STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510158	A. BUILDING: _____ B. WING _____	C 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF GRANITE CITY MC	3432 VILLAGE LN GRANITE CITY, IL 62040

(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 Annual Licensure Survey Violation cited: 295.6010 Facility Reported Incident Investigation to Incident dated 4/18/25 IL191249 Violation cited: 295.6010	A 000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Type 3 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: 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	A6010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510158	A. BUILDING: _____ B. WING _____	C 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF GRANITE CITY MC	3432 VILLAGE LN GRANITE CITY, IL 62040

(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 1 premises for 12 months after the date of the report. Based on interview and record review the facility failed to ensure staff reports a staff to resident allegation of abuse to management in a timely manner. Findings include: The Facility Policy and Procedures on Abuse, Neglect and Exploitation Prevention, Prohibition, and Investigation, undated, documents, in part, "Policy: 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 on anything they see or hear that does not seem appropriate towards a resident. Simply, if they see something or hear something, they soul say something. Witnessed or Suspected Abuse, Neglect, and Exploitation Procedures: 3. Immediately report the alleged abuse to your supervisor and Executive Director by phone call. Your State agency will be notified by Executive Director or designee per state guidelines." The Facility Accidents/Incidents Reports and Investigation Worksheet dated 4/21/25 documents,"Employee (E8/Resident Assistant) reported that on 4/18/25 she did not like the way employee (E9/RA) spoke to (R1) and the way she handled the resident and that (E9) was mean and was aggressive."	A6010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510158	A. BUILDING: _____ B. WING _____	C 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF GRANITE CITY MC	3432 VILLAGE LN GRANITE CITY, IL 62040

(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 2 On 5/14/25 at 9:59 AM, E1 (Executive Director) confirmed that upon notification on 4/21/25 of the alleged abuse incident, E1 conducted a full investigation and reported it to the Department, physician and family immediately and E8 was suspended effective 4/21 although the last day she reported to work was the evening of the incident. E1 admitted she will reeducate all staff of the importance of immediately notifying her of any allegation of abuse incident they witnessed or heard. The Final Allegation of Abuse Outcome Report dated 4/25/25 documents the allegation of abuse was unfounded, E8 came across as demanding and almost aggressive towards coworkers and management but was never witnessed or reported in the past as verbally or physically abusive towards residents. E8 was given a final warning for violating the company's Respectful Workplace policy, Non-harassment Policy and Violent Workplace Policy and all staff were re-educated on Abuse Policy and Procedures and Resident Rights.	A6010		