PRINTED: 11/06/2024 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	
			A. BUILDING			
		IL6001663	B. WING		09/27/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
HIGHLANI	D HEALTH CARE CENTE	R 1450 26TH HIGHLANI	STREET D, IL 62249			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
S 000	Initial Comments		S 000			
	Annual Licensure and	d Certification				
S9999	Final Observations		S9999			
	Statement of Licensu	re Violations				
	300.661					
	Section 300.661 Hea Check	lth Care Worker Background				
	A facility shall comply Worker Background C Care Worker Backgro	Check Act and the Health				
	This Requirement is I	Not Met as evidenced by:				
	failed to conduct com screenings and obtain checks to determine i criminal history that w	f employees have a prior yould disqualify them for d the potential to affect all				
	Findings Include:					
	1/4/24. The Facility's Background Check for eligibility to work in th until 6/13/24.	vity Assistant, was hired on				
	they were previously					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

10/11/24 **Electronically Signed**

STATE FORM 6899 If continuation sheet 1 of 3 MGCG11

TITLE

(X6) DATE

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6001663	B. WING		09	/27/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		1450 26	TH STREET			
HIGHLAN	D HEALTH CARE CENTE	ER .	ND, IL 62249			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From page	e 1	S9999			
	(CNA), was hired on Healthcare Worker B Documentation which	ified Nursing Assistant 7/30/24. The Facility's				
	(HR), stated there was verification of V19's (Administrator, stated the Facility until 8/15/ unable to provide doo					
	(DON), stated she ex	M, V2, Director of Nursing pects background checks to staff begin working in the				
	and Procedure" docu employment at (Facil clear results of a thor Background checks we candidates and on al promoted, as deemed Worker Background (46): includes review of probation. Certify correquirements and regional the Illinois Health Call Check Act." "Final call background check auto Human Resources Resources/Payroll wi	ity) are contingent upon ough background check. vill be conducted on all final I employees who are d necessary." "Health Care Check Ref. Act (225 ILCS of criminal convictions and inpliance with all gulations issued pursuant to be Worker Background indidates must complete a uthorization form and return it				

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STATE FORM 6899 MGCG11 If continuation sheet 2 of 3

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		IL6001663	B. WING		09/27/2024			
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
HIGHLAN	HIGHLAND HEALTH CARE CENTER 1450 26TH STREET HIGHLAND, IL 62249							
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)						
S9999	Continued From page 2		S9999					
	and either internal HR/Payroll staff or an employment screening service will conduct the checks."							
		are and Medicaid" Form 4/2024 documents there are						
	(C)							

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STATE FORM 6899 MGCG11 If continuation sheet 3 of 3