Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: IL6004758 B. WING ____ 10/31/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **50 NORTH JANE RIVER VIEW REHAB CENTER** ELGIN, IL 60123

(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) COMPLET DATE
S 000	Initial Comments	S 000		
	Annual Licensure Certification Survey			
S9999	Final Observations	S9999		
	Statement of Licensure Violations			
	300.615e)			
	300.615f)			
	Section 300.615 Determination of Need			
	Screening and Request for Resident Criminal			
	History Record Information			
	e) In addition to the screening required by Section			
	2-201.5(a) of the Act and this Section, a facility	0		
	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.			
	This REQUIREMENT was not met as evidenced			
	by:			
	Based on record review and interview, the facility			
	failed to submit background checks, check the			
	int of Public Health			
	RECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
ctronica	Ily Signed			11/08/24

STATE FORM

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Ulinois De	epartment of Public Hea	alth			FURM	APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED			
		IL6004758	B. WING		10/3	1/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST/	ATE, ZIP CODE		
		50 NORT	TH JANE			
		ELGIN, I	L 60123			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE	
\$9999	website within 24 hou This applies to 7 of 10 (R79,R82,R153,R173) were reviewed for crim sample of 10. The findings include: R79's electronic face showed R79 was adm 10/1/24. The IDOC we were checked on 10/2 admission to the facili R82's electronic face showed R82 was adm 9/27/24. The backgrou submitted on 10/2/24, the facility. R153's electronic face showed R153 was add 8/26/24. The backgrou submitted on 9/5/24, for the facility. R173's electronic face showed R173 was add 9/13/24. The backgrou submitted on 9/19/24, the facility.	Corrections (IDOC) e Illinois State Police (ISP) rs of admission. Presidents ,R174,R329,R330) that ninal backgrounds in the sheet printed on 10/29/24 hitted to the facility on ebsite and the ISP website 19/24, 28 days after ty. sheet printed on 10/29/24 hitted to the facility on and check form was 5 days after admission to e sheet printed on 10/29/24 mitted to the facility on and check form was 11 days after admission to e sheet printed on 10/29/24 mitted to the facility on and check form was 11 days after admission to e sheet printed on 10/29/24 mitted to the facility on and check form was 12 days after admission to e sheet printed on 10/29/24 mitted to the facility on and check form was 13 days after admission to	S9999			
	R174's electronic face	sheet printed on 10/29/24				

R174's electronic face sheet printed on 10/29/24 showed R174 was admitted to the facility on 9/23/24. The background check form was submitted on 9/26/24, 3 days after admission to the facility.

Illinois Department of Public Health STATE FORM

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If continuation sheet 2 of 4

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	OF CORRECTION	F DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IL6004758	B. WING		10/31/2024		
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE			
RIVER VIE	W REHAB CENTER		TH JANE IL 60123				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
S9999	Continued From page 2 R329's electronic face sheet printed on 10/29/24 showed R229 was admitted to the facility on 10/24/24. The background check form was submitted on 10/29/24, 5 days after admission to the facility.		S9999				
	R330's electronic face sheet printed on 10/29/24 showed R330 was admitted to the facility on 10/11/24. The background check form was submitted on 10/15/24, 4 days after admission to the facility.						
	checks on residents facility usually. I make	d, "I perform all of the IDOC before they arrive to the ke sure they are done within re why (R79's) wasn't done					
	Director) stated "The supposed to be done admission. I try to do information about the one that does them a Tuesday/Wednesday aren't done right awa trained how to do the are done within 24 he resident has a crimin	o them as soon as I get the e admission. I am the only					
	The facility's policy ti Checks" dated 10/20 provide guidelines fo on all new admission resident is admitted t name-based backgro	tled, "Resident Background 24 showed, "General: To r running background checks is. Guidelines: 1. When a to a facility, an electronic bund check must be ordered ss the resident was admitted					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6004758	B. WING		10/31/2024	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE		
RIVER VIE	W REHAB CENTER	50 NORT ELGIN, II				
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
S9999	Continued From page 3		S9999			
	from a hospital AND the facility that the name of the second seco	ne hospital notified the check was ordered"				
	(C)					
nois Departm	ent of Public Health					