STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5108078	A. BUILDING: _____ B. WING _____	C 12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF FRANKFORT	21507 SOUTH WOLF ROAD FRANKFORT, IL 60423

(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 Entity Reported Incident IL181746- Substantiated	A 000		
A3040	Section 295.3040 Health Care Worker Background Check This Regulation is not met as evidenced by: Type 3 Violation Section 295.3040 Health Care Worker Background Check An establishment shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. (Source: Amended at 36 Ill. Reg. 13632, effective August 16, 2012) Section 955.145 Employment Verification a) Each health care employer or its designee shall provide an employment verification and update the demographic information for each employee no less than annually. (Section 33(i) of the Act) 1) The health care employer or its designee shall log into the Health Care Worker Registry through a secure login in a method prescribed by the Department. (Section 33(i) of the Act) 2) The health care employer or its designee shall indicate employment and termination dates (separation dates) within 30 days after hiring or terminating an employee. (Section 33(i) of the Act)	A3040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5108078	A. BUILDING: _____ B. WING _____	C 12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF FRANKFORT	21507 SOUTH WOLF ROAD FRANKFORT, IL 60423

(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
A3040	Continued From page 1 3) The health care employer shall provide the employment category and type. (Section 33(i) of the Act) b) Failure to comply with this Section constitutes a licensing violation. A fine of up to $500 may be imposed upon a health care employer for failure to maintain these records. (Section 33(i) of the Act) c) The information required in this Section shall be used by the Department of Public Health to notify any current employer of any disqualifying offenses that are reported by the Department of State Police. (Section 33(i) of the Act) (Source: Amended at 43 Ill. Reg. 3665, effective March 1, 2019) These requirements are not met as evidenced by: Based on interview and record review the establishment failed to complete the 6 Registry search on the website provided by Healthcare Worker Registry for one (E3) employee reviewed for abuse. This deficient practice has the probability to affect all residents. Findings include: An onsite visit was conducted on 12/24/24. E3's (Terminated Resident Assistant) employee file was reviewed. E3 was hired on 7/3/24. After an allegation of resident abuse E3 was terminated on 11/27/24. E3's employee file did not include documents indicating the 6 Registry (internet) searches were completed. There was only a documented search on the Office of the Inspector General web page	A3040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5108078	A. BUILDING: _____ B. WING _____	C 12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF FRANKFORT	21507 SOUTH WOLF ROAD FRANKFORT, IL 60423

(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
A3040	Continued From page 2 that was completed. On 12/24/24 at approximately 1:14pm, E1 (Executive Director) that it was done, and should be on the employee file. E3's file did not contain the required documents.	A3040		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 3 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; 2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment; 3) The right to retain and use personal property, unless such use infringes on the health, safety, or welfare of other individuals, and a place to store personal items that is locked and secure; 4) The right to designate any individual to	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5108078	A. BUILDING: _____ B. WING _____	C 12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF FRANKFORT	21507 SOUTH WOLF ROAD FRANKFORT, IL 60423

(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
A6000	Continued From page 3 participate with the resident or in the resident's name in the development of the written service plan; 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; 6) The right to direct his or her own care and negotiate the terms of his or her own care; 7) The right to refuse services unless such services are court ordered or the health, safety, or welfare of other individuals is endangered by the refusal, and to be advised of the consequences of that refusal; 8) The right to exercise free choice in selected activities, schedules, and daily routine; 9) The right to exercise free choice in selecting a primary care provider, pharmacy, home health provider, or other service provider and to assume responsibility for any additional costs incurred as a result of such choices. However, an establishment may specify how medications are packaged by a pharmacy if the resident receives administration of medication; 10) The right to request to relocate or refuse to relocate within the facility based upon the resident's needs, desires, and availability of such options; 11) The right to the free exercise of religion and to participate or refuse to participate in religious, social, recreational, rehabilitative, political or community activities;	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5108078	A. BUILDING: _____ B. WING _____	C 12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF FRANKFORT	21507 SOUTH WOLF ROAD FRANKFORT, IL 60423

(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
A6000	Continued From page 4 12) The right to be free of chemical and physical restraints; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; 14) The right to confidentiality of the resident's medical, financial, or other records. The release of a record shall be by written consent of the resident or the resident's representative and shall specify the circumstances under which each individual record may be released, except as specified by law; 15) The right to privacy in financial and personal affairs; 16) The right of access and the right to review and copy the resident's personal files maintained by the establishment, during normal business hours or at a time agreed upon by the resident and the establishment; 17) The right to privacy with regard to mail, phone calls, and visitors; 18) The right to uncensored access to the State Ombudsman or his or her designee, and the right to refuse access to a State Ombudsman or Department reviewer; 19) The right to be free of retaliation for or constraint from criticizing the establishment or making complaints to appropriate agencies or any agency or individual; 20) The right to 24 hour access to the establishment and all common areas of the establishment;	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5108078	A. BUILDING: _____ B. WING _____	C 12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF FRANKFORT	21507 SOUTH WOLF ROAD FRANKFORT, IL 60423

(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
A6000	Continued From page 5 21) The right to a minimum of 30-day notice of any change in a fee or charge or the availability of a service; 22) The right to a minimum of 90-day notice of a planned establishment closure; 23) The right to a minimum of 30-day notice of an involuntary residency termination, except where the resident poses a threat to himself or others, or in other emergency situations, and the right to appeal such termination; 24) The right to a 30-day notice of delinquency and at least 15 days right to cure delinquency. (Section 95 of the Act) b) Nothing in this Part is meant to limit a resident's right to choose his or her health care provider. (Section 75(h) of the Act) These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to ensure one (R1) of four residents reviewed was free from abuse. This deficient practice has the potential to affect all residents. Findings include: An onsite visit was conducted on 12/24/24. Per R1's health records, R1 is 89 years old. R1's diagnoses included but not limited to Unspecified Dementia, mild with anxiety, and Diabetes Mellitus. R1 moved to the Assisted Living unit on 5/18/24.	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5108078	A. BUILDING: _____ B. WING _____	C 12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF FRANKFORT	21507 SOUTH WOLF ROAD FRANKFORT, IL 60423

(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
A6000	Continued From page 6	A6000		

According to incident investigation, on 11/26/24 at 3:00am, R1 had a fall in his apartment requiring multiple staff assistance.

On 12/24/24 at 10:34am, R1 was observed and interviewed in his apartment. R1 appeared alert and oriented. R1 uses walker to ambulate.

A written statement of E4 (Resident Assistant) who was present at the time of incident, documented "When I got to apartment 50, he (R1) was bleeding and (E3) was yelling at him and he was crying. I opened the bathroom door and asked (E3) what happened and she didn't tell me what happened, she was just mad and yelling at the patient ...I went to get (E5-Resident Assistant) and she was still yelling at him that you can hear her voice outside room door. (E5) told (E3) to calm down but (E3) never calm down all she kept doing was hollering at him and he was shaking and crying because she was yelling and with hand movements ...When we took the patient to his room so he can lay down in his bed she (was) still yelling at him and he (was) still crying and (E3) said, "ugh that's how I feel" and he said, "please stop yelling at me don't be upset with me and I'm sorry." I recorded it because I was sad and upset because no patient should be shaking scared or being yelled at ...."

On 12/24/24 at 10:06am, E4 said, "He seemed embarrassed, he was upset. I feel like it was abuse, she was yelling at him, he was crying, he was apologizing to her while she was yelling at him."

On 12/24/24 at 9:45am, E5 said, "She (E3) was screaming on top of her voice, she was wailing. Resident's reaction was remorseful, saying "I am sorry, I don't want to put you guys in trouble." E5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5108078	A. BUILDING: _____ B. WING _____	C 12/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF FRANKFORT	21507 SOUTH WOLF ROAD FRANKFORT, IL 60423

(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
A6000	Continued From page 7 said, people have ways of self-expression. "She shouldn't have an outburst no matter what." On 12/24/24 at 12:17pm, E2 (Regional Operations Specialist) indicated E3 was terminated. E2 said, it was verbal abuse, (E3) used inappropriate language towards the resident. Establishment's document titled "Abuse, Neglect, and Exploitation Prevention, Prohibition, and Investigation Policy and Procedures" stated in part; "Abuse" means: -Results in physical harm or discomfort or loss of human dignity, failure to provide agreed upon care or services.. -Verbal, written, facial or body gestures communicated to a Resident in a disparaging or derogatory manner. -Mental abuse include humiliation, harassment, threats of punishment or deprivation directed toward the Resident. This incident was investigated and reported to all concerned entities as required. Both E4 and E5 stated Abuse Prevention training was part of employee orientation. Establishment has ongoing Abuse Prevention inservices.	A6000		