Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000624	A. BUILDING: _____ B. WING _____	04/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TURNER MANOR	P.O.BOX 303, 901 OGLESBY ROAD HARRISBURG, IL 62946

(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) COMPLETE DATE
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		

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TITLE (X6) DATE

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