Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
			A. BUILDING:	A. BUILDING:		
IL6008072		B. WING		10/24/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
ROBINGS	MANOR RHC		RTH MAIN			
240.15	CLIMMADV CT		ON, IL 62012	DROVIDEDIS DI AN OF CORRECTIO	N Over	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
S 000	Initial Comments		S 000			
	Annual Licensure and	d Recertification Survey				
S9999	Final Observations		S9999			
	Statement of Licensu	re Violations				
	300.650c) 300.650d) 300.660a) 300.660c)1) 300.661					
	Section 300.650 Pers	sonnel Policies				
	that requires a State contact the Illinois De Professional Regulati individual's license is	any individual in a position license, the facility shall epartment of Financial and ion to verify that the active. A copy of the license individual's personnel file.				
	d) The facility shall chapplicants with the Heprior to hiring.	neck the status of all ealth Care Worker Registry				
	Section 300.660 Nurs	sing Assistants				
	nursing assistant, hor services rehabilitation individual who may he resident's living quart financial, or medical r the facility has inquire Health Care Worker F	employ an individual as a me health aide, psychiatric naide, or newly hired as an ave access to a resident, a ers, or a resident's personal, records, nurse aide unless ed of the Department's Registry and the individual is care Worker Registry as nealth care employer.				
	ment of Public Health	SUPPLIER REPRESENTATIVE'S SIGNATUF	RE .	TITLE	(X6) DATE	

11/14/24 **Electronically Signed**

Illinois Department of Public Health

IL6008072 STREET ADDRESS, CITY, STATE, ZIP CODE SOZ NORTH MAIN BRIGHTON, IL 62012 (X4] ID PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CONTINUED FROM THE APPROPRIATE DATE CONTINUED FROM THE APPROPRIATE DATE S9999 Continued From page 1 c) The facility shall ensure that each nursing assistant complies with one of the following conditions: 1) Is approved on the Department's Health Care Worker Registry. "Approved" means that the nurse aide has met the training or equivalency requirements of Section 300.663 of this Part and does not have a disqualifying criminal background check without a waiver. Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. These requirement were not met as evidence by: Based on interview and record review, the facility	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH MAIN BRIGHTON, IL 62012 (X4) ID PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG COMPLETE DEFICIENCY TAG CONTINUED FROM THE APPROPRIATE DEFICIENCY S9999 Continued From page 1 c) The facility shall ensure that each nursing assistant complies with one of the following conditions: 1) Is approved on the Department's Health Care Worker Registry. "Approved" means that the nurse aide has met the training or equivalency requirements of Section 300.663 of this Part and does not have a disqualifying criminal background check without a waiver. Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. These requirement were not met as evidence by: Based on interview and record review, the facility						
ROBINGS MANOR RHC SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (KS) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	IL6008072			B. WING		10/24/2024
Summary Statement of Deficiencies Deficiency Must be Preceded by Full Regulatory or Local Deficiency Must be Preceded by Full Regulatory or Local Demonstration Deficiency Must be Preceded by Full Regulatory or Local Demonstration Deficiency Must be Preceded by Full Regulatory or Local Demonstration Deficiency Deficie	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 1 c) The facility shall ensure that each nursing assistant complies with one of the following conditions: 1) Is approved on the Department's Health Care Worker Registry. "Approved" means that the nurse aide has met the training or equivalency requirements of Section 300.663 of this Part and does not have a disqualifying criminal background check without a waiver. Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. These requirement were not met as evidence by: Based on interview and record review, the facility	ROBINGS MANOR RHC					
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failed to obtain and conduct pre-employment screening, including the Illinois Sex Offender Registry, the Illinois Department of Corrections (IDOC) Sex Offender Registry, the IDOC Inmate Search, the IDOC Wanted Fugitive Search, or the HHS (Health and Human Services) OIG (Office of Attorney General) check to determine if employees had a prior criminal history which would disqualify them for employment. This has the potential to affect all 29 residents living in the facility. Findings include: On 10/23/24, 10 employee files were randomly selected and reviewed for pre-employment screening. The following was documented: V26, Certified Nursing Assistant (CNA), was hired	S9999	c) The facility shall er assistant complies wi conditions: 1) Is approved or Care Worker Registry the nurse aide has me requirements of Sectidoes not have a disquibackground check with Section 300.661 Hear Check A facility shall comply Worker Background Care Worker Backgro	In the Department's Health In the Department's Health In Tapproved" means that tet the training or equivalency on 300.663 of this Part and utalifying criminal thout a waiver. Ith Care Worker Background With the Health Care Check Act and the Health bund Check Code. The Illinois Sex Offender Department of Corrections Registry, the IDOC Inmate anted Fugitive Search, or the man Services) OIG (Office of the Incomment of Inc	S9999	DEPICIENCI)	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED	
		IL6008072	B. WING		10)/24/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
ROBINGS	MANOR RHC	**= ****	RTH MAIN ON, IL 62012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
\$9999	Illinois Sex Offender Offender registry, the IDOC Wanted Fugitive checks prior to V26's V26 had a disqualify. V28, CNA, was hired completed a Health of but failed to initiate a registry, the IDOC Son HS OIG checks pridetermine if V28 had v29, CNA, was hired completed a Health of but failed to initiate a registry, the IDOC Son IDOC Inmate Search Search, and the HHS start date, to determine conviction. V27, CNA, was hired completed a Health of but failed to initiate a registry, the IDOC Son IDOC Inmate Search Search, and the HHS start date, to determine conviction. V23, CNA, was hired completed a Health of but failed to initiate a registry, the IDOC Son IDOC Inmate Search Search, and the HHS start date, to determine conviction.	26, but failed to initiate an registry, the IDOC Sex IDOC Inmate Search, the re Search, and the HHS OIG start date, to determine if	S9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	, ,	E SURVEY PLETED	
		IL6008072	B. WING		10)/24/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
ROBINGS	MANOR RHC		TH MAIN ON, IL 62012			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From page	3	S9999			
	facility completed a H on V25, but failed to in Offender registry, the Registry, the IDOC In Wanted Fugitive Sear checks prior to V25's V25 had a disqualifyin V24, Laundry Aide, w facility completed a H on V24, but failed to in Offender registry, the Registry, the IDOC In Wanted Fugitive Sear checks prior to V24's V24 had a disqualifyin	IDOC Sex Offender mate Search, the IDOC rch, and the HHS OIG start date, to determine if ng conviction. as hired on 8/15/24. The ealth Care Registry check nitiate an Illinois Sex IDOC Sex Offender mate Search, the IDOC rch, and the HHS OIG start date, to determine if				
	search for licensure o	y initiated an Illinois sional Regulation (IDFPR) n 7/8/24. The facility did not Nursing License on file.				
	to initiate a IDFPR se					
	stated "All we have fo	PM, V1, Administrator, or background checks for our althcare Registry. There was				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _					
IL6008072		B. WING	B. WING		24/2024		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
PORINGS	MANOR PHC	502 NOR	TH MAIN				
ROBINGO	ROBINGS MANOR RHC BRIGHTON						
(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 ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
S9999	Continued From page	e 4	S9999				
	On 10/23/24 at 1:12 PM, V22, Business Office Manager, stated "We did not do any other background checks on employees. That is all we have is the Healthcare Registry check. On 10/23/24 at 2:40 PM, V1, Administrator, stated "It looks like there was no IDFPR licensure check completed on (V30, LPN) and (V5, LPN), or at least it is not in their file. I will get on and print them out. The facility's "Abuse Prevention Program" Policy, undated, documents "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. this facility therefore prohibits mistreatment, exploitation, neglect, or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all						
	within its control to pr mistreatment, exploit	at the facility is doing all event occurrences of ation, neglect, or abuse of ill be done by: Conducting					
	required pre-employr employees. This facil	· · · · · · · · · · · · · · · · · · ·					
	disciplinary action tak license by a state lice finding of abuse, neg residents or a finding resident property. Pro Pre-Employment Scr Employees. This facil	sen against a professional ensure body as a result of a lect, or mistreatment of of misappropriation of ocedures for Prevention: 1.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION IDENTIFICATION NOWIBER.		A. BUILDING:		COMP	LETED	
IL6008072		B. WING		10/	24/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		502 NOR	TH MAIN			
ROBINGS	MANOR RHC		N, IL 62012			
(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 (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
S9999	g a managa a managa a		S9999			
	Background Check A	e Illinois Healthcare Worker ct (unless waivered under				
	listed on the Illinois H	ct), or with findings of abuse lealth Care Worker Registry.				
	Prior to a new employ schedule, this facility	yee starting a work will: Initiate a reference				
	check from previous	employer(s), Obtain a copy				
		f any individual being hired				
	for a position requiring a professional license and check the licensee's status with the licensing entity, Check the Illinois Health Care Worker Registry on all individuals being hired for a position and potentially bordering states that the					
	· ·	lly bordering states that the have been licenses/certified				
		riduals resume or other				
	employment information available to the facility; and Under the Health Care Worker Background					
		46/1) and facility "Criminal				
	`	olicy" policy, we are required				
	_	nt based criminal history				
		non-licensed employees. It				
	is the facility policy th	at we request a				
		criminal history record				
	check for all licensed	employees."				
		round Check" Policy, dated				
	· ·	Under the Health care				
	are required to reque	Check Act (225 ILCS 46), we				
	criminal history record	• .				
	_	ment applicant who may				
		resident or access to the				
		ers or the financial, medical				
		of the resident via the Health				
	I	/. It is the policy of Petersen				
		st a background check on all				
		pe terminated if the either the				
		Registry or Background				
	T	s a record of conviction of				
	any of the offenses enumerated below or for					

Illinois Department of Public Health

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED	(X3) DATE SURVEY COMPLETED	
IL6008072 B. WING 10/24/2	10/24/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
ROBINGS MANOR RHC 502 NORTH MAIN BRIGHTON, IL 62012		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE	
S9999 Continued From page 6 other offenses the facility feels would preclude continued employment.* The Long-Term Care Facility Application for Medicare and Medicaid, dated 10/21/2024, documents the total number of residents living in the facility was 29. (C)		

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