(X6) DATE

(X3) DATE SURVEY

Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	COMPLETED	
		IL6013023	B. WING		05/2	3/2024	
		SPITAL ROAD	TATE, ZIP CODE				
(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	0 Initial Comments		S 000				
	Annual Licensure S	urvey					
S9999	Final Observations		S9999				
	Statement of Licens	sure Violations:					
	Statement of Licensure Violations: 300.625a) 300.625b) 300.625c) 300.625d) 300.625e) 300.625f)1)2)3)A)B) Section 300.625 Identified Offenders a) The facility shall review the results of the criminal history background checks immediately upon receipt of these checks. b) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based check are pending; while the results of a request for a waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending. c) If the results of a resident's criminal history background check reveal that the resident						
	is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following: 1) Immediately notify the Department of State Police, in the form and manner required by the Department of State Police, that the resident is an identified offender. 2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified						

(X2) MULTIPLE CONSTRUCTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

06/13/24 **Electronically Signed**

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
IL6013023		B. WING		05/23/2024		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ILLINI R	ESTORATIVE CARE		_	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
\$9999	IL6013023 B. PROVIDER OR SUPPLIER RESTORATIVE CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		S9999			

Illinois Department of Public Health

STATE FORM 6899 KA1S11 If continuation sheet 2 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
IL6013023		B. WING		05/2	23/2024	
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
ILLINI R	ESTORATIVE CARE	1455 HOS SILVIS, IL	PITAL ROAD 61282)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
S9999	felony offense who a resident of a licent offender, any federa enforcement officer shall be permitted requirements of the Act, to verify compliance with probation, parole, or release. (Section 2-Reasonable access interfere with the idepsychiatric care. 2) The facility senforcement official to develop, if needed address the present registered sex offer parole, mandatory sprobation for a felor compliance with Section 2-Reasonable access interfere with the idepsychiatric care. 2) The facility senforcement official to develop, if needed address the present registered sex offer parole, mandatory sprobation for a felor compliance with Section 2-Reasonable access interfere with the idepsychiatric care. 3) Every licenselvery prospective a resident's guardian, employee, a written Department, advisite employee of his or residents of the facility shall conference of the facility shall conference are residing the notice is posted within every section.	are residents of the facility. If used facility is an identified al, State, or local law or or county probation officer easonable access to the overify compliance with the Sex Offender Registration iance with the requirements of and Public Act 94-752, or to with applicable terms of a mandatory supervised and and the provision shall not entified offender's medical or staff shall meet with local law lest of discuss the need for and and policies and procedures to be of facility residents who are not of a mandatory supervised release, or not offense, including action 300.695 of this Part. Seed facility shall provide to and current resident and and to every facility and the facility.	S9999			

Illinois Department of Public Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
IL6013023		IL6013023	B. WING		05/23/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ILLINI R	ESTORATIVE CARE)		
(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
\$9999	F PROVIDER OR SUPPLIER STREET ADDRE 1455 HOSPIT SILVIS, IL 6 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		\$9999			

Illinois Department of Public Health STATE FORM

KA1S11 If continuation sheet 4 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	IL6013023		B. WING		05/23/2024	
II LINI RESTORATIVE CARE 1455 HOSP			DRESS, CITY, S PITAL ROAL 61282	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
\$9999	On 5/22/24 at 12:04 Coordinator) stated obtaining backgrou prior to their admiss that due to the result Record, V14 sent a fingerprinted. V14 s V14 has not receive fingerprinting nor has fingerprinting result not send R8's Crim the facility's request the IOP. V14 stated to do when a reside criminal record. On 5/23/24 at 11:50 had not sent R8's C Results or the facility fingerprinted to the going on yesterday to look into it yet." On 5/23/24 at 11:07 stated that V12 is F V12 was not aware Identified Offender was considered an expect to know. On 5/23/24 at 10:24 Program Manager) History Record Ressex offender and st facility's request to have been reported Program/IOP. V13 notified, a State Posent to the facility to	ge 4 4 PM, V14 (Business Office V14 is responsible for Indichecks on the residents is ion to the facility. V14 stated Its of R8's Criminal History request for R8 to be stated as of this date and time, and V14 inquired into R8's s. V14 also verified V14 did inal History Record Results or to for R8 to be fingerprinted to the V14 was not trained on what ent returns with a HIT on their Criminal History Record ty's request for R8 to be IOP. V14 stated, "I had a lot and I hadn't had the chance of R8 being considered an in any way. V12 (Registered Nurse) R8's current nurse. V12 stated of R8 being considered an in any way. V12 stated if R8 Identified Offender, V12 would to the Identified Offender stated that R8's results and the have R8 fingerprinted should I to the Identified Offender stated that if the IOP had been be interview R8 and identify the old be to the facility as an	\$9999			

Illinois Department of Public Health

STATE FORM 6899 KA1S11 If continuation sheet 5 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		C) MULTIPLE CONSTRUCTION (X3) DATE S COMPLI		
		IL6013023	B. WING		05/23/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ILLINI RI	ESTORATIVE CARE	1455 HOS SILVIS, IL	PITAL ROAD 61282)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 5	S9999			
	IOP has not receive	At this time, V13 verified the ed any information from the B's Criminal History Results.				
		:00 PM, R8's medical record information identifying R8 as der.				
	The Department of Health and Human Services Centers for Medicare & Medicaid Services Form-671, dated 5/21/2024, documents 72 residents reside in the facility.					
	(C)					

Illinois Department of Public Health STATE FORM