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 10/29/2025

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

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A 000	Initial Comment Complaint Investigation 25710326/IL198159 295.4010a)g)1)A)B)C)2) cited	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; B) dietary needs, if the establishment provides therapeutic diets; and C) special accommodations for the resident; 2) The amount, type, and frequency of health-related services needed by the resident; This requirement was not met as evidenced by: Based on interviews and record review, the facility failed to ensure fall interventions were updated and individualized after a fall incident for 1 of 3 residents (R3) and failed to follow the service plan of a resident at risk for falls by not conducting scheduled safety checks or frequent rounding to prevent falls for 2 of 3 residents (R2,	A4010		

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A4010	Continued From page 1 R3) reviewed for falls in the sample of 3. This failure has the potential to cause harm to a resident or residents. The findings include: Resident roster provided by facility and dated 10/29/2025 showed that R2, and R3 all reside on the memory care unit. 1. R2's face sheet documented a move-in date of 06/01/2023 with a past medical history not limited to dementia with mood disturbance, anxiety, and mild cognitive impairment. R2's incident report dated 10/26/2025 at 5:40 AM documented, "her daughter called and said she was on the floor" then showed that staff went into R2's room and she was found lying on her back by the bed. R2's observation note dated 10/26/2025 at 7:15 AM documented by E2 showed that R2's daughter reported R2 was observed on camera on the floor in her apartment and was requesting that R2 be sent to the hospital for further evaluation. R2's care plan dated 10/29/2025 read in part: history of falling and need monitoring, high risk for falls, please monitor me frequently for falls. Post fall intervention dated 10/26/2025 showed that staff are to assist resident through the night when resident is awake in room during safety check. Review of R2's observation log provided by facility from 10/22/2025 - 10/29/2025 showed no documentation that frequent monitoring or safety checks were being done for day of fall incident on 10/26/2025.	A4010		

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A4010	Continued From page 2 On 10/29/2025 at 11:08 AM, R2 was not in room. Observed sign posted next to room door indicating "room is electronically monitored". At 11:25 AM, R2 was observed eating lunch in dining area. R2 was alert to self with noted confusion and was not interviewable. 2. R3's face sheet documented a move-in date of 09/14/2025 with a past medical history not limited to dementia and depression. Review of undated incident log provided by the facility on 10/29/2025 documented that R3 had an unwitnessed fall in the common area on 10/28/2025 at 7:30 AM; an unwitnessed fall in resident's room on 10/18/2025 at 1:55 AM; an unwitnessed fall in the common area on 10/02/2025 at 1:44 PM; and an unwitnessed fall in resident's room on 09/29/2025 at 10:22 PM; an unwitnessed fall in resident's room on 09/27/2025 at 12:05 AM; and an unwitnessed fall in the common area on 09/22/2025 at 2:10 PM. R3's incident report dated 09/22/2025 at 2:10 PM showed R3 was observed lying on the floor in the common area. Incident report dated 09/27/2025 at 12:05 AM showed R3 slipped from the bed. Incident report dated 09/29/2025 at 10:22 PM showed that R3 was found on the floor during wellness check. Incident report dated 10/02/2025 at 1:44 PM showed that R3 slid down from the couch and was observed lying on the floor. Incident report dated 10/18/2025 at 1:55 AM	A4010		

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A4010	Continued From page 3	A4010		

showed R3 was found on the floor bleeding from the left side of her head.

Incident report dated 10/28/2025 at 7:30 AM showed R3 was observed lying on the floor in front of her wheelchair in the common area.

R3's care plan dated 10/29/2025 read in part: please monitor me for falls, safety checks every two hours at 12:00 AM, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, 10:00 PM, as needed for a total of twelve checks. Post fall interventions were not updated after R3's fall incidents on 09/27/2025, 09/29/2025, 10/02/2025, 10/18/2025, or 10/28/2025.

Review of R3's care history log provided by facility on 10/29/2025 from 07/29/2025 thru 10/29/2025 showed:

No documentation of safety checks from 9:56 AM thru 4:32 PM for day of fall incident on 09/22/2025 at 2:10 PM. Checks scheduled for 12:00 PM, 2:00 PM, and 4:00 PM were not documented.

No documentation of safety checks from 11:39 PM on 09/26/2025 thru 1:56 AM on 09/27/2025 for day of fall incident on 09/27/2025 at 12:05 AM. Check scheduled for 12:00 AM was not documented.

No documentation of safety checks from 9:42 PM thru 11:55 PM for day of fall incident on 09/29/2025 at 10:22 PM.

No documentation of safety checks from 4:48 AM thru 2:03 PM for day of fall incident on 10/02/2025 at 1:44 PM. Checks scheduled for 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM were not documented.

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A4010	Continued From page 4 No documentation of safety checks from 5:41 AM thru 9:24 AM for day of fall incident on 10/28/2025 at 7:30 AM. Check scheduled for 6:00 AM was not documented. Review of R3's progress notes showed she was hospitalized and remained during time of survey. On 10/29/2025 at 9:21 AM, E2 (Memory Care Nursing Director) said residents in memory care have safety checks done every two hours if indicated in their service plan. E2 added that after a fall in memory care, frequent checks are done every hour and documented. E2 then said post fall interventions are updated after each fall by E2 and the current director of nursing for assisted living who is new to the facility. E2 also said that during the night, safety checks are to be done every two hours and documented, and if a resident is up during these checks, they should be toileted, and briefs should be changed every two hours as well. On 10/29/2025 at 11:02 AM, E3 (Licensed Practical Nurse) indicated all residents on the memory care unit are fall risks so they usually stay in common areas throughout the day for better staff monitoring. She added that caregivers round on all residents they are assigned to every two hours and document these checks electronically. E3 said they are to document where the resident is at time of check and what they are doing. At 11:22 AM, E3 said she was working on day of R3's fall on 10/28/2025. She added that she heard a resident yell out "she needs help" and when she went to the common area, E3 saw R3 on the floor in front of her wheelchair.	A4010		

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A4010	Continued From page 5 On 10/29/2025 at 11:12 AM, E4 (Resident Assistant) said most residents on the memory care unit stay in common areas and the residents who stay in their rooms are checked on every two hours. E4 added that caregivers document every resident check electronically and what the resident was doing at time of check. E4 said she was working the day R3 fell on 10/28/2025. E4 said R3 was in her wheelchair in the common area but the pad on her seat was not in place correctly so she slid out of the chair. On 10/29/2025 at 01:18 PM, E2 (Memory Care Nursing Director) said safety checks are to be documented every 2 hours and if they are not documented, then they were not done. On 10/29/2025 at 1:58 PM, E2 said R1 and R3's fall interventions are not all updated post fall. E2 then said that R2 had a care plan meeting previous day and discussed safety checks with her family. She said that R2's family did not want R2 to be awoken during the night. E2 said R2 should be on scheduled safety checks because she is a high fall risk. On 10/29/2025 at 2:05 PM, E2 said safety checks populate on the caregiver's electronic charting to be completed every two hours. E2 added that the facility started running reports on documentation for resident assistants on all three shifts about a week ago due to "low percentage of completed documentation and falls on the night shift." The undated Fall Risk Policy & Procedures showed all residents moving into memory care communities are identified at risk for fall. Interventions or a plan needs to be established and added to their care plan .... When a resident falls ...implement fall prevention interventions and	A4010		

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A4010	Continued From page 6 consider if resident needs a PT (physical evaluation) or medication regime evaluation by the MD (medical doctor). Note interventions on individualized service plan. The undated Individualized Service Plans & Plan of Care Meetings Policy & Procedures showed it is the policy of the community to assure all community staff understand the importance of the plan of care and the plan of care meeting. All plans must reflect the resident's needs, as identified in the initial evaluation and the on-going evaluations ...All plans of care will be developed using your community's plan of care tool. All plans of care will be readily available for staff to view.	A4010		