STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E897	A. BUILDING _____ B. WING _____	C 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTHCARE CENTER	**1750 WEST WASHINGTON SPRINGFIELD, IL 62702**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #1642790/IL85691	F 000		
F 354 SS=C	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide the required Registered Nurse coverage. This failure has the potential to affect all 44 residents living at the facility. Findings include: 1. The Facility's Nurses Working Schedule, dated 5/15-6/11/16, documents that on 5/15, 5/28, 5/29 and 6/11/16, no Registered Nurses (RN) were on duty. On 6/2/16 at 11:30 AM, E1, Administrator, said there were no RNs on those dates of the schedule. E1 stated "We have had an ad (advertisement) out for RNs, but no reply, they	F 354		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E897	A. BUILDING _____ B. WING _____	C 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTHCARE CENTER	**1750 WEST WASHINGTON SPRINGFIELD, IL 62702**

(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) COMPLETION DATE
F 354	Continued From page 1 just aren't out there." On 6/2/16 at 1:00 PM, E2, Director of Nurses (DON), stated "We don't have an RN working every day. We haven't had to use Agency nurses, we usually patch together enough help." E2 also stated that the only Facility Policy related to staffing is Mandatory-Mandating policy The Mandatory-Mandating policy, dated 10/24/13, documents, in part, "It is (the facility's) responsibility to provide adequate staff coverage per the IDPH (Illinois Department of Pubic Health) guidelines. These guidelines are for the benefit and safety of out residents and staff." 2. The Facility Date Sheet, dated, 6/2/16 documents that the facility has 44 residents living in the facility.	F 354		