(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:		(X3) DATE SURVEY COMPLETED			
			A. BOILDING.					
		IL6007504	B. WING		04/1	1/2024		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
PLEASANT VIEW REHAB & HCC 500 NORTH JACKSON STREET MORRISON, IL 61270								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
S 000	Initial Comments		S 000					
	Annual Licensure S	Survey						
S9999	Final Observations		S9999					
	Statement of Licensure Violations:							
	300.661							
	Section 300.661 He Check	ealth Care Worker Background						
	Worker Background	oly with the Health Care d Check Act and the Health ground Check Code.						
	This REQUIREMENT was not met as evidenced by:							
	Based on interview and record review, the facility failed to ensure background checks were completed prior to allowing staff to work in the facility.							
	This failure has the residents.	potential to affect all 28						
	The findings include	e:						
		application for Medicare and wed there were 28 residents in						
	worker background	an annual survey healthcare check task, staff background sted for V7 Certified Nursing d V8 cook.						
	The facility's active	employee list showed V7 was						

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

05/04/24 **Electronically Signed**

TITLE

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		
		IL6007504	B. WING		04/1	1/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
PLEASA	NT VIEW REHAB & H	CC	TH JACKSON STREET ON, IL 61270				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
S9999	Continued From page 1		S9999				
	hired on 9/26/2018.						
	The background checks showed the state health care worker registry was checked for V7 on 10/11/2018.						
	The facility's active employee list showed V8 was hired 10/2/2023.						
	The facility was una background checks	able to provide evidence any swere done for V8.					
	V8's time report showed he worked 19 days from 10/5-10/29/23.						
	need to make sure are vetted, and do not background. We manufact in their background offender or wanted keep the residents. And to ensure they their experience started credentials needed Employee backgrounds.	ake sure there's no abuse or kground, they're not a sex fugitive. The bottom line is to and other employees safe. I're qualified to do the work. Hould reflect they have the to serve the residents. Line und checks should be done the ere for the safety of the					
	she keeps employed V5 said V7 was hired background checks Said V8 was hired checks were done does the background checks prior to hire and wo	usiness Office Manager said be personnel files in her office. Bed on 9/25/2018 and se were done on 10/11/2018. V5/10/2/2023 and no background on him. V5 said corporate and checks. V5 said se should "absolutely" be done wrking. "We don't know their make sure the residents are					

Illinois Department of Public Health

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Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PRO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				OATE SURVEY OMPLETED	
		IL6007504	B. WING		04/1	1/2024	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
PLEASANT VIEW REHAB & HCC 500 NORTH JACKSON STREET MORRISON, IL 61270							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 2	S9999				
	showed a health caemploy, or retain, we basis, any individual involving direct care residents, who has abuse, neglect, mist theft denoted on the Registry. The facility's 11/28/showed the purposfacility is doing all the prevent occurrence.	orker Background Check Act are employer shall not hire, whether paid or on a volunteer all in a position with duties are of clients, patients, or a finding by the Department of sappropriation of property, or a Health Care Worker 2016 Abuse Prevention Policy are of this policy is to assure the nat is within its control to as of mistreatment, at or abuse of residents. This					
	will be done by con						

6899

Illinois Department of Public Health STATE FORM

ZF4Y11 If continuation sheet 3 of 3