(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 | |
|---|---|--|---|---|-------------------------------|--------------------------|
| | | IL6005011 | B. WING | | 06/0 | 5/2024 |
| NAME OF F | PROVIDER OR SUPPLIER | | , , | STATE, ZIP CODE | | |
| KEWANE | EE CARE HOME | | OR AVENUE E, IL 61443 | | | |
| (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 | | S 000 | | | |
| | Annual Licensure S | Survey | | | | |
| S9999 | Final Observations | | S9999 | | | |
| | Statement of Licens 300.660a) 300.660c)1)2) 300.661 300.650d) | sure Violations I of II: | | | | |
| | Section 300.660 Nursing Assistants a) A facility shall not employ an individual as a nursing assistant, home health aide, psychiatric services rehabilitation aide, or newly hired as an individual who may have access to a resident, a resident's living quarters, or a resident's personal, financial, or medical records, nurse aide unless the facility has inquired of the Department's Health Care Worker Registry and the individual is listed on the Health Care Worker Registry as eligible to work for a health care employer. | | | | | |
| | assistant complies conditions: 1) Is approved on the Worker Registry. "Inurse aide has met requirements of Sedoes not have a district background check and with 120 days submits documents accordance with Sedoes registered on the Registry. | without a waiver. after initial employment, ation to the Department in ection 300.663 of this Part to e Health Care Worker | | | | |
| | Section 300.661 He | ealth Care Worker Background | | | | |

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

06/24/24 **Electronically Signed**

TITLE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | IL6005011 | B. WING | | 06/0 | 5/2024 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AL | DRESS, CITY, S | STATE, ZIP CODE | | |
| KEWANE | EE CARE HOME | | OR AVENUE E, IL 61443 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / 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) | LD BE | (X5) COMPLETE DATE |
| \$9999 | Check A facility shall comp Worker Background Care Worker Background Care Worker Background Care Worker Background The facility shall applicants with the prior to hiring. This REQUIREMEN Based on interview failed to perform he checks prior to emp employee records in Worker Background failure has the pote residing in the facilit Findings Include: The facility staffing (Director of Nursing V10 (Certified Nurs (Cook), V24 (CNA) (CNA), V29 (Licens V30 (Registered Nu in the facility. The following Empl the following docum 1. V2 (DON) was hi | oly with the Health Care d Check Act and the Health ground Check Code. ersonnel Policies I check the status of all Health Care Worker Registry NT is not met as evidenced by: and record review, the facility ealth care worker background ployee hire date for 10 of 10 reviewed for Health Care d Check completion. This nitial to affect all 43 residents ty. schedules document V2 g/DON), V6 (Housekeeper), ing Assistant/CNA), V13, V25 (CNA), V27 (CNA), V28 red Practical Nurse/LPN), and urse/RN) are currently working oyee files were reviewed with | | | | |
| | 2. V6 (Housekeepe | er) was hired on 2/15/24 and | | | | |

Illinois Department of Public Health

STATE FORM 6899 FUFR11 If continuation sheet 2 of 7

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|----------------------------|---|-------------------------------|--------------------------|
| | | IL6005011 | B. WING | | 06/ | 05/2024 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | STATE, ZIP CODE | - | |
| KEWANE | EE CARE HOME | | IOR AVENUE EE, IL 61443 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| \$9999 | not initiated until 5/2 3. V10 (CNA) was hear Care Worker Backginitiated until 6/4/24 4. V13 (Cook) was hear Worker Backginitiated until 6/4/24 5. V24 (CNA) was hear Care Worker Backginitiated until 5/16/2 6. V25 (CNA) was hear Care Worker Backginitiated until 6/4/24 7. V27 (CNA) was hear Care Worker Backginitiated until 11/10/3 8. V28 (CNA) was hear Care Worker Backginitiated until 6/4/24 9. V29 (LPN) was hear Worker Backginitiated until 6/4/24 10. V30 (RN) was hear Worker Backginitiated until 6/4/24 10. V30 (RN) was hear Worker Backginitiated until 2/21/2 Record documents offenses on 5/30/19 and 2/02/1990. V30 State Agency on 8/2 | r Background Checks were 21/24. hired on 3/22/24 and Health ground Checks were not hired on 1/25/24 and Health ground Checks were not hired on 5/15/24 and Health ground Checks were not 4. hired on 1/5/24 and Health ground Checks were not 5. hired on 1/5/24 and Health ground Checks were not 6. hired on 10/25/23 and Health ground Checks were not 7. hired on 12/15/23 and Health ground Checks were not 6. hired on 3/1/24 and Health ground Checks were not 7. hired on 2/17/22 and Health ground Checks were not 7. hired on 2/17/22 and Health ground Checks were not 7. hired on 2/17/22 and Health ground Checks were not 7. hired on 2/17/29 and Health ground Checks were not 7. hired on 2/17/29 and Health ground Checks were not 7. hired on 2/17/29 and Health ground Checks were not 7. hired on 2/17/29 and Health ground Checks were not 7. hired on 2/17/29 and Health ground Checks were not 7. hired on 2/17/29 and Health ground Checks were not 7. hired on 2/17/29 and Health ground Checks were not 7. hired on 2/17/29 and Health ground Checks were not 7. hired on 3/1/24 and Health ground Checks were not 9. hired on 3/1/24 and Health ground Checks were not 9. hired on 3/1/24 and Health ground Checks were not 9. hired on 3/1/24 and Health ground Checks were not 9. | S9999 | | | |
| | On 6/5/24 at 2:00 p | m, V1 (Administrator in | | | | |

Illinois Department of Public Health

STATE FORM 6899 FUFR11 If continuation sheet 3 of 7

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|---------------------|--|--------|--------------------------|
| | | IL6005011 | B. WING | | 06/0 | 5/2024 |
| | PROVIDER OR SUPPLIER | 144 JUNIO | R AVENUE | STATE, ZIP CODE | | |
| | | KEWANEE | E, IL 61443 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES 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 | Continued From pa | ge 3 | S9999 | | | |
| | Checks are to be demployee. V1 state has not had anyone Background Check documentation prio having to go back at The Long Term Car Medicare and Medicare and Medicare and Medicare 43 residents cu | alth Care Worker Background one prior to hiring an d due to staffing problems she to do the Health Care Workers, does not have any reto January 2024, and is and do the checks herself. The Facility Application for caid, CMS (Central ces) Form 671, signed and V2 (DON), documents there reently residing in the facility. Source Violations II of II: | | | | |
| | Screening and Req History Record Info b) All persons seek facility must be scree for nursing facility s admitted, regardles funding source. (Se screening assessm one of the condition rules of the Departr Services titled Medi Code 140.642(c)) is | king admission to a nursing bened to determine the need ervices prior to being s of income, assets, or ection 2-201.5(a) of the Act) A ent is not required provided as in Section 140.642(c) of the ment of Healthcare and Family ical Payment (89 III. Adm. is met. | | | | |
| | e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a | | | | | |

Illinois Department of Public Health

STATE FORM 6899 FUFR11 If continuation sheet 4 of 7

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE_ZIP CODE 144 JUNIOR AVENUE KEWANEE CARE HOME 144 JUNIOR AVENUE KEWANEE, IL 61443 SUMMARY STATEMENT OF DEPICIENCIES IPACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ILS DIENTIFYING INFORMATION) S9999 Continued From page 4 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 check was initiated by a hospital pursuant to the Hospital Licensing Act. 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) f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc. state.il.us to determine if the individual is listed as a registered sex offender. ii) The facility shall provide for or arrange for any required fingerprint-based checks to be taken on the premises of the facility. If a fingerprint-based check is required, the facility is unable to conducted in a manner that is respectful of the resident's dignity and that minimizes any emotional or physical hardship to the resident. (Section 2-201.5(b) of the Act) If a facility is unable to conduct a fingerprint-based background check in compliance with this Section, then it shall provide conclusive evidence of the resident's immobility or risk nullification of the waiver issued pursuant to Section 3-20.1.5(b) of the Act. Section 300.625 Identified Offenders g) Facilities shall maintain written documentation of compliance with this Section 300.615 of this Part. | STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|--|--|--|-------------------------------|----------|
| NAME OF PROVIDER OR SUPPLIER KEWANEE CARE HOME TAG JUNIOR AVENUE KEWANEE, IL 61443 CAS JUNIOR AVENUE KEWANEE, IL 61443 CAS JUNIOR AVENUE KE | | | | | | | |
| CACH DOME SUMMARY STATEMENT OF DEFICIENCIES L 61443 | | | IL6005011 | B. WING | | 06/0 | 5/2024 |
| (X4) ID PREFIX TAG (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (X5) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (X6) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (X6) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (X6) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (X6) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (X6) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (X6) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (X6) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (X6) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (X6) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (X6) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (X6) ID REFIX TAG (X6) ID RAPPROPRIATE COMPLETE COMPLET COMPLETE C | NAME OF F | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| PRÉFIX TAG REGULATORY OR USC IDENTIFYING INFORMATION) S9999 Continued From page 4 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) f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp. state.il. us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il. us to determine if the individual is listed as a registered sex offender. i) The facility shall provide for or arrange for any required fingerprint-based check is to be taken on the premises of the facility. If a fingerprint-based check is required, the facility shall arrange for it to be conducted in a manner that is respectful of the resident's dignity and that minimizes any emotional or physical hardship to the resident. (Section 2-201.5(b) of the Act) If a facility is unable to conduct a fingerprint-based background check in compliance with this Section, then it shall provide conclusive evidence of the resident's immobility or risk nullification of the waiver issued pursuant to Section 2-201.5(b) of the Act. Section 300.625 Identified Offenders g) Facilities shall maintain written documentation | KEWANE | EE CARE HOME | | | | | |
| 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) f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc. state.il. us to determine if the individual is listed as a registered sex offender. i) The facility shall provide for or arrange for any required fingerprint-based checks to be taken on the premises of the facility. If a fingerprint-based check is required, the facility shall arrange for it to be conducted in a manner that is respectful of the resident's dignity and that minimizes any emotional or physical hardship to the resident. (Section 2-201.5(b) of the Act) If a facility is unable to conduct a fingerprint-based background check in compliance with this Section, then it shall provide conclusive evidence of the resident's immobility or risk nullification of the waiver issued pursuant to Section 2-201.5(b) of the Act. Section 300.625 Identified Offenders g) Facilities shall maintain written documentation | PRÉFIX | (EACH DEFICIENCY | / MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO | LD BE | COMPLETE |
| Section 300.626 Discharge Planning for Identified | \$9999 | facility shall, within resident, request a check pursuant to t Information Act for admission to the facheck was initiated Hospital Licensing a be based on the reand other identifiers Department of Statiof the Act) f) The facility shall name on the Illinois website at www.isp Department of Corr page at www.idoc.s individual is listed at i) The facility shall required fingerprint the premises of the check is required, the conducted in a resident's dignity are motional or physic (Section 2-201.5(b) unable to conduct a check in compliance shall provide concluresident's immobility waiver issued pursu the Act. Section 300.625 Ideg) Facilities shall mof compliance with | 24 hours after admission of a criminal history background he Uniform Conviction all persons 18 or older seeking cility, unless a background by a hospital pursuant to the Act. Background checks shall sident's name, date of birth, as a required by the e Police. (Section 2-201.5(b) check for the individual's Sex Offender Registration state.il.us and the Illinois rections sex registrant search state.il.us to determine if the as a registered sex offender. provide for or arrange for any based checks to be taken on facility. If a fingerprint-based he facility shall arrange for it to manner that is respectful of the add that minimizes any call hardship to the resident. To of the Act) If a facility is a fingerprint-based background e with this Section, then it usive evidence of the cy or risk nullification of the uant to Section 2-201.5(b) of entified Offenders naintain written documentation Section 300.615 of this Part. | S9999 | | | |

Illinois Department of Public Health

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| | | IL6005011 | B. WING | | 06/0 | 5/2024 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| KEWANE | EE CARE HOME | | OR AVENUE E, IL 61443 | | | |
| (X4) ID PREFIX TAG | | | | PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPL CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| S9999 | Continued From pa | ge 5 | S9999 | | | |
| | Offenders c) When a resident who is an identified offender is discharged, the discharging facility shall notify the Department. | | | | | |
| | This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to perform state required background checks for residents including Criminal History Informational Response Process, Illinois Department of Corrections, Illinois Sex Offender and failed to notify the state department of identified offender discharges. This has the potential to affect all 43 residents residing in the facility. | | | | | |
| | | | | | | |
| | Findings include: | | | | | |
| | Report," dated 5/29 residents as curren however facility recoll/O discharge dates R248 discharged 1/2 unknown; R250 dis | fenders (I/O) Program Facility I/24, documents the following I/O residents of the facility, ord documents the following I/O/24; I/O/20; R249 discharge date charged 12/17/19; R251; and R252 discharge date | | | | |
| | checks had a hit on | 5/9/23 and Identified Offender the background, and no story Informational Response with fingerprints. | | | | |
| | | e facility on 5/29/24 to present artment of Corrections/IDOC | | | | |

Illinois Department of Public Health STATE FORM

FUFR11 If continuation sheet 6 of 7

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|--------------------------|--|-------|--------------------------|
| | | A. BUILDING: | | | | |
| | | IL6005011 | B. WING | | 06/0 | 5/2024 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, S | STATE, ZIP CODE | | |
| KEWANI | EE CARE HOME | | OR AVENUE E, IL 61443 | | | |
| (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 6 | S9999 | | | |
| | R249 admit 1/18/15, and R252 admit 12/15/15 and no ISO/Illinois Sex Offender or IDOC checks conducted. | | | | | |
| | | | | | | |

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Illinois Department of Public Health STATE FORM

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