

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6000715</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/03/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>STAUNTON HEALTH AND REHAB CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>215 WEST PENNSYLVANIA AVENUE STAUNTON, IL 62088</b>
--	---

(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
S 000	Initial Comments  Annual Licensure and Certification Survey	S 000		
S9999	Final Observations  Statement of Licensure Violations  300.661  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.  This Requirement is NOT MET as evidence by:  Based on interview and record review, the facility failed to conduct pre-employment screening and obtain results of fingerprint checks to determine if employees had a prior criminal history which would disqualify them for employment. This had the potential to affect all of the 45 residents living in the facility.  Findings include:  On 5/3/2024 five employee files were reviewed for pre-employment screening. The following was documented:  V16, Registered Nurse, was hired on 2/6/2024. The facility failed to ensure a criminal background check was completed prior to employee providing care to residents.  V29, Licensed Practical Nurse, was hired on 4/29/2024. The facility failed to ensure a criminal	S9999		

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

TITLE

(X6) DATE  
05/23/24

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6000715</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/03/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>STAUNTON HEALTH AND REHAB CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>215 WEST PENNSYLVANIA AVENUE STAUNTON, IL 62088</b>
--	---

(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	<p>Continued From page 1</p> <p>background check was completed prior to employee providing care to residents.</p> <p>V30, Certified Nursing Assistant, was hired 2/9/2024. The facility failed to ensure a criminal background check was completed prior to employee providing care to residents.</p> <p>V31, Certified Nursing Assistant, was hired on 3/26/2024. The facility failed to ensure a criminal background check was completed prior to employee providing care to residents.</p> <p>V32, Certified Nursing Assistant, was hired 3/7/2024. The facility failed to ensure a criminal background check was completed prior to employee providing care to residents.</p> <p>On 5/3/2024 at 1:30 PM, V1, Administrator, stated that the facility was recently audited by the company corporate office and healthcare worker background checks were found not to be completed.</p> <p>The facility's Abuse Prevention Policy, dated 10/24/2022, documented, "The facility will not knowingly employ an individual who has been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law: or have a disciplinary action against their license by a state licensing body as the result of a finding of abuse, neglect, exploitation, misappropriation of property or mistreatment."</p> <p>The Long -Term Care Facility Application for Medicare and Medicaid form, dated 4/30/2024, documented that the facility had a census of 45 residents.</p> <p>(C)</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6000715</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/03/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>STAUNTON HEALTH AND REHAB CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>215 WEST PENNSYLVANIA AVENUE STAUNTON, IL 62088</b>
--	---

(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