Illinois Department of Public Health

STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	LE CONSTRUCTION	(X3) DATE SURVEY						
		IDENTIFICATION NUMBER:	A. BUILDING	3:	COMPLETED						
		IL6008213	B. WING		02/08/2023	i					
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	<u> </u>						
SANDW	SANDWICH REHAB & HCC 902 EAST ARNOLD STREET										
			CH, IL 60548								
(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 CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	D BE COMPLE	ETE					
S 000	Initial Comments		S 000								
<u>.</u>	Annual Licensure S	survey									
S9999	Final Observations	,	S9999	2							
	Statement of Licens	sure Violations:									
	300.615e) 300.615f)			4.							
		etermination of Need quest for Resident Criminal rmation	8								
	2-201.5(a) of the Ac Section, a facility sh admission of a resid	nall, within 24 hours after dent, request a		0 60 60 60 60 60 60 60 60 60 60 60 60 60							
	Uniform Conviction Information Act [20 I or older seeking adn	ILCS 2635] for all persons 18 mission to									
	the facility, unless a initiated by a hospita Hospital Licensing A	a background check was al pursuant to the Act. Background checks shall									
	be based on the resiname, date of birth, required by the Depa Police. (Section 2-20)	and other identifiers as partment of State		. 8 .							
0	on the Illinois Sex Of Registration website the Illinois Departme	e at www.isp.state.il.us and ent of									
'	www.idoc.state.il.us	istrant search page at to determine if the s a registered sex offender.		Attachment A Statement of Licensure Violations							
	These requirements	were not met as evidenced	1								

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

TITLE

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	LE CONSTRUCTION		(X3) DATE SURVEY	
ANDICAN	OF CONNECTION	IDENTIFICATION NUMBER	A. BUILDING:		СОМ	PLETED	
iL6008213		B. WING		02/6	02/08/2023		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
SANDW	CH REHAB & HCC	902 EAST	ARNOLD S	TREET			
OANDIN			CH, IL 60548	3			
(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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	(X5) COMPLETE DATE		
S9999	Continued From page 1		S9999				
	by:					2 2	
	Based on interview failed to complete re and website checks to the facility. This a	and record review the facility esident background checks within 24 hours of admission applies to 9 of 10 residents					
		7, R28, R29, R30, R84, R234) round checks in the sample of	**			6	
	The findings include	: :					
	new residents admit then provided copie the Illinois Sex Offer of Corrections webs documents shows: R3 was admitted on check was complete R14 was admitted o	n 1/16/23. Both websites				.A.J.	
20	was completed on 2 R20 was admitted o checked on 2/6/23. I completed on 2/7/23	n 1/7/23. Both websites were His background check was		# # # # # # # # # # # # # # # # # # #	962 - 17 962 - 10 1	2 p	
	check was complete being held for furthe R28 was admitted or	ed on 2/7/23 and is currently r review. n 1/1/23. Both websites were			2		
	completed on 2/7/23 R29 was admitted or checked on 2/6/23. I completed on 2/7/23	n 1/9/23. Both websites were Her background check was					
	were checked on 2/6 was completed on 2/ R84 was admitted or	n 1/11/23. Both websites 6/23. Her background check /7/23. n 1/3/23. Both websites were Her background check was			E.	4 . 10	

Illinois Department of Public Health STATE FORM

PRINTED: 03/21/2023 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED IL6008213 B. WING 02/08/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 902 EAST ARNOLD STREET SANDWICH REHAB & HCC SANDWICH, IL 60548 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 completed on 2/7/23. R234 was admitted on 1/8/23. Both websites were checked on 2/6/23. His background check was completed on 2/7/23. On 2/7/23 at 8:40AM V3 (Business Office Manager) stated, "Corporate office is running them for me because I can't get into the system. When I did them, I didn't print them. I have one that I did print but the others, I forgot. " The facility Abuse Policy dated 1/28/16 does not address the facility's responsibility to complete background checks on residents within 24 hours of admission to the facility. (C) linois Department of Public Health

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