

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510489	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2025
NAME OF PROVIDER OR SUPPLIER CEDARHURST OF NAPERVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 3333 75TH STREET WOODRIDGE, IL 60517		
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A 000	Initial Comment Facility Report Incidents of: 3/31/25/IL#190365 - 295.6000 a)1)13 4/28/25/IL#192409 - 295.6000 a)1)13 and 295.6010 a)1)b)5) 5/4/25/IL#192874 - 295.6000 a)1)13 and 295.6010 a)1)b)5)	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: 295.6000a)1)3) Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; This REQUIREMENT was NOT MET as evidenced by: Based on observation, interview and record review the establishment failed to ensure residents were free from physical abuse, sexual	A6000		

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

TITLE

(X6) DATE

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A6000	Continued From page 1 abuse, and misappropriation of property for 3 of 3 residents (R1, R2, R3) reviewed for resident rights in the sample of 3. 1. R1's face sheet showed he moved into the establishment 7/31/24 with diagnoses to include hyperlipidemia, major depressive disorder, generalized anxiety disorder, neurocognitive disorder with Lewy bodies, insomnia, metabolic encephalopathy, and spinal stenosis. R1's undated Service Plan showed he requires staff assistance with all cares. On 6/8/25 at 10:45 AM, Z1 (R1's Power of Attorney) said there are two police investigations that were filed for R1 but he doesn't remember the dates. Z1 said the first incident, there was a CNA (Certified Nursing Assistant) showing R1 some pornographic videos on her phone. Z1 said there is a camera in R1's room. Z1 said he knows it was a temporary agency CNA and not a full time employee. Z1 said he could not see what was in the video on the CNA's phone in the video but that R1 had reported to the nurse that he was shown pornographic videos. Z1 said in the video R1 was lying in bed. Z1 said he couldn't hear the CNA say anything on the video. Z1 said he believes the camera gets covered after the CNA shows R1 the video and it was not uncovered for a couple of hours when R1 removes it himself. Z1 said he believes it was a pillow that was placed in front of the camera. Z1 said R1 had no injuries from the incident. Z1 said according to R1 the content shown on the phone was a pornographic of a male having intercourse with a female and he said the CNA made a comment like "don't you want to be strong to be able to do this type of thing." Z1 said the second incident, there was a CNA who was removed from the facility. Z1 said there is a video of the CNA kind of hitting or	A6000			

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A6000	Continued From page 2 "backhanding" R1 in the face. Z1 said the CNA was assisting R1 with cares and he was complaining about putting his feet up on the foot pedals of his wheelchair. Z1 said the CNA was walking by R1 and kind of slapped him with the back of her hand. Z1 said at the time of the incident R1 was saying "You hit me in the face." to which the CNA was responded "no I didn't" and she walked out of the room. Z1 said he gave the video to the facility and to the police department. The facility's Abuse, Neglect, & Exploitation Investigation Form dated 3/31/25 showed, "... On 3/31/25, resident reported the nurse that the agency CNA, hurt him by hitting his head against the wall. The resident also reported that the agency CNA showed him an inappropriate video. This all took place when the agency CNA [E4] was helping the resident get ready for the day. There was a red mark on the residents head and the nurse had to apply bandages to the right knee... The nurse on staff conducted a head to toe assessment on the resident. the nurse assessed a scrape to the resident's right knee and redness to their forehead and top of their head. The nurse explained in their statement that the agency CNA was showing the resident pornographic images. The resident has a camera in their apartment; therefore, as part of the investigation, the Director of Nursing, reached out to the resident's family to obtain video footage. The family told the Director of Nursing that they can see in the video the agency CNA showing the resident something on their phone then they cover the camera up..." The facility's Abuse, Neglect, & Exploitation Investigation Form dated 5/12/25 showed, "... On 5/12/25, family of resident, [R1], reported that the agency CNA [E12] slapped him while getting him	A6000		

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A6000	Continued From page 3 ready for the day. The family was able to view this through the camera that they have in [R1's] apartment... Description of the event as it was reported: ... On 5/12/25, it was reported to [E2] DON (Director of Nursing) by the family that an agency CNA hit [R1] while she was getting him ready for the day. The DON asked the family to send the video footage, and it is seen in the video footage that the agency CNA hit [R1].... [E2] spoke with the agency CNA [E12] and [E12] stated that she did hit the resident because the resident kicked her... The final reportable was submitted to IDPH (Illinois Department of Public Health) as abuse findings substantiated..." On 6/8/25 at 11:55 AM, E5 LPN (Licensed Practical Nurse) said she was the nurse for both incidents with R1. E5 said the one incident she remembers vividly because family came in and notified her of the incident because there is a camera in the room. E5 said she notified the managers and we swiftly got her off of the unit and away from the resident. E5 said she assessed R1 and there was no bruising or no redness noted. E5 said R1 told her he was slapped. E5 said R1 was visibly upset. E5 said the family showed her the video and she could see E12 did hit R1. E5 said E12 slapped at R1's cheek and R1 reacted by putting his arms up like he was defending himself. E5 said the other incident in which R1 was shown pornographic images was reported to her by R1. E5 said R1 came to her and said E4 CNA showed him an inappropriate video and hit his head against the wall. E5 said R1 kept saying he loves his wife and doesn't know why someone would show him that "stuff". E5 said R1 was in bed when the video was shown to him. E5 said she remembers R1 had two red lines on his head from the incident. E5 said R1 was very specific that it was a	A6000			

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A6000	Continued From page 4 pornographic video he was shown. E5 said R1 was upset and he was crying. On 6/8/25 at 3:10 PM, E16 DON (Director of Nursing) said, "According to R1 (regarding the incident 3/31/25) [E4] was trying to change him and he hit his head on the wall. In my mind she is probably trying to make up for it so she was showing him dirty videos. At first she said she didn't show him anything. Then she said she was trying to show him a video of ROM. I told her that he told us she was showing him pornographic videos. According to his son, she went into the room and had a conversation with him and 15-20 minutes into the video she covered the camera. Which to me means it was premeditated. He (Z1) would know better than I would because I didn't see the video. I wish he did share that video with us. The scrape on his knee must have happened at the same time as she was turning him and hit his head. His head was red that day so she definitely did hit his head." On 6/8/25 at 9:35 AM, V2 DON (Director of Nursing Memory Care) said, E4 CNA had called the E5 LPN to help her get R1 up into the wheelchair. After they got R1 into the wheelchair E5 left the room. R1 's family member came and said E4 hit R1. V2 said they went through the whole process, called the police, and E4 admitted to hitting R1. V2 said E4 said she hit R1 in the face because he had kicked her. V2 said she was unfamiliar with the investigation regarding pornographic content. The facility's Abuse, Neglect, and Exploitation Prevention, Prohibition, and Investigation Policy and Procedure showed, "Policy: The Community will make every reasonable effort to avoid hiring, or continuing to employ, persons with a history	A6000			

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A6000	Continued From page 5 of/or propensity for abuse... All allegations of abuse will be treated as serious and will be investigated, documented, and reported as per the standards set forth in this policy and procedure, or per State or Federal definitions and regulations, whichever is more stringent. Failure to follow the policy and procedure as set forth will be considered a serious violation of one's employee responsibilities, and will result in disciplinary action, up to, and including, termination... Abuse means: any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to a resident. Any physical or mental injury or sexual assault inflicted on a resident... Physical injuries include injuries that a reasonable and prudent person would be able to prevent such as hitting, pinching, or striking, or injury resulting from rough handling. 2. On 6/8/25 at 11:25 AM, R2 was sitting in the recliner in his apartment. R2's speech was clear and he was able to carry on a conversation with ease. R2 said he'd been at the facility since November 2024. R2 stated, "A strange thing happened to me at the end of April. I have 2 wallets I use and one is a little billfold. I left the little billfold out and someone took all my money that was greater than a five dollar bill. It was less than \$100, but it's a lot of money to me. My sister reported it, then some lady came to talk to me. I told them what I knew. All the doors are open around here, but this is the first time I ever had any issue like this. I rarely leave my room, but I do sleep pretty hard. I have no idea who did it, but they must have gone through my things when I was sleeping. I just know the money was there the week before and I noticed it missing the day it was reported(4/28/25). The police came and talked to me twice. The first time was that day, then about a week later they came back with	A6000			

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A6000	Continued From page 6 pictures. It sounds the theft wasn't a singular event. I'd like to see the pattern analysis on this one. The second time the police came back with pictures, but I told them I didn't know who took my money." R2's Facesheet dated 6/8/25 showed he moved into the facility on 11/18/24 and had diagnoses to include depression and adjustment disorder, with anxiety. R2's Progress Notes did not contain any documentation of the theft allegation on 4/28/25. R2's Progress note dated 4/19/25 showed he was alert and oriented to person, place, and time and able to make his needs know. R2's Abuse, Neglect & Exploitation Investigation Form dated 4/28/25 showed, "... On 4/28/25 it was reported to the Resident Care Manager, Regional Nurse Specialist, and Director of Nursing from his sister that he was missing money. The friend explained that he has two separate wallets. he said he first noticed his money missing when he went to lunch today, 4/28/25, with his sister. He said in one wallet he is missing around 4 or 5 \$20 bills and he only has his \$1 bills left in the wallet. In the other wallet he was missing up to \$100 and no money was left in it. He cannot recall when he last saw the money, but he said it was sometime last week. He let me look through his bank charges on his phone. He had numerous charges that he says are not from him. These include [local country club], [subscription based website], and [retail store]. The [local police department] was notified and police report was filed..." The report showed E17 (Regional Nurse Specialist), E13 (Resident Care Manager), E2 (Director of Nursing - Memory Care), R2, and the local police were involved. The	A6000		

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A6000	Continued From page 7 document showed there were no suspected employees. The only interviews conducted by the facility were with R2 and R2's sister/friend. The Agency Staff List dated 4/1/25-6/7/25 showed E3 (Agency CNA - identified as stealing R3's money and making unauthorized credit card charges) worked 4/25/25. (During the week timeframe, R2's money went missing and fraudulent charges were made). On 6/8/25 at 9:28 AM, E2 (Director of Nursing (DON) - Memory Care) said E3 (Agency CNA) was involved in both of the thefts. E2 said the police were called for both allegations. E2 said the police came and E3 was escorted off the property on 5/4/25 (after R3's theft allegation and 1 week after R2's theft allegation). E2 said the resident apartments can be locked with a key, but most resident's do not lock their apartments. E2 stated, "Theft isn't something that normally happens here. I was shocked when [R2] reported it. Our regular staff are great, but we are short staffed and need to use agency. It's agency staff that are involved in these abuse allegations." At 2:28 PM, E2 (DON) said she was not at the facility for the theft investigations. E2 said the staff involved would be listed. The surveyor showed E2 her name was listed on the form. E2 replied, "I left before the police came." E2 said she wasn't directly involved in the investigations. On 6/8/25 at 1:14 PM, E13 (Resident Care Manager) said she only works at the facility PRN (As needed) now, but she was a Resident Care Manager. E13 said she mostly worked the floor and was working numerous hours. E13 said when the facility started using more agency staff in April 2025. E13 said R2 was very oriented and a super nice guy. E13 said R2's sister told her that	A6000			

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A6000	Continued From page 8 someone must have made copies of R2's credit card and had stolen some money. E13 said R2 was pretty independent and just needed reminders at meal times. E13 said R2 was able to provide information and wouldn't make up any stories. E13 said there were charges for a theater that was closer to Chicago, stores, and websites. E13 said E3 (Agency CNA) was caught "red-handed" by R3. E13 said E3 could have taken R2's money too. E13 said R2 was adamant that his money was missing and he didn't make the charges. On 6/8/25 at 3:10 PM, E16 (DON - Assisted Living) said according to the agency, E3 (Agency CNA) no longer works for them. E16 said it's really sad that the residents' were taken advantage of; this is their home and we are supposed to keep them safe. On 6/9/25 at 7:36 AM, E17 (Regional Nurse Specialist) said she covers covers 20 facilities in the division. E17 said E1 was not at the facility when R2's theft allegation was made. E17 said she went to R2's room with E2 (DON) to interview him. E17 said R2 had gone out with his sister and they realized he was missing money. E17 said R2 explained he had two separate wallets and there was money missing from both wallets. E17 said R2 pulled up his bank statement and showed charges that he said he didn't make. E17 said she called the police and they came to interview R2. E17 said if a resident reports missing money or fraudulent charges, then a thorough investigation should be completed and the police should be notified. All the information regarding the investigation should be included in the report. E17 stated, "I just spoke to [R2], I didn't complete any other aspect of the investigation. I didn't interview any other residents or staff regarding	A6000			

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A6000	Continued From page 9 theft. I wasn't involved in R3's theft investigation. [E1 (Executive Director)] and [E2 (DON)] should have handled that. I'm not aware of any other reports of theft at the facility. The residents shouldn't be subjected to theft and fraudulent credit card charges." On 6/9/25 at 9:34 AM, E1 (Executive Director) said she wasn't in the building for the first theft allegation by R2 (4/28/25). E1 said E17 called and said someone was making unauthorized charges and money was missing from R2. E1 said R2 doesn't come out of his room often, so E1 asked E17 to go interview him. E1 said R2 reported someone must have been going through his stuff at night because he's a heavy sleeper. E1 said R2 didn't know exactly when the money was taken and he didn't know who took it. E1 said R2's sister tried to find out who made the purchases on [the subscription based website], but she was unable to. E1 said the facility didn't interview any other residents or staff regarding theft during R2's investigation. The residents' money should not be stolen and there should not be unauthorized charges on their credit cards. That is theft and against their rights. The facility should be providing a safe home. 3. On 6/8/25 at 11:15 AM, R3 was in his wheelchair visiting with Z3 (R3's POA). R3 had fine generalized, fine tremors; was slow to respond; and was able to provide details of the theft. R3 said E3 (Agency CNA) was getting him ready for bed. R3 said he knows E3 was agency because he was wearing regular clothes, not scrubs. R3 said E3 left him in the bathroom and he heard E3 going through his closet. R3 said he heard a zipper and asked E3 what that noise was. R3 said E3 replied, "I'm zipping up my pants." R3 shook his head and placed his head in his hands.	A6000			

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A6000	Continued From page 10 R3 sat up, wringing his hands and stated, " I wanted to believe him. I've never had anything like this happen to me and it's very upsetting." R3 said he received notifications that there were fraudulent charges made to his account a few hours later. R3 said the next morning, he called his bank and found out there were purchases totaling \$1300 made to his account. R3 said Z3 (R3's POA) came to the facility and they found that his wallet was still in the backpack (with a zipper), but they noticed receipts on the closet floor. R3 said those receipts had been inside his wallet. R3 said E3 also took \$60 in cash. R3 stated, "when I heard that zipper, he was in my stuff." Z3 (R3's POA) said E3 must have taken a photo of R3's credit card and made purchases online because the card was still in his wallet. Z3 stated, "They shouldn't have people like that working in a facility with vulnerable residents. Luckily he (R3) heard what was going on and was able to report it and stop it, but what if he had dementia or didn't hear him? Who knows how bad it could have been." R3's Facesheet dated 6/8/25 showed he moved into the facility on 4/26/24. This document showed diagnoses to include, but not limited to: anemia, unspecified severe protein-calorie malnutrition, major depressive disorder, other specified anxiety disorders, Parkinson's disease, chronic pain syndrome, open angle glaucoma to the right eye, hypertension, acute thrombosis, and spinal stenosis. R3's Progress Notes were reviewed from 4/6/25 to 5/26/25. There were no notes related to R3's theft allegation. R3's undated Service Plan showed, "I am alert and oriented and need no orientation to person,	A6000			

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A6000	Continued From page 11 place, or time." R3's Abuse, Neglect & Exploitation Investigation Form dated 5/4/25 showed, "On 5/4/25, resident reported that they had money missing from their wallet and had unauthorized charges on their credit card..." The facility's investigation included statements from R3 and E3 (Agency CNA). This document showed Z3 (R3's POA) notified E1 (Executive Director) that money was stolen from R3's apartment by an African American CNA (identified by the facility as E3 (Agency CNA)). R3 reported E3 was helping him get ready for bed on 5/3/25. R3 reported E3 left R3 in the bathroom and R3 heard E3 going through his closet. R3 asked E3 what he was doing and E3 said he was "zipping up his pants." R3 said at 10:11 PM he received a text asking about an unauthorized transaction. On 5/5/25, Z3 (R3's POA) reported R3 was missing \$60 and the credit card was still in his wallet. This document showed E15 (Environmental Services Director) interviewed R3 and E3, then called the police. This document showed after the police interviewed E3 he was sent home and would not longer be allowed to return to the facility. The document showed R3's alleged perpetrator was E3 (Agency CNA). On 6/8/25 at 9:28 AM, E2 (Director of Nursing (DON) - Memory Care) said E3 (Agency CNA) was involved in the both the thefts. E2 said the police were called for both allegations. E2 said the police came and E3 was escorted off the property on 5/4/25 (after R3's theft allegation and 1 week after R2's theft allegation). E2 stated, "Theft isn't something that normally happens here. I was shocked when [R2] reported it. Our regular staff are great, but we are short staffed and need to use agency. It's agency staff that are involved in these abuse allegations." E2 said E3	A6000		

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A6000	Continued From page 12 (Agency CNA) was caught stealing by R3. E2 said R3 was an alert and oriented resident and heard E3 stealing from him. On 6/8/25 at 1:14 PM, E13 (Resident Care Manager) said she only works at the facility PRN (As needed) now, but she was a Resident Care Manager. E13 said she mostly worked the floor and was working numerous hours. E13 said when the facility started using more agency staff in April 2025. E13 said she wasn't working at the facility full-time when R3's theft investigation was happening, but she was in contact with several facility staff. E13 said she was told that R3 caught E3 (Agency Staff) "red-handed" taking money out of his backpack. E13 said R3 was alert and oriented. E13 said R3 had Parkinson's Disease and his functional abilities may change from day to day or as the day went on. E13 said some days R3 needed more assistance than others, but the always knows what's going on. On 6/8/25 at 1:44 PM, E15 (Environmental Services Director) he was the manager on duty 5/4/25. E15 said he received a call from E1 (Executive Director) regarding the theft allegations. E15 said E1 told him to get statements from R3 and E3, call the police, and remove E3 from the building. E15 said he took an RA (Resident Assistant) who understands R3. E15 did not recall the RA's name. E15 said she wrote R3's statement for him and signed it with R3 for the police. E15 said he couldn't find E3 when the police were there the first time, but he found him in the break room. E15 said the police came back and interviewed E3 (Agency CNA), then he escorted him out of the building. E15 said the police officers did go speak with R2 because they had been here a few days prior and it was the same "MO." E15 said the police had photos to	A6000			

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A6000	Continued From page 13 show R2, but R2 said he didn't know who took his money. E15 said he received a police report and the officers number. E15 said he gave the written statements and police report number to E1 (Executive Director). E3 said On 6/9/25 at 9:34 AM, E1 (Executive Director) said Z3 (R3's POA) reported to me on Sunday (5/4/25) that the Agency CNA (E3) went through R3's belongings. Z3 said E3 must have taken a picture or R3's credit card and took his money because R3's credit card was still in his wallet. E1 said R3 didn't know E3's name, but described him and E1 (Executive Director) was able to determine it was E3 (Agency CNA). E15 (Environmental Services Director) was the MOD (Manager on Duty) that weekend. I called him, told him to remove E3 from resident care and asked him to interview R3. R3 said E3 was getting him ready for bed the evening of 5/3/25. R3 said E3 left him in the bathroom and he could hear him going through his things. R3 caught E3. He asked E3 what that noise was and E3 said he was zipping up his pants. The police were called. They interviewed R3 and E3. E3 was escorted out of the facility and was dnr'd (do not return). The residents' money should not be stolen and there should not be unauthorized charges on their credit cards. That is theft and against their rights. The facility should be providing a safe home.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: 295.3010a)2b)5)	A6010		

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A6010	Continued From page 14 Violation Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting 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 within 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: 5) A list of individuals and agencies interviewed or notified by the establishment; This requirement was not met as evidenced by: Based on observation, interview, and record review the facility failed to implement their Abuse Policy, conduct a thorough investigation, and submit a final report to the state agency within 14 days for 2 of 3 residents (R2, R3) reviewed for abuse in the sample of 3. The findings include: 1. On 6/8/25 at 11:25 AM, R2 was sitting in the recliner in his apartment. R2's speech was clear and he was able to carry on a conversation with ease. R2 said he'd been at the facility since November 2024. R2 stated, "A strange thing	A6010		

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A6010	Continued From page 15 happened to me at the end of April. I have 2 wallets I use and one is a little billfold. I left the little billfold out and someone took all my money that was greater than a five dollar bill. It was less than \$100, but it's a lot of money to me. My sister reported it, then some lady came to talk to me. I told them what I knew. All the doors are open around here, but this is the first time I ever had any issue like this. I rarely leave my room, but I do sleep pretty hard. I have no idea who did it, but they must have gone through my things when I was sleeping. I just know the money was there the week before and I noticed it missing the day it was reported(4/28/25). The police came and talked to me twice. The first time was that day, then about a week later they came back with pictures. It sounds the theft wasn't a singular event. I'd like to see the pattern analysis on this one. The second time the police came back with pictures, but I told them I didn't know who took my money." R2's Abuse, Neglect & Exploitation Investigation Form dated 4/28/25 showed, "... On 4/28/25 it was reported to the Resident Care Manager, Regional Nurse Specialist, and Director of Nursing from his sister that he was missing money. The friend explained that he has two separate wallets. he said he first noticed his money missing when he went to lunch today, 4/28/25, with his sister. He said in one wallet he is missing around 4 or 5 \$20 bills and he only has his \$1 bills left in the wallet. In the other wallet he was missing up to \$100 and no money was left in it. He cannot recall when he last saw the money, but he said it was sometime last week. He let me look through his bank charges on his phone. He had numerous charges that he says are not from him. These include [local country club], [subscription based website], and [retail store].	A6010			

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A6010	Continued From page 16 The [local police department] was notified and police report was filed..." The report showed E17 (Regional Nurse Specialist), E13 (Resident Care Manager), E2 (Director of Nursing - Memory Care), R2, and the local police were involved. The document showed there were no suspected employees. The only interviews conducted by the facility were with R2 and R2's sister/friend. There were no staff interviews or other residents interviewed during this investigation. E1's final signature on the report was dated 5/15/25 (17 days after reported incident reported by R2). On 6/8/25 at 2:28 PM, E2 (DON) said she was not at the facility for the theft investigations. E2 said the staff involved would be listed. The surveyor showed E2 her name was listed on the form. E2 replied, "I left before the police came." E2 said she wasn't directly involved in the investigations. E2 said she did not interview any other residents or staff regarding theft. On 6/8/25 at 1:14 PM, E13 (Resident Care Manager) said she only works at the facility PRN (As needed) now, but she was a Resident Care Manager. E13 said she mostly worked the floor and was working numerous hours. E13 said when the facility started using more agency staff in April 2025. E13 said R2's sister told her that someone must have made copies of R2's credit card and had stolen some money. E13 said she didn't interview any staff or residents regarding R2's theft allegations. On 6/8/25 at 3:10 PM, E16 (DON - Assisted Living) said she was off work during the theft allegations. E16 said she wasn't involved in the investigations. On 6/9/25 at 7:36 AM, E17 (Regional Nurse	A6010		

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A6010	Continued From page 17 Specialist) said she covers covers 20 facilities in the division. E17 said E1 was not at the facility when R2's theft allegation was made, E17 said if a resident reports missing money or fraudulent charges, then a thorough investigation should be completed and the police should be notified. All the information regarding the investigation should be included in the report. E17 stated, "I just spoke to [R2], I didn't complete any other aspect of the investigation. I didn't interview any other residents or staff regarding theft. I wasn't involved in R3's theft investigation. [E1 (Executive Director)] and [E2 (DON)] should have handled that. I'm not aware of any other reports of theft at the facility. The residents shouldn't be subjected to theft and fraudulent credit card charges." On 6/9/25 at 9:34 AM, E1 (Executive Director) said she wasn't in the building for the first theft allegation by R2 (4/28/25). E1 said E17 called and said someone was making unauthorized charges and money was missing from R2. E1 said the facility didn't interview any other residents or staff regarding theft during R2's investigation. E1 said R2 was unsure when the theft occurred, so we didn't know who to interview. E1 stated, "Normally I would interview staff and residents working to see if anyone witnessed anything." The surveyor asked if the facility should have interviewed other residents/staff. E1 said we probably should have tried. Our policy is to interview any witnesses and whoever was involved. The facility's Abuse, Neglect and Exploitation Prevention, Prohibition, and Investigation Policy & Procedures dated 3/14/22 showed, "The Community will make every reasonable effort to avoid hiring, or continuing to employ, persons with a history of/ or propensity for abuse. All staff	A6010		

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A6010	Continued From page 18 members and residents will be educated about what constitutes abuse, neglect, and exploitation, that they are considered mandated reporters, and to err on reporting anything they see or hear that does not seem appropriate towards a resident. Simply, if they see something or hear something, they should say something. All allegations of abuse will be treated as serious and will be investigated, documented, and reported as per the standards set forth in this policy and procedure, or per State and Federal definitions and regulations, whichever is more stringent. Failure to follow the policy and procedure set forth will be considered a serious violation of one's employee responsibilities, and will result in disciplinary action, up to, and including, termination... Witnessed or Suspected Abuse, Neglect, and Exploitation Procedures: ...7) Immediately write a dated and timed statement on Abuse, Neglect, and Exploitation Investigation Form [500-05] of what was seen, heard or what is suspected. Completed statement shall be given to supervisor or Executive Director. An investigation shall be started immediately when the Executive Director or designee receives notification of an alleged violation and thoroughly investigated and reported to the appropriate state agency within the corresponding timeframes. If alleged abuse refuses to write and sign a statement, document what the alleged abuser said, and note that the employee refused to write his/her statement. ED and DOW will conduct interview with alleged abuser. Using Abuse, Neglect, and Exploitation Investigation Form [500-05] and Abuse Notification Checklist [500-02], obtain as much information as possible. Interview all staff who may have witnessed or may have knowledge of the alleged abuse. Interview the Resident, or any other Resident(s) who may have knowledge of any similar	A6010			

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A6010	Continued From page 19 actions..." 2. On 6/8/25 at 11:15 AM, R3 was in his wheelchair visiting with Z3 (R3's POA). R3 had fine generalized, fine tremors; was slow to respond; and was able to provide details of the theft. R3 said E3 (Agency CNA) was getting him ready for bed. R3 said he knows E3 was agency because he was wearing regular clothes, not scrubs. R3 said E3 left him in the bathroom and he heard E3 going through his closet. R3 said he heard a zipper and asked E3 what that noise was. R3 said E3 replied, "I'm zipping up my pants." R3 shook his head and placed his head in his hands. R3 sat up, wringing his hands and stated, "I wanted to believe him. I've never had anything like this happen to me and it's very upsetting." R3 said he received notifications that there were fraudulent charges made to his account a few hours later. R3 said the next morning, he called his bank and found out there were purchases totaling \$1300 made to his account. R3 said Z3 (R3's POA) came to the facility and they found that his wallet was still in the backpack (with a zipper), but they noticed receipts on the closet floor. R3 said those receipts had been inside his wallet. R3 said E3 also took \$60 in cash. R3 stated, "when I heard that zipper, he was in my stuff." Z3 (R3's POA) said E3 must have taken a photo of R3's credit card and made purchases online because the card was still in his wallet. Z3 stated, "They shouldn't have people like that working in a facility with vulnerable residents. Luckily he (R3) heard what was going on and was able to report it and stop it, but what if he had dementia or didn't hear him? Who knows how bad it could have been." R3's Abuse, Neglect & Exploitation Investigation Form dated 5/4/25 showed, "On 5/4/25, resident	A6010			

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A6010	Continued From page 20 reported that they had money missing from their wallet and had unauthorized charges on their credit card..." The facility's investigation included statements from R3 and E3 (Agency CNA). This document showed Z3 (R3's POA) notified E1 (Executive Director) that money was stolen from R3's apartment by an African American CNA (identified by the facility as E3 (Agency CNA)). R3 reported E3 was helping him get ready for bed on 5/3/25. R3 reported E3 left R3 in the bathroom and R3 heard E3 going through his closet. R3 asked E3 what he was doing and E3 said he was "zipping up his pants." R3 said at 10:11 PM he received a text asking about an unauthorized transaction. On 5/5/25, Z3 (R3's POA) reported R3 was missing \$60 and the credit card was still in his wallet. This document showed E15 (Environmental Services Director) interviewed R3 and E3, then called the police. This document showed after the police interviewed E3 he was sent home and would not longer be allowed to return to the facility. The document showed R3's alleged perpetrator was E3 (Agency CNA). The investigation provided by the facility did not contain other resident interviews or facility staff interviews. E1's final signature on the report was dated 5/22/25 (18 days after theft reported by R3). The Agency Staff List dated 4/1/25-6/7/25 showed E3 (Agency CNA - identified as stealing R3's money and making unauthorized credit card charges) worked a double shift on 5/3/25. On 6/8/25 at 2:28 PM, E2 (DON) said she was not at the facility for the theft investigations. E2 said the staff involved would be listed and interviews would be provided. The surveyor showed E2 her name was listed on the form. E2 replied, "I left before the police came." E2 said	A6010		

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A6010	Continued From page 21 she wasn't directly involved in the investigations. E2 said she did not interview any other residents or staff regarding theft. On 6/8/25 at 1:44 PM, E15 (Environmental Services Director) he was the manager on duty 5/4/25. E15 said he received a call from E1 (Executive Director) regarding the theft allegations. E15 said E1 told him to get statements from R3 and E3, call the police, and remove E3 from the building. E15 said he did not interview anyone else regarding R3's theft allegation. On 6/9/25 at 7:36 AM, E17 (Regional Nurse Specialist) said she covers covers 20 facilities in the division. E17 said if a resident reports missing money or fraudulent charges, then a thorough investigation should be completed and the police should be notified. All the information regarding the investigation should be included in the report. E17 stated, "I just spoke to [R2], I didn't complete any other aspect of the investigation. I didn't interview any other residents or staff regarding theft. I wasn't involved in R3's theft investigation. [E1 (Executive Director)] and [E2 (DON)] should have handled that. I'm not aware of any other reports of theft at the facility. The residents shouldn't be subjected to theft and fraudulent credit card charges." On 6/9/25 at 9:34 AM, E1 (Executive Director) said E15 obtained R3's and E3's statements regarding the theft allegation. E1 said no other staff were interviewed because R3 identified E3 as the perpetrator. E1 said no other residents or staff were interviewed regarding the theft investigation.	A6010			