STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012520	A. BUILDING: _____ B. WING _____	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNWOOD ESTATES	301 RODDY ROAD SALEM, IL 62881

(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
Z 000	COMMENTS ANNUAL LICENSURE SURVEY	Z 000		
Z9999	FINDINGS Statement of Licensure Violation: 350.681 Section 350.681 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. These regulations were not met as evidenced by: Based on record review and interview, the facility failed to comply with the healthcare worker registry act, impacting all 14 individuals residing at the facility, (R1-R14). Findings include: Resident Roster undated, received 1-28-25, identifies R1-R14 as residents residing in the facility. E10/Direct Support Person (DSP) healthcare worker registry employee record documents a start date of 8-2-23. The registry does not include evidence of a finger-print based criminal history background check was completed. On 1-29-25 at 2:00 PM, E1/Administrator confirmed no further records are available to verify a background check was completed for E10.	Z9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012520	A. BUILDING: _____ B. WING _____	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNWOOD ESTATES	301 RODDY ROAD SALEM, IL 62881

(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
Z9999	Continued From page 1 (C)	Z9999		