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						
		IL6008239	B. WING		03/2	8/2024					
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
REGENCY CARE 2120 WEST WASHINGTON SPRINGFIELD, IL 62702											
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE						
S 000	Initial Comments		S 000								
	Annual licensure ar	nd Certification survey.									
S9999	Final Observations		S9999								
	Statement of Licensure Violations										
	300.615e)										
	300.615 e.) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility										
	failed to do criminal checks on 2 out of	l history information response 5 (R230,R16) residents round checks in a sample of									
	Findings include:										
		dated 3/28/2024, documented of 3/22/2024 to facility.									

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

Electronically Signed 04/11/24

STATE FORM 6899 If continuation sheet 1 of 2 L88S11

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			COMPLETED						
		II 000000	B. WING			0.4000.4						
		IL6008239	B. WING		03/2	8/2024						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2420 WEST MASUNICTOR												
REGENCY CARE 2120 WEST WASHINGTON SPRINGFIELD, IL 62702												
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE							
S9999	Continued From page 1		S9999									
	Criminal History Information Response document was dated 3/25/2024.											
	an admission date	ated 3/28/2024, documented of 3/6/2024 to facility. Criminal Response document was										
	On 3/27/2024 at 3:00 PM, V16, Admissions, stated that upon admission, R230, & R16 Criminal History Information Response and backgrounds did not get checked until a few days after residents were admitted. On 3/27/2024 at 3:15 PM, V1, Administrator, stated that she was not aware that the background checks were not getting done prior to admissions. V1 continued to stated that she expects her staff to complete the resident background checks prior to admission date.											
	procedure," undated	dure titled, "Offender d, documented that will be completed within 24										
	(C)											

Illinois Department of Public Health STATE FORM

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