STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510489	A. BUILDING: _____ B. WING _____	C 12/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF NAPERVILLE	3333 75TH STREET WOODRIDGE, IL 60517

(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 Facility Reported Incident IL199131 295.3000a)h)3) 295.4010a)d)e) Complaint Investigation IL199198 - Unsubstantiated. No Violations Cited	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 1 Violation Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) h) The establishment shall have sufficient personnel to provide the following for its current resident population: 3) Service to meet the needs of each resident, including 24 hour scheduled and unscheduled needs, general supervision, and the ability to intervene in a crisis; These requirements were not met, as evidenced by: Based on observation, interview and record	A3000		

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A3000	Continued From page 1	A3000		

review, the facility failed to identify the need of an assistive device for a transfer during wet conditions and failed to investigate and analyze the possible root cause of a fall and implement an individualized plan of care to prevent additional falls from occurring for one resident (R1) out of three residents reviewed. This failure resulted in R1 fracturing her right fifth metatarsal of the foot and has the substanial probability to cause severe harm to other residents.

Findings Include:

R1's incident report dated 12/2/25 documents "Approximately 1824 Staff noted to this writer that the resident slid off the shower chair. Upon entering the resident room, this writer observed the patient sitting on the shower floor facing the shower faucet. Staff noted to this writer that the resident did not hit her head. She is alert and oriented times two (normal baseline). ROM (Range of Motion) to all extremities good but limited. Redness noted to right breast and no complaints of pain or discomfort."

R1's Nursing Note dated 12/3/25 documents "Approximately 1824 Staff noted to this writer that the resident slid off the shower chair. Upon entering the resident room, this writer observed the patient sitting on the shower floor facing the shower faucet. Staff noted to this writer that the resident did not hit her head. She is alert and oriented times two (normal baseline). ROM (Range of Motion) to all extremities good but limited. Redness noted to right breast and no complaints of pain or discomfort."

On 12/26/25 10:46 am, during interview with E4 caregiver, E4 stated that while transfering R1to the shower, R1 slipped and fell. When E4 was

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A3000	Continued From page 2	A3000		

asked why the report documents she slipped out of the shower chair (E4 was provided a copy of the incident report), E4 read the report and said "This is not how it happend. She didn't slip out of the shower chair, she fell as we were transfering her." E4 was asked if anyone had asked her any questions about the incident. E4 stated "No". E4 then stated that she was not assigned to R1 and was only assisting another caregiver to help transfer R1 onto the shower bench. E4 stated they did not ues a gait belt during the transfer and instead they scopped R1 under the arms, had her hold onto the grab bar and as they were transfering her, R1 stepped into the shower, slipped on the water and fell. E4 stated the shower was wet because they had the shower running to get the water warm. During the interview, E4 stated "I didn't know she couldn't stand. No one told me. I wasn't her caregiver." At this time, E4 escorted this surveyor to R1's shower and demonstrated how R1 was transfered. E4 stated that the caregivers stood next to R1 outside the shower as R1 stepped into the shower. The transfer was away from the caregivers body, without a gait belt, onto a wet surface. E4 stated "I'm not sure why the caregiver decided to shower (R1) in here, I wouldn't have. There's not enough room."

On 12/26/25 at 10:57 am, E5 caregiver, confirmed she was R1's cargiver. E5 stated R1 can't really take steps, so they use more of a stand and pivot to transfer her. E5 was asked if R1 requires a gait belt. E5 stated "I don't use one. I grab the back of her pants and hold on when I transfer her." E5 stated the facility has gait belts and are only used on residents that have issues with standing. E5 stated that R1 really doesn't need one becuase R1 can stand and pivot, but confirmed she can't take steps without difficulty.

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A3000	Continued From page 3 On 12/26/25 at 1:00 PM, E1, Executive Director, stated that each caregiver was given a gait belt and it should be used across the board with any resident needing hands on assistance with transfers. On 12/27/25 at 1:33 PM, E2 stated the facility reached out to R1's family to obtain some shower shoes after the fall and after talking with E1, Executive Director, they will be adding the use of a gait belt for transfers to R1's service plan. The facility's transfer in-service docuements: 7. General Techniques and Best Practices a. Decide the destination and choose the shortest, most obstacle-free route. b. Eliminate hazards and obstacles, position any furniture or equipment, and lock any wheels involved (i.e., wheelchair wheels, wheels on carts, etc.) c. Agree on any plan prior to moving or lifting a resident or equipment. d. If the resident is assisting during transfers, provide clear, simple instructions on how they can help. e. You should always face the resident during a lift or move. f. Move the resident toward, not away from you. g. When lowering a resident, sit them down standing as close to the destination as possible. h. When lifting and lowering, bend at the legs, not at the waist. Bending at the waist will multiply the weight and apply pressure on the vertebrae in your spine. i. Do not lift directly after sitting for a long time. Walk or stretch to loosen up. This is true of moving items as well. i. Bend at the hips and knees, keep your back straight, and use your legs, not your back to lift.	A3000		

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A3000	Continued From page 4 ii. Lift items close to your body with your legs shoulder width apart for stabilization all while maintaining a grasp of the object from between your waist and shoulders. j. Shift your feet to turn or pivot instead of twisting your back k. Avoid uneven and slippery surfaces. Transferring a Resident Transfers, Falls, Back Safety In-Service [655-83] Page 4 of 7 Last Updated: February 14, 2025 (PRESENTER: Demonstrate each transfer/lift) a. Bed to Wheelchair/Chair Transfer Techniques · Place the wheelchair near the head of the bed. · Be sure to lock the wheels on the chair. · Secure a transfer/gait belt for the resident. · Assist the resident to a sitting position on the edge of the bed by placing your hands under their neck and shoulders and under their knees. · Place gait belt around the waist · With your feet shoulder-width apart, bend your knees and use both hands to grasp the resident around the transfer belt. · Prop your knees against the resident ' s knees to help them stand up and lock their legs in place. · If able, the resident may assist by using their arms to push off from the bed. · Bend your knees and move your feet to pivot and lower the resident into the wheelchair. · Again, if they are able, the resident may help by placing their hands on the armrests for support. b. Wheelchair to Bed, Couch, Other Chair Techniques · Move the wheelchair close to the bed and lock the wheels. · secure a transfer/gait belt for the resident. · Use the same method as above to move the	A3000		

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A3000	Continued From page 5 resident back to a sitting position on the edge of the bed. · Help lower the resident to lie down (if moving to bed or couch to lie down)	A3000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 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. 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 resident's physical, cognitive, or functional condition (see Section 295.4000). Based on interview and record review, that facility failed to include the use of an assitive device for	A4010		

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A4010	Continued From page 6	A4010		

transfers and update a resident's serivice plan with individualized interventions after a fall for one resident (R1) out of three residents reviewed for falls. This failure has the substantial probability to cause severe harm to a resident or residents residing in the facility.

Findings Include:

R1's incident report dated 12/2/25 documents "Approximately 1824 Staff noted to this writer that the resident slid off the shower chair. Upon entering the resident room, this writer observed the patient sitting on the shower floor facing the shower faucet. Staff noted to this writer that the resident did not hit her head. She is alert and oriented times two (normal baseline). ROM (Range of Motion) to all extremities good but limited. Redness noted to right breast and no complaints of pain or discomfort."

On 12/26/25 10:46 am, during an interview with E4 caregiver, E4 stated that while transfering R1 to the shower, R1 slipped and fell. E4 stated that she was not assigned to R1 and was only assisting another caregiver to help transfer R1 into the shower bench. E4 stated they did not ues a gait belt during the transfer and instead they scooped R1 under the arms, had her hold onto the grab bar and as they were transfering her, R1 stepped into the shower, slipped on the water and fell. E4 stated the shower was wet because they had the shower running to get the water warm. During the interview, E4 stated "I didn't know she couldn't stand. No one told me. I wasn't her caregiver."

On 12/26/25 at 10:57 am, E5 caregiver confirmed she was R1's cargiver. E5 stated R1 can't really step, so they use more of a stand and pivot. E5

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A4010	Continued From page 7 was asked if R1 requires a gait belt. E5 stated "I don't use one. I grab the back of her pants and hold on when I transfer her." On 12/26/25 at 1:00 PM, E1, Executive Director, stated that each caregiver was given a gait belt and it should be used across the board with any resident needing hands on assistance with transfers. R1's current service plan does not include the use of a gait belt for transfers or the fall and fall interventions for the fall that occured on 12/2/25. On 12/27/25 at 1:14 PM, E2, Assistant Director, confirmed that R1's fall on 12/2/25 was not added to the service plan and that the full hands on assist with bathing was added on 12/26, after the survey entrance. On 12/27/25 at 1:33 PM, E2 stated the facility reached out to R1's family to obtain some shower shoes and after talking with E1, Executive Director, they will be adding the use of a gait belt for transfers to R1's care plan.	A4010		