

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/13/2024
NAME OF PROVIDER OR SUPPLIER CEDARHURST OF JACKSONVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 2225 W MORTON AVE JACKSONVILLE, IL 62650		
(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 Original complaint #176259 The allegation was substantiated and violations were cited. Violations cited 295.6000 13) Type 3.	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 3 violation Section 295.6000 Resident Rights 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 evidenced by: Based on interview the establishment failed to keep residents free from neglect. Findings include: Interview: Interview with E1 and E2 was completed. Both confirmed that E3 fell asleep on their shift in a patients room on 5/18/24.	A6000		

Illinois Department of Public Health

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

TITLE

(X6) DATE