(X6) DATE

Illinois Department 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				
IL6002539			B. WING		C <b>05/24/2024</b>			
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
DOCTOR	S NURSING & REHA	B CENTER	1201 HAV SALEM, I	VTHORN RO	AD			
(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 CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	TION SHOULD BE COMPLETE THE APPROPRIATE DATE		
S 000	Initial Comments			S 000				
	Compliant Investiga	ation: 2453738/	IL173078					
S9999	Final Observations			S9999				
	Statement of Licens	sure Violations.						
	300.661							
	Section 300.661 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 requirements are not met as evidenced by:							
	Based on interview and record review the facility failed to ensure all required internet website background checks were completed for employees. This has the potential to affect all 66 residents residing at the facility.							
	Findings Include:							
	1. V1's untitled, und provided by the faci documents, V1's (C Assistant-CNA) dat background checks include a Departme website checks, the (OIG) website checks.	ility with employ Certified Nursing e of hire as 4/0 s provided by the ent of Correction e Office of Inspe	vee hire date g g g g g g g g g g g g g g g g g g g					
	2. V4's untitled, und provided by the faci documents, V4's (C	ility with employ	ee hire date					

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

**Electronically Signed** 05/30/24

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
IL6002539			B. WING			C <b>05/24/2024</b>	
	PROVIDER OR SUPPLIER	B CENTER		THORN ROA	TATE, ZIP CODE <b>AD</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING INI	ENCIES ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	Assistant-CNA) dat background checks include a Departme website checks, the (OIG) website checks.  3. V5's untitled, und provided by the fact documents, V5's (OAssistant-CNA) dat background checks include a Departme website checks.  4. V6's untitled, und provided by the fact documents, V6's (OAssistant-CNA) dat background checks include a Departme website checks, the (OIG) website checks include a Departme website checks, the (OIG) website checks.  5. V7's untitled, und provided by the fact documents, V7's (OAssistant-CNA) dat background checks include a Departme website checks, the (OIG) website checks include a Departme website checks, the (OIG) website checks include a Departme website checks, the (OIG) website checks.  On 5/24/2024 at 9:3	e of hire as 2/7/s provided by the sent of Correction e.k, or the state sent at the sent of Correction e.k, or the state s	e facility did not as (DOC) ector General ex offender  ent form ree hire date 3 21/2023. V5's e facility did not as (DOC) ector General ex offender  ent form ree hire date 3 6/2024. V6's e facility did not as (DOC) ector General ex offender  ent form ree hire date 3 3/2024. V7's e facility did not as (DOC) ector General ex offender  ent form ree hire date 3 3/2024. V7's e facility did not as (DOC) ector General ex offender  ent form ree hire date 3 3/2024. V7's e facility did not as (DOC) ector General ex offender	S9999			
	Manager/BOM) sta boarding process for	ted, she comple	etes the on				

Illinois Department of Public Health

STATE FORM 6899 HII811 If continuation sheet 2 of 5

		(X1) PROVIDER/S IDENTIFICATI		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
IL6002539			B. WING			C <b>05/24/2024</b>		
	PROVIDER OR SUPPLIER RS NURSING & REHA	B CENTER	THORN RO	TATE, ZIP CODE				
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
\$9999	DRS NURSING & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		S9999					

Illinois Department of Public Health

STATE FORM 6899 HII811 If continuation sheet 3 of 5

Illinois Department of Public Health								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
IL6002539		B. WING	B. WING		C <b>05/24/2024</b>			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE				
ростог		1201 HA	WTHORN RO					
DOCTOR	RS NURSING & REHA	SALEM,	IL 62881					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y 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		
S9999	Continued From pa	age 3	S9999					
	electronically to the conducting Internet sites, including with Offender Registry, 1 Sex Offender Searc Corrections' Inmate Department of Corr Search Engine, and Individuals and Entiof the Health and H Inspector General thas been adjudicate prison inmate, or has been adjudicate prison inmate, or h	e Department of Public Health; it searches on certain web nout limitation the Illinois Sex the Department of Corrections chengine, the Department of Search Engine, the rections Wanted Fugitives it the List of Excluded cities database on the website duman Services Office of to determine if the applicant as committed Medicare or conducting similar searches as dhaving the student, applicant erprints collected and inically to the Illinois State is employer files. The health ill retain on file for a period of 5 iminal records requests for all ealth care employer shall retain on authorization forms, can request form, all ing from the fingerprint-based ords check and waiver, if a duration of the individual's iles shall be subject to gency responsible for g, or certifying the health care up to \$500 may be imposed agency for failure to maintain Department of Public Health tronic record of criminal history is for an individual for as long mains active on the Health stry."						
	On 4/24/24 at 11:30 that the facility did r	•						

STATE FORM 6899 If continuation sheet 4 of 5 HII811

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED				
IL6002539		B. WING			C <b>05/24/2024</b>				
	NAME OF PROVIDER OR SUPPLIER  DOCTORS NURSING & REHAB CENTER  \$TREET ADDRESS, CITY, STATE, ZIP CODE  1201 HAWTHORN 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
\$9999	checks for Health C requested.  The facility "Reside and provided to the	ge 4 Care providers when  Int Roster" dated 5/23/20 Surveyor on 5/24/24 Idents reside at the facilit		S9999					

Illinois Department of Public Health

STATE FORM 6899 HII811 If continuation sheet 5 of 5