PRINTED: 12/04/2024 FORM APPROVED

STATEMEN	epartment of Public T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 11/01/2024	
		IL6009427	B. WING			
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
TOULON	REHAB & HEALTH (CARE CENTER	Y 17 EAST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	I, IL 61483 ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLE	
S 000	Initial Comments		S 000			
	Annual Licensure S	Survey				
S9999	Final Observations		S9999			
	Statement of Licen	sure Violations:				
	300.661					
	Section 300.661 He Check	ealth Care Worker Background	1			
	Worker Backgroun	bly with the Health Care d Check Act and the Health ground Check Code.				
	These requirement evidenced by:	s have not been met as				
	failed to conduct ba policy prior to empl work for seven of te Nurse, V12/License V13/Housekeeping	, V14-17/Certified Nursing hose personnel files were				
	Findings include:					
	Program", revised facility will not know engage individuals action taken agains state licensure bod abuse, neglect, or r finding of misappro	led, "Abuse Prevention 11/28/2016, document: "This vingly employ or otherwise who have had a disciplinary st a professional license by a y as a result of a finding of mistreatment of residents or a priation of resident property. knowingly employ any staff				
	tment of Public Health / DIRECTOR'S OR PROVIE	DER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE		(X6) DATE
Electroni	ically Signed					11/23/24
	М		⁶⁸⁹⁹ P	PPK11	lf continu	ation sheet

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		11 0000 107	B. WING				
		IL6009427			11/	01/2024	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
OULON	REHAB & HEALTH (CARE CENTER	Y 17 EAST I, IL 61483				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET E DATE	
S9999	Continued From pa	ige 1	S9999				
	Healthcare Worker (unless waivered un or with findings of a Health Care Worker employee starting a will: Initiate a refere employers. Obtain any individual being a professional licen status with the licen Health Care Worker being hired for a por bordering states that have been licensed individuals resume information availab Health Care Worker ILCS 46/1) and fac Check Policy" polic fingerprint based or for all non licensed policy that we reque criminal history rece employees." On 11/1/2024, at 9: confirmed employe completed, prior to being hired and sta stated, "I stand by the V3 was hired and sta	the crimes listed in the Illinois Background Check Act inder the provision of the Act), abuse listed on the Illinois er Registry. Prior to a new a work schedule this facility ence check from previous a copy of the state license of g hired for a position requiring use and check the licensee's using entity. Check the Illinois er Registry on all individuals position and potentially at the individual is known to l/certified in, based on the or other employment le to the facility; and Under the er Background Check Act (225 ility "Criminal Background y, we are required to request a riminal history records check employees. It is the facility est a non fingerprint based ord check for all licensed 20 a.m., V1/Administered e background checks were no the employees listed below, rting work at the facility. V1 hose dates."	a a				
	6/3/2021. V12 was hired and						

PPPK11

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SURVEY LETED	(X3) DATE COMP			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Department of Public NT OF DEFICIENCIES OF CORRECTION	TATEMEN
1/2024	11/0		B. WING	IL6009427		
		TATE, ZIP CODE	DDRESS, CITY, S		PROVIDER OR SUPPLIER	AME OF P
			VY 17 EAST N, IL 61483	CARE CENTER	I REHAB & HEALTH C	OULON
(X5) COMPLET DATE	N SHOULD BE E APPROPRIATE	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ID PREFIX TAG	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(EACH DEFICIENC)	(X4) ID PREFIX TAG
		· · · · ·	S9999	ge 2	Continued From pa	S9999
				05.	done until 12/15/20	
				nd started working at the as a Housekeeper. V13's id screening was not done	facility on 1/6/2010	
				nd started working at the 1 as a CNA. V14's required ing was not done until	facility on 6/22/202	
				nd started working at the 4 as a CNA. V15's required ing was not done until	facility on 9/16/2004	
				nd started working at the as a CNA. V16's required ing was not done until	facility on 2/3/2010	
				nd started working at the as a CNA. V17's required ing was not done until	facility on 3/3/2020	
				(C)		
	If continua	PPK11	6899		tment of Public Health	nois Depart

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