STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510249	A. BUILDING: _____ B. WING _____	C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING OF GODFRY	1373 D'ADRIAN PROFESSIONAL PARK 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 Facility Reported Incident Investigation to Incident Report dated 6/26/25 / IL195495 Violations cited: 295.6000 a) 1) 13) 295.6010 c)	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 These requirements were not met as evidenced by: Based on interview and record review the facility failed to ensure residents are free from any form	A6000		

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A6000	Continued From page 1	A6000		

of abuse including verbal abuse in the facility. This failure creates a substantial probability of harm to the resident and other residents in the facility.

Findings include:

The Facility Policy on Allegations of Abuse/Neglect/Exploitation, dated 2020, documents," Purpose: It is the policy of (Facility) to maintain the rights of all residents to be free from abuse, neglect,exploitation, and mistreatment. This policy will provide a mechanism for prompt identification, reporting, and investigation of any allegation and/or reasonable suspicion of abuse, or complaint by a resident or others of abuse. (Facility) has zero tolerance for abuse, neglect, or exploitation of its residents. All allegations of abuse, neglect or exploitation of a resident will be thoroughly investigated by the community and reported as required to the proper authorities/agencies. Investigation of Alleged Abuse, Neglect, and Exploitation Procedures: 1. The administrator will immediately be notified when abuse/neglect/exploitation is suspected. 4. The Administrator or designee shall conduct and document a thorough investigation and take immediate and appropriate action to prevent further abuse. 9. Immediate measures shall be taken to ensure the safety of the resident and to prevent further abuse, neglect , or exploitation. Separate the resident and the person allegedly abusing the resident."

E1's Abuse Investigation Report, documents," Incident Date and Time: 6/18/25 approximately 9 PM. Description of Incident/Accident: The

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A6000	Continued From page 2 Executive Director was notified by a caregiver late evening on 6/18/25 and told that another caregiver was verbally aggressive with a resident. Executive Director suspended accused caregiver pending an investigation, notified all concerned. Follow up on incident: 6/23/25 Investigation completed by Executive Director: 1. Findings of the accused have been substantiated and said caregiver has been terminated. 2. Inservice has been completed for all staff on policy and procedures for neglect and abuse and signed." On 6/30/25 at 9:20 AM, E1 (Executive Director) stated she received the call at around 9 PM of the incident on the Memory Care unit that E3 was verbally aggressive with R1 and E3 was sent home right away. E1 stated that upon conducting the investigation it was found out there were previous incidents of E3 being verbally aggressive towards multiple residents prior to 6/18 as well as E3 refusing request to do laundry and refusing requests for night snacks. E1 stated all staff were re-educated on the abuse policy with emphasis on reporting immediately to her. E1 stated she just had a meeting with all staff that very same morning reminding them to let management know if they are overwhelmed at work and needed a break from their assignment so somebody can take over and they can either go home or be switched to a different unit. E1 stated families loved E3, she worked above and beyond, they thought she was a good fit at the memory care unit. E1 stated E3's last day of work was on 6/18/25 and her termination date was 6/23/25. E1 stated all staff underwent training on the whole abuse prevention program upon hire, as needed and yearly and reeducated after the 6/18/ incident. During a phone interview on 7/1/25 at 1:26 PM,	A6000		

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A6000	Continued From page 3	A6000		

E5 (Caregiver) stated that she was working with E3 (former Caregiver) one night and heard R1 ask E3 if she could do his laundry and E3 rudely said "no, I'm not doing your sh*** laundry". E5 stated she did R1's laundry that night. E5 added that R1 and R2 routinely ask for bedtime snacks and if they happen to ask E3 she would tell them they already ate using foul language and curse words when she answer them. E5 stated all sorts of snacks including sandwiches are readily available for bedtime snacks and E3 could have given something to them. E5 stated she gave R1 and R2 snacks those times when E3 would tell them they already ate. E5 stated that on 6/18/25 she called E1 (Executive Director) about E3's verbal aggression towards R1. E5 stated that on nights when she worked with E3, E3 would be agitated and irritable and would speak rudely towards R1. E5 stated she did not think of reporting previous incidents between E3 and R1 but she finally did report to E1 that night on 6/18. E5 admitted to having undergone training on abuse and reporting to E1 right away when she was on orientation and during staff meetings.

During a phone interview on 7/1/25 at 3:08 AM, E4 (Caregiver) stated on previous occasion when she worked with E3 on the night shift she heard E3 being verbally abusive to R3 when he would try to get out of bed, saying "don't make me pick you up from the f*** floor, you need to stay in bed." E4 stated lately she felt E3 was not a good fit at taking care of residents in the memory care and told E3 if she can't handle it to let another staff know. E4 stated she should have reported to E1 right away about previous incidents of E3 being verbally aggressive and using profanity and curse words when talking to residents but she was scared of E3. E4 stated she went through abuse training upon hire and she attended all

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A6000	Continued From page 4 staff meetings when E1 would review the abuse policy and to report right away but admitted she failed to do it.	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. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report. 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. These requirements were not met as evidenced by: Based on interview and record review the facility failed to internally report an alleged staff to resident verbal abuse to the Executive Director in a timely manner. This failure resulted in delayed investigation of an earlier verbal abuse incident	A6010		

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A6010	Continued From page 5	A6010		

by E3 towards residents in the Memory care unit to determine if there was actual harm done and subsequently protect residents from future harm. This creates a substantial probability of harm to residents in the facility.

Findings include:

The Facility Policy on Allegations of Abuse/Neglect/Exploitation, dated 2020, documents," Purpose: It is the policy of (Facility) to maintain the rights of all residents to be free from abuse, neglect,exploitation, and mistreatment. This policy will provide a mechanism for prompt identification, reporting, and investigation of any allegation and/or reasonable suspicion of abuse, or complaint by a resident or others of abuse. (Facility) has zero tolerance for abuse, neglect, or exploitation of its residents. All allegations of abuse, neglect or exploitation of a resident will be thoroughly investigated by the community and reported as required to the proper authorities/agencies. Investigation of Alleged Abuse, Neglect, and Exploitation Procedures: 1. The administrator will immediately be notified when abuse/neglect/exploitation is suspected. 4. The Administrator or designee shall conduct and document a thorough investigation and take immediate and appropriate action to prevent further abuse. 9. Immediate measures shall be taken to ensure the safety of the resident and to prevent further abuse, neglect , or exploitation. Separate the resident and the person allegedly abusing the resident."

E1's Abuse Investigation Report, documents," Incident Date and Time: 6/18/25 approximately 9

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A6010	Continued From page 6	A6010		

PM. Description of Incident/Accident: The Executive Director was notified by a caregiver late evening on 6/18/25 and told that another caregiver was verbally aggressive with a resident. Executive Director suspended accused caregiver pending an investigation, notified all concerned. Follow up on incident: 6/23/25 Investigation completed by Executive Director: 1. Findings of the accused have been substantiated and said caregiver has been terminated. 2. Inservice has been completed for all staff on policy and procedures for neglect and abuse and signed."

On 6/30/25 at 9:20 AM, E1 (Executive Director) stated she received the call at around 9 PM of the incident on the Memory Care unit that E3 was verbally aggressive with R1 and E3 was sent home right away. E1 stated that upon conducting the investigation it was found out there were previous incidents of E3 being verbally aggressive towards multiple residents prior to 6/18 and all staff were re-educated on the abuse policy with emphasis on reporting immediately to her. E1 stated E3's last day of work was on 6/18/25 and her termination date was 6/23/25. E1 stated all staff underwent training on the whole abuse prevention program upon hire, as needed and yearly.

During a phone interview on 7/1/25 at 1:26 PM, E5 (Caregiver) stated that she was working with E3 (former Caregiver) one night prior to 6/18 and heard R1 ask E3 if she could do his laundry and E3 rudely said "no, I'm not doing your sh*** laundry". E5 stated she did R1's laundry that night. E5 added that R1 and R2 routinely ask for bedtime snacks and if they happen to ask E3 she would tell them they already ate using foul language and curse words when she answered them. E5 stated all sorts of snacks including

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A6010	Continued From page 7	A6010		

sandwiches are readily available for bedtime snacks and E3 could have given something to them and on those nights she would give R1 and R2 some snacks. E5 stated that on nights when she worked with E3, E3 would be agitated and irritable and would speak rudely towards R1. E5 stated that on 6/18/25 she called E1 (Executive Director) about E3's verbal aggression towards R1. E5 stated she did not think of reporting previous incidents between E3 and R1 but she finally did report to E1 that night. E5 admitted to having undergone training on abuse and reporting to E1 right away if she feels something is not right about how others treat residents when she was on orientation and during staff meetings and she failed to do it and was given coaching.

During a phone interview on 7/1/25 at 3:08 AM, E4 (Caregiver) stated that on previous occasion when she worked with E3 on the night shift she heard E3 being verbally abusive to R3 when he would try to get out of bed, saying "don't make me pick you up from the f*** floor, you need to stay in bed." E4 stated lately she felt E3 was not a good fit at taking care of residents in the memory care and told E3 if she can't handle it to let another staff know. E4 stated she should have reported to E1 right away about previous incidents of E3 being verbally aggressive and using profanity and curse words when talking to residents but she was scared of E3. E4 stated she went through abuse training upon hire and she attended all staff meetings when E1 would review the abuse policy and to report right away if residents are being disrespected and mistreated or something feels off but admitted she failed to do it and was provided retraining after the 6/18/incident.