STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008213	A. BUILDING: _____ B. WING _____	03/18/2025

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(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 First Probationary Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 7 300.340c)3)C)iii Section 300.340 Incorporated and Referenced Materials c) The following statutes and State regulations are referenced in this Part: 3) State of Illinois rules: C) Department of Public Health: iii) Food Code (77 Ill. Adm. Code 750) This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the dishwasher reached the required washing temperature. This has the potential to affect all 24 residents residing in the facility. The findings include: The Resident Census dated 3/17/2025 showed 24 residents residing in the facility. On 3/17/2025 at 12:50PM, the temperature of the dishwasher was reading 110 degrees Fahrenheit during the wash and rinse cycle. On 3/17/2025 at 12:50PM, V18 Cook said the machine use to be 120 or higher. I don't know why it's lower now.	S9999		

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S9999	Continued From page 1 On 3/18/2025 at 8:35AM, V1 Administrator said the facility dishwasher was a low temperature dishwasher. The facility provided Dishwasher Temperature/Sanitizer Log for the month of March 2025 shows a wash temperature of less than 120 degrees Fahrenheit for 3/1/2025-3/15/2025 for breakfast, lunch, and dinner. Breakfast and lunch on 3/16/2025 and 3/17/2025 were also less than 120 degrees Fahrenheit. Dinner on 3/16/2025 was the only temperature check that reached 120 degrees Fahrenheit. The facility provided Machine Washing and Sanitizing policy, revised 2017, states Low Temperature Dishwashing Machine dishwashing machines using chemicals (typically chlorine) for sanitizing may be used if the temperature of the wash water is not less than 120 degrees Fahrenheit. . . (C) Statement of Licensure Violations: 2 of 7 300.615e) 300.625a) 300.625c)1)2) 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 Information Act for all persons 18 or older seeking admission to the facility, unless a	S9999		

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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)

Section 300.625 Identified Offenders

a) The facility shall review the results of the criminal history background checks immediately upon receipt of these checks.

c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following:

1) Immediately notify the Department of State Police, in the form and manner required by the Department of State Police, that the resident is an identified offender.

2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c)(2), any criminal history record information contained in its files.

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S9999	Continued From page 3 These REQUIREMENTS were not met as evidenced by: Based on interview and record review the facility failed to initiate a criminal history background check on a resident within 24 hours of the resident's admission for 1 of 5 residents (R9) reviewed for the identified offender protocol/new admissions to the facility in the sample of 12. The facility also failed to order fingerprints on a resident with a HIT for qualifying offenses on his registry background check for 1 of 5 residents (R9) reviewed for the identified offender protocol/new admissions to the facility in the sample of 12. This failure has the potential to affect all 24 residents in the facility. The findings include: A facility roster dated 3/17/25 showed a resident census of 24. R9's admission record showed R9 was admitted to the facility on 12/6/24. R9's criminal history background check was not completed until 12/9/24. R9's criminal history background check dated 12/9/24 showed a "HIT" for qualifying offenses of theft, domestic battery/bodily harm, possession of a controlled substance, and resisting a police officer. On 3/18/25 at 8:35 AM, V1 Administrator and V5 Business Office Manager each stated resident background checks are to be initiated within 24 hours of a resident's admission. V1 stated, "A member of corporate does all the background checks on our new admissions."	S9999		

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S9999	Continued From page 4 On 3/18/25 at 8:35 AM, V1 Administrator and V5 Business Office Manager each stated fingerprints had never been ordered or completed on R9. V1 stated the facility had never notified the State Police that R9 was an identified offender. V1 stated, "A member of corporate does all the background checks on our new admissions. I didn't know until yesterday that (R9) had a HIT on his background check. No one from corporate let us know." V5 stated that she also was not aware that R9 had a HIT on his background check until 3/17/25. V5 stated, "If a resident has a HIT on their background check, fingerprints are to be ordered within 72 hours." The facility's Determination of Need and Background Screening of Residents policy dated September 2024 showed, "Policy: To ensure all individuals seeking admission to the facility are screened to determine, the need for nursing services prior to being admitted regardless of income, assets or funding sources ... The criminal background check is made through the UCIA (Illinois Uniform Conviction Information Act). The facility completes the appropriate forms and submits them to the corporate office ...". If the background check is inconclusive, fingerprints are obtained and sent to State Police, as indicated. A binder will be maintained with written documentation of the verification of an identified offender's status of all residents, as indicated ... The facility will inform the appropriate county and local law enforcement offices of the identified offenders being admitted to the facility ..." (C) Statement of Licensure Violation: 3 of 7 300.650d)	S9999		

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Section 300.650 Personnel Policies

d) The facility shall check the status of all applicants with the Health Care Worker Registry prior to hiring.

This REQUIREMENT was not met as evidence by:

Based on interview and record review the facility failed to initiate Health Care Worker Registry background checks on 6 new employees (V6, V7, V8, V4, V10, V9) prior to hire.

This failure had the potential to affect all 24 residents in the facility.

The findings include:

A facility roster dated 3/17/25 showed a resident census of 24.

A facility list dated 3/18/25 showed V6 Certified Nursing Assistant (CNA) was hired by the facility on 1/23/25. V6's Health Care Worker Registry background check was completed on 2/13/25.

A facility list dated 3/18/25 showed V7 Registered Nurse (RN) was hired by the facility on 1/21/25. V7's Health Care Worker Registry background check was completed on 3/17/25.

A facility list dated 3/18/25 showed V8 CNA was hired by the facility on 1/20/25. V8's Health Care Worker Registry background check was completed on 2/13/25.

A facility list dated 3/18/25 showed V4 Licensed Practical Nurse (LPN) was hired by the facility on

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1/23/25. V4's Health Care Worker Registry background check was completed on 3/17/25.

A facility list dated 3/18/25 showed V10 CNA was hired by the facility on 10/2/24. V10's Health Care Worker Registry background check was completed on 2/12/25.

A facility list dated 3/18/25 showed V9 CNA was hired by the facility on 2/6/25. V9's Health Care Worker Registry background check was completed on 2/13/25.

On 3/17/25 at 12:27 PM, V5 Business Office Manager stated background checks on new employees should be completed prior to hire. V5 stated, "The checks were done late because if I am not here, they don't get done. I work here and at another facility."

The facility's Background Check policy dated December 2024 showed, "The Personnel/Human Resources Director, or other designee, will conduct employment background checks, reference check and criminal conviction checks, (including fingerprinting as may be required by state law), on persons making application for employment with this facility. Such investigation will be initiated upon hire and during the onboarding process..."
(C)
Statement of Licensure Violations: 4 of 7
300.1035d)

Section 300.1035 Life-Sustaining Treatments

d) Any decision made by a resident, an agent, or a surrogate pursuant to subsection (c) of this Section must be recorded in the resident's

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medical record. Any subsequent changes or modifications must also be recorded in the medical record.

This REQUIREMENT was not met as evidenced by:

Based on interview and record review the facility failed to ensure Advanced Directives were updated in the medical record for 1 of 4 residents (R8) reviewed for Advanced Directives in the sample of 12.

An Illinois Department of Public Health Uniform Practitioner Order for Life-Sustaining Treatment (POLST) signed by R8's designee on 1/4/2025 shows R8 had elected to be a DNR (Do not Attempt Resuscitation).

On 3/17/25, R8's active Physician's Orders (POS) and face sheet both show her advanced directive status as a full code.

On 3/17/25 at 1:15 PM, V4 (Licensed Practical Nurse/LPN) reviewed R8's Electronic Medical Record (EMR) with this surveyor and verified that the EMR shows R8 to be a full code, but her POLST shows she had chosen to be a DNR. V4 said according to the EMR if R8 was found in need of CPR it would have been administered to her and that is not what R8 had designated in her POLST.

On 3/17/25 at 1:20 PM, V2 (Director of Nursing) said she is the person who should be updating advanced directives and R8's should have been updated to full code, but it was missed.

The facility provided Advanced Directive policy last revised September 2024 shows resident's

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advanced directives should be entered and updated in the EMR and a physician order should also be obtained.
(C)
Statement of Licensure Violations: 5 of 7
300.1060a)
300.1060b)
300.1060c)
300.1060d)

Section 300.1060 Vaccinations

a) A facility shall annually administer or arrange for administration of a vaccination against influenza to each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention that are most recent to the time of vaccination, unless the vaccination is medically contraindicated or the resident has refused the vaccine. Influenza vaccinations for all residents age 65 and over shall be completed by November 30 of each year or as soon as practicable if vaccine supplies are not available before November 1. Residents admitted after November 30, during the flu season, and until February 1 shall, as medically appropriate, receive an influenza vaccination prior to or upon admission or as soon as practicable if vaccine supplies are not available at the time of the admission, unless the vaccine is medically contraindicated or the resident has refused the vaccine. (Section 2-213(a) of the Act)

b) A facility shall document in the resident's medical record that an annual vaccination against influenza was administered, arranged, refused or medically contraindicated. (Section 2-213(a) of the Act)

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c) A facility shall administer or arrange for administration of a pneumococcal vaccination to each resident in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility unless the resident refuses the offer for vaccination or the vaccination is medically contraindicated. (Section 2-213(b) of the Act)

d) A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, refused, or medically contraindicated. (Section 2-213(b) of the Act)

This REQUIREMENT was not met as evidenced by:

Based on interview and record review the facility failed to ensure residents were offered, provided education on, and/or administered the influenza and pneumococcal vaccinations for 4 of 5 residents (R8, R6, R4, R2) reviewed for influenza and pneumococcal vaccinations in the sample of 12.

The findings include:

R8's Resident Face Sheet showed R8 was admitted to the facility on 12/7/24.
On 3/17/25, R8's electronic medical records dated 12/7/24-3/17/25 showed no documentation R8 was offered, educated on, and/or received a pneumococcal or influenza vaccination. The facility's Vaccine Binder was reviewed and showed no documentation of R8 being offered and/or receiving either vaccine.

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R6's Resident Face Sheet showed R6 was admitted to the facility on 6/3/24.
On 3/17/25, R6's electronic medical records dated 3/17/24-3/17/25 showed no documentation R6 was offered, educated on, and/or received a pneumococcal vaccination. The facility's Vaccine Binder was reviewed and showed no documentation of R6 being offered and/or receiving a pneumococcal vaccine.

R4's Resident Face Sheet showed R4 was admitted to the facility on 5/29/24.
On 3/17/25, R4's electronic medical records dated 5/29/24-3/17/25 showed no documentation R4 was offered, educated on, and/or received a pneumococcal vaccination. The facility's Vaccine Binder was reviewed and showed no documentation of R4 being offered and/or receiving a pneumococcal vaccine.

R2's Resident Face Sheet showed R2 was admitted to the facility on 10/25/23.
On 3/17/25, R2's electronic medical records dated 3/17/24-3/17/25 showed no documentation R2 was offered, educated on, and/or received a pneumococcal vaccination. The facility's Vaccine Binder was reviewed and showed no documentation of R2 being offered and/or receiving a pneumococcal vaccine.

On 3/17/25 at 12:00 PM, V2 Director of Nursing (DON)/Infection Preventionist (IP) and V3 Nurse Consultant each stated R8 had never received education on, offered, and/or administered the influenza vaccination in the facility. V2 DON/IP and V3 Nurse Consultant each stated R2, R4, R6, and R8 had never received education on, offered, and/or administered the pneumococcal vaccination in the facility. V2 DON/IP stated she

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was responsible for overseeing the facility's immunization program as the IP. V2 stated each resident should be screened for and offered the influenza and pneumococcal vaccines upon admission to the facility and annually.

The facility's Influenza Vaccine policy dated October 2024 showed, "Policy: To ensure residents are offered the influenza vaccine to aid in preventing influenza infection ... Residents will be offered the vaccine upon admission to the facility, unless the vaccine is medically contraindicated or the resident has already been vaccinated. Resident or representative will be educated on the benefits and potential side effects of the immunization. Influenza vaccine will be administered as ordered by the physician ..."

The facility's Pneumococcal Vaccine policy dated October 2024 showed, "Policy: To ensure residents are offered the pneumococcal vaccine to aid in preventing pneumococcal infection ... Residents will be offered the vaccine upon admission to the facility, unless the vaccine is medically contraindicated or the resident has already been vaccinated. Resident or representative will be educated on the benefits and potential side effects of the immunization. Pneumococcal 2 vaccine will be administered as ordered by the physician ..."
(B)

Statement of Licensure Violations: 6 of 7
300.1630b)

Section 300.1630 Administration of Medication

b.) The facility shall have medication records that shall be used and checked against the licensed

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prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available, a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility.

These REQUIREMENTS were not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure resident's medication were reconciled and administered as ordered for 1 of 4 residents (R6) reviewed for medication administration in the sample of 12.

The findings include:

On 3/18/25 at 8:17 AM, V4 (Licensed Practical Nurse/LPN) administered morning medication to R6. V4 did not administer Ferrous Sulfate (FeroSul- medication for iron deficiency, anemia) to R6.
After medication pass was completed on 3/18/25 at 8:45 AM, R6's electronic medical record (EMR) was reviewed. R6's Physician Order Summary (POS) shows an active order with an order date of 11/20/24, for FeroSul 325 milligrams (mg.) to be administered once a day, there was no time indicated for when it should be given.

R6's Medication Administration Record (MAR) for December 2024 and January, February and

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S9999	Continued From page 13 March 2025 show Ferrous Sulfate was not listed and was not given. On 3/18/25 at 10:00 AM, V4 reviewed R6's EMR with this surveyor. V4 verified that there was an active order for R6 to have Ferrous Sulfate, but the order was incorrectly entered as not scheduled so it did not carry over to the MAR and had not been being given. V4 said what probably happened was the facility went from one EMR to a different system and the order didn't get properly entered. On 3/18/25 at 10:05 AM, V2 (Director of Nursing) said she was not working at the facility in November when the facility changed EMR systems, but R6 did miss doses of medication due to it being entered in the computer as an inactive order. V2 said she was not sure who is responsible to review residents monthly POS to be sure they are accurate. V2 said she is unable to log into the facility's prior EMR system so she cannot print a November 2024 MAR or check the November MAR. On 3/18/25 at 10:14 AM, V3 (Nurse Consultant) said the pharmacy consultant for the facility should have reviewed R6's POS and MAR and should have caught that the medication had not been carried over or given. The facility provided Physicians Orders policy last reviewed 1/24, shows monthly the consulting pharmacy will review the physician orders and make sure they are carried out. The facility provided Medication Administration policy last updated on January 2024 shows that the resident MAR should be verified against the physician orders and administered as ordered.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008213	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 14 (B) Statement of Licensure Violations: 7 of 7 300.3240g) Section 300.3240 Abuse and Neglect g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act. This REQUIREMENT was not met as evidenced by: Based on interview, and record review the facility failed to report potential abuse. This failures applies to 2 of 2 residents (R6, R12) reviewed for abuse in the sample of 12. The findings include: On 3/17/2025 at 1:18PM, V14 Registered Nurse (RN) said on 3/15/2025 she heard R12 yell out and saw R6 with his hand on R12's dress. V14 said R12 has behaviors of yelling out normally. V14 said she separated R6 from R12. V14 said R6 has a diagnosis of dementia and is confused. V14 said in retrospect she should have called about it and reported to the administrator. V14 said she receives annual abuse training from the facility. On 3/17/2025 at 10:59AM, V1 Administrator said he did not have any abuse investigations in the last 90 days. V1 said nobody had reported any allegations of abuse to him over the weekend. On 3/17/2025 at 12:07PM, V2 Director of Nursing	S9999		

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S9999	Continued From page 15 (DON) said if there is any suspected abuse it should be reported to the abuse coordinator V1 right away. R6's progress notes dated 3/15/2025 authored by V14 states, We heard a female resident yelling, "leave me alone" and when investigated observed (R6) touching her dress, possible pushing it up higher. He stated, "I was just letting her know about her dress." We have talked to him multiple times about keeping his hands to himself but these incidents continue to occur. The facility provided Illinois - Abuse Prevention Policy dated 10/24/2022 states . . . employees are required to report any incident, allegation or suspicion of potential abuse . . . they observe, hear about, or suspect to the administrator immediately. . . (C)	S9999		