STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510176	A. BUILDING: _____ B. WING _____	C 07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VIEW ALZHEIMER'S SCC	6210 N UNIVERSITY STREET PEORIA, IL 61614

(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 IL00202577 295.6010a)1)c)	A 000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Type 1 Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting 295.6010a)1)c) 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. This regulation is not met as evidenced by: Based on interview and record review, the establishment failed to ensure employees reported alleged staff to resident verbal abuse immediately per establishment protocol and failed to notify the Department within 24 hours after receiving the abuse allegation. This failure has	A6010		

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A6010	Continued From page 1	A6010		

the probability to affect all residents who reside in the establishment and creates a substantial probability of severe harm to a resident or residents.

The findings include:

Review of R1's medical record showed a move-in date of 02/28/2025 with a past medical history that included dementia. Cognitive evaluation dated 02/18/2026 indicated that R1 has severe cognitive impairment. Service Plan dated 06/10/2026 reads in part: extensively requires redirection six times or more in a 24-hour period and requires partial assistance with dressing and grooming.

Review of incident reports submitted to the Department for the last three months showed an report for R1 that reads: on 06/19/2026 it was reported to the E1 (Executive Director) by E2 (Certified Nursing Assistant/CNA) that while giving cares to resident (R1) another CNA (E3) was assisting and R1 said to E3, "you're a bitch". E2 claimed that E3 responded to R1, "you're a bitch". E3 has been suspended pending investigation ...

Final Incident description reads: there is no evidence to support the claim with no witnesses, and the resident is not coherent to interview ... All staff will receive retraining on resident abuse protocols and procedures and reporting. Resident roster dated 06/28/2026 indicated that R1 is "out of the building".

On 06/30/2026 at 10:20 AM, E1 (Executive Director) said regarding R1's incident: E2 (CNA) reported the alleged verbal abuse on 06/19 but indicated that the incident had occurred either on

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A6010	Continued From page 2	A6010		

Thursday or Friday of the previous week. E1 then indicated that E2 was re-educated after she reported R1's incident to report any abuse allegation to a nurse or manager if E1 is not present. E1 added that all staff are educated upon hire to report abuse immediately. Staff must sign that they received the establishment's abuse policy and handbook which includes abuse reporting, and they complete online abuse training during orientation. E1 indicated that E2 received verbal corrective counseling for not reporting the alleged incident immediately. At 10:35 AM, E1 said E2 was educated on the abuse policy and procedures three separate ways prior to R1's incident and once again post incident for a total of four since her hire date and should have reported the incident immediately. At 12:50 PM, E1 said R1's incident was reported to her on 06/19 which was a Friday, but she did not submit the initial report to Illinois Department of Public Health (IDPH) until Monday the 22nd because it was her understanding that the initial report is to be submitted to the Department within 24 business hours of the incident occurring or when it is reported to her.

On 06/30/2026 from 11:58 AM to 12:06 PM, E2 (CNA) said verbatim regarding R1's incident: she was trying to get R1 ready for bed by herself when E3 (CNA) was walking by R1's room and came in to assist. E3 took over and finished getting R1 ready for bed. She (E3) tried to stand R1 up, but he was fighting her, and he was angry. R1 called her a "bitch", and she said "you're a bitch" back to him. E2 said she "felt uncomfortable" after hearing this but didn't say anything because she "completely forgot about it at the time" but when she cared for R1 on the 19th, she recalled the incident (chuckled after making this statement) and reported it to E1

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A6010	Continued From page 3 about 2:00 PM on the 19th. E2 indicated that she believed the actual incident occurred on the 17th or 18th at about 9:30 PM but she was unsure on the actual day. E2 added that she had training during her orientation that any type of abuse should be reported immediately. E2 then said she was re-educated on abuse reporting by E1 after she reported the incident. Review of E2's training records showed she signed acknowledgement of receiving and reading the establishment's abuse and neglect policy and employee handbook that included abuse reporting procedures on 05/20/2026. E2's online training records showed she also received abuse and neglect training, and abuse prevention, recognizing, reporting training on 05/22/2026. E2 was also counseled on reporting suspicion of abuse timely on 06/24/2026 by E1. Resident Abuse and Neglect policy last revised 03/10/2023 that was provided by E1 on 06/30/2026 reads in part: ... All staff members and residents will be educated about abuse and neglect in the assisted living setting, including definitions, prevention, and reporting. All allegations of abuse or neglect will be treated as serious and will be investigated, documented, and reported per the standards set forth in this policy and procedure, or per State or Federal regulations, whichever is more stringent ... The alleged abuse will be immediately reported by the person who witnessed it, to the supervisor on duty, or the Administrator, and to the appropriate state agency, following the guidelines for mandatory reporting ...	A6010		