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	146076	A. BUILDING _____ B. WING _____	02/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS Annual Licensure and Certification Licensure Survey for Subpart S: SMI First Complaint Follow up to Complaint 1260112/IL55892	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observations the facility failed to follow the reduction plan for releasing the lap belt for one of four residents (R2) with restraints in the sample of 19. Findings include: During initial tour on 2/21/12 9:00 am E7 (Licensed Practical Nurse/Minimum Data Coordinator and Care Plan Coordinator) stated (R2) wore a self releasing seat belt while up in the chair and "(R2) is unable to remove it on her own." The facility policy dated 3/03 under procedure states: "An assessment done by licensed staff and reassessment done at least every 90 days with the least restrictive restraint method to be	F 221		

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

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F 221	Continued From page 1	F 221		

used. Must have signed consent by the resident or resident's family..., guardian or legal representative for the use of restraints.....Must have a physician's order with the following: 1) Reason for restraint 2) Type of restraint 3) Length of time to be used.....Monthly documentation shall include the following: 1) Resident's response ....Attempts made in ways of using less restrictive measures and why they were unsuccessful.....Progress must be evident over a three month period or if the resident is not meeting goals of the restraint reduction program, the record must indicate that staff is addressing the lack of progress..."

On 2/24/12 at 12:30 pm E1 (Administrator) stated, "There is no physicians order and therefore there is no consent signed by the power of attorney." E1 stated the reduction plan is what the care plan says to release the belt every two hours and at meals. The quarterly MDS (Minimum Data Set) would be our reassessments.

The facility care plan dated 1/20/12 states to release the seat belt every two hours and during meals/activities when staff is available.

On 2/22/12 at 7:45 am E13 (Certified Nursing Assistant/CNA) was feeding R2 with the seat belt in the fastened position. At 7:55 am E14 (CNA) began feeding R2 and the seat belt remained fastened.

On 2/22/12 at 12:15 pm E13 was feeding R2 with the seat belt fastened.

On 2/24/12 at 8:45 am R2 was asked if she could

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F 221	Continued From page 2 release the "self releasing seat belt." R2 stated "I sure would like to get rid of this thing." E11 also asked R2 to remove the belt. R2 fumbled with her left hand but after 2 minutes became distracted and no longer attempted to release the belt.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225		

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F 225	Continued From page 3 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to initiate a criminal background check on one of 15 employees (E6). Findings include: Review of the personnel file of E6/CNA (Certified Nursing Assistant) provides no documentation that a criminal background check was conducted on E6. On 2-23-12 at 1:40 PM, E1 stated that the facility has been unable to locate any documentation that a criminal background check was done on E6.	F 225		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by:	F 273		

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F 273	Continued From page 4 Based on record review and interview the facility failed to complete a resident assessment within 14 days after admission for one resident (R15) of 19 reviewed for assessments in the sample of 19. Findings include: Facesheet dated 2/23/12 for R15 lists an admission date of 1/17/12. MDS (Minimum Data Set) dated 1/24/12 for R15 has the sections A0100-A1700 completed. The remaining sections of R15's MDS (sections A1800-S9003) were left blank. On 2/23/11 at 2:45 PM E7/MDS Coordinator verified that R15's MDS from 1/24/2012 was incomplete.	F 273		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete a quarterly assessment within 92 days of the previous assessment for two of 19 (R1 and R7) residents in the sample of 19. Findings include: 1. Initial RAI (Resident Assessment Instrument) for R7 has an ARD (Assessment Reference Date) of 11-8-11. On 2-21-12 Quarterly MDS assessment for R7, with ARD of 2-7-12, was incomplete, having only sections A through F	F 276		

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F 276	Continued From page 5 completed. 2. Quarterly MDS Assessment for R1 has an ARD of 11-8-11. On 2-21-12 Quarterly MDS assessment for R1, with ARD of 2-7-12, was incomplete, having only sections A through F completed. On 2-23-2 at 2:25 PM, E7/CPC (Care Plan Coordinator) confirmed that MDS assessments for R1 and R7, both having an ARD of 2-7-12 were incomplete. E7 stated that E7 was "unsure why they didn't get done."	F 276		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		

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F 279	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to include identified problem areas in the resident's care plan for two (R4 and R7) of 19 residents reviewed for care plans in the sample of 19. Findings include: 1. R4's POS (Physician's Order Sheet) dated 2-20-12 shows R4 has orders for care of a feeding tube, urinary catheter, psychotropic and pain medications, pressure sores and is a potential for falls On 2-23-12 at 11:10, R4 was in bed with a pressure sore to her left hip and coccyx, a Peg tube and a urinary catheter. R4's Care Area Assessment (CAA) Summary column A dated 1-11-12 shows the following areas triggered to be addressed in R4's care plan: ADL (Activities of Daily Living) Functional/Rehabilitation Potential, Falls, Nutritional Status, Feeding Tube, Dehydration/Fluid Maintenance, Psychotropic Drug Use and Pain. The section "B Addressed in Care Plan" column is totally blank. R4's care plan dated reviewed on 2-22-12 shows the following areas care planned; Activities, Pressure Sores and Discharge. On 2-23-12 at 2:30 PM, E3 (DON/Director of Nursing) confirmed the care plan did not contain and should have contained interventions relating to ADL function, falls, nutritional issues, feeding	F 279		

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F 279	Continued From page 7 tube, dehydration, and psychotropic/pain medications that were triggered on the CAA. 2. Progress Notes dated 12-16-11 to 12-29-11 document that R7 had significant behavior issues including yelling out, being disruptive and sarcastic, and using profanity. Physician's orders document that R7 had an increase in antipsychotic medication (risperdal) and a change of her antianxiety medication (from lorazepam to diazepam) on 12-16-11 and then had an increase in the antianxiety medication on 12-21-11. Vital Signs flow sheet documents the following weights on R7: 10-26-11=87 lbs (pounds), 1-23-12=102 lbs, 1-30-12=91 lbs, and 2-7-12=99 lbs. Physician's Order dated 1-13-12 documents the initiation of a high calorie/high protein supplements for R7. Current Care Plan for R7, with a revision date of 2-16-12, includes no identified problem areas or interventions related to behaviors, use of psychotropic medications, or significant weight fluctuations. On 2-23-12 AT 2:25 PM, E7/CPC (Care Plan Coordinator) confirmed that behaviors, psychotropic medication, and weight fluctuations are not addressed in the care plan.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280		

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F 280	Continued From page 8 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, and record review the facility failed to revise the care plan for one of 19 sampled residents (R7). Findings include: On 2-21-12 at 9:20 AM, E3 stated that R7 had recently had a decline in condition and now requires a reclining wheel chair when out of bed for positioning and extensive assistance of staff for bed mobility. Physician's Order dated 2-3-12 documents that R7 receives a puree diet and Physician Order dated 2-9-12 documents that R7 receives Honey-thick consistency liquids.	F 280		

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F 280	Continued From page 9 Resident Care Information Sheet, used as a care guide by Certified Nursing Assistants, states that R7 uses a wheelchair with a lap cushion and turns and positions herself. R7's current care plan, with a revision date of 2-16-12, states "(R7) is on a regular diet." On 2-23-12 at 2:25 PM, E7 confirmed that the Resident Care Information Sheet was inaccurate regarding R7's use of a wheelchair and turning and positioning herself and that R7's diet was incorrect in the care plan.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a urinary catheter bag was not raised above the level of a resident's bladder or placed directly on the floor for one of four residents (R4) reviewed with urinary catheters in a total sample of 19. Findings include:	F 315		

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F 315	Continued From page 10 On 2-22-12 at 11:10 am, E8 and E9 (CNAs/Certified Nursing Assistants) transferred R4 from bed to wheelchair. E8 lifted R4's urinary catheter bag out of the privacy bag holding it above the level of R4's bladder and then laid it on the bed. E9 (CNA) then picked up the urinary catheter bag again above the level of R4's bladder, stating she (E9) needed to empty it before they transferred R4 since the bag was full of urine. After R4 was transferred into her wheelchair, E9 (CNA) took the empty urinary catheter bag and placed it on the floor under R4's wheelchair, went behind the wheelchair and got the bag off the floor and placed it in the privacy bag on the back of R4's wheelchair. R4's POS for 2-2012 shows R4 has diagnoses of Diabetes, muscle weakness and atrophy, feeding tube, pressure sores and history of septicemia. Review of R4's care plan on 2-21-22 showed no interventions developed relating to the care and treatment of R4's urinary catheter. Facility's urinary catheter policy dated 1-04 states "attach drainage bag below hip level if out of chair or ambulatory...attached drainage bag to bed frame, below level of resident's bladder -not touching floor." On 2-23-12 at 2:30 pm, E3 confirmed E8 and E9 did not follow facility procedure when they lifted R4's full urinary catheter bag above R4's bladder. E3 also stated R4's catheter bag should not have been placed on the ground.	F 315		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures	F 334		

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F 334	Continued From page 11 that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal	F 334		

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F 334	Continued From page 12 representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to show evidence that the pneumococcal vaccine was offered or pneumococcal vaccine education was provided for 10 residents (R1-R7 and R9-R11) in a total sample of 19 residents. Findings include: Facility policy under the subject "Immunizations" dated 6/06 (no year provided), reads, "All residents will be immunized against influenza and pneumococcal disease as recommended by the	F 334		

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F 334	Continued From page 13 Advisory Committee for Immunization Practices. The vaccine will be provided to all residents unless medically contraindicated, or the resident or responsible part refuses." Facesheet dated 2/23/12 for R1 lists an admission date of 12/10/11. There is no evidence in the clinical record or on the facility immunization list that R1 was offered a pneumococcal vaccine or was provided education for the vaccine. Facesheet dated 2/23/12 for R2 lists an admission date of 4/21/11. There is no evidence in the clinical record or on the facility immunization list that R2 was offered a pneumococcal vaccine or was provided education for the vaccine. Facesheet dated 2/23/12 for R3 lists an admission date of 5/28/09. There is no evidence in the clinical record or on the facility immunization list that R3 was offered a pneumococcal vaccine or was provided education for the vaccine. Facesheet dated 2/23/12 for R4 lists an admission date of 2/7/12. There is no evidence in the clinical record or on the facility immunization list that R4 was offered a pneumococcal vaccine or was provided education for the vaccine. Facesheet dated 2/23/12 for R5 lists an admission date of 1/23/09. There is no evidence in the clinical record or on the facility immunization list that R5 was offered a pneumococcal vaccine or was provided education for the vaccine. Facesheet dated 2/23/12 for R6 lists an admission date of 4/8/11. There is no evidence in the clinical record or on the facility immunization list that R6 was offered a pneumococcal vaccine	F 334		

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F 334	Continued From page 14 or was provided education for the vaccine. Facesheet dated 2/23/12 for R7 lists an admission date of 10/26/11. There is no evidence in the clinical record or on the facility immunization list that R7 was offered a pneumococcal vaccine or was provided education for the vaccine. Facesheet dated 2/23/12 for R9 lists an admission date of 2/15/12. There is no evidence in the clinical record or on the facility immunization list that R9 was offered a pneumococcal vaccine or was provided education for the vaccine. Facesheet dated 2/23/12 for R10 lists an admission date of 5/6/09. There is no evidence in the clinical record or on the facility immunization list that R10 was offered a pneumococcal vaccine or was provided education for the vaccine. Facesheet dated 2/23/12 for R11 lists an admission date of 5/28/09. There is no evidence in the clinical record or on the facility immunization list that R11 was offered a pneumococcal vaccine or was provided education for the vaccine. On 2/22/12 at 11:45 AM, E2 verified that the pneumococcal vaccine was not offered and education was not provided to R1-R7 and R9-R11.	F 334		
F 368 SS=C	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a	F 368		

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	146076	A. BUILDING _____ B. WING _____	02/24/2012

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F 368	Continued From page 15 substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to offer bedtime snacks to one resident (R8) in a sample of 19 residents and three residents (R24-R26) in the supplemental sample. Findings include: Weekly Menu dated 2/21/12 shows no evidence of a bedtime snack included in menu planning for the week. On 2/22/12 at 1:30 PM, R24 stated he had not been offered a bedtime snack. On 2/22/12 at 1:30 PM, R25 stated she had not been offered a bedtime snack. On 2/22/12 at 1:30 PM, R26 stated she had not been offered a bedtime snack. On 2/23/12 at 1:15 PM, R8 stated he had not been offered a bedtime snack but he thought it was a good idea.	F 368		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		

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F 431	Continued From page 16 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview and observation the facility failed to keep medications securely locked up and/or within view of Licensed Professional Staff	F 431		

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F 431	Continued From page 17 potentially affecting two residents (R22, R28) on the supplemental sample. Findings include: On 2/22/12 at 7:00 am E10 (Registered Nurse) took the following medications from the drawer on the medication cart and placed them on the top of the cart: Calcium 600 mg with Vitamin D 400 units, RenaVite, Aspirin 81 mg Enteric Coated, Multi-Vitamin with minerals, Loratidine 10 mg, Colace 100 mg, Vitamin C 500 mg and Vitamin E 1000 units. E10 stated,"I just put the OTC (over the counter) medications I use alot on top of my cart so it's easier." On 2/22/12 at 7:05 am E10 administered medications to R27 in R27's room. The medication cart was not in view of E10. At 7:10 am on 2/22/12 E10 administered medications to R22 in residents room with R22 in bed. The medication cart with the OTC bottles was not in view of E10. On 2/22/12 at 7:18 am E10 prepared medications for R23. E10 stated she had no more Loratidine in the OTC bottle and left the cart with the OTC medications in the hall outside the door to R23 and R28's room. E10 went to the nursing station where the medication room is located to obtain a new bottle. During this time R22, whose MDS dated 11/22/11 showing severe cognitive impairment, was walking in the hallway. R28 was standing in the doorway of her room with the cart containing the OTC medications directly outside her door. MDS dated 2/12/12 shows R28 is severely cognitively impaired.	F 431		

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F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 19	F 441		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to place a resident on isolation precautions in a private room as required by facility policy for one of two residents (R7) on isolation precautions in a total sample of 19 residents.

Findings include:

Laboratory result from local hospital, dated 2-20-12, documents that a stool sample obtained from R7 on 2-19-12 tested positive for Clostridium difficile.

On 2-21-12 at 2:07 PM, E12/CNA (Certified Nursing Assistant) stated that R7 is on contact isolation for a Clostridium difficile infection.

Facility Policy#: 3.29 (IL) "Categories of Transmission-based Precautions" states that when a resident is on Contact Isolation precautions staff should "Place the resident in a private room, or place with a resident with the same infection with the same microorganism.."

On 2-23-12 at 2:07 PM, R7 was in bed and there was another resident in the bed next to R7 in the same room.

On 2-23-12 at 2:35 PM, E3 confirmed that R7 should have been placed in a private room when isolation precautions were initiated and stated, "I overlooked that" when referring to the isolation policy. E3 also confirmed that R7's roommate does not have Clostridium difficile or any other

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F 441	Continued From page 20 infection requiring isolation.	F 441		
F 496 SS=D	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	F 496		

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F 496	Continued From page 21 failed to check the Health Care Worker Registry prior to the first day of work for two of ten Certified Nursing Assistants (E5 and E6). Findings include: 1. Personnel file of E5 documents that E5's date of hire is 9-19-11. Printed page from Illinois Department of Public Health Health Care Worker Registry documents that the registry was checked regarding E5 on 9-20-11. 2. Personnel file of E6 documents that E6's date of hire is 2-15-11. Printed page from Illinois Department of Public Health Health Care Worker Registry documents that the registry was checked regarding E6 on 2-16-11. On 2-23-12 at 1:40 PM, E1 confirmed that the registry checks for E5 and E6 were completed after their dates of hire.	F 496		