

Illinois Department of Public Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>ASL510286</b>       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/27/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>RED OAK MEMORY CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>421 N 16TH AVE<br/>CANTON, IL 61520</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                          | Initial Comment<br><br>Annual Licensure Survey                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | A 000                                                                               |                                                                                                                          |                                                        |
| A3020                                                          | Section 295.3020 Employee Orientation and<br>Ongoing Training<br><br>This Regulation is not met as evidenced by:<br>Section 295.3020 Employee Orientation and<br>Ongoing Training<br>a) Each new employee shall complete orientation<br>within 10 days after the starting date of<br>employment that includes:<br>5) Abuse and neglect prevention and reporting<br>requirements; and<br>c) Each manager and direct care staff member<br>shall complete a minimum of 8 hours of ongoing<br>training, applicable to the employee's<br>responsibilities, every 12 months after the starting<br>date of employment. The training shall include:<br>5) Abuse and neglect prevention and reporting<br>requirements; and<br><br>Type 3 Violation.<br><br>Based on interview and record review, the<br>establishment failed to provide abuse and neglect<br>training to new employees within the required 10<br>days and then annually for three of six employees<br>(E1, E3, and E8). This has the potential to affect<br>all 21 residents currently residing in the<br>establishment.<br><br>Findings include:<br><br>The establishment's employee list documents E1 | A3020                                                                               |                                                                                                                          |                                                        |

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>ASL510286</b>       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/27/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>RED OAK MEMORY CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>421 N 16TH AVE<br/>CANTON, IL 61520</b> |                                                                                                                          |                                                        |
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| A3020                                                          | <p>Continued From page 1</p> <p>started on 9-10-18, E3 on 10-6-19 and E8 started on 8-17-19.</p> <p>None of the above employee's 10 day orientation includes abuse and neglect training. E1, E3 and E8 do have documented abuse training completed 5-2-22 but none documented yearly after that date.</p> <p>On 1-27-25 at 10:30 am, E9 (Aide Supervisor) verified E1, E3 and E8's abuse training wasn't completed until 5-2-22.</p> <p>On 1-27-25 at 12:20 pm, E2 (Director of Nursing) stated abuse and neglect training should be completed yearly. E2 stated she could not locate any other recent abuse training for E1, E3 and E8.</p> <p>The establishment's Abuse Prevention policy documents "During orientation of new employees, the facility will cover at least the following topics." "what constitutes abuse (physical, mental, sexual, verbal), neglect, exploitation, mistreatment, and misappropriation of resident property."</p> | A3020                                                                               |                                                                                                                          |                                                        |