STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510137	A. BUILDING: _____ B. WING _____	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD VILLAGE OF KEWANEE	860 SUNSET DR KEWANEE, IL 61443

(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
A 000	Initial Comment Change of Ownership License Survey	A 000		
A3010	Section 295. 3010 Manager's Qualifications This Regulation is not met as evidenced by: Section 295.3010 Manager's Qualifications a) Each assisted living establishment shall have a full-time manager. Type 3 Violation Based on observation, interview and record review, the establishment failed to have a full time manager on duty. This has the potential to affect all 29 residents currently residing in the establishment. Findings include: On 1-22-25 at 11:15 am, E1 (Executive Director) was not in the building. At approximately 11:45 am, E1 arrived stating she had been at the Memory Care establishment close by. On 1-23-25 at 11:40 am, E1 stated she was the Executive Director of both this Assisted Living establishment and the Memory Care 25 bed unit located in a separate building close by. E1 and E6 (Business Office Manager) stated on Monday and Tuesday, E1 is working at this establishment. On Wednesday, Thursday, and Friday, E1 works at the Memory Care establishment. The establishment license documents the establishment has 39 regular assisted living units.	A3010		