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 06/06/2025

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

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A 000	Initial Comment Facility Reported Incident Investigation to Incident Report dated 5/29/25 / IL193341 Violations cited: 295.6000. a) 1) 13) 295.6010. a) 1) c) d)	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 Repeat 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; 2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor;	A6000		

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A6000	Continued From page 1 Based on interview and record review the facility failed to ensure residents are protected of their rights against physical abuse and violation of privacy/dignity at all times. These failures resulted in a staff member hitting R1 in the face with an adult incontinent brief and capturing R1's photo in his underwear during care while the incident occurred. These failures create a substantial probability of harm to the resident and other residents in the facility. Findings include: The Facility Policy on Abuse, Neglect and Exploitation Prevention, Prohibition, and Investigation, undated, documents, "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 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 standard 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 employee responsibilities, and will result in disciplinary action, up to, and including, termination." The Policy further states," Witnessed or	A6000		

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A6000	Continued From page 2	A6000		

Suspected Abuse, Neglect, and Exploitation Procedures: 1. Immediate measures shall be taken to ensure the safety of the resident and prevent further abuse, neglect or exploitation. Separate the Resident and the person allegedly abusing the Resident. 2. Immediately report the alleged abuse to your supervisor or your local Adult Protective Services Agency."

The Facility Abuse Investigation Form dated 5/28/25 documents," Writer (E2, Director of Wellness) was notified at all staff meeting on 5/28/25 by a 3rd party Resident Assistant (E5) that she felt she needed to report something. A picture showed a Resident Assistant (E4) and (R1) with what appeared to be (E4) hitting (R1) with an (adult incontinent brief). An investigation was started immediately. Time, date, place and names of those present: 5/27/25 at 2:18 AM, resident's bathroom. RAs (E4 and E6) were trying to get R1 changed and he was fighting them. E6 stated she felt uneasy about the event so she took out her phone. She stated that E4 hit R1 in the face with the depend because he was hitting and kicking at them. Action Taken: Investigation started, statements collected, E4 suspended, Police, IDPH, physician, and POA (Power of Attorney) all notified."

R1's Observation Note created by E4 dated 5/27/25 documents,"5/27/25 3:00 AM. Went to change him and he was smacking me, hit me with depend (adult incontinent brief), try to punch me like had his fist ball up to try to punch me. smacked me and (E6) on our face.

R1's Observation Note created by E3 (Assistant Director of Wellness) dated 5/28/25 at 6:15 PM documents, "Staff reported allegation of abuse this morning after all staff meeting, head to toe

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A6000	Continued From page 3	A6000		

body assessment completed. Resident monitored for signs and symptoms of fearfulness, pain or discomfort and none were noted. R1's Full Body Assessment dated 5/28/25 and conducted by E3 documents presence of reddish/purplish discoloration on the left side of the face.

Written statement by E6 (RA/eyewitness) dated 5/28/25 documents, (in part), "R1 was in other's room and he was swinging on me and (E4), hitting me in the face also hitting (E4) multiple times. We got back to his room and we were in the bathroom and (E4) did hit him in the face with a depend and I got a picture of the moment just in case. He threw it back and finally got him in bed and kinda helped us change him and then we left his room..."

On 6/5/25 at 9:47 AM, E5 stated that she was off work on 5/27 and received a call from E6 telling her E6 witnessed E4 hitting R1 in the face with a depend/adult incontinent brief and forwarded a photo of the incident she took from her phone to E5. E5 stated she reported the incident to E2 and E3 after the staffing meeting on 5/28 and shared the photo with E2, E5 stated she thought E6 had already reported the incident to management the morning right after the incident happened.

On 6/5/25 at 5:05 PM, E6 stated she was working overnight on 5/27 and was helping E4 change R1 who was fighting them. E6 admitted she witnessed E4 hit R1 in the face with a depend and took a photo of the incident as proof. E6 admitted she should have reported the incident right away to E1 (Executive Director) and E2. E6 also stated she should not have taken the picture to protect R1's privacy.

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A6000	Continued From page 4 On 6/6/25 at 8:03 AM, E1 stated there should never be pictures taken of residents at any time specially during care. E1 stated an all employee reeducation and retraining provided regarding Abuse Prevention, Immediate Reporting to her, No Picture Taking of Residents was conducted right after the incident. E1 added Abuse Prevention inservice is provided upon orientation, annually and as needed. E1 stated E4 was suspended right away on 5/28 , her last day of work was the shift the incident happened and she was terminated on 6/6/25. The Facility Policy on Resident Rights, documents, "Illinois Department of Public Health specifically outlines a basic set of "resident rights". (Facility) informs you of these when you are admitted and must protect and promote these rights for all residents. Residents have the following 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; 2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor;	A6000		

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A6000	Continued From page 5 "	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: 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. c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department. d) When the establishment has a reasonable belief that abuse, neglect or financial exploitation occurred, the perpetrator, if an employee or volunteer, shall be removed from direct contact with residents. Based on interview and record review the facility failed to ensure an abuse incident is immediately reported to a supervisor/management following facility policy and procedure. This failure resulted in allowing the perpetrator to continue to stay in direct contact with the resident/s and potentially exposing the resident/s to further harm, creating a substantial probability of harm to resident/s in the facility.	A6010		

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A6010	Continued From page 6 Findings include: The Facility Policy on Abuse, Neglect and Exploitation Prevention, Prohibition, and Investigation, undated, documents, "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 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 standard 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 employee responsibilities, and will result in disciplinary action, up to, and including, termination." The Policy further states," Witnessed or Suspected Abuse, Neglect, and Exploitation Procedures: 1. Immediate measures shall be taken to ensure the safety of the resident and prevent further abuse, neglect or exploitation. Separate the Resident and the person allegedly abusing the Resident. 2. Immediately report the alleged abuse to your supervisor or your local Adult Protective Services Agency." The Facility Abuse Investigation Form dated 5/28/25 documents," Writer (E2, Director of Wellness) was notified at all staff meeting on 5/28/25 by a 3rd party Resident Assistant (E5)	A6010		

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On 6/6/25 at 8:03 AM, E1 stated there should never be pictures taken of residents at any time

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A6010	Continued From page 8 specially during care. E1 stated an all employee reeducation and retraining provided regarding Abuse Prevention, Immediate Reporting to her, No Picture Taking of Residents was conducted right after the incident. E1 added Abuse Prevention inservice is provided upon orientation, annually and as needed. E1 stated E4 was suspended right away on 5/28 , her last day of work was the shift the incident happened and she was terminated on 6/6/25.	A6010		