(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED		
,			A. BUILDING:					
	IL6004451		B. WING		03/07/2025			
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
HILLSID	HILLSIDE REHAB & CARE CENTER  1308 GAME FARM ROAD YORKVILLE, IL 60560							
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE			
S 000	Initial Comments		S 000					
	Annual Health Surv	rey						
S9999	Final Observations		S9999					
	Statement of Licensure Violations:							
	300.615e)							
		etermination of Need uest for Resident Criminal rmation						
	2-201.5(a) of the Adshall, within 24 hou resident, request a check pursuant to the Information Act for admission to the facheck was initiated Hospital Licensing abe based on the resand other identifiers	escreening required by Section ct and this Section, a facility rs after admission of a criminal history background he Uniform Conviction all persons 18 or older seeking cility, unless a background by a hospital pursuant to the Act. Background checks shall sident's name, date of birth, is as required by the e Police. (Section 2-201.5(b)						
	This requirement w	as NOT met as evidenced by:						
	failed to do residen hours of admission	and record review, the facility t background checks within 24 . This applies to 6 of 10 5, R249, R250, R251, R252) in						
	The findings include	e:						
		48 AM, V10 (Social Services ate surveyor were conducting						

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 03/26/25

TITLE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		IL6004451	B. WING		03/0	7/2025		
NAME OF I	DPOVIDED OD SLIDDLIED			STATE ZID CODE	1 03/0	112025		
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  1308 GAME FARM ROAD							
HILLSID	E REHAB & CARE CE	NTFR	LE, IL 60560					
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE			
S9999	Continued From page 1		S9999					
	record reviews for residents' background checks.							
	1. R8's EHR (Electric that she was admitted (Criminal History In Illinois Sex Offender department of Correction Response of the Sex Offender Registry & Correction was done of the Sex Offender Registry & Correction Response of the Response of the Response of the	ronic Health Record) showed ted on 2/14/25 and her CHIRP formation Response Process), or Registry, & Illinois ection was done on 2/17/2025.  Wed that she was admitted on dIRP (Criminal History ase Process), Illinois Sex & Illinois department of the on 2/17/2025.  Wed that she was admitted on RP (Criminal History ase Process), Illinois Sex & Illinois department of the on 2/17/2025.						
	2/14/25 and her CH Information Respon	wed that he was admitted on HIRP (Criminal History nse Process), Illinois Sex & Illinois department of the on 2/17/2025.						
	2/1/25 and her CHI Information Respor	wed that she was admitted on RP (Criminal History use Process), Illinois Sex Illinois department of the on 2/3/2025.						
	1/28/25 and his CH Information Respor	wed that he was admitted on IRP (Criminal History use Process), Illinois Sex Illinois department of use on 1/31/2025.						
	On 3/5/2025 at 11:4	18 AM V10 (SSD-Social						

Illinois Department of Public Health

Services Director) said background checks are

STATE FORM 6899 XJIU11 If continuation sheet 2 of 3

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		IL6004451	B. WING		03/0	7/2025		
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1308 GAME FARM ROAD  YORKVILLE, IL 60560							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE		
\$9999	done on the day restresident is admitted the weekends, back the next business of the next bus	sident is admitted. She said if after her working hours or on ground checks are done on	S9999					

6899

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