PRINTED: 01/29/2024 FORM APPROVED

(X3) DATE SURVEY

Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		L6015135	B. WING		01/10/2024		
NAME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, STATE, ZIP CODE				
GOLFVIEW DEVELOPMENTAL CENTER		ST GOLF ROAD INES, IL 60016					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE		
Z 000	COMMENTS		Z 000				
	Annual Health Survey	,					
Z9999	FINDINGS		Z9999				
	Statement of Licensure Violations:						
	Nursing services (DO Nurse (RN) and whos immediate supervision services. This person of 36 hours, four days percent of this person scheduled between 7 2) A facility may, the Department, have share the duties of thi unable to obtain a full arrangement will be g through written documents.	ave a full-time Director of N) who is a Registered e only responsibility is the n of the facility's health shall be on duty a minimum per week. At least 50 's hours shall be regularly A.M. and 7 P.M. with written approval from two Registered Nurses s position if the facility is -time person. Such an					
	qualified individual to						
	nent of Public Health DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	1	TITLE	(X6) DATE		

(X2) MULTIPLE CONSTRUCTION

01/25/24

PRINTED: 01/29/2024 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.	A. BUILDING: _		COMP	LETED	
		 L6015135	B. WING		01	01/10/2024	
NAME OF D	POVIDED OD SUDDI IED		DESS CITY STA	TE ZID CODE	, , , , , , , , , , , , , , , , , , , ,		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA				
GOLFV I E\	W DEVELOPMENTAL CE	NTER	T GOLF ROAD NES, IL 60016				
	OLUMAN DV OT		1	DDOWDEDIO DI ANI OF 6	A CONTRACTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
Z9999	Continued From page	e 1	Z9999				
	an advertisement tha	t nas appeared in a I circulation in the area for at					
		e names, addresses and					
		persons who applied for the					
	•	ons why they were not					
	T	not work full time; and					
		number and availability of					
		he area. The Department					
	will grant approval only when such documentation						
	indicates that there were no qualified applicants						
	who were willing to accept the job on a full-time						
	basis, and the pool of registered nurses available						
		expected to produce, in the					
	near future, a qualified person who is willing to						
	work full time.						
	b) Residents shall be provided with nursing						
	services, in accordance with their needs, which						
		not limited to, the following:					
	The DON shall partic						
	Pre-admission evaluation study and plan.						
	Evaluation study, program design, and placement of the resident at the time of						
	admission to the facil						
		aluation of the type, extent,					
	and quality of service	• • • • • • • • • • • • • • • • • • • •					
		of discharge plans, and the					
		e community resources.					
		bits in personal hygiene and					
	activities of daily living	g.					
	6) Development	of a written plan for each					
		r nursing services as part of					
	the total habilitation p						
		f the resident care plan, in					
		s daily needs, as needed.					
	c) A Registered Nurse	· · · · · · · · · · · · · · · · · · ·					
		ng and implementing the					
	training of facility pers						
	d) Direct care personnel shall be trained in, but						
	are not limited to, the						
	 1) Detecting sign 	ns of illness, dysfunction or					

Illinois Department of Public Health

STATE FORM JRGF11 If continuation sheet 2 of 3

PRINTED: 01/29/2024 FORM APPROVED

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) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
IL60		IL6015135	B. WING		01/10/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLFVIEW DEVELOPMENTAL CENTER 9555 WEST GOI						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE		
Z9999	needs and problems (3) First aid in the illness. These requirements a Based on interview at failed to have a full-tir (DON) who is a Regis whose only responsit supervision of the fac 8 residents (R1-R8) i residents (R9-R22, R sample, who reside in Findings Include: On 1/8/24 at 2:34 PM the facility had a Direct October 2022 - May 2 does not have a Direct Review of the facility's 9/24/23 - 1/10/24 sho	that warrant medical, ial intervention. quired to meet the health of the residents. presence of accident or are not met as evidenced by: Independent of the resident or are not met as evidenced by: Independent of the resident of the resident of the facility medical price of the facility is the immediate of the sample and for 108 (24-R118) outside the facility. In the facility. In the facility outside the facility of the fac	Z9999			

Illinois Department of Public Health

STATE FORM 6899 JRGF11 If continuation sheet 3 of 3