STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		IL6009799	B. WING		05/2	1/2015
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET AD			STATE, ZIP CODE		
PAVILION OF WAUKEGAN 2217 WASHINGTON STREET						
TAVILIO	TO WAOKEGAN	WAUKEG	AN, IL 6008	5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	300.615e) 300.3060a)4 300.2010 300.2100					
	300.615e) 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 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).					
	•	not met as evidenced by: view and interview, the facility				
	failed to initiate crim	ninal background checks a resident's admission.				
	R31, R32, R33, R3	of ten residents (R29, R30, 5, R36, R37 and R38) al background verification.				
	The findings include	e:				
	2015. The facility's	d to the facility on May 9, records showed R29's d check was initiated on May				
			<u> </u>			

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

(X6) DATE

TITLE

06/08/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IL6009799	B. WING		05/	21/2015	
	PROVIDER OR SUPPLIER N OF WAUKEGAN	2217 WA	DRESS, CITY, S SHINGTON S AN, IL 60085				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
\$9999	2. R30 was admitte 2015. The facility's criminal background 18, 2015. 3. R31 was admitte 2015. The facility's criminal background 4, 2015. 4. R32 was admitte 2015. The facility's criminal background 18, 2015. 5. R33 was admitte 2015. The facility's criminal background 18, 2015. 6. R35 was admitte 2015. The facility's criminal background 4, 2015. 7. R36 was admitte 2015. The facility's criminal background 7, 2015. 8. R37 was admitte 2015. The facility's criminal background 5, 2015. 8. R37 was admitte 2015. The facility's criminal background 30, 2015. 9. R38 was admitte 2015. The facility's criminal background 30, 2015.	ge 1 d to the facility on May 9, records showed R30's d check was initiated on May d to the facility on May 1, records showed R31's d check was initiated on May d to the facility on May 5, records showed R32's d check was initiated on May d to the facility on May 5, records showed R33's d check was initiated on May d to the facility on May 5, records showed R33's d check was initiated on May ed to the facility on May 2, records showed R35's d check was initiated on May ed to the facility on February ity's records showed R36's d check was initiated on d to the facility on April 28, records showed R37's d check was initiated on April d to the facility on April 27, records showed R38's d check was initiated on April	S9999				

Illinois Department of Public Health

STATE FORM 6899 WVNM11 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6009799	B. WING		05/2	1/2015
PAVILION OF WALKEGAN 2217 WAS		DRESS, CITY, S HINGTON S AN, IL 6008				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
S9999	On 5/19/2015 at 2:0 stated that the staff background check the staff designated from work and or relate Fridays or week no system in place checks to be initiate that does the background system in place checks to be initiate that does the background system in place checks to be initiate that does the background system in place checks to be initiate that does the background system in place checks to be initiate that does the background system in place checks to be initiate that does the background system in place checks to be initiate that does the background system in place checks that does the background system in place checks the ground system in place checks that does the background system in place checks that does the background system in place checks to be initiate that does the background system in place checks the background system	on P.M., E1 (Administrator) did not initiate the criminal win a timely manner because I to do the check was either off esidents were admitted on a kends. E1 also said there is for criminal background and in the absence of this staff ground checks. Director of Food Services in, qualified by training and eresponsible for the total food es of the facility. This person ininimum of 40 hours each I be either a dietitian or a ervisor. at 23 III. Reg. 8106, effective INOT MET as evidenced by: and record review, the facility bod service manager who ions as dietetic food service esidents receiving oral diets in	S9999			
	provided document	AM, E1 (Administrator) ation of E14's (Corporate ccessful completion of the				

Illinois Department of Public Health

STATE FORM 6899 WVNM11 If continuation sheet 3 of 5

Illinois D	epartment 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	
		IL6009799	B. WING		05/2	1/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PAVILIO	N OF WAUKEGAN		SHINGTON S AN, IL 6008			
(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 APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 3	S9999			
	food service operat in addition to visits one day a week. E E14 was not preser basis. On 5/19/15 at 10:30	5 AM, E14 stated she visits the ion two to three times a week by E 18 (Consultant Dietitian) 13 (Dietary Manager) verified at the facility on a full time D AM E13 stated she had not anager's course nor was she				
	a qualified dietitian.					
		AM, E13 stated E14 visits the ays a week and the E18 visits				
	rules entitled "Food Adm. Code 750).	andling Sanitation comply with the Department's Service Sanitation" (77 III. at 13 III. Reg. 4684, effective				
	750.540 Managem Certification	ent Sanitation Training and				
	in Section 750.10, e shall be under the o certified food service Category III facilitie	sion of a certified food service				
	as defined in Section food service sanital at all times that pot being handled, exception	acilities. Category I facilities on 750.10 shall have a certified tion manager on the premises entially hazardous food is ept as specified in subsections this Section. A certified food				

STATE FORM 6899 WVNM11 If continuation sheet 4 of 5 Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		IL6009799	B. WING		05/2	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PAVILIO	N OF WAUKEGAN		HINGTON S AN, IL 6008			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
\$9999	service sanitation in premises during ho products sold have commercially or preof a certified food sold a certified food sold a certified food sold a certified in sanitation at all times during the perishable foods. This affects all 95 returned the facility. The findings included On 5/20/15 at 9:00 department sanitating facility showed only (Dietary Manager), are licensed by the as being certified in dietary schedules dishowed 16 out of 5 and served perishal	nanager is not required on the urs of operation when all food been prepared and packaged epared under the supervision ervice sanitation manager. NOT MET as evidenced by: on, interview and record ailed to ensure individuals n were present on premises he preparation and service of esidents receiving oral diets in	\$9999			
		(B)				
1						

Illinois Department of Public Health

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