PRINTED: 11/20/2024 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	
IL6009211		B. WING	B. WING		09/13/2024	
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
SULLIVA	N REHAB & HLTH CA	ARF CTR	HORNE LANI N, IL 61951	Ē		
(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		S 000			
	Annual Licensure a	nd Certification Survey				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	300.661 955.100 955.165c)					
	Section 300.661 He Check	ealth Care Worker Background				
	Worker Background	oly with the Health Care d Check Act and the Health ground Check Code.				
	PART 955 HEALTH BACKGROUND CH					
	Section 955.100 Applicability					
	employed or retained as home health care assistants, printraining personnel, similar health-related provides direct care child care/habilitation disabilities aides, as services aides) or horizontesidents or the livit medical, or personaresidents. This Paremployees of licensifacilities who have considents or accessions.	all unlicensed individuals and by a health care employer re aides, nurse aides, personal wate duty nurse aides, day or an individual working in any red occupation where he or she re (e.g., resident attendants, on aides/developmental red psychiatric rehabilitation has access to long-term careing quarters or financial, all records of long-term careit also applies to all unlicensed seed or certified long-term care or may have contact with a to the living quarters or the				
Ilinois Depa	l rtment of Public Health Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed 09/30/24

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6009211	B. WING		09/1	3/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SULLIVA	N REHAB & HLTH CA	ARF CTR	HORNE LAN N, IL 61951	E		
(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		S9999			
	financial, medical, or personal records of residents. (Section 10 of the Act)					
	Section 955.165 Fir History Records Ch	ngerprint-Based Criminal eck				
	c) Educational entities and health care employers shall conduct Internet searches on certain web sites, including without limitation the Illinois Sex Offender Registry, the Department of Corrections' Sex Offender Search Engine, the Department of Corrections' Inmate Search Engine, the Department of Corrections Wanted Fugitives Search Engine, and the website of the Health and Human Services Office of Inspector General to determine if the applicant has been adjudicated a sex offender, has been a prison inmate, or has committed Medicare or Medicaid fraud, or shall conduct similar searches as provided by the web-based application. (Section 15 of the Act)					
	Based on interview failed to conduct the Health and Human General (OIG). This	AT is not met as evidenced by: and record review, the facility e required checks of the Services Office of Inspector is failure has the potential to its residing in the facility.				
	Findings include:					
	8/3/23 and did not in	ursing Assistant's, file documents a hire date of nclude the required Health es Office of Inspector General.				
		lursing Assistant's, file documents a hire date of include the required Health				

Illinois Department of Public Health

STATE FORM 6899 XGKZ11 If continuation sheet 2 of 3

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Illinois Department of Public Health

IL609211 INAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 HAWTHORNE LANE SULLIVAN, IL 61951 PROVIDERS PLAN OF CORRECTION FRACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CROSS-REFERENCED TO THE APPROPRIATE DATE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER						DATE SURVEY COMPLETED	
SULLIVAN REHAB & HLTH CARE CTR SUMMARY STATEMENT OF DEFICIENCIES SULLIVAN, IL 61951	IL6009211			B. WING 09		09/	9/13/2024	
(A) ID PREFIX TAG SULLIVAN, IL 61951 (A) ID PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 2 and Human Services Office of Inspector General. 3) V8's, Activity Designee's, background checks file documents a hire date of 11/2/20 and did not include the required Health and Human Services Office of Inspector General. 4) V5's, Certified Nursing Assistant's, background checks file documents a hire date of 67/7/23 and did not include the required Health and Human Services Office of Inspector General. 5) V10's, Certified Nursing Assistant's, background checks file documents a hire date of 8/25/24 and did not include the required Health and Human Services Office of Inspector General. On 9/12/24 at 10:10 AM, V1, Administrator, stated, "I did find an OIG (Office of Inspector General). On 9/12/24 at 10:10 AM, V1, Administrator, stated, "I did find an OIG (Office of Inspector General) check for (V3, Cook), all the rest of the OIG checks I had to recheck and print yesterday." The facility's Resident Roster (undated) provided by V1 on 9/10/24 at 9:50 AM documents 71	NAME OF F	PROVIDER OR SUPPLIER						
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