PRINTED: 10/30/2024 FORM APPROVED

(X6) DATE

Illinois Department of Public Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	
		IL6012587	B. WING		10/1	0/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
CELEBRATE SR LIVING OF MOLINE  7300 34TH AVENUE  MOLINE, IL 61265						
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Annual Licensure S	urvey				
S9999	Final Observations		S9999			
	Statement of Licens 300.610a) 300.661	sure Violations:				
	a) The facility shall procedures governifacility. The written be formulated by a Committee consisting administrator, the amedical advisory conformer of nursing and othe policies shall complete the facility and shall by this committee, cand dated minutes.	dvisory physician or the ommittee, and representatives r services in the facility. The ly with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed				
	A facility shall comp Worker Background	oly with the Health Care d Check Act and the Health ground Check Code.				
	This REQUIREMEN	NT is not met as evidenced by:				
	failed to perform all prior to date of hire (V14-V19) reviewed	and record review, the facility required background checks for 6 of 10 employees d for Healthcare Worker. This failure has the potential				

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

10/17/24 **Electronically Signed** 

TITLE

PRINTED: 10/30/2024 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/S IDENTIFICAT	SUPPLIER/CLIA TION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL601258	37	B. WING		10/1	0/2024
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CELEBRATE SR LIVING OF MOLINE 7300 34TH AVENU MOLINE, IL 6126							
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC <sup>N</sup> REGULATORY OR L		DED 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
S9999	Continued From pa	ige 1		S9999			
	to affect all 93 resid	dents residing i	n the facility.				
	Findings include:						
	On 10/08/24, V3 (His the individual at the performing background checks following employee contain searches coff Corrections Warror the Department Search Engine: V1 Assistants), and V1	the facility respound checks problem. V3 then pel files containing that were concluded from the fugitives to facilities that were from the fugitives to facilities that (Certifies).	onsible for ior to an provided 10 ng the npleted. The es did not the Department Search Engine Sex Offender				
	On 10/09/24 at 11:0 searches from the Wanted Fugitives S Department of Corr Engine were not co	Department of Search Engine rections' Sex C	Corrections and the Offender Search				
	The facility's Room 93 residents curren						
	The facility's Abuse Investigations polic documents the followill screen all poter ways: Level II FBI femployee if they hat the previous 5 year work references on and the facility will references in regar background; All heclicensure or certific provision of care of	y (revised 09/0 pwing: "Screen tial employees inger printing for every not had one is; The facility so the prospective make effort to do to work perforalth care providuation will be very entire the care providuation will be very providuation will be very entire the care providuatio	18/22) ing: The facility ing: The facility ing in the following or any potential e conducted in shall request we employee contact those ormance and ders that require rified prior to				

Illinois Department of Public Health

STATE FORM 6899 HMTT11 If continuation sheet 2 of 3

PRINTED: 10/30/2024 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

ILEO12587

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  7300 34TH AVENUE  MOLINE, IL 61265						
	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) COMPLET DATE		
(X4) ID PREFIX TAG S9999	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	S9999  ho  of n in by a	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLET		

Illinois Department of Public Health

STATE FORM 6899 HMTT11 If continuation sheet 3 of 3