| Illinois D  | epartment of Public  | Health   |   |                 | FORM                                 | APPROVE               |
|---|--|--|---|-----------------|--------------------------------------|-----------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING:   |                 | (X3) DATE SURVEY<br>COMPLETED        |                       |
|   |  | IL6001713  | B. WING   |                 | 12/05/2024                           |                       |
| NAME OF F   | ROVIDER OR SUPPLIER  | STREET AI  | DDRESS, CITY, S   | STATE, ZIP CODE |                                      |                       |
|   | I CARE WEST CHICA  | AGO  | T NORTH AV  | -               |                                      |                       |
|   |  | WEST CI  | HICAGO, IL 6  |                 |                                      |                       |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID PROVIDER'S PLAN OF C<br>PREFIX (EACH CORRECTIVE ACTION<br>TAG CROSS-REFERENCED TO TH<br>DEFICIENCY |                 | ON SHOULD BE COM<br>HE APPROPRIATE D |                       |
| S 000   | Initial Comments   |  | S 000   |                 |                                      |                       |
|   | Annual Licensure S   | Survey   |   |                 |                                      |                       |
| S9999   | Final Observations   |  | S9999   |                 |                                      |                       |
|   | Statement of Licens  | sure Violations:   |   |                 |                                      |                       |
|   | 1 of 2   |  |   |                 |                                      |                       |
|   | 300.625 c)2)   |  |   |                 |                                      |                       |
|   | background check<br>identified offender a<br>of the Act, the facilit<br>2) Within 72 ho<br>fingerprint-based or<br>be requested on the<br>The inquiry shall be<br>sex, race, date of b<br>other identifiers req<br>State Police. The in<br>through the files of<br>Police and the Fede<br>locate any criminal<br>may exist regarding<br>Bureau of Investiga<br>Department of State<br>inquiry under this se<br>history record inform | entified Offenders<br>resident's criminal history<br>reveal that the resident is an<br>as defined in Section 1-114.01<br>ty shall do the following:<br>ours, arrange for a<br>riminal history record inquiry to<br>e identified offender resident.<br>based on the subject's name,<br>irth, fingerprint images, and<br>uired by the Department of<br>nquiry shall be processed<br>the Department of State<br>eral Bureau of Investigation to<br>history record information that<br>g the subject. The Federal<br>tion shall furnish to the<br>e Police, pursuant to an<br>ubsection (c)(2), any criminal<br>mation contained in its files. |   |                 |                                      |                       |
|   | by:<br>Based on interview<br>failed to set up a fin  | and record review, the facility<br>gerprint order within 72 hours<br>IRP (Criminal History   |   |                 |                                      |                       |
|   | tment of Public Health   |  |   |                 |                                      |                       |
|   | <pre>/ DIRECTOR'S OR PROVID<br/>cally Signed</pre>   | DER/SUPPLIER REPRESENTATIVE'S SIC  | 5NAI URE  | TITLE           |                                      | (X6) DATE<br>12/11/24 |
|   |  |  | 6899 6  | 2Q011           |                                      | ation sheet 1         |

| STATEMEN                 | epartment of Public  | (X1) PROVIDER/SUPPLIER/CLIA  |   | CONSTRUCTION   | ידעם (גא)                     | SURVEV                  |
|--------------------------|--|--|---|--|-------------------------------|-------------------------|
| AND PLAN OF CORRECTION   |  | IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                         |
|                          |  | IL6001713  | B. WING                                 |  | 12/                           | 05/2024                 |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, ST                        | TATE, ZIP CODE   |                               |                         |
| APERIO                   | N CARE WEST CHICA  | AGO  | ST NORTH AVE                            |  |                               |                         |
|                          | -  | WEST C   | HICAGO, IL 60                           |  |                               |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENC | TION SHOULD BE                | (X5)<br>COMPLET<br>DATE |
| S9999                    | Continued From pa  | ge 1   | S9999                                   |  |                               |                         |
|                          | This applies to 1 of 1 resident (R142) for reviewed for Identified Offenders requiring fingerprinting in the sample of 5.                                |  |   |  |                               |                         |
|                          | The findings include:  |  |   |  |                               |                         |
|                          |  | ronic Medical record showed<br>I to the facility on June 6, 2024   |   |  |                               |                         |
|                          |  | wed it was reviewed by the<br>024, and it showed he had<br><i>v</i> ictions.   |   |  |                               |                         |
|                          | (Administrator) said<br>fingerprinted on Jul<br>fingerprinted on Au<br>was because R142<br>when he was admit<br>unable to provide a<br>said the PRSC (Ps | 024, at 12:14 PM, V1<br>d R142 signed a consent to be<br>y 31, 2024, and was<br>gust 8, 2024. V1 said the delay<br>refused to sign the consent<br>ted to the facility, but was<br>ny documentation. V1 also<br>ychiatric Rehabilitation Service<br>vorked with R142 on admission<br>e company. | y<br>a                                  |  |                               |                         |
|                          | (C)<br>2 of 2  |  |   |  |                               |                         |
|                          | 300.610 a)<br>300.650 c)<br>300.650 d)   |  |   |  |                               |                         |
|                          | a) The facility<br>procedures govern<br>facility. The written<br>be formulated by a<br>Committee consist   | esident Care Policies<br>shall have written policies and<br>ing all services provided by the<br>policies and procedures shall<br>Resident Care Policy<br>ng of at least the<br>dvisory physician or the  | •                                       |  |                               |                         |

Illinois Department of Public Health STATE FORM

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If continuation sheet 2 of 4

| Illinois Department of Public Health<br>STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |  |  | (X2) MUI TIPI F                         | CONSTRUCTION  | (X3) DATE SURVEY               |            |
|---|--|--|---|---|--------------------------------|------------|
| AND PLAN OF CORRECTION  |  | IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   | COMPLETED                      |            |
|   |  | IL6001713  | B. WING                                 |   | 12/                            | 12/05/2024 |
| NAME OF F   | PROVIDER OR SUPPLIER   | STREET AI  | DDRESS, CITY, ST                        | TATE, ZIP CODE  |                                |            |
| APERIO  | N CARE WEST CHICA  | AGO  | T NORTH AVE                             | -   |                                |            |
| (X4) ID   | SUMMARY STA  |  |   | PROVIDER'S PLAN OF (  | CORRECTION                     | (X5)       |
| PREFIX<br>TAG   |  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG                           | (EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC | ON SHOULD BE<br>HE APPROPRIATE | COMPLET    |
| S9999   | Continued From page 2  |  | S9999                                   |   |                                |            |
|   | policies shall comp<br>The written policies<br>the facility and shal<br>by this committee, of<br>and dated minutes<br>Section 300.650 Per<br>c) Prior to employin<br>that requires a Stat<br>contact the Illinois I<br>Professional Regul<br>individual's license<br>shall be placed in th<br>d) The facility shall<br>applicants with the<br>prior to hiring.<br>These REQUIREM<br>evidenced by:<br>Based on record re<br>failed to ensure new<br>Worker Registry ch<br>Department of Prof<br>checks were compl<br>This applies to 4 of<br>employees reviewe<br>Background checks<br>The findings include<br>The facility provided<br>employee and the of | ersonnel Policies<br>ag any individual in a position<br>e license, the facility shall<br>Department of Financial and<br>ation to verify that the<br>is active. A copy of the license<br>he individual's personnel file.<br>check the status of all<br>Health Care Worker Registry<br>ENTS are not met as<br>eview and interview, the facility<br>w employee Health Care<br>tecks and IDPFR (Illinois<br>ressional Regulation) license<br>leted prior to hire.<br>10 (V10, V11, V12, V13)<br>d for Health Care Worker<br>s.<br>e:<br>d the hire date for each<br>document of the Health Care<br>the IDPFR license check for |   |   |                                |            |
|   |  | Nurse/RN) hire date was<br>25, 2024. The IDPFR license   |   |   |                                |            |

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| Illinois Department of Public Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         ILL6001713 |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING:   |                | (X3) DATE SURVEY<br>COMPLETED             |                 |      |
|--|--|---|----------------|---|-----------------|------|
|  |  | II 6001713  | B. WING        |   | 12/05/2024      |      |
| IAME OF F  | PROVIDER OR SUPPLIER   |   | DRESS, CITY, S | TATE, ZIP CODE                            | 12/03/20        | 24   |
| PERION   | N CARE WEST CHIC   | AGO 201 WES   | T NORTH AVE    | INUE                                      |                 |      |
| (X4) ID<br>PREFIX  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL   |   | ID<br>PREFIX   | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC |                 |      |
| TAG  |  | SC IDENTIFYING INFORMATION)   | TAG            | CROSS-REFERENCED TO<br>DEFICIENC          | THE APPROPRIATE | DATE |
| S9999  | Continued From pa  | Continued From page 3   |                |   |                 |      |
|  | look up for V10 was dated May 9, 2024, 2 months after hire.  |   |                |   |                 |      |
|  | was reported as No   | rrsing Assistant/CNA) hire date<br>ovember 5, 2024. V11's Health<br>stry check was dated<br>4 at 12:24 PM.                        |                |   |                 |      |
|  | V12 (CNA) hire date was reported as October 11, 2024. V12's Health Care Worker Registry check was dated October 16, 2024, at 12:30 PM. |   |                |   |                 |      |
|  | 2024. V13's Health   | e was reported as October 7,<br>Care Worker Registry check<br>8, 2024, at 11:59 PM.   |                |   |                 |      |
|  |  | worked in the nursing<br>e potential to affect all the<br>n the facility.   |                |   |                 |      |
|  | Resources staff) st<br>background checks   | 024, at 10:30 AM, V16 (Human<br>ated she knows the<br>s for new employee hires are<br>hire, but she has not seen a<br>tates that. |                |   |                 |      |
|  | regarding backgrou   | er V1 did not provide a policy  |                |   |                 |      |
|  | (C)  |   |                |   |                 |      |
|  |  |   |                |   |                 |      |
| ia Dan   | tment of Public Health   |   |                |   |                 |      |

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