Illinois Department of Public Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	COMPLETED				
		IL6001143	B. WING	<u> </u>	C 04/26/2024		
	BRIAR PLACE NURSING 6800 WES			ADDRESS, CITY, STATE, ZIP CODE EST JOLIET HEAD PARK, IL 60525			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES BY 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				
	Complaint Investiga	pation 23910329/IL167685 23910726/IL168156					
S9999	Final Observations		S9999				
	Statement of Licen	sure Violations					
	300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3) 300.1210d)6)						
	Section 300.610 R	Resident Care Policies					
	procedures governifacility. The written be formulated by a Committee consisti administrator, the a medical advisory confinersing and other policies shall compolicies the facility and shall be confined by the written policies.	advisory physician or the committee, and representatives er services in the facility. The ply with the Act and this Part. It is shall be followed in operating all be reviewed at least annually documented by written, signed					
	Section 300.1210 (Nursing and Person	General Requirements for anal Care					
	a) Comprehen facility, with the par	nsive Resident Care Plan. A rticipation of the resident and					

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

Electronically Signed

TITLE

(X6) DATE

05/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6001143	B. WING		C 26/2024	
NAME OF				TATE, ZIP CODE	1 04/2	20/2024
BRIAR P	LACE NURSING		ST JOLIET IEAD PARK, I	L 60525		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
\$9999	the resident's guardapplicable, must de comprehensive car includes measurab meet the resident's and psychosocial resident's comprehallow the resident to provide for dischargestrictive setting beneeds. The assess the active participar resident's guardian applicable. (Section b) The facility care and services to practicable physical well-being of the reeach resident's complan. Adequate and care and personal care and personal care and personal care and personal care and be knowledged resident to meet the care needs of the recomplant of the care shall in the following and shall is seven-day-a-week to objective of the care needs of the recomplant of the care needs of the recomplant of the care shall in the following and shall is seven-day-a-week to objective of the care needs of the care needs of the recomplant of	dian or representative, as evelop and implement a re plan for each resident that le objectives and timetables to medical, nursing, and mental leeds that are identified in the ensive assessment, which of attain or maintain the highest independent functioning, and ge planning to the least assed on the resident's care sment shall be developed with tion of the resident and the or representative, as in 3-202.2a of the Act) shall provide the necessary of attain or maintain the highest light mental, and psychological sident, in accordance with inprehensive resident care light properly supervised nursing care shall be provided to each the total nursing and personal resident. care-giving staff shall review while about his or her residents' care plan. subsection (a), general include, at a minimum, the per practiced on a 24-hour,				

Illinois Department of Public Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: B. WING 04/26/2024 IL6001143 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **6800 WEST JOLIET** BRIAR PLACE NURSING INDIAN HEAD PARK, IL 60525 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 S9999 Continued From page 2 made by nursing staff and recorded in the resident's medical record. All necessary precautions shall be taken 6) to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were not met evidenced by: Based on interview and record review, the facility failed to effectively supervise a resident with history of drug abuse. This deficient practice affects one resident of three residents reviewed for change in condition. R28 had multiple incidents of noncompliance for bringing in contraband and R28 tested positive for cocaine once during R28's stay in the facility. R28 expired on 12/2/23 in the facility with cause of death as combined drug toxicity: Drug fentanyl Acetyl despropionyl fentanyl. Findings Include: R28 was admitted in the facility on 6/8/2023 and expired on 12/2/23. R28 is a 39 year old female resident. R28 has diagnoses but not limited to: post traumatic stress disorder, psychoactive substance abuse, anxiety disorder, major depressive disorder, attention-deficit hyperactivity disorder and suicidal ideation. R28's notes for Initial Meeting for MISA/Alcohol

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
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NAME OF I	PROVIDER OR SUPPLIER	R STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
BRIAR P	LACE NURSING		ST JOLIET HEAD PARK, I	L 60525			
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S9999	6/9/23, reads in particular cocaine. R28 also prescribed Vicodin medication) after of to start using again heroin for 5 or 6 yewas noncompliant medications. R28 referred to the MIS abuse. R28 was make and outside (Urine Drug Screet Concentration) will suspicion of using. Social Service Not writer met with R28 smoking restriction found in her room. Smoking policy and from bringing control Sample of the writer the house rules. Af R28 began to under R28. Care plan will will continue to mo	use program/Introduction dated art: R28 noted using heroin and reported that she was a (controlled substance pain ar accident which caused R28 h. R28 further reported using ears. Per medical records, R28 with her psychotropic was told that R28 will be 6A program for poly0substance hade aware that this facility has using alcohol, THC pinol-found in cannabis) or any stances while in treatment the facility and random UDS ning) and BAC (Blood Alcohol be administered and for as there was contraband Writer re-educated R28 on the dencouraged R28 to refrain raband into the facility. The dated 7/16/23, reads in part: R28 was seen with contraband raband into the facility. The dated 7/16/23, reads in part: R28 was seen with contraband raband into the facility. The dated 7/16/23, reads in part: R28 was seen with contraband raband into the facility. The dated 7/16/23 in part: R28 was seen with contraband raband rab					

AND DIAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	IL6001143		B. WING		C 04/26/2024	
	PROVIDER OR SUPPLIER	6800 WES		TATE, ZIP CODE		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
S9999	R28 stated to have out and forgot to tuon the house rules outside of designat to turn in material at Due to multiple viole will be taken for 30 and Social Service Note Writer notified that contraband. Upon was not smoky as unlit cigarette was was educated about smoking inside the smoking for 30 day. Social Service Note reads in part: Condon Drug Screening) are THC and opioids. It uses THC and opioids. It uses THC and opioids. It uses THC and R28 and facility's supersigning at the reunion alcohol". CADC (Counselor) comme mood-altering substold R28 that R28 of treatment. Offered R28 refused, statin continue MISA (me abuse) programming Social Service Note reads in part: Write contraband. Upon enot smoky as R28 of the stating contraband. Upon enot smoky as R28 of the stating contraband. Upon enot smoky as R28 of the stating contraband. Upon enot smoky as R28 of the stating contraband. Upon enot smoky as R28 of the stating contraband. Upon enot smoky as R28 of the stating contraband. Upon enot smoky as R28 of the stating contraband.	e gotten them when R28 went arn it over. Writer educated R28 regarding smoking materials and area and encouraged R28 at the front desk upon re-entry. Illations, R28 smoking privileges days. The dated 7/23/23 reads in part: on 7/20/23 R28 had entering the room bathroom R28 exiting the bathroom. An located in R28's bedroom. R28 at the hazards/safety risks of facility. R28 is restricted from a facility. R28 is restricted from a facility series and subtract a pain pill under doctor's a sapparent that R28 currently a takes pain pill under doctor's a but did not do other drug or entified Alcohol and Drug anded R28 not using other stances. Furthermore, CADC cannot use marijuana while in another level of treatment but g "it's only marijuana". Will not illness and substance and dated 9/18/23 at 12:36PM, or met with R28 due to having entering room, bathroom was was exiting the bathroom. A an R28's bedroom. R28 is	\$9999			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
/ IND I EXIL	OF CONTROL OF THE PROPERTY OF	BENTI TOXT TO THOMBET.	A. BUILDING:				
		IL6001143	B. WING		04/26/2024		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE			
BRIAR P	LACE NURSING	6800 WES INDIAN HI	T JOLIET EAD PARK,	IL 60525			
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S9999	Continued From pa	ge 5	S9999				
	R28 mother called a was out of town, R2	e dated 9/25/23, reads in part: and spoke to writer, when she 28 was caught using cocaine d lying about her drug use. Will					
	CADC and R28's m impromptu as she w current drug use ac (THC and Cocaine) meeting. Both agree	e dated 10/1/23, reads in part: from met briefly yesterday was coming to visit R28. R28's tivity and last positive UDS were discussed in the ed that inpatient or residential is recommended, will continue					
	Treatment dated 10 been observed on sund taking while under so other IDT members for cocaine. Her Droffered R28 an oppor residential Treatmissues but R28 ada On 3/22/24 at 11:15 Coordinator) stated positive result of coshould have docum positive for cocaine denied it, and there medication that can "Based on my clinic assessment that da positive, but I did no see it would be imposed to the state of the sta	y, the result was false of document because I did not ortant to document my clinical					
		dated 11/28/23, reads in part:					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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		IL6001143	B. WING			26/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BRIAR P	PLACE NURSING		ST JOLIET EAD PARK, I	L 60525			
(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 ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
\$9999	Writer was informe possession of conticonfiscated the iter performed consens on 90-day smoking. On 3/20/24 at 1PM regarding delivered and if the social seralso check. Unfortusearch for visitors, the package is left Regarding 11/28/23 vape /THC pen was searched the whole found. R28 was placannot recall how Falready on red pass community with famous unsupervised. Subfore R28 can go On 3/21/24 at 1:15F off essential items a brings it to the resident and giving it to the ready and giving it to the resident. Also, for service that a family coming in with bag social service will covisitor is staying and then the reception visitor is staying and that V4 will notify the confidence of the continuous of the conti	d that resident was caught in raband. Social service staff ins (Vape and THC pens) and sual room search. R28 placed restriction. V4 (Social Service Director) litems, reception will check rvices are available they will inately we are not able to do We check the package once by the visitor to any residents. We confiscated contraband, is found. We checked and room and nothing else was ced on smoking restriction. V4 828 got the vape. R28 was social service and groceries, social service lents. Reception will call the get the food delivered and the have checked it prior to calling nurse. Unless the resident is unit by the reception area, the ck the bag before giving it to ront desk will inform the social of member/other visitors of items. If dropping it off, then ome down and search and if droming in with bag of items will check the bag. M, V24 (Receptionist) stated a nurse that a family member	S9999				
	that V4 will notify the will bring a bag of si	e nurse that a family member nacks for the nurse to check					

PRINTED: 06/06/2024 FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: B. WING 04/26/2024 IL6001143 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6800 WEST JOLIET **BRIAR PLACE NURSING INDIAN HEAD PARK, IL 60525** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG** TAG DEFICIENCY) S9999 S9999 Continued From page 7 in the nurses station. "Because I do not know the residents diet. I will call the nurse and let them know that a family member is on their way with a bag of snacks". Outside deliveries, they come in they show us their phone and show us they are here to deliver something. Sometimes residents will come down and wait for the delivery person and wait for them on the other side of the door (receptionist area to facility floor unit). In regards to groceries, Social service will check. "I will inform social service that a grocery is delivered or dropped off". Social service need to be present when handing the bag to the resident. Food delivery service, it has to be given unopened to the resident. We don't check if with the receipt and the bag is closed. On 3/28/24 at 3:30 PM, V17 (Substance Abuse Coordinator), stated that due to history of drug use while in the facility, R28 was counseled not to do drugs anymore. In general, a resident that tested positive for illegal drugs we will try to find out where they got the drugs from. We notify the MD. If they have a guardian we will notify the quardian. High level treatment which is inpatient was offered to R28, R28 refused. Our intervention was to continue with the current intervention in the care plan. No new specific intervention added at the time she tested positive for cocaine. Staff to encourage R28 to attend group meeting such as AA meeting. Increase one to one meeting. Nurses Notes dated 12/2/2023 05:45, reads in

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part: Upon rounds at this time, observed R28 in bed lying on Left side. Called her name, not easily aroused. Unresponsive verbally and tactile. Upon further assessment she appeared not to be breathing. Code blue immediately called, CPR Initiated. All staff Nurses responded. 911 Emergency was called and they arrived

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER	IL6001143	B. WING	TATE, ZIP CODE	04/2	26/2024
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S9999	Continued From pa	ge 8	S9999			
	Medical Services) r Patient's mother alr as well as the Direct	Cardio Pulmonary inuous EMS (Emergency esumed CPR. Police present. ready notified and in the facility etor of Nursing. EMS en called the Time of Death				
	in part: Unit notified arrived at scene at 6:04AM. Called for home staff attempti resident. Unknown patient was seen no patient was found no cyanotic from the nothroughout body. 4 asystole. Local ER	unsheet dated 12/2/23, reads 12/2/23 at 5:56AM, Unit 6:03AM, and patient contact at Cardiac Arrest. Found nursing ng CPR on 38 year old PMH. Unknown last time ormal. Unknown what time not breathing. Exam, patient eck up. Patient with full rigor lead applied confirmed call for medical control. firmed DOA (Dead on Arrival)				
	Reported that after R28's text message was in communicat driver stating that the hair coloring boof drugs it was and of this transaction of	M, V60 (R28's complainant) R28's death, they checked es on her cellphone and R28 ion with somewhat an Uber ne drugs will be placed inside x. Was not specific what kind was not able to give the date conversation through text orted that R28 died of drug				
	personnel) confirme written in R28's Dea	6AM, V61 (Coroner's office ed cause of death for R28 as ath Certificate as combined entanyl Acetyl despropionyl				
	Physician Order she	eet reviewed and there is no				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETE C	
IL6001143 B. WING 04/26/2	2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIAR PLACE NURSING 6800 WEST JOLIET INDIAN HEAD PARK, IL 60525	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999 Continued From page 9 order for Fentanyl medication. Resident Handbook revision date 1/7/23, reads in part: Room, Personal and Body Searches. Staff members perform room checks every day. Staff will check each resident room to ensure a clean and safe environment. You may be present at the times of these room checks. Please be aware that staff will be checking all closets, dressers, suitcases and shelving. Certain items are not permitted in your room for your safety and safety of others. Some items not allowed in the facility, include but not limited to: Firecrackers or any kind of chemicals or flammable materials. Any poisonous materials. Guidelines for Community Access Determination dated 2/8/23, reads in part: Resident personal belongings will be searched upon entry and re-entry to the facility. June 2017 Alcohol/Substance Use/Abuse policy reads in part: Substance Use/Abuse Policy objective It is the policy of the nursing facility to provide a safe and healthy living environment. The facility recognizes that persons requiring long-term care present with significant physical and mental health problems. In some situations, the person may have a history of substance abuse. The facility recognizes that substance use/abuse disorders result in substantial physical and mental impairment disability and recognize the personal responsibility of the individual to seek and remain engaged in treatment. The facility shall work with the individual to provide appropriate treatment referrals to enable the individual to work on abstinence, sobriety, personal improvement and reducing chances of recidivism. Appropriate interventions are strongly	

PRINTED: 06/06/2024 FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6001143 04/26/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6800 WEST JOLIET BRIAR PLACE NURSING INDIAN HEAD PARK, IL 60525** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 S9999 Continued From page 10 recommended to persons with substance abuse problems. Each resident (and/or representative) is informed that facility policy prohibits the use of alcohol without a doctor's order. Facility policy prohibits use of illicit drugs. As a condition of residence, each person living in the facility acknowledges that he/she will not use alcohol or illicit drugs during residence in this building. Persons returning from the community who present with signs and symptoms of intoxication will be evaluated by the nurse on duty or charge nurse. The nurse is responsible for taking vital signs and assessing the person's present behavior. The nurse will be responsible for contacting the attending physician (A.P.) if the resident is determined to be in need of medical attention and/or a decision is required regarding withholding prescribed medications. Documentation will be placed in the chart regarding signs/symptoms of intoxication/inebriation. Documentation should include the resident's own admission of alcohol/drug use. The facility reserves the right to have the person submit to blood/urine testing at any time if policy violation is suspected. Follow-up interventions and treatment recommendations will be communicated to the

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aftercare

resident/representative and documented in the medical record. Outside treatment sources will be utilized as appropriate. Residents with substance abuse disorders are expected to participate in acute/active treatment, sobriety counseling, or

Persons who continually jeopardize their health

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STATE FORM