STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5106171	A. BUILDING: _____ B. WING _____	C 10/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF BETHALTO	903 NORTH MORELAD ROAD BETHALTO, IL 62010

(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
A 000	Initial Comment Facility Reported Incident Investigation to Incident Report dated 8/27/25 / IL197725 Violations cited: 295.6000 a) 1) 13)	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Based on interview and record review the facility failed to ensure residents are free from any form of abuse including verbal abuse. This failure creates a substantial probability of harm to residents in the facility.	A6000		

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A6000	Continued From page 1 Findings include: The Facility Policy on Abuse, Neglect, and Exploitation, Prevention, Prohibition, and Investigation Policy, updated 12/2023 documents, "The Community will make every reasonable effort to avoid hiring, or continuing to employ, persons with a history of/or propensity for abuse. All staff members and Residents will be educated about what constitutes abuse, neglect, and exploitation, that they are all considered mandated reporters, and to err on reporting anything they see or hear that does not seem appropriate towards a Resident. Simply, if they see something or hear something, they should say something. All allegations of abuse will be treated as serious and will be investigated, documented, and reported as per the standards set forth in this policy and procedure, or per State or Federal definitions and regulations, whichever is more stringent. Failure to follow the policy and procedure as set forth will be considered a serious violation of one's employment responsibilities and will result in disciplinary action, up to, and including, termination. Definitions, in part, includes: Verbal, written, facial or body gestures communicated to a Resident in a disparaging or derogatory manner. This includes verbal, written, and facial or body gestures to a visitor, staff, or Resident about another Resident." R1's Reportable Incident Report dated 8/27/25 documents, "On 8/27/25 resident went out of community with her husband to get a haircut. This outing was approved by her POA (Power of Attorney) and son. When resident returned she	A6000		

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A6000	Continued From page 2	A6000		

was very upset and crying and stated her husband was mean to her and told her he hated her. Resident's husband was asked what happened and he said he was done with her. He was asked to leave the community and left willingly."

On 10/2/25 at 11:10 AM, R1 stated Z1 drove her to a hair appointment and got upset and was calling her a greedy bitch and a whore and that he never loved her and continued talking to her harshly even when they got back to the unit within hearing of other residents and staff. R1 stated she was still crying and went straight to the nursing office and talked to the nurse who checked if she had any physical harm done to her which she denied. R1 stated Z1 left when told by E3 to leave. R1 stated they have been married for more than 20 years and he is still her husband but it was decided he could not be allowed to visit her until Z2 (R1's son and Power of Attorney) decides otherwise. R1 stated she has made good friends in the facility and feels safe there.

E3's signed statement dated 8/27/25 documents, "(R1) was sobbing and stated that her husband was mean to her and that he told her that he hated her, that she and the boys ruined their marriage 20 years ago, called her a greedy bitch and he was not going to come and see her anymore until she was at the cemetery. When I asked husband what happened he told me, "she doesn't know how to love" and that he was done with her. Resident's son was notified that husband was unkind to her and caused resident to be upset and crying. Son stated husband may no longer visit the community or take her out anywhere."

On 10/2/25 at 12:05 PM, E4/Licensed Practical

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A6000	Continued From page 3 Nurse stated she was working on 8/27/25 and observed R1 in tears when she entered the nursing office. E4 stated R1 told her that Z1 (R1's husband) was mean to her and called her derogatory names and added he did not want to see again until she's at the cemetery. E4 stated Z1 was talking very harshly to R1 and R1 was visibly upset. E4 stated Z1 was made to leave the facility. E4 added she checked R1 for injuries or any signs of concern and none were noted. E4 stated R1 was still visibly upset when Z1 left but was sitting quietly in the dining room waiting for lunch. On 10/3/25 at 9:10 AM, Z2 stated he was notified of the incident on 8/27/25 and decided to not let Z1 be allowed to visit R1. Z2 admitted it was the right decision to move R1 out of the home where she lived with Z1 to the assisted living facility due to Z1's mood swings and increasing verbal aggression towards others. Z2 stated he felt it was a good decision for the facility to file a police report of the incident to give legal support to his decision to not allow Z1 to visit the facility and R1.	A6000		