PRINTED: 12/19/2024 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
			A. BOILDING.				
		IL6006639	B. WING		10/1	8/2024	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
SHORE I	SHORE HOMES EAST 503 MICHIGAN AVENUE EVANSTON, IL 60202						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (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	
Z 000	COMMENTS		Z 000				
	ANNUAL LICENSU	IRE SURVEY					
Z9999	FINDINGS		Z9999				
	Statement of Licensure Violations:						
	350.670c) 350.670d)1)2)3)4)5 350.680a) 350.681	5)					
	Section 350.670 P	ersonnel Policies					
	that requires a Stat contact the Illinois I Professional Regul individual's license	ng any individual in a position e license, the facility shall Department of Financial and ation to verify that the is active. A copy of the placed in the individual's					
	applicants with the	check the status of all Health Care Worker Registry mation on the Health Care Il include:					
	1) Whether the indi Registry;	vidual is active on the					
		vidual has findings of abuse, opriation of property;					
	3) The date of the i	ndividual's most recent ords check;					
	disqualifying offens	vidual has a conviction for a e pursuant to Section 25 of orker Background Check Act;					

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

TITLE

(X6) DATE 10/18/24

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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	
		IL6006639	B. WING		10/	10/18/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
SHORE I	HOMES EAST		HIGAN AVENU ON, IL 60202	JE			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
Z9999	Continued From pa	nge 1	Z9999				
	and						
	5) Whether the indi	ividual has a waiver.					
	a)A facility shall not employ an individual as a nursing assistant, habilitation aide, home health aide, a developmental disabilities aide, or a direct support person, or newly hired as an individual who may have access to a resident, a resident's living quarters, or a resident's personal, financial, or medical records, unless the facility has checked the Department's Health Care Worker Registry and the individual is listed on the Health Care Worker Registry as eligible to work for a health care employer. The facility shall not employ an individual as a nursing assistant, habilitation aide, a developmental disabilities aide, or a direct support person, if that individual is not on the registry unless the individual is enrolled in a training program under Section 3-206 (a)(5) of the Act and Section 350.683. (Section 3-206.01 of the Act)						
	Background Check A facility shall comp	oly with the Health Care					
		d Check Act and the Health ground Check Code.					
	These Regulations by:	were not met as evidenced					
Illingis Denga	failed to initiate req Registry checks an licensure status pri	and record review, the facility uired Health Care Worker d verification of nursing or to employment, to ensure re history of client abuse,					

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Illinois Department of Public Health

	DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	IL6006639	B. WING		10/18/2024	
NAME OF PROVIDER OR SUPPLIER SHORE HOMES EAST	503 MICH	DRESS, CITY, S IGAN AVENU N, IL 60202			
(X4) ID SUMMARY STATEMEN' PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
z9999 Continued From page 2 neglect or mistreatment a potential to impact 3 of 3 (R1, R2, R3) and 6 of 6 c sample (R4 - R9.) Findings include: Review of Health Care W (HCWR) identified one st Worker Registry check of started employment at the submitted for E6 (Resider date of 7/19/2024 and a H on 8/2/2024. E6's Health check was not completed E9 (Licensed Practical Not 6/24/2024 and her nursing checked through the Illing Financial and Professions website on 7/3/2024. Z1, Nurse/RN did not have a license status check com work at the facility. On 10/16/2024 at 2:26 pm Officer stated the facility of checks for everyone befor at 11:46 AM, E5 stated th IDFPR nursing license state her hire. E5 stated that Es reviewed and it was curre website check for nursing completed.	clients in the sample dients outside of the dients o	Z9999			

Illinois Department of Public Health STATE FORM

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