STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510524	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF SPRINGFIELD	3520 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62711

(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 Complaint Investigation 2647220/IL00202312 295.4010 b) c) 295.5000 d)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident; c) The service plan shall be signed and dated by all individuals involved in its development. Based on record review and interview the facility failed to ensure service plans were signed by resident representative or resident. This failure creates a substantial probability of harm to a resident or residents. Findings include: R2's service plan 6/11/26 does not include documentation of signature of resident representative or resident. R3's service plan 4/14/26 does not include documentation of signature of resident representative or resident. Interviewed E2 (Regional Nurse) and E3 (Director of Nursing) on 6/18/26 at approximately 10:40	A4010		

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A4010	Continued From page 1 requesting R2's and R3's signed service plans. E2 and E3 stated they do not have the signed signatures of the POA's for R2's and R3's service plans.	A4010		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by:	A5000		