STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010110	A. BUILDING: _____ B. WING _____	C 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY NURSING & REHAB CENTER	6909 WEST NORTH AVENUE OAK PARK, IL 60302

(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) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification Survey Complaint Investigation 2591856/IL187521	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 3 300.610a) 300.1210b) 300.1210d)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010110	A. BUILDING: _____ B. WING _____	C 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY NURSING & REHAB CENTER	6909 WEST NORTH AVENUE OAK PARK, IL 60302

(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) COMPLETE DATE
S9999	Continued From page 1	S9999		

resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

These requirements were not met as evidence by:

Based on interview and record review, the facility failed to follow their change in condition policy by not calling advance life support services (911) for two hours after R48 was found with an altered mental status and verbally unresponsive. This failure resulted in R48 immediate intubation by emergency medical service and mechanical ventilation for 1 of 1 residents reviewed for change in condition.

Findings Include:

R48 has the diagnosis of Atrial Fibrillation, Lack of coordination, abnormalities of gait and mobility, need for assistance with personal care and Adult Failure to Thrive. R48's physician order summary dated 2/7/25 documents: Rivaroxaban (antithrombotic/prevent blood clots) fifteen milligrams given by mouth at bedtime for atrial fibrillation. Medication administration record dated 2/1/25-2/28/25 and 3/1/25 documents: R48 received Rivaroxaban as prescribed. Fall risk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010110	A. BUILDING: _____ B. WING _____	C 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY NURSING & REHAB CENTER	6909 WEST NORTH AVENUE OAK PARK, IL 60302

(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) COMPLETE DATE
S9999	Continued From page 2	S9999		

review dated 2/28/25 documents: R48 was at high risk for falls. Is resident receiving a medication that affects awareness, judgement or safety (e.g. anti-anxiety, antibiotics, anticoagulants) yes. Ambulation with assist. Gait Balance: balance problem while standing/walking. Requires use of assistive device.

On 4/1/25 at 10:34am, V3 (Complainant) said, he was called to the facility for a fall. R48 had signs of a severe brain bleed (hemorrhage). R48 had a fall the previous day, was not assessed or sent to the hospital. R48 presented with his arm flexed, hyper-extended, leg stiff, and toes pointed. V3 said, he was not sure how long R48 was in that position. R48 had a decrease level of consciousness and a pulse oxygen saturation of 83% on room air. R48 was breathing at ten breathes per minutes which was irregular. R48 was started on oxygen, high flow non-breather mask, which did not adjust R48's rate/oxygenation. R48 was sedated for intubation to establish an airway.

On 4/2/25 at 10:04pm, V15 (Nurse) said, she was informed by V18 (Certified Nursing Assistant/CNA) that R48 was on the floor. R48 was assessed and denied hitting his head. R48 was not wet and had a urinary catheter in place. V15 said, R48 was alert and orient times 1-2 at the time of the incident. That was R48 baseline. V15 said, if a resident has an unwitnessed fall and is taking anticoagulants that resident should be sent to the hospital at the time of the incident to rule out possible brain bleed. Statement dated 3/1/25 documents: CNA reported the resident (R48) was on the floor. Immediately responded. Observed resident on his left side laying on the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010110	A. BUILDING: _____ B. WING _____	C 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY NURSING & REHAB CENTER	6909 WEST NORTH AVENUE OAK PARK, IL 60302

(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) COMPLETE DATE
S9999	Continued From page 3	S9999		

V18's statement dated 3/1/25 documents: I saw resident in room three on the floor informed the nurse (V15).

Progress note dated 3/1/25 documents: 5:30pm (V18) CNA reported that resident (R48) is on the floor. Immediately responded. Observed resident on his left side laying on the floor. Assessment done. No visible injuries noted, no change of level of consciousness or range of motion, no complain of pain or discomfort at this time. Assisted resident back to bed via two person assist.

Incident report dated 3/1/25 documents: CNA reported that resident is on the floor. (R48) stated he wanted to go to the bathroom when asked what he was trying to do. Predisposing environmental factors: wheelchair/recliner, medical equipment (IV pole, etc). Predisposing Physiological Factors: Fragile/sensitive skin, recent change in medication, medication affecting blood coagulation, recent illness, weakness/fainted, high risk for significant injury: use of anticoagulants and decrease strength/endurance. Predisposing situation factors: Incident during self-transfer from bed.

On 4/2/25 at 1:49pm, V8 (CNA) said, she saw R48 on 3/2/25 in the bed around 7:00am. V8 said, she reports to work early at 6:30am to complete her resident rounds. V8 said, R48 was not yelling which was his baseline. V8 said, R48 was in bed sleeping when she saw him. V8 said, she took R48 his breakfast tray between 8:00am - 8:30am. V8 said, she called R48's name. R48 did not respond. V8 said, she shook R48 to get him to wake up, but did not respond. V8 said, she informed the nurse. V8 said, R48 needs help ambulation to the bathroom. R48 was shaky/unsteady when he stood up. V8 said, she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010110	A. BUILDING: _____ B. WING _____	C 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY NURSING & REHAB CENTER	6909 WEST NORTH AVENUE OAK PARK, IL 60302

(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) COMPLETE DATE
S9999	Continued From page 4	S9999		

did not get any report about R48 from the off-going CNA/Nurse.

Facility Final Incident report form dated 3/6/25 document: R48 was observed on the floor next to his bed. No one witnessed R48 falling. The following morning, R48 was observed with a change in condition. Physician was notified with order to transfer resident to the hospital for further evaluation.

On 4/4/25 at 2:46pm, V16 (Nurse) said, when she completed her morning rounds, nothing was out of ordinary with R48. V16 said, she completed a second round on R48. V16 said, R48 was observed not his normal self. R48 was usually very verbal, out spoken, making jokes and could make his needs known. V16 said, she was use to R48 speaking to her. V16 said, she called out R48's name with no reply. V16 said, R48 was breathing with his eye's open but wasn't as verbal per usual. V16 said, R48 did not eat his breakfast which was not normal. V16 said, she notified the doctor who gave orders to discharge R48 to the hospital. V16 said, she called basic life support ambulance service (BLS). V16 said, when emergency medical technician (EMT) from the basic life support ambulance arrive they stated that 911 should have been called. V16 said, when the EMT did their assessment, they felt R48 should have gone out 911. V16 said, she did not notice anything different with R48 after the EMT assessment that different from V16's initial assessment. V16 said, the EMT never shared why they felt R48 should have been discharged to the hospital via 911 instead of BLS.

V16's progress note dated 3/2/25 at 9:22am documents: During rounds notice resident hasn't ate breakfast. Observed altered mental status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010110	A. BUILDING: _____ B. WING _____	C 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY NURSING & REHAB CENTER	6909 WEST NORTH AVENUE OAK PARK, IL 60302

(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) COMPLETE DATE
S9999	Continued From page 5	S9999		

Nurse practitioner ok to send out to the hospital. Contacted ambulance states 30 (thirty) minute estimate time of arrival (eta.)

Progress note dated 3/2/25 at 10:12am documents: BLS ambulance arrived 2 EMTs with stretcher. After assessment (BLS) has decided to send resident out 911.

Ambulance Run report dated 3/2/25 documents (10:08AM): Provider's Primary Impression: Unspecified Altered Mental Status. Initial Patient Acuity: Critical (Red) Basic life support unit called to the scene for R48 with chief complaint of altered mental status. Upon arrival to patient (R48), patient was found in the supine position. Patient was alert and oriented time one baseline was alert and oriented time four and would open his eyes to verbal stimulus. CSS was attempted but unable to be completed because patient was unable to respond to verbal. Slurred speech inconclusive. Arm lift inconclusive and no facial droop notices. Med control was contacted per trauma systems of care and advised to contact 911 for advance life support (ALS) upgrade. 911 was contacted.

Fire department report dated 3/2/25 documents: Patient contact (10:35AM).Emergency medical service was greeted by a basic life support crew who had been called to transport the patient, but determined that patient needed advance life support intervention. EMS was informed the patient had been found down on the ground yesterday at 5:00pm, it was unwitnessed fall, and was unknown if the patient had loss of consciousness. This morning during checks around 9:00am staff at the nursing home reported finding the patient was altered level of consciousness (ALOC) and was having issues

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010110	A. BUILDING: _____ B. WING _____	C 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY NURSING & REHAB CENTER	6909 WEST NORTH AVENUE OAK PARK, IL 60302

(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) COMPLETE DATE
S9999	Continued From page 6	S9999		

rousing him. Staff reported the patient was normally CAOx4 (Conscious. Alert and Oriented times four means a patient is fully aware and can accurately identify who they are (person), where they are (place), what time it is (time) and what is happening around then (situation) with a Glasgow Coma Scale (GCS) of 15. Pt was taking blood thinners. As EMS entered the room they found the patient laying supine in bed with decerebrate posturing (an abnormal body posture characterized by involuntary extension of the arms and legs with the head and neck arched backward) hyper-extension of the upper extremities. Patient was found to have irregular bradypnea (abnormally slow breathing), with ALOC, presenting with a GCS of 7 (score 7 indicated a severe head injury, often associated with a come and high risk of mortality), responsive to painful stimuli and pinpoint pupils. Patient was lifted and place on the cot and secured. Patients vital were obtained. A 4- lead ECG was obtained showing a-fibrillation (heart (atria) beats irregularly and rapidly, instead of contraction in a coordinated rhythm). EMS established intravenous access and place the patient on high flow oxygen. An inbound patient care report was called into the hospital emergency department via phone. Hospital recommended EMS attempt intubation of the patient. Patient was pre-oxygenated with a bag-value mask (BVM). Pt was intubated.

Progress note dated 3/2/25 documents: Writer spoke with nurse at hospital that is caring for resident, Nurse inform writer that he is currently being intubated.

Progress note dated 3/4/25 documents: R48 was diagnosis with fractured ribs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010110	A. BUILDING: _____ B. WING _____	C 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY NURSING & REHAB CENTER	6909 WEST NORTH AVENUE OAK PARK, IL 60302

(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) COMPLETE DATE
S9999	Continued From page 7 Hospital paperwork dated 3/2/25 documents: Patient brought in to Trauma A via Fire Department. Alerted Mental Status (AMS) after fall yesterday at 1700 (5:00pm). Positive + blood thinners. Patient was sating 90% on non-rebreather and posturing. Patient arrived EMS bagging. Patient found down at nursing home on 3/1/25. EMS called for AMS on 3/2/25. Patient was intubated for inability to protect airway. Transferred to ICU for ventilator management. Patient with left 8, 9 rib fracture, COVID and Pneumonia. Patient remains on vent. Patient not waking up. GSC 3 (lowest possible level of consciousness, suggesting deep unconsciousness or coma and is associated with very poor prognosis often indicating a high mortality rate) in trauma bay. Change on condition policy not dated: documents: During medical emergencies such as unstable vital signs, respiratory distress, uncontrolled bleeding and unresponsiveness 911 will be notified for transport to the hospital. (A) Statement of Licensure Violations 2 of 3 300.615e) 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 shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010110	A. BUILDING: _____ B. WING _____	C 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY NURSING & REHAB CENTER	6909 WEST NORTH AVENUE OAK PARK, IL 60302

(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) COMPLETE DATE
S9999	Continued From page 8	S9999		

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 interview and record review, the facility failed to follow the Abuse Policy by failing to perform resident background checks (CHRP (Criminal History Response Process), State Sex Offender, and Department of Corrections) for 1 resident (R98) of 5 reviewed for resident background checks.

Findings include:

On 4-3-25 at 2:00 PM, surveyor and V1 (Administrator/ Admissions) were reviewing resident background checks and could not locate the CHRP, State Sex Offender, and Department of Corrections inquiries.

On 4-4-25 at 9:45 AM, V1 (Administrator/Admissions) said R9 was admitted on 3-28-25. R1 said is unable to locate CHRP inquiry, CHRP, State Sex Offender, and Department of Corrections inquiries for R9. On 4-4-25 at 10:20 AM, V1 said cooperate ran the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010110	A. BUILDING: _____ B. WING _____	C 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY NURSING & REHAB CENTER	6909 WEST NORTH AVENUE OAK PARK, IL 60302

(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) COMPLETE DATE
S9999	Continued From page 9 CHRP inquiry for R98 today (4-4-25). Email dated 4-4-25 documents CHRP inquiry (R98) was requested on 4-4-25. R98's State Sex Offender, and Department of Corrections inquiries dated 4-3-25 were reviewed. CHRP dated 4-4-25 was reviewed. R98's Face Sheet documents R98 was admitted 3-28-25. (C) Statement of Licensure Violations 3 of 3 300.625g) 300.625k) Section 300.625 Identified Offenders g) Facilities shall maintain written documentation of compliance with Section 300.615 of this Part. i) For current residents who are identified offenders, the facility shall review the security measures listed in the Identified Offender Report and Recommendation provided by the Department of the State Polices j) Upon admission of an identified offender to a facility or a decision to retain an identified offender in a facility, the facility, in consultation with the medical director and law enforcement, shall specifically address the resident's needs in an individualized plan of care. k) The facility shall incorporate the Identified Offender Report and Recommendation into the identified offender's care plan. (Section 2-201.6(f) of the Act) l) If the identified offender is a convicted (see 730 ILCS 150/2) or registered (see 730 ILCS 150/3) sex offender or if the Identified Offender Report and Recommendation prepared pursuant to Section 2-201.6(a) of the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010110	A. BUILDING: _____ B. WING _____	C 04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY NURSING & REHAB CENTER	6909 WEST NORTH AVENUE OAK PARK, IL 60302

(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) COMPLETE DATE
S9999	Continued From page 10	S9999		

Act reveals that the identified offender poses a significant risk of harm to others within the facility, the offender shall be required to have his or her own room within the facility subject to the rights of married residents under Section 2-108(e) of the Act. (Section 2-201.6(d) of the Act)

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to develop a plan of care for one resident (R24) who was identified as a high risk identified offender and failed to place R24 in a private room for one of five reviewed for identified offenders.

Findings include:

R24 was admitted to the facility on 8/12/2021 with a diagnosis of cerebral infarction,dementia with behavioral disturbances and schizoaffective disorder.

On 4/3/25 at 1:53PM, V1 (Administrator) said any resident who is identified as a high risk offender will be placed in a private room and have a care plan in place. V1 was unable to find R24's risk analysis. V1 said he was not aware that R24 was a high-risk offender.

R24's plan of care does not document R24 being a high-risk offender or any interventions in place.

During the survey, R23 was R24's roommate.

Identified offenders program facility report dated 4/1/25 documents R24 as a current identified offender with a risk analysis of high documented.

(C)