## Statement of Deficiencies and Plan of Correction

### Illinois Department of Public Health

**NAME OF PROVIDER OR SUPPLIER:**

TURNER MANOR

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

P.O. BOX 303, 901 OGLESBY ROAD
HARRISBURG, IL 62946

**DEFICIENCY AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
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</thead>
</table>
| Z 000             | COMMENTS
LICENSURE FOLLOW UP VISIT TO THE SURVEY OF 05/17/2012
(COMPLAINT #1251420) | Z 000 |  |  |  |
| Z9999             | FINDINGS
The facility is in compliance with their imposed plan of correction for 350.620, 350.1210, 350.1230 b) 6) 7) and 350.3240 a) for licensure findings found during the survey of 05/17/2012. | Z9999 |  |  |  |