		DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: B. WING		C 09/30/2024		
		IL6009765					
AME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST				
ATSEK	A REHAB & HLTH CA		「RAYMOND F A, IL 60970	ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE	
S 000	Initial Comments		S 000				
	Facility Reported In	cident of 9/13/24/IL178535					
S9999	Final Observations		S9999				
	Statement of Licens	sure Violations					
	300.610a) 300.3240a)						
	Section 300.610 R	esident Care Policies					
	procedures governi facility. The written be formulated by a Committee consisti administrator, the a medical advisory co of nursing and othe policies shall compl The written policies the facility and shall	dvisory physician or the ommittee, and representatives r services in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least annually documented by written, signed					
	Section 300.3240 A	Abuse and Neglect					
	employee or agent	censee, administrator, of a facility shall not abuse or (Section 2-107 of the Act)					
	These regulations v	vere not met as evidenced by:					
	failed to ensure a re misappropriation of (Business Office Ma	and record review the facility esident (R1) was free from funds by an employee (V3 anager/BOM). This failure ocial harm for R1. R1 is one of					
ORATORY	ment of Public Health DIRECTOR'S OR PROVID cally Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 10/14/24	

If continuation sheet 1 of 4

Illinois D	epartment of Public	Health				APPROVE
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	IL6009765		B. WING			C 30/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
WATSEK	A REHAB & HLTH CA		T RAYMOND F A, IL 60970	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From page 1		S9999			
	four residents reviewed for misappropriation of property in the sample list of six.					
	Findings include:					
	The facility's Abuse Prevention Program dated 11/28/16 documents abuse includes misappropriation of resident property and exploitation, which includes unauthorized use of a resident's belongings or money.					
	Procedure docume security measures managed by the fac theft or mismanage vouchers for all res computerized track	ing of account activity, monthly ility Administrator, and signed				
	Worksheet IDPH (I Health) Notification documents on 9/13 Administrator In Tra allegation of misapp involving V3 and V4 Final Report to IDP the anonymous call \$600 from R1's Tru	Electronic Facsimile) Ilinois Department of Public Form dated 9/13/24 /24 at 11:00 PM V1 aining was notified of an propriation of R1's property 4 Activity Aide. The facility's H for this incident documents ler alleged V3 and V4 took st Fund which was given to V5 hily Member) for car repairs.				
	July 2024 documen was deducted for \$ document R1's sign transaction, as pror cash was used for.	t Fund Transaction Log dated hts on 7/30/24 Check #6633 200 in cash. This log does not nature authorizing this mpted on the form, or what the The facility's Check #6633 ments the check was made				

NMOM11

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:	A. BUILDING: B. WING		COMPLETED C 09/30/2024	
		IL6009765				
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
NATSEK	(A REHAB & HLTH CA	ARE CTR	T RAYMOND R (A, IL 60970	ROAD		
(X4) ID			ID	PROVIDER'S PLAN OF	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
S9999	Continued From pa	ige 2	S9999			
	out to "cash" for an amount of \$200. This check documents "(R1's) cash" on the memo line, and the check was signed by V1 and V3.					
	V3's Notice of Termination dated 9/17/24 documents V3's employment was terminated due to failing to follow facility policy and procedure.					
	documents R1 has	a Set dated dated 9/9/24 a Brief Interview for Mental the higher end of moderate nt.				
	V1 talked to R1 abo asked if R1 had giv stated R1 never rec or quarterly statem prior unknown trans reviewed R1's trans was one cash trans that R1 was unsure V3 had been giving repairs, which R1 c made R1 feel very suppose to be kept R1 only receives \$6 just recently receives 11:40 AM R1's Trus with R1. R1 denied \$200 that was dedu 7/30/24. R1 stated	AM R1 stated the other day but R1's Trust Fund, and V1 ren money to V3 or V4. R1 ceives receipts for transactions ents, so R1 did not notice any sactions. R1 stated V1 sactions with R1, and there saction for an amount of \$300 e of. R1 stated R1 was told that a R1's money to V5 for car lid not authorize. R1 stated this insecure since R1's money is a safe by the facility. R1 stated 60 per month for disability and ed a large back payment. At st Fund records were reviewed authorizing the check for ucted from R1's account on that must have been the was thinking of during R1's	t 5			
	months ago R1 had V3 was only able to resident requests o	AM V3 BOM stated a few d requested \$500 in cash, but give R1 \$200. V3 stated if a eash for \$200 or more, a check mount and the cash is given to				

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ILE009765		CIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
		B. WING			09/30/2024		
NAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, ST				
VATSEK	A REHAB & HLTH CA	ARE CTR	T RAYMOND R (A, IL 60970	OAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
S9999	the cash box log wh On 9/30/24 at 8:59 Training stated V3's for not following fac Resident Trust Fun residents. At 9:50 A Training stated on 9 received an anonyr overhearing a phon and V5 in which V3 trouble" and "would installments". V1 st there were two che Trust Fund, and V5 to get the money. A Trust Fund logs. V1 signing the logs ney including checks fo confirmed V1 and V \$200 cash withdraw documentation of F	ge 3 ted the resident has to sign hen V3 provides the cash. AM V1 Administrator In semployment was terminated cility policy by not providing d receipts and statements to M V1 Administrator In D/13/24 at 11:00 PM the facility nous phone call alleging te conversation between V3 stated V3 would "get into big need to take out money in ated the caller alleged that cks for \$600 taken from R1's had been going to the facility attated residents should be at to each check written, r cash withdrawals. V1 /3 signed the check for R1's val, and confirmed there is no R1's authorization for this r that this cash was given to	S9999	DEFICIENC	Y)		

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