of facility personnel. This requirement was not met as evidenced by the following: Based on record review and interview, the facility failed to ensure that least two disaster drills were conducted on night shift. These failures have the potential to affect all 71 residents. Findings include: The facility's fire and disaster drills records were reviewed for the past 12 months. Disaster drills were not documented for the night shift (10:00 P.M. to 6:00 AM). E5, Maintenance Director stated on 8-4-15 at 3:20 P.M. that he conducts fire and disaster drills. E5 stated at that time, he does not recall or have evidence that disaster drills were conducted on the night shift in the past vear. The facility's Resident Census and Conditions of Resident form dated 8-3-15, documents 71

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

a) A full-time person, qualified by training and

(B)

residents reside at the facility.

300.2010 Director of Food Services

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

STATE FORM

GP9F11

If continuation sheet 1 of 3

Illinois Department of Public Health

IIIIIOIS L	Illinois Department of Fublic Health					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6012157	B. WING		08/	05/2015
NAME OF PROVIDER OR SUPPLIER STREET ADD		DDRESS, CITY, STATE, ZIP CODE				
LEROY MANOR 509 SOUT			DAD, PO BOX 149			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From page 1		S9999			
	experience, shall be responsible for the total food and nutrition services of the facility. This person shall be on duty a minimum of 40 hours each week.					
	This person sha dietetic service superior	ll be either a dietitian or a ervisor.				
	300.330 Definitions: Dietetic Service Supervisor - a person who is a dietitian; or is a graduate of a dietetic technician or dietetic assistant training program, corresponding or classroom, approved by the American Dietetic Association; or is a graduate, prior to July 1, 1990, of a Department approved course that provided 90 or more hours of classroom instruction in food service supervision and has had experience as a supervisor in a health care institution which included consultation from a dietitian; or has successfully completed a Dietary Manager's Association approved dietary managers course; or is certified as a dietary manager by the Dietary Manager's Association; or has training and experience in food service supervision and management in a military service equivalent in content to the programs in the second, third, or fourth paragraph of this definition.					
	These requirements the following:	are not met as evidenced by				
	failed to have a qual Supervisor who has training and works 4 dietary department. effect all 71 resident	and record review, the facility ified Dietetic Services completed the required 0 hours per week in the This has the potential to s.			į	
	Findings include:					

6899

Illinois Department of Public Health STATE FORM

GP9F11 If continuation sheet 2 of 3

PRINTED: 09/09/2015 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
		IL6012157	B. WING		08/	05/2015						
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, STATE, ZIP CODE			03/2013						
LEROY MANOR 509 SOUTH BUCK ROAD, PO BOX 149												
LE ROY, IL 61752												
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE						
S9999	Continued From page 2		S9999									
S9999	E4, Dietary Manage P.M. that she becar August 2014. E4 st University of North I Dietary Manager co completed four of the enrolled in the corre November of 2014. E4's personnel file, on 7-28-14. E2, Add on 8-5-15 at 12:10 F Manager on 7-28-14 University of North I	er stated on 8-3-15 at 12:36 me the Dietary Manager in stated she is enrolled in the Dakota correspondence urse. E4 stated she has ne 14 lessons. E4 stated she espondence course in E4 began as Dietary Manager ministrator in Training verified P.M. that E4 began as Dietary 4 and enrolled into the Dakota on 11-17-14.	S9999									
and observations		PERMIT										
		DATA A CANADA PARA PARA PARA PARA PARA PARA PARA P										

Illinois Department of Public Health