FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C IL6015648 B. WING 03/22/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3701 WEST 183RD STREET CHARTER SNR LVG OF HAZEL CREST HAZEL CREST, IL 60429 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) **Initial Comments** S 000 S 000 Complaint Investigation: 2292008/IL144603 S99991 Final Observations S9999 Statement of Licensure Violations: 330.710a) 330.710b) 330.710c)2) 330.4240a) 330.4240b) 330.4240d) 330.4240e) Section 330.710 Resident Care Policies The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. All of the information contained in the b) policies shall be available for review by the Department, residents, staff and the public. The written policies shall include, but are not limited to, the following provisions: Resident care services including physician services, emergency services, personal care services, activity services, dietary services Attachment A Statement of Licensure Violations and social services.

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

TITLE

(X6) DATE

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(R1) told me he started yelling for (V4) to leave him alone and then she slapped him and left the

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