STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510156	A. BUILDING: _____ B. WING _____	C 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGEVITY LIVING OF GODFREY	1000 AIRPORT RD GODFREY, IL 62035

(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 Complaint Investigation 25412857 / IL199339 Violations cited: 295.6000 a) 1) 5) 19) 295.6010 a) 1) 2) b) 1)	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; 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; 19) The right to be free of retaliation for or constraint from criticizing the establishment or making complaints to appropriate agencies or any agency or individual;	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510156	A. BUILDING: _____ B. WING _____	C 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGEVITY LIVING OF GODFREY	1000 AIRPORT RD GODFREY, IL 62035

(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
A6000	Continued From page 1 Based on interview and record review the facility failed to follow facility policy on gifts, gratuities regarding staff eating resident's food; failed to follow facility policy and procedure on staff solicitation and failed to follow policy on allegation of staff getting rough or mean toward resident. These failures resulted in staff eating resident's food supplied by family and staff asking for gas money and payment for staff car insurance from resident and creates a substantial probability of harm to R3 and other residents in the facility. Findings include: On 1/7/26 at 2:52 PM, E1/Executive Director stated that R3 reported to Z1/R3's Power of Attorney) an allegation that E2 (Resident Assistant/RA) while in R3's apartment, ate R3's ice cream bar that R3 offered and that E2 asked for money to help pay for car insurance and that E3, another RA, was telling R3 she was overdrawn on her checking account. E1 added that E2 reportedly was being rough to R3 during transfers and incontinent care. E1 stated she was notified by Z1 of these allegations involving E2 and E3 during three different occasions. When asked if she investigated these allegations, E1 stated she could not present documentation that investigations for each allegation were done and admitted she did not think of reporting the allegations to the Department. On 1/7/2026, E1 presented a timeline listing R3's issues with E2 and E3, which documents, in part, "On December 13th, I received a call from (Z1/R3's Daughter) reporting that (E2) ate an ice cream bar from (R3's) freezer. I asked (R3) if it was true and she admitted to offering one to (E2) and that they ate together. I sent a message out	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510156	A. BUILDING: _____ B. WING _____	C 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGEVITY LIVING OF GODFREY	1000 AIRPORT RD GODFREY, IL 62035

(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
A6000	Continued From page 2	A6000		

to all staff reminding them of the policy that it was unacceptable to take anything offered from any resident including food and drinks. On December 15th, (Z1) and her husband met in my office for a meeting. During this meeting (E2) and (E3) were reportedly not being friendly with (R3). I told (Z1) that I told them not to speak to (R3) about anything that was not related to (R3's) care. (Z1) said that (E2) asked R3 for help pay her car insurance, and that (E3) let (R3) know she was overdrawn on her checking account. I spoke with them and each denied the allegation. On Tuesday, January 6th, (Z1) text me to say that (E2) was being rough with (R3). She said she is flopping her into the wheelchair. I explained to her that (R3) is a difficult transfer. The Staff are not being rough, or mean, it is very difficult to transfer her. It took 4 staff to give her a shower, so we started to do bed baths. It takes 2-3 people to transfer her. (R3) is not able to assist Staff with her transfers. I told (Z1) I would again speak with Staff but that it was not due to being mean or rough."

On 1/7/26 at 1:29 PM, R3 stated Z1 brings her ice cream bars of 6 in a pack that she eats a bar once or twice a week, and lasts for 2-3 weeks because she is diabetic. And at one time she offered E2 an ice cream bar which E2 took from her freezer and when E2 was done she asked for another one and R1 stated she could not say no. R3 added that the whole pack was gone in a week. R3 also stated that E2 asked her at least a couple times for help pay E2's car insurance and E3 asked her for gas money. R3 stated she did not give any money to E2 or E3 because she did not have cash or a checkbook with her. R3 stated Z1 only provides a prepared monthly check payable to the beauty parlor. R3 stated that after Z1 reported their complaints about E2 and E3 she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510156	A. BUILDING: _____ B. WING _____	C 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGEVITY LIVING OF GODFREY	1000 AIRPORT RD GODFREY, IL 62035

(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
A6000	Continued From page 3	A6000		

felt E2 got rougher with her and started getting anxious when she hears a knock on her door in answer to her call for assist, anxiety that it might be E2 or E3 and are they going to be rough again. R3 stated E2 doesn't make assisting her comfortable and easy like the rest of the RAs do when the others come to help her. R3 admitted she would rather not be changed when she is wet/dirty than have E2 or E3 come to change her.

On 1/5/26 at 1:55 PM, Z1 stated R3 is paralyzed on her left side after a stroke in July but her memory is still very good, she is on medication reminder only and uses a sliding board that staff are taught to use to transfer R3 safely with a gaitbelt. Z1 stated that during her last meeting with E1 about her concerns with E2 and E3, she told E1 to fire E2 and E3. Z2 stated she was not aware that the allegations she reported to E1 were addressed at all because E2 and E3 continued to be assigned to R3.

R3's record documents she moved into the facility on 8/21/25 with multiple diagnoses to include Hemiplegia (Paralysis of one side of the body), Hemiparesis (Weakness of one side of the body) secondary to a stroke 7/2025, Major Depression and Diabetes Mellitus 2, needs assist of 2 staff for transfers using a sliding board and gaitbelt, 2 staff assist for dressing and toileting. R3 has a Mini Mental State Examination score of 27/30 (No cognitive impairment).

Facility Inservice Sign In Sheet on Gifts, Gratuities and Special Arrangements dated 1/2/26 showed a list of staff attendance including E2 and E3 printed in the same handwriting with no signatures of each listed participant.

The Facility Policy on Gifts, Gratuities, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510156	A. BUILDING: _____ B. WING _____	C 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGEVITY LIVING OF GODFREY	1000 AIRPORT RD GODFREY, IL 62035

(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
A6000	Continued From page 4 Special Arrangements, undated, documents, " On occasion you may be offered a gratuity in appreciation for something you have done. You are not allowed to accept any gifts, tips, or gratuities from a resident, family member, visitor, vendor or outside service provider. You should courteously decline to accept and individual gift. You are never permitted to borrow money or personal items from any resident, family member of a resident, vendor or outside provider. You may not make arrangements with residents or family members to provide additional services for residents (e.g., private care, laundry, etc.) Any financial exploitation of a resident or family member or misappropriation of resident property is grounds for termination of employment. Food items to be shared with all employees may be accepted. " The Facility Policy on Elder Abuse, Neglect, and Exploitation, undated, documents, "Policy: Resident abuse, neglect, and exploitation are prohibited. Should any resident experience abuse by staff, residents, family, or others or when any form of abuse is suspected, staff and volunteers are required to immediately provide notification to persons/agencies as described in this policy. The term abuse as used in this policy also includes, but is not limited to, neglect, abandonment, exploitation and any other form of abuse. Procedure. 2. All staff and volunteers are "mandated reporters". 3. If any Community staff member or volunteer has observed, suspects, has knowledge of, or is told by a resident or other staff member, of an incident which appears to be any form of abuse, the incident will be immediately reported to the Director of Wellness, or if not available, the incident will be reported to the Executive Director	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510156	A. BUILDING: _____ B. WING _____	C 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGEVITY LIVING OF GODFREY	1000 AIRPORT RD GODFREY, IL 62035

(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
A6000	Continued From page 5 (ED). In all cases the ED will be informed as soon as possible. Staff is encouraged to take seriously any resident's comments about potential abuse or unusual physical or mental signs/conditions that may indicate possible abuse. 4. Upon the notice of reported observed, suspected,, or at imminent risk of any form of abuse: a) Immediate steps will be taken to ensure the resident is protected from potential future abuse and neglect while the investigation is being conducted. b) A thorough investigation will be conducted by the Director of Health and Wellness or ED. 1) The resident is interviewed and responses documented. 5. Reporting of any suspected, alleged, or witnessed abuse, neglect, or exploitation will be completed according to state reporting requirements. 6. An investigation will take place surrounding the cause of the abuse. Any staff member willfully participating in this abuse will be terminated and reported to proper authorities and state licensing agencies. "	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall:	A6010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510156	A. BUILDING: _____ B. WING _____	C 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGEVITY LIVING OF GODFREY	1000 AIRPORT RD GODFREY, IL 62035

(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
A6010	Continued From page 6 1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report. 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report. b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following: 1) Dates, times, and description of the alleged abuse, neglect or financial exploitation; Based on interview and record review the facility failed to report to IDPH and investigate the following: allegation of staff to resident solicitation; of staff getting rough and mean to resident, and allegation of staff eating resident's food. These failures create a substantial probability of harm to R3 and other residents in the facility. Findings include: On 1/7/26 at 2:52 PM, E1/Executive Director stated that R3 reported to Z1/R3's Power of Attorney) an allegation that E2 (Resident	A6010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510156	A. BUILDING: _____ B. WING _____	C 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGEVITY LIVING OF GODFREY	1000 AIRPORT RD GODFREY, IL 62035

(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
A6010	Continued From page 7	A6010		

Assistant/RA) while in R3's apartment, ate R3's ice cream bar that R3 offered and that E2 asked for money to help pay for car insurance and that E3, another RA, was telling R3 she was overdrawn on her checking account. E1 added that E2 reportedly was being rough to R3 during transfers and incontinent care. E1 stated she was notified by Z1 of these allegations involving E2 and E3 during three different occasions. When asked if she investigated these allegations, E1 stated she could not present documentation that investigations for each allegation were done and admitted she did not think of reporting the allegations to the Department.

On 1/7/2026, E1 presented a timeline listing R3's issues with E2 and E3, which documents, in part, "On December 13th, I received a call from (Z1/R3's Daughter) reporting that (E2) ate an ice cream bar from (R3's) freezer. I asked (R3) if it was true and she admitted to offering one to (E2) and that they ate together. I sent a message out to all staff reminding them of the policy that it was unacceptable to take anything offered from any resident including food and drinks.
On December 15th, (Z1) and her husband met in my office for a meeting. During this meeting (E2) and (E3) were reportedly not being friendly with (R3). I told (Z1) that I told them not to speak to (R3) about anything that was not related to (R3's) care. (Z1) said that (E2) asked R3 for help pay her car insurance, and that (E3) let (R3) know she was overdrawn on her checking account. I spoke with them and each denied the allegation.
On Tuesday, January 6th, (Z1) text me to say that (E2) was being rough with (R3). She said she is flopping her into the wheelchair. I explained to her that (R3) is a difficult transfer. The Staff are not being rough, or mean, it is very difficult to transfer her. It took 4 staff to give her a shower, so we

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510156	A. BUILDING: _____ B. WING _____	C 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGEVITY LIVING OF GODFREY	1000 AIRPORT RD GODFREY, IL 62035

(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
A6010	Continued From page 8	A6010		

started to do bed baths. It takes 2-3 people to transfer her. (R3) is not able to assist Staff with her transfers. I told (Z1) I would again speak with Staff but that it was not due to being mean or rough."

On 1/7/26 at 1:29 PM, R3 stated Z1 brings her ice cream bars of 6 in a pack that she eats a bar once or twice a week, and lasts for 2-3 weeks because she is diabetic. And at one time she offered E2 an ice cream bar which E2 took from her freezer and when E2 was done she asked for another one and R1 stated she could not say no. R3 added that the whole pack was gone in a week. R3 also stated that E2 asked her at least a couple times for help pay E2's car insurance and E3 asked her for gas money. R3 stated she did not give any money to E2 or E3 because she did not have cash or a checkbook with her. R3 stated Z1 only provides a prepared monthly check payable to the beauty parlor. R3 stated that after Z1 reported their complaints about E2 and E3 she felt E2 got rougher with her and started getting anxious when she hears a knock on her door in answer to her call for assist, anxiety that it might be E2 or E3 and are they going to be rough again. R3 stated E2 doesn't make assisting her comfortable and easy like the rest of the RAs do when the others come to help her. R3 admitted she would rather not be changed when she is wet/dirty than have E2 or E3 come to change her.

On 1/5/26 at 1:55 PM, Z1 stated R3 is paralyzed on her left side after a stroke in July but her memory is still very good, she is on medication reminder only and uses a sliding board that staff are taught to use to transfer R3 safely with a gaitbelt. Z1 stated that during her last meeting with E1 about her concerns with E2 and E3, she told E1 to fire E2 and E3. Z2 stated she was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510156	A. BUILDING: _____ B. WING _____	C 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGEVITY LIVING OF GODFREY	1000 AIRPORT RD GODFREY, IL 62035

(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
A6010	Continued From page 9	A6010		

aware that the allegations she reported to E1 were addressed at all because E2 and E3 continued to be assigned to R3.

R3's record documents she moved into the facility on 8/21/25 with multiple diagnoses to include Hemiplegia (Paralysis of one side of the body), Hemiparesis (Weakness of one side of the body) secondary to a stroke 7/2025, Major Depression and Diabetes Mellitus 2, needs assist of 2 staff for transfers using a sliding board and gaitbelt, 2 staff assist for dressing and toileting. R3 has a Mini Mental State Examination score of 27/30 (No cognitive impairment).

Facility Inservice Sign In Sheet on Gifts, Gratuities and Special Arrangements dated 1/2/26 showed a list of staff attendance including E2 and E3 printed in the same handwriting with no signatures of each listed participant.

The Facility Policy on Gifts, Gratuities, and Special Arrangements, undated, documents, " On occasion you may be offered a gratuity in appreciation for something you have done. You are not allowed to accept any gifts, tips, or gratuities from a resident, family member, visitor, vendor or outside service provider. You should courteously decline to accept and individual gift. You are never permitted to borrow money or personal items from any resident, family member of a resident, vendor or outside provider. You may not make arrangements with residents or family members to provide additional services for residents (e.g., private care, laundry, etc.) Any financial exploitation of a resident or family member or misappropriation of resident property is grounds for termination of employment. Food items to be shared with all employees may be accepted. "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510156	A. BUILDING: _____ B. WING _____	C 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGEVITY LIVING OF GODFREY	1000 AIRPORT RD GODFREY, IL 62035

(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
A6010	Continued From page 10 The Facility Policy on Elder Abuse, Neglect, and Exploitation, undated, documents, "Policy: Resident abuse, neglect, and exploitation are prohibited. Should any resident experience abuse by staff, residents, family, or others or when any form of abuse is suspected, staff and volunteers are required to immediately provide notification to persons/agencies as described in this policy. The term abuse as used in this policy also includes, but is not limited to, neglect, abandonment, exploitation and any other form of abuse. Procedure. 2. All staff and volunteers are "mandated reporters". 3. If any Community staff member or volunteer has observed, suspects, has knowledge of, or is told by a resident or other staff member, of an incident which appears to be any form of abuse, the incident will be immediately reported to the Director of Wellness, or if not available, the incident will be reported to the Executive Director (ED). In all cases the ED will be informed as soon as possible. Staff is encouraged to take seriously any resident's comments about potential abuse or unusual physical or mental signs/conditions that may indicate possible abuse. 4. Upon the notice of reported observed, suspected,, or at imminent risk of any form of abuse: a) Immediate steps will be taken to ensure the resident is protected from potential future abuse and neglect while the investigation is being conducted. b) A thorough investigation will be conducted by the Director of Health and Wellness or ED. 1) The resident is interviewed and responses documented. 5. Reporting of any suspected, alleged, or witnessed abuse, neglect, or exploitation will be completed according to state reporting requirements.	A6010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510156	A. BUILDING: _____ B. WING _____	C 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGEVITY LIVING OF GODFREY	1000 AIRPORT RD GODFREY, IL 62035

(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
A6010	Continued From page 11 6. An investigation will take place surrounding the cause of the abuse. Any staff member willfully participating in this abuse will be terminated and reported to proper authorities and state licensing agencies. "	A6010		