

Illinois Department of Public Health

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| 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 04/18/2025 |
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| NAME OF PROVIDER OR SUPPLIER KEYSTONE PLACE AT MAGNOLIA COMMONS | STREET ADDRESS, CITY, STATE, ZIP CODE 245 MAGNOLIA DRIVE GLEN CARBON, IL 62034 |
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| (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 |
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| A 000 | <p>Initial Comment</p> <p>The Complaint Survey COI #2543342 / IL190424, Facility Reported Incident of 04/08/25 IL190123, and COI 2543202 / IL190050 were all completed together.</p> <p>Complaint: #2543342 / IL190424. Allegations cannot be substantiated. No violations cited.</p> <p>Facility Reported Incident of 04/08/25 IL190123. No violations cited.</p> <p>Complaint: #2543202 / IL190050. Allegations cannot be substantiated. No violations cited.</p> <p>For this survey, the establishment is in compliance with Part 295 Assisted Living and Shared Housing Establishment Administrative Code and 210 ILCS 9/1 Assisted Living and Shared Housing Act.</p> | A 000 | | |

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| Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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