

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 6023661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 11/24/2025
NAME OF PROVIDER OR SUPPLIER KEYSTONE PLACE AT MAGNOLIA COMMONS			STREET ADDRESS, CITY, STATE, ZIP CODE 245 MAGNOLIA DRIVE GLEN CARBON, IL 62034		
(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 IL198580- 295.6000 cited.	A 000			
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Repeat Violation Type 2 Section 295.6000 Resident 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; Based on interview and record review the facility failed to ensure residents are not deprived of their right to be treated with respect, dignity and are not subjected to psychosocial abuse from others including employees. This failure creates a substantial probability of harm to a resident/residents in the facility. Findings include: The Establishment's Resident Rights and Promotion of Resident Dignity, Independence , Self Determination, Right to Privacy and Choice Policy, dated 9/25/23 documents, "(Establishment) mission is to be unfailing in serving our resident's needs. in order to accomplish this mission, it is imperative that we take the necessary steps to ensure residents rights are followed at all times." On 11/17/2025 at 2:00 PM, E1, Executive	A6000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A6000	Continued From page 1 Director, stated R1 reported E4, CNA, to E3, LPN, for speaking inappropriately to him. R1's Mini Mental Exam dated 6/25/25 documents R1 has a cognition score of 27/30, indicating R1 is cognitively intact. R1's Service Plan documents R1 requires stand by and verbal assistance with mobility and transfers. On 11/17/2025 at approximately 2:30 PM, R1 stated "That girl was really ugly towards me. I reported it to the head nurse. I was having trouble transferring to my chair- I'm afraid I'm losing my eyesight. She told me I better watch out because if I fell, I was on my own. Nobody else around here treats me like that." At this time, R1's wife, R2 stated everyone treats her fine, but stated that particular staff member was "unkind" to R1. On 11/17/2025 at 3:29 PM, E1 stated, "(R1) is cognitively 'with it' and is not one to say anything. He did feel like it (interaction with E4) was a threat." On 11/17/25, at 3:33 PM, E2, Wellness Director, stated, "(R1) was very detailed about the encounter and described (E4). He was very vocal about not wanting her taking care of him." E2 stated she did believe the interaction was a violation of R1's dignity and E4 made R1 "feel bad". The Establishment's Investigation Summary dated 11/5/2025 documents R1 reported verbal abuse to E3, the nurse on duty. It further documents the allegation was against E4, Resident Aid. It continues do document all parties were made aware, an investigation was initiated	A6000		

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A6000	Continued From page 2 and E4 was placed on suspension. It documents R1 reported E4 had verbally abused him and was aggressive towards him, to the point that he was concerned. R1 stated E4 told R1, "I hate the way you transfer, if you call I'm going to let you because I am not going to jeopardize my health to catch you." When E3 asked R1 if it was the first time E4 spoke to him like that R1 stated E4 always spoke with him like this and stated she is "always mean and talks crazy to him, but the other night was worse." The Establishment's Disciplinary Action form documents E4 was in violation of Resident Rights on 11/5/25 and failed to "Act at all times with proper decorum to all residents, visitors, vendors and co-workers including with politeness, courtesy, appropriate behavior, tact, civility, dignity, respectability and orderliness".	A6000		