PRINTED: 11/21/2024 FORM APPROVED

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				A. BUILDING.				
		IL6006597		B. WING		10/2	21/2024	
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
WHITE H	ALL NURSING & REI	HAB CENTER		ΓBRIDGEPO ALL, IL 6209				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN / MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
S 000	Initial Comments			S 000				
	Annual Health Surv	rey						
S9999	Final Observations			S9999				
	Statement of Licens	sure Violations:						
	300.660c)1) 300.661							
	Section 300.660 N	ursing Assistants						
	c) The facility shall ensure that each nursing assistant complies with one of the following conditions:							
	1) Is approved Care Worker Regis the nurse aide has requirements of Se does not have a disbackground check	met the training or ction 300.663 of the equalifying crimina	neans that r equivalency nis Part and					
	Section 300.661 H Background Check		r					
	A facility shall comp Worker Background Care Worker Backg	d Check Act and th	he Health					
	This Requirement is	s NOT MET as ev	idence by:					
	Based on interview failed to follow their Nursing Assistants backgrounds check fingerprint scans we manner, and Illinois	policy to ensure ((CNAs) Healthcar s were performed ere obtained in a ti	Certified e worker I upon hire, imely					

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

11/01/24 **Electronically Signed**

TITLE

PRINTED: 11/21/2024 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6006597		B. WING		10/:	21/2024
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	·	
WHITE H	IALL NURSING & REI	HAR CENTER	620 WEST	F BRIDGEPO	RT		
WHITE HALL NURSING & REHAB CENTER WHITE HALL, IL 62092							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1		S9999			
	Department of Corr Department of Corr Department of corr Health and Human General searches a for 2 of 10 employe care Worker Backg has the potential to facility.	rections Inmate Sea ections wanted fugit Services Office of I all were completed be ses reviewed for the pround Protocol. Thi	arch, tive and the nspector pefore hire Health s failure				
	Findings include: 1. V25, CNA, has a hire date of 1/15/2024. V25's Health care Worker Registry, dated 2/14/2024, documents Works Eligibility: Eligible. V25's Illinois Sex Offender Search, Department of Corrections Sex Offender, Department of Corrections Inmate Search, Department of corrections wanted fugitive and the Health and Human Services Office of Inspector General all were completed on 2/14/2024.						
	V25's Illinois Sex Of Corrections Sex Of Corrections Inmate corrections wanted Human Services Of were completed on	Norker Registry, dants Works Eligibility: Iffender Search, Delender, Department Search, Department fugitive and the Healfice of Inspector Gelender, 3/22/2023.	ted Eligible. partment of of of alth and eneral all				
	On 10/21/24 at 9:50 acknowledged all e completed before the residents and the fatter than the	mployees' checks s ney work for the saf	hould be				
	Procedures Manua	n Resources Policie I with effective date ted, "It is the Facility	of				

Illinois Department of Public Health

STATE FORM 6899 VJF811 If continuation sheet 2 of 3

PRINTED: 11/21/2024

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ B. WING __ IL6006597 10/21/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **620 WEST BRIDGEPORT** WHITE HALL NURSING & REHAR CENTER

(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 2 verify possible criminal backgrounds of pending new hires prior to the commencement of	S9999		
	employment." (C)			

Illinois Department of Public Health

STATE FORM 6899 VJF811 If continuation sheet 3 of 3