Illinois Department of Public Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
712 . 271	G. GG	.52		A. BUILDING:			
		IL6008106		B. WING		11/0	6/2024
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROCHEL	LE REHAB & HEALT	H CARE CENTER		TH 3RD STRI .E, IL 61068			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
S 000	Initial Comments			S 000			
	Complaint Investiga 2419118IL180586 Investigation of Fac 11-06-2024/IL1805	cility Reported Incident	of				
S9999	Final Observations			S9999			
	Statement of Licens 300.610a) 300.3300v)2) 300.3300y)	sure Findings:					
	Section 300.610 R	esident Care Policies					
	procedures governifacility. The written be formulated by a Committee consisti administrator, the a medical advisory confinering and other policies shall compositive written policies the facility and shall	dvisory physician or the mittee, and represe or services in the facility with the Act and this shall be followed in our least documented by writter	ne entatives y. The Part. perating annually				
	Section 300.3300	Transfer or Discharge					
		fer or discharge condo (q) through (t) of this S :					
	be removed, to the any, and to a memb	tten notice to any resident's representatoer of the resident's faprior to the removal.	ive, if mily,				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

12/11/24

TITLE

Electronically Signed

(X6) DATE

Illinois Department of Public Health

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		, ,	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
				A. BUILDING:			
		IL6008106		B. WING			C 06/2024
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DOOLIE	LLE DELLAD & LIEALT	U OADE GENTED	900 NORT	H 3RD STRI	EET		
ROCHE	LLE REHAB & HEALT	H CARE CENTER	ROCHELL	E, IL 61068			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
\$9999	notice will state the discharge is ordered of the resident's rig discharge under sure The Department with the resident or prior to transfer or or the representative to the proposed transitive placement (and the proposed transitive placement). y) The administrative placement (and the Act shall voluntarily closing a facility, or prior to colosing such part with discharge of more Such notice shall be the Office of State to any resident who discharged, to the practicable. If the I revokes, or denies license, then notice the date specified is shall state the propreason for closing closure plan to the shall address the propression of the practicable and the shall address the propression of the practicable and the shall address the propression for closing closure plan to the shall address the propression of the notion of the practical placement and shall available alternative unable to choose a not under guardian notified of the needs	reason for which transed and will inform the resident (x) of this Secill hold an informal contract the resident's represed discharge at which the resident's represed discharge at which the resident (Section 3-420(b)) astrator of a facility lice give 60 days notice plant. (Section 3-420(b)) astrator of a facility or closing any losing any part of a facility require the transfer than 10% of the resident given to the Department or the Department suspends renewal of the facility ashall be given no late to the Department. No sed date of closing any the Department. No sed date of closing as The facility shall substitute the safe and the saf	resident insfer or rection. Inference entative entation or in or entation or entation entatio	S9999			

Illinois Department of Public Health

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Illinois Department of Public Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		II 6009406	B. WING		44/0	
		IL6008106			11/0	6/2024
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROCHEL	LE REHAB & HEALTI	I CARE CENTER	H 3RD STRI E, IL 61068			
(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 APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	submitted to the Dethis Part. The facilial applicable laws and closing, including the discharge of reside place a relocation to under subsection (to 3-423 of the Act). These Regulations Based on observation review, the facility for and R2) were given the facility for and R2) were given this failure resulted psychosocial harm. This applies 2 of 7 transfer and discharch and the findings included to the findings inclu	rafter the date written notice is partment under the Act and ty shall comply with all regulations until the date of lose related to transfer or ints. The Department will earn in the facility as provided in of this Section. (Section are not met as evidenced by: on, interview and record called to ensure residents (R1 notice prior to discharge. It in R1 experiencing residents (R1 R2) reviewed for the rege in the sample of 7.	\$9999			

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	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			,
		IL6008106	B. WING			6/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ROCHEL	LE REHAB & HEALT	H CARE CENTER	TH 3RD STRI .E, IL 61068			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	call the facility right spoke to V3 (Direct said-they are closin have until Wednesd (R1) out from the fa 3:15 PM, I was at that due to a lot of its doors. I asked, V3 said, they have Woodstock, Aurora mom (R1) can move that was in their system another facility which I am on my own (and the transport) V3 we mome or my feelings move your mome by was disheartening, to my mome himself Mom (R1) said she her defibrillator. She since 1930's. I was my mome to stay in she was not going from I'll do my bessitay in Rochelle. Vertouring facilities until said R1 was movin Rochelle, and she was one of media that was aire Monday 11/4/24. Rewhole thing. R1 as disconnected so she not given enough media that was aire whole thing. R1 as disconnected so she not given enough media that was aire whole thing. R1 as disconnected so she not given enough media that was aire whole thing. R1 as disconnected so she not given enough media that was aire whole thing. R1 as disconnected so she not given enough media that was aire whole thing. R1 as disconnected so she not given enough media that was aire whole thing. R1 as disconnected so she not given enough media that was aire whole thing. R1 as disconnected so she not given enough media that was aire whole thing. R1 as disconnected so she not given enough media that was aire whole thing.	away. I called back and for of Development) who ag the nursing home, that I only day (today) to get my mom acility. I was in disbelief. By the facility. V3 again said to me issues the facility was closing "What am I supposed to do." other facilities at Morrison, or Sterling. V3 then said my the to their facility in Morrison as clearly not considering my as The rush to say "you need to the Wednesday" (within 48 hours). I told him he needs to tell this which he did, that's when a wanted to die, just disconnect the always lived in Rochelle as scrambling to find a place for Rochelle that Monday evening, to Morrison. I assured my to find a place for her and to find	S9999			

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	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		IL6008106		B. WING		l l	C 06/2024
	PROVIDER OR SUPPLIER	H CARE CENTER	900 NOR1	DRESS, CITY, S TH 3RD STRI LE, IL 61068			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM,	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
\$9999	On 11/6/24 at 1PM, Monday he was ins due to facility closin (Director of Busines spoke to resident's day notices was just On 11/6/24 at 12 Pl Monday 11/4/24, V3 came to the facility, room to tell the resimove out because Families were also thing; they have unones. They were withe other facilities the Aurora, or Woodsto V1 said today was notice of closure be On 11/6/24 at 11:42 facility on Monday to that the facility was miscommunication was corrected by V Operations) yestero letter with 60 days in the control of the control o	V5 (Business HR) structed to call residency then connect the cass Development) who families. V5 said less to being mailed today M, V1 (Administrator B and V11 (Clinical D they went to each redents they have untit the facility was closing called and told the still today to transfer they and to the still today to transfer they and more sock. The first time she save sing sent out to familiar 2 AM, V3 said he care to tell residents and following. V3 said who that was relayed that 4 (Regional Director day. All residents we notices today.	nts POAs call to V3 of then sters of 60 of 11/6/24. c) said last birector) esident's I today to have to sterling, which letters of ies. The to the same stever at Monday of the given a haday	S9999			
	closing, staff from t R2 agreed to move transferred yesterd given the 60-day no given today 11/6/24 V6 (CNA Superviso	or) said letter of notic oday. R2 did not get	as here. g and was s not ere just es was				

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER:

IL 6008106

IL 6008106

STREET ADDRESS, CITY, STATE, ZIP CODE

900 NORTH 3RD STREET

FORM APPROVEL

(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

11/06/2024

X4) ID REFIX 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	(X5) COMPLET DATE
	·		DEFICIENCY)	
59999	Continued From page 5 On 11/6/24 at 10:21 AM, V4 (Regional Director of	S9999		
	Operations) said he saw the news and the social media posts that residents were given only until today to move out from the facility. V4 said "that was not right, residents should be given 60-day notice and can move to their facility of choice." V4 said letters are being send to residents and their families today.			
	The facility Policy entitled Transfer and Discharge Procedure undated show, Except for the case of late payment or nonpayment, the facility shall notify the resident and the residents family member, surrogate or representative of the transfer and the reason of the transfer.			
	(B)			

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Illinois Department of Public Health STATE FORM

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