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 02/05/2026

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CEDARHURST OF FRANKFORT	21507 SOUTH WOLF ROAD FRANKFORT, IL 60423

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A 000	Initial Comment Complaint Investigation 2671134/ IL00199877 295.4010 a)d)e)g)2)h) 295.6010 a)2)b)1-7)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: General Violation Section 295.4010 Service Plan a, d, e, g (2), h 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 residents' choices regarding the service plan. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act). e) The service plan shall be reviewed and revised, if necessary, immediately after a significant change in the residents' physical, cognitive, or functional condition (see Section 295.4000). g) Service plans shall address: 1) The level of service the residents receive, including: A) assistance with activities of daily living.	A4010		

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A4010	Continued From page 1 B) dietary needs, if the establishment provides therapeutic diets; and C) special accommodation for the residents. 2) The amount, type, and frequency of health-related services needed by the residents. h) The service plan shall include all support services provided or arranged for by the establishment. These requirements were not met, as evidenced by: Based on observation, interview, and record review, the facility failed to: 1. Revise the service plan to address R1's changes in behavior. 2. Conduct a significant change of status for R1 and R2. 3. Implement specific interventions to promote safety environment. 4. Develop an interdisciplinary approach integrating external services. This is for 2 (R1 and R2) in the sample of 3 residents. This failure has the probability to affect all residents in the establishment. The findings include: A. R1 moved into the community on January 29, 2025, with diagnoses to include hypertension and hyperlipidemia. On January 29, 2026, at 11:28 AM, E2 (Memory Care Director/LPN) and E1 (Director of Nursing/LPN) explained, "R1 can carry on a conversation, just depends on the day. Upon admission [December 20, 2025], R1 requires a one person assist with activities of daily living, walks with a walking device (rollator) at times, is exit seeking, anxious, and always wanting to go home. No, there were no other behaviors."	A4010		

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A4010	Continued From page 2 At 11:35 AM, R1 was in the dining room sitting in a wheelchair. R1 was requesting to be toileted. R1 was assisted by E6 (CNA) to transfer from wheelchair to the toilet. R1 was able to follow instructions to grab the bathroom bar to stand. R1 was able to pivot but unable to maintain standing longer than five minutes. R1 started saying, "I can't, that hurts!" E2 and E6 stated, "Yes, R1 has been declining. R1 needs [one staff physical] assistance with all of activities of daily living." On January 27, 2026, R1's daughter (Z5) reported to the community staff (unidentified) R1's allegation of sexual assault. On January 27, 2026, at 6:00 PM (via phone interview), Z5 explained, upon arriving at the community, Z2 was providing R1 a shower. Z5 said, "I stayed in the hallway waiting. No, there was no commotion or yelling. R1 then whispered to me something that sounded like, 'They are trying to kill me,' and said that he was raped. R1 was getting agitated and kept saying, 'let's get out of this place! Call the police.'" On January 28, 2026, at 11:28 AM, E2 said, "Yes, this is a new behavior for R1. Yes, this is the first time R1 claimed they were raped. The most recent service plan dated December 20, 2025, was presented. There was no revision made to identify R1's new behavior or a significant change of status made related to hospice admission on January 22, 2026. This was discussed and confirmed by E1 and E2 on January 28, 2026, at 4:00 PM. B. R2 moved in the establishment on December 18, 2025 (no diagnosis was found in	A4010		

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A4010	Continued From page 3 R2's clinical record). On January 28, 2026, at 2:01 PM, E1 described R2 as alert and oriented (x3), independent in performing activities of daily living except bathing and dressing; requires assistance in putting on pants and with history of fall prior to moving to the establishment (home). A reportable incident dated January 7, 2026, at 3:12 AM, staff answered the call light. Upon entering (R2's) apartment, R2 was observed on the floor next to the bed. R2 complained of left leg pain. R2 was transported to the Emergency Room and was diagnosed with a left hip fracture. R2's most recent service plan dated December 23, 2025, shows the following: - Full assistance in bathing, - Use of bathroom (toileting)- require assistance. - Fall Risk- ambulates with walker and wheelchair and may require assistance at times. - Safety checks- check on me throughout the day, at mealtimes and at night. This service plan was not revised or R2's significant change of status identified. There were no interventions listed under fall to prevent further occurrence of fall incidents. R2's fall risk service plan show: - Needs/Preferences and Individualized service- none identified. - Approaches and /or Interventions -" I ambulate with my walker and wheelchair and may require assistance at times." - Provider of service -Residents/self, community staff.	A4010		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr	A6010		

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A6010	Continued From page 4 This Regulation is not met as evidenced by: General Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting A (2), b (1-7) a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall: 2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report. b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following: 1) Dates, times, and description of the alleged abuse, neglect or financial exploitation. 2) Description of any injury to the resident. 3) Description of any change in the resident's physical, cognitive, functional, or emotional condition. 4) Any actions taken by the licensee. 5) A list of individuals and agencies interviewed or notified by the establishment. 6) Names of witnesses to the alleged abuse, neglect, or financial exploitation; and 7) If the abuse, neglect, or financial exploitation is substantial, a description of the action to be taken by the establishment to prevent	A6010		

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the abuse, neglect or financial exploitation from occurring in the future.

These requirements were not met, as evidenced by:

Based on observation, interview and record review, the facility failed to:
1. Conduct a thorough investigation to rule out abuse or neglect.
2. Implement the establishment's policies and procedures related to abuse, including interviewing of all staff who may have witnessed or may have knowledge of the alleged (R1's) abuse.

These failures resulted in not thoroughly investigating:
(1) R1's allegation of sexual assault on January 27, 2026. R1 claimed that they were raped and stated, "They are trying to kill me."
(2) R2's unwitnessed fall on January 7, 2026, which resulted in a fracture to the left hip.
This is for two (R1 and R2) of three residents in the sample.
This failure has the probability to affect all residents.

The findings include:

1. On January 27, 2026, at 6:00 PM (via phone interview), Z5 stated, "when we arrived at the community, a hospice Aide (Z2) was giving a shower to R1. I stayed in the hallway and waited for them to finish. When they [R1 and Z2] came out from the [spa] shower room, Z2 said, 'See you tomorrow R1.' R1 then whispered to me (Z5) something that sounded like, 'They are trying to kill me,' and said that he was raped. R1 was getting agitated and kept saying, 'let's get out of

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this place! Call the police.' It was so difficult to re-direct R1 that day. I am usually able to calm R1 down but that day the more I tried, the more R1's behavior escalated. R1 never said things like that or acted like this before. R1 was so agitated and kept asking me if the police were coming. It was too distressing to me of what R1 was saying and how R1 was acting that day. I do not know what's going on! No, I didn't hear any commotion or yelling while I was waiting. The hospice aide seems nice. Yes, I did tell the nurse (name unknown) and told her everything, same thing that I am telling you now. No, R1 didn't say she (Z2), R1 said they!"

On January 28, 2026, at 10:00 AM, the nature of the complaint was presented to E2 (Memory Care Director), E1 (Director of Nursing/LPN), E4 (Regional Operation Specialist) and E5 (Regional Director Operation), these staff claimed they are aware of R1's allegation.

A copy of the community reported incident submitted to the Department was provided, this report read as follows:
On January 28, 2026, MC nurse (E3/LPN) reported daughter to MC resident JK [sic] [R1's daughter reported to Memory Care Nurse], stated he (R1) was sexually assaulted, and staff attempted to kill him. The resident is alert and oriented X1. Upon assessment no visible injury was observed. The resident presented with paranoia and agitation (on February 3, 2026, at 1:18 PM, E2 confirmed R1 had not been previously documented to display paranoia or agitation). A full body check was completed with no injuries noted. Prior to the allegation, R1 was assisted with a shower by a CNA from hospice. Hospice was notified of allegation. Abuse prevention and reporting procedures were

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initiated and followed per facility policy. An investigation was initiated regarding this matter. Appropriate notifications were made, and staff were reeducated on abuse prevention and reporting policies. The resident remains under observation, and the investigation is ongoing.

In addition to the initial report submitted to the Department dated January 28, 2026, the community presented a statement from E3(LPN) that reads as follows:
"January 27, 2026, at 1:30 PM. Residents daughter approached this nurse, stating that her father stated to her, 'They are going to kill me, they are trying to kill me.' Residents daughter was visibly upset and I explained that resident was in good spirits all day and involved with activities that this behavior was new for residents today. Resident was with hospice CNA watching western TV and went back to his room when family got here. She also stated resident stated to her he was raped. This nurse went to residents room to do a body check on resident, resident was sitting in his chair with daughter, wife and granddaughter with him. Resident asked this writer, 'who do you work for?' This writer replied '[Facility Name], I'm the nurse.' Resident then stated, 'That lady is going to kill me, she's going to cut my balls off and slit my throat.' This writer replied "No one here is going to hurt you, you are safe here with us." This writer informed daughter that she should sit with resident in the common area and have coffee and a snack to try to redirect resident and I also informed her I would be calling hospice to inform them of new behavior, as well as I let the Director of Nursing know what was stated. Resident came into common area with daughter, wife and granddaughter who had coffee but [still anxious and wanting to leave."

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On January 28, 2026, at 12:30 PM, E1 explained, "E3/LPN was informed by R1's daughter that R1 told her, 'They are trying to kill him, and they raped him'. When I went to see R1, R1 said, they are trying to cut my throat and my balls. They are out to get me; we need the police.' R1 refused assessment at that time."

E2 and E1 explained, "I (E2) was informed by the nurse (E3) that R1 claimed that they are trying to kill him, and they raped him. I (E2) was off that day (January 27,2026), so the next day (January 28, 2026) when I came back to work, I went to talk to R1. R1 said, 'They are trying to cut his throat and his balls, and they are trying to get him, so we need police.' Yes, R1 said, "raped."

On January 28, 2026, at 1:00 PM, the community was unable to present evidence of initiating a working investigation. E2 said, "There was no further investigation conducted because the [alleged] abuser was not a community staff member. The hospice CNA was the one that gave R1 the shower." The community was encouraged and was provided with time to conduct an investigation and to submit the final report to the department.
The establishment abuse policy and procedure (updated on March 12, 2024), page 3 of page 5 reads: "Interview all staff who may have witnessed or may have knowledge of the alleged abuse." This procedure was not followed for this incident. On January 30, 2026, the community's final report was submitted to the department. The community was unable to present documentation showing that staff were interviewed. On February 3, 2026, at 12:00 PM, E2 confirmed that R1 did not identify who raped or who was trying to kill him. R1 did not confirm the gender(s) of the alleged abusers. E2 stated, "No, R1 didn't say

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A6010	Continued From page 9 who or 'she' (indicating Z2). R1 said 'they.'" 2. A reportable incident dated January 7, 2026, at 3:21 AM, staff responded to R2's call light and was found R2 on the floor complaining of pain to the left hip. R2 was sent to the hospital and diagnosed with a facture to the left hip. The reportable incident reads: January 7, 2026, at 3:21 AM. "Staff answered the call light for resident. Upon entering the apartment, staff observed resident lying on the floor next to his bed. Resident stated, 'I fell out of bed.' Staff assessed for visible injury. Resident stated, 'My left leg hurts.' Stayed with resident, ensured safety and called Director of Nursing ... Director of Nursing informed staff to send R2 out ... Resident was diagnosed with left hip fracture." The establishment was unable to provide evidence of an investigation regarding R2's incident and was unable to provide the final report submitted to the department. On January 28, 2026, at 2:30 PM, E1 and E2 said, "We only send one report. They [the department] will call us if they need additional information."	A6010		