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 07/08/2025

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 Facility Reported Incident Investigation to Incident Report dated 6/25/25 IL195767 Violation cited: 295.6000a)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; These requirements were not met as evidence by: Based on interview and record review the facility failed to ensure residents are free from all forms of abuse including physical abuse in the facility. This resulted in a resident sustaining bruising on	A6000		

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A6000	Continued From page 1	A6000		

the right forearm as a result of staff forcefully and wrongfully putting hands on the resident. This failure created actual harm to the resident and creates a substantial probability of harm to other residents.

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.
Definition of Abuse: Any act or failure to act performed intentionally or recklessly that causes or likely to cause harm to a Resident. Any physical or mental injury or sexual assault inflicted on a Resident, other than by accidental means. Results in physical harm or discomfort, or loss of human dignity, failure to provide agreed

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A6000	Continued From page 2	A6000		

upon care or services to a Resident. Corporal punishment and involuntary seclusion of a Resident for convenience of staff..."

R1's Reportable Incident Report dated 6/25/25 documents, "6/25/25 2:00 PM. Director of Nursing (E2) was on the Memory Care floor and heard (R1) yelling. (E2 came upon (R1) sitting in her wheelchair with employee (E3/Resident Assistant) standing to the side of (R1). (E2) asked if everything was ok. (E2) then witnessed R1 pull her purse from the table to her lap. (E3) went to zip up purse while it was on resident's lap. (R1) may have placed her hand over (E3) but what (E2) observed was (E3) pushed (R1)'s arms or purse into resident's chest forcefully. (E2) reported incident to Executive Director (ED). ED suspended (E3) for suspicion of potential abuse. Investigation initiated."

On 7/8/25 at 9:45 AM, E2 stated after she heard R1 yelling, she approached R1 and E3 and asked if everything was ok and witnessed E3 shoving R1's purse to R1's chest and forcefully pushed R1's arms to R1's chest. E2 stated she literally blocked E3 in front of R1 and asked E3 what is wrong with her. E2 stated E3 immediately went on break and E2 reported the incident to E1. E2 stated after E3 gave her statement and was sent home, E2 went to assess R1 and found bruising on R1's right forearm and proceeded to report to Z2/R1's physician and Z1/R1's Power of Attorney. R1 was put on 72 hour alert watch after the incident and her bruising was monitored every shift for three days with no further injuries, no swelling, no complaints of pain, no limitations to passive range of motion to upper extremities and no signs and symptoms of fearfulness noted.

On 7/8/25 at 9:20 AM, E1 stated that E3 clocked

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A6000	Continued From page 3 out at 2:30 PM and was sent home for the day after E3 was asked for her statement in which she denied she was trying to push R1 and claiming it was R1 who grabbed her hand and would not let go. E1 stated E3's last day of work was 6/25/25 and she was terminated on 7/1/25. E1 stated it was determined that R1 sustained bruising on her right forearm due to E3 wrongfully grabbing R1 on the forearm during the incident. E1 stated all new employees undergo abuse training during orientation, as needed and annually. E1 added that retraining and re-education/inservice on abuse prevention, prohibition policy was provided to all staff after the 6/25 incident.	A6000		