	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION 5:	(X3) DATE SURVEY COMPLETED
		IL6008726	B. WING		C 07/02/2015
	PROVIDER OR SUPPLIER	CARE 512 SOUT	DDRESS, CITY, S TH FRANKLI R HILL, IL 620		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETE
S 000	Initial Comments		S 000		
	Complaint investiga 1543430/IL78246 - 1543406/IL78213 - c,1,2)e) f 3, A, B) j) Statement of licens	- 330.920,d) - 330.715 a)c) and 330.725) k) n) q)			
S 715		equest for Resident Criminal	S 715		
	Section 330.715 a) A facility shall, wof a resident, requebackground check Conviction Informational older seeking admissibackground checks pursuant to the Hosbackground checks resident's name, da	within 24 hours after admission est a criminal history pursuant to the Uniform ation Act for all persons 18 or ission to the facility, unless a was initiated by a hospital spital Licensing Act. s shall be based on the ate of birth, and other red by the Department of State			
	inconclusive, the factingerprint-based check is waived by based on verification resident is completed resident meets other resident meets other resident's health on the existence of a semedical, or mental of potential risk preser 2-201.5 (b) of the Action fingerprint based	he background check are acility shall initiate a heck, unless the fingerprint the Director of Public Health on by the facility that the ely immobile or that the er criteria related to the lack of potential risk, such as severe, debilitating physical, condition that nullifies any nted by the resident. (Section act) The Facility shall arrange d background check or om the Department within 5		Attachment A Statement of Licensure Vi	•

Illinois Department of Public Health

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

TITLE

(X6) DATE

STATE FORM 6899 1SM211 If continuation sheet 1 of 11

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		7 C DOILDING			3
	IL6008726	B. WING		1	2/2015
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SOUTH LAWN SHELTERED CAR	(E	H FRANKLI HILL, IL 620			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRESSION OF THE APPROPRIED TO T	D BE	(X5) COMPLETE DATE
conducted within 25 da inconclusive results of Based on record review failed to request backghours, and initiate finguindividuals who have in checks, for 4 (R8, R9, reviewed for required be sample of 15. Findings include: 1. The Admission She documents that he was Facility on 1/6/06. E1, on 6/25/15 at 2:20 PM, was conducted and reconstituted and reconstituted and reconstituted and reconstituted and the state Police) on R15 of admission), but she did Department until the mathat she realizes that R too old and they need to 2. R8's Admission She was originally admitted There is no record in R Background Check was (8 years after admission Background Check was and the results were doquality". E1 said on 6/2 Facility has not yet conditions.	conclusive results of a und check. The aground check shall be ays after receiving the fithe name-based check. Ew and interview, the Facility ground checks within 24 perprint-based checks for noconclusive background R14 R15) of 15 residents background checks in the et in R15's clinical record soriginally admitted to the Owner, said in an interview, that a Background Check ceived from ISP (Illinois on 3/26/15 (9 years after d not fax the results to the norning of 6/25/15. E1 said R15's Background Check is to run a new one. Beet documents that she is to the Facility on 2/8/07. R8's clinical record that a les conducted until 6/11/15, on). A fingerprint-based is conducted on 6/11/15 ocumented as "poor 25/15 at 2:20 PM, that the iducted another R8. E1 said that she is	S 715	DEFICIENCY		

Illinois Department of Public Health

1SM211

PRINTED: 08/05/2015 **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: _ C B. WING IL6008726 07/02/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **512 SOUTH FRANKLIN** SOUTH LAWN SHELTERED CARE **BUNKER HILL, IL 62014** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S 715 Continued From page 2 S 715 Z1, State Police Investigator, stated during a telephone interview on 6/30/15 at 2:36 PM, that R8 is an Identified Offender and E1 is well aware of that fact. Z1 said she initially brought it to E1's attention on 3/10/15. 3. R9's Admission Sheet documents that he was originally admitted to the Facility on 10/31/12. There is no record in R9's clinical record that a Background Check was conducted until 6/11/15 (3 years after admission). A fingerprint-based Background Check was conducted on 6/11/15 and the results were documented as "poor quality". E1 said on 6/25/15 at 2:20 PM, that the Facility has not yet conducted another Background Check for R9. Z1, State Police Investigator, stated during a telephone interview on 6/30/15 at 2:36 PM, that R9 is an Identified Offender and E1 is well aware of that fact. Z1 said she initially brought it to E1's attention on 3/10/15. 4. R14's Admission Sheet documents that he was originally admitted to the Facility on 6/10/15. The Facility has a copy of R14's Background Check, which is dated 6/20/15. E1 confirmed on 6/25/15 at 2:20 PM, that she did not complete a Background check for R14 within the first 24

Illinois Department of Public Health

Section 330.725

(B)

hours after admission.

S 725 Section 330.725 Identified Offenders

This Regulation is not met as evidenced by:

S 725

PRINTED: 08/05/2015 FORM APPROVED

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PR

	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION		E SURVEY IPLETED
		IL6008726	B. WING		ı	C /02/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AF	IDDESS CITY S	STATE, ZIP CODE		<u></u>
			TH FRANKLII			
SOUTH	LAWN SHELTERED C	AIL	HILL, IL 620			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		DDECTION	
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
S 725	Continued From pa	ge 3	S 725			
	background check ridentified offender a of the Act, the facilit 1) Immediately notif Police, in the form a Department of State identified offender. 2) Within 72 hours, fingerprint-based cribe requested on the The inquiry shall be sex, race, date of bi other identifiers requested on the ridentifiers requested on the ridentifiers requested on the Folice. The incomplete in through the files of the Police and the Fede locate any criminal representation of State inquiry under this su	resident's criminal history reveal that the resident is an as defined in Section 1-114.01 by shall do the following: The Department of State and manner required by the Police, that the resident is an arrange for a siminal history record inquiry to be identified offender resident. Sased on the subject's name, orth, fingerprint images, and suired by the Department of quiry shall be processed the Department of State aral Bureau of Investigation to history record information that the subject. The Federal ion shall furnish to the Police, pursuant to an bsection (c)(2), any criminal nation contained in its files.				
	history record inquiring the partment of State form and manner present of State Police. The may charge the Faciname-based and finguistory record inquiries	nd fingerprint-based criminal es shall be submitted to the Police electronically in the escribed by the Department Department of State Police lity a free for processing gerprint-based criminal es. The fee shall be ate Police Service Fund.				
r S r	prospective and curre guardian, and to ever notice, prescribed by	ecility shall provide to every ent resident and resident's ry facility employee, a written the Department, advising				

Illinois Department of Public Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		22,2010
SOUTH	LAWN SHELTERED O	.ARP	ΓH FRANKLII HILL, IL 620			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF O (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S 725	right to ask whether are identified offen whether identified of Facility. A) The notice shall within every licenses B) The notice shall information regarding persons mandatory supervisity from the Illinois Dewebsite, www.isp.s regarding persons mandatory supervisity of the Act) j) Upon admission facility or a decision offender in a facility with the medical dischall specifically an individualized plk) The facility shall Offender Report an identified offender's of the Act) n) The facility shall quarterly for identification appropriateness an specific to the identification. The faccontinuously evaluation and for making any are necessary to error of the facility shall implementing changing in the care plan if necessary to error of the facility shall implementing changing in the care plan if necessary to error of the facility shall implementing changing in the care plan if necessary to error of the facility shall implementing changing in the care plan if necessary to error of the facility shall implementing changing in the care plan if necessary to error of the facility shall implementing changing in the care plan if necessary to error of the facility shall implementing changing in the care plan if necessary to error of the facility shall implementing changing in the care plan if necessary to error of the facility shall implementing changing in the care plan if necessary to error of the facility shall implementing changing in the care plan if necessary to error of the facility shall implementing changing in the care plan if necessary to error of the facility shall implementing changing in the care plan if necessary to error of the facility shall implementing changing in the care plan if necessary to error of the facility shall implementing changing in the care plan if necessary to error of the facility shall in the care plan if necessary to error of the facility shall in the care plan if necessary to error of the facility shall in the care plan	er any residents of the facility ders. The facility shall confirm offenders are residing in the also be prominently posted ed facility. Include a statement that ing registered sex offenders om the Illinois State Police state.il.us, and that information serving terms of parole or sed release may be obtained partment of Corrections. State.il.us. (Section 2-216 of of an identified offender to a not oretain and identified of the facility, in consultation rector and law enforcement, and research the Identified and Recommendation into the secare plan. (Section 2-201.6(f) evaluate care plans at least fied offenders for and effectiveness of the portions stified offense and shall riew. The facility shall modify essary in response to this cility remains responsible for a ting the identified offender changes in the care plan that neure the safety of residents. In develop procedures for ges in resident care and on the resident no longer meets.	S 725			

Illinois Department of Public Health

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STATEMENT OF DEFICIENCIES

OTATEME	UT OF DEFIDIENCIES		· · · · · · · · · · · · · · · · · · ·			
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION		SURVEY
		IDENTIFICATION NOMBER.	A. BUILDING:		COMP	PLETED
						C
		IL6008726	B. WING			02/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	IDDESS CITY	STATE, ZIP CODE		
		F40.001				
SOUTH	LAWN SHELTERED C	ARE	TH FRANKLI HILL, IL 62(
(VA) 1D	SUMMADV STA		TILL, IL 620			
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR	OPRIATE	DATE
***************************************				DEFICIENCY)		- COURT OF THE COU
S 725	Continued From pa	ge 5	S 725			
	•					
	Based on record re-	view and interview, the Facility				
	failed to notify the C	Department of State Police	MT TO COLOR			
	concerning sex offe	enders residing in the Facility;				
	failed to electronica	lly submit criminal history				
	inquires to the Depa	artment of State Police; failed	***			
	to notify resident an	d resident's guardians				
	concerning their rigl	ht to ask if a sex offender	au a			
	resides in the Facili	ty; failed to develop a plan of				
	care incorporating to	he Identified Offender Report				
	and Recommendati	on for sex offenders; failed to				
	least quarterly; and	for identified offenders at	- Anna Anna Anna			
	implementing change	implement procedures for ges in resident care and				
	facility policies when	n the resident no longer meets				
	the definition of ider	ntified offender for 2 of 2 (R1,	The same			
	R2) Sex Offenders	and 3 of 3 (R8, R9, R15)				
	identified offenders	in the sample of 15				
		all operations and the second				
Among	Findings include:					
	1. R1's facility "Adm	ission Sheet" documents that				
	he was originally add	mitted to the Facility on				
	11/26/02. R1's "Stat	te of Illinois - Identified Sex				
	Offender Information	n" documents two counts of				
	criminal sexual abus	se of a child. R1 "State Police				
	Background Checks	" documents "no record".				
	On 6/25/15 at 2:25 F	DM E1 Owner still to				
	Was aware that D1	PM, E1, Owner, said that she was a sex offender since his				
	admission to the Fac	cility but, it has been more				
	than 10 years since	he committed the crime so			100 pp. 100 pp	
	R1 no longer shows	up on the Sex Offender				l
	Registry E1 said tha	at she does not know what to	A CONTRACTOR OF THE CONTRACTOR		1000	į
	do since R1's Backg	round Check comes up "no	Action and the second			Ī
j 1	record". E1 stated th	nat the Facility has never				
(conducted a fingerpr	int-based Background Check				
(on R1. E1 said that:	she has not sent information				
į t	o the State Police or	the Department regarding				
	₹1. E1 said that she	has never electronically				Ī

(X3) DATE SURVEY

Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

ANDILAN	TOF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	•	COMF	PLETED
		IL6008726	B. WING		•	C 02/2015
	PROVIDER OR SUPPLIER LAWN SHELTERED C	ARF 512 SOUT	DRESS, CITY, : TH FRANKLI HILL, IL 620			
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
S 725	submitted criminal is State Police and do There is no docume regarding a plan of Sexual Offender. Osaid that the Facility of care for R1. 2. R2's facility "Adrhe was originally ad 3/22/02. R2's "Iden Information" docum sexual abuse of a 1 "State Police Backg "no record." On 6/25/15 at 2:25 was aware that R2 admission to the Fanot know what to do Check comes up "n Facility has never considered and the partment regardine pepartment of Sknow how to do so. There is no docume regarding a plan of Sexual Offender. The Management Plan" behavior", dated Se documents "no behavior and the partment of Sknow how to do so.	nistories to the Department of les not know how to do so. entation in R1's clinical record care or R1's history of being a on 6/29/15, at 11:52 AM, E1 or has never developed a plan inission Sheet" documents that lmitted to the Facility on tified Sex Offender ents one count of criminal 4 year old individual. R2's ground Checks" documents PM, E1, Owner, said that she was a sex offender since his inicility. E1 said that she does on since R2's Background or record". E1 stated that the onducted a fingerprint-based on R2. E1 said that she has a to the State Police or the ling R2. E1 said that she has submitted criminal histories to state Police and does not entation in R2's clinical record care or R2's history of being a here is a "Behavior for "sexually inappropriate ptember 2013 which aviors exhibited." There is no on in R2's clinical record. On 6/29/15, at 11:52 AM, sility has never developed any	S 725			

(X2) MULTIPLE CONSTRUCTION

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Illinois Department of Public Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		IL6008726	B. WING	77.000000000000000000000000000000000000	· ·	C 02/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY,	STATE, ZIP CODE		
SOUTH	LAWN SHELTERED C	AKE	ΓΗ FRANKL HILL, IL 62			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
	3. R8's Admission was originally admir There is no record Background Check A fingerprint-based conducted on 6/11/documented as "ponot yet conducted a R8. R9's Admission Shoriginally admitted to There is no record in Background Check A fingerprint-based conducted on 6/11/documented as "po 6/25/15 at 2:20 PM, conducted another of the Admission Shedocuments that he was a conducted another of the Admission Shedocuments that he was conducted another of the Admission Shedocuments that he was conducted another of the Admission Shedocuments that he was conducted another of the Admission Shedocuments that he was conducted another of the Admission Shedocuments that he was conducted another of the Admission Shedocuments that he was conducted another of the Admission Shedocuments that he was conducted another of the Admission Shedocuments and the Shedocuments of the Admission Shedocuments and the Shedocuments of the Shedocu	Sheet documents that she ted to the Facility on 2/8/07. In R8's clinical record that a was conducted until 6/11/15. Background Check was 15 and the results were or quality". The Facility has mother Background Check for eet documents that he was to the Facility on 10/31/12. In R9's clinical record that a was conducted until 6/11/15. Background Check was 15 and the results were or quality". E1 said on that the Facility has not yet Background Check for R9. In R15's clinical record was originally admitted to the E1, Owner, said in an interview PM, that R15's Background ed on 3/26/15, but she did not nent until the morning of at she realizes that R15's is too old and they need to ment a Background Check for 1 said that she is unsure what of the she process. E1 has never notified resident's that she is unsure what has never notified resident's that she is unsure what has never notified resident's that she is unsure what has never notified resident's that she is unsure what has never notified resident's that she is unsure what has never notified resident's that she is unsure what has never notified resident's that the she is unsure what has never notified resident's that the she is unsure what has never notified resident's that the she is unsure what has never notified resident's that the she is unsure what the she is	S 725			

Illinois Department of Public Health

or resident's guardians of their right to ask

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION		SURVEY
		IL6008726	B. WING		1	C 0 2/2015
	PROVIDER OR SUPPLIER	ARE 512 SOUT	DRESS, CITY, H FRANKL HILL, IL 62			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
	whether any reside Offenders. E1 also developed care pla who are Offenders. not have policies or changes in resident longer meets the dead of the changes in resident longer meets the dead of the changes in resident longer meets the dead of the changes in resident longer meets the dead of the changes in resident longer meets the dead of the changes and that Offenders and that Offenders and that Offenders. Z1 said R2 do not need to change longer lo	nt of the Facility are Identified of stated that they have not ans for any of the resident's E1 said that the Facility does a procedures for implementing to care when the resident note inition of identified offender. Investigator, stated during a con 6/30/15 at 2:36 PM, that at R1 and R2 are Sexual R8, R9 and R15 are Identified that after 10 years, R1 and continue to register with the Offenders however, the ue to follow the protocol and	S 725			

Illinois Department of Public Health

STATE FORM 1SM211 If continuation sheet 9 of 11

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		IDENTIA TOTALIONALIA.	A. BUILDING	S:	COMPLETED
		IL6008726	B. WING		C 07/02/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
SOUTH L	LAWN SHELTERED C	ARE	TH FRANKL HILL, IL 62		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETE
S 725	Continued From pa	ge 9	S 725		
	(B)		* University of the Control of the C		
S 920	Section 330.920 Co	onsultation Services	S 920		
	Section 330.920 Cod) If the facility does professional nurse, consultation from a consultant shall ass methods and proceoprogram, medication medications and insof personal care. Based on observation fails to employee or nurse. This has the residents who live in	s not employ a registered the facility shall arrange for registered nurse. The sist with developing policies, edures relating to the medical on, in-service on these service training on all aspects on and interview, the Facility consult with a registered e potential to effect all 40			
	throughout the days E2, Administrator, st 6/29/15 at 11:25 AM without a nurse for a weeks". On 6/29/15, at 11:52 Facility does not curr nurse nor do they ha The Facility Data She documents that there	e present in the Facility of 6/25/15 and 6/29/15. Stated in an interview on at least "the past three 2 AM, E1, Owner, said that the crently employ a registered ave a consulting nurse.			
	living in the Facility. (B)		Parameter Constitution of the Constitution of		
				i e	

Illinois Department of Public Health

STATE FORM 6899 1SM211 If continuation sheet 10 of 11 Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 512 SOUTH LAWN SHELTERED CARE 512 SOUTH FRANKLIN BUNKER HILL, IL 52014 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFINITION REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY REGULATORY OR LSC IDENTIFYING INFORMATION DEFICIENCY SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY TAG CROSS-REFERENCED TO THE APPROPRIATE COUNTY OF THE PROPERTY OF THE PROP	AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SOUTH LAWN SHELTERED CARE SUNKER HILL, IL 62014 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 12 SOUTH FRANKLIN BUNKER HILL, IL 62014 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CONSTRUCTED TO THE APPROPRIATE CONSTRUCTED TO TH			IL6008726	B. WING			
SOUTH LAWN SHELTERED CARE 512 SOUTH FRANKLIN BUNKER HILL, IL 62014 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FRANKLIN BUNKER HILL, IL 62014 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	NAME OF PE	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	SOUTH LA	AWN SHELTERED C	512 SO	UTH FRANKLIN	l		
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