PRINTED: 12/03/2024 FORM APPROVED

Illinois Department of Public Hea STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6013783	B. WING		11/22/2024	
			DRESS, CITY, STATE			
DWARD	SVILLE TERRACE		THWEST PLACE SVILLE, IL 62025			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET	
Z 000	COMMENTS		Z 000			
	Annual Licensure Su 350.625f)	rvey				
Z9999	FINDINGS		Z9999			
	Statement of Licensu	ire Violations				
	350.625f)					
	Section 350.625 Dete Screening and Reque History Record Inform	est for Resident Criminal				
	on the Illinois Sex Off at www.isp.state.il.us of Corrections sex re www.illinois.gov/idoc,	eck for the individual's name fender Registration website and the Illinois Department gistrant search page at /Pages/default.aspx to idual is listed as a registered				
	These regulations we	ere not met as evidenced by:				
	failed to provide evide Department of Correc	ew and interview, the facility ence of the required Illinois ctions sex registrant search, iduals residing at the facility,				
	Findings include:					
		ted, received on 11-19-24, residents residing in the				
		vide evidence of registry vith the Illinois Department of				
	 ment_of Public Health DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURI		TITLE	(X6) DATE	
					11/27/24	

M63O11

PRINTED: 12/03/2024 FORM APPROVED

Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IL6013783		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 11/22/2024	
			SVILLE TERRACE	808 SOU	ITHWEST PLACE DSVILLE, IL 62025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLET DATE
Z9999	and R15. On 11-19-24 at 6:00 Training confirmed th documentation of reg with the Illinois Depa	e 1 quested for R2, R3, R5, R14 PM, E2/Administrator in he facility is unable to provide gistry background checks intment of Corrections had all residents residing at the		DEFICIEN		
ois Departr	nent of Public Health					

M63O11