STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510216	A. BUILDING: _____ B. WING _____	C 03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF WATERLOO MC	518 LEGACY DRIVE WATERLOO, IL 62298

(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 Investigation to Incident dated 1/30/26 / IL200786 Violation cited 295.6000 a) 5)	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: TYPE 2 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: 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; Based on interview and record review the facility failed to ensure resident at risk for falls received the services specified in the service plan to prevent falls. This failure resulted in R1 sustaining a laceration to the forehead needing sutures in the Emergency Room. This failure creates a substantial probability of harm to residents who are at risk for falls in the facility.	A6000		

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A6000	Continued From page 1 Findings include: The facility is licensed as a Memory Care Facility. R1's Fall Service Plan prior to the 1/30/26 fall documents, "I have been assessed as a high fall risk. I have periods of confusion and impaired judgment and need help finding my way around the community. I sometimes do not sleep well at night and can be tired during the day. I have a history of falling and need monitoring." The Fall Service Plan further documents several progressive interventions to include, in part, "Please keep me in your line of sight and monitor me." R1's Incident Report dated 1/30/26 documents, "1/30/26 1:39 PM. (R1) was in common area and noted to be leaning forward. This nurse noted and readjusted her and went to get assistance to help put this resident on the couch. As this nurse was explaining the situation to coworker, this resident's alarm went off. Both of us went to check on this resident and found this resident lying on her left side. Once resident's head was lifted, resident started bleeding significantly from her head. This nurse and coworker sat this resident up and assessed the wound. This resident has a laceration to her head near her left eye. EMS, Hospice and POA were called. Resident was taken to the hospital. On 3/16/26 at 10:37 AM, E3 (Licensed Practical Nurse) stated he was the nurse who was with R1 and trying to reposition R1 who was leaning forward and at risk of falling out of the wheelchair. E3 stated he called staff for help to reposition R1 and to assist her to the couch thinking she was	A6000		

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A6000	Continued From page 2	A6000		

tired. E3 stated he waited for 5 minutes for help to arrive and when nobody came he walked to the office area to ask E2 (Director of Wellness) for help turning his back to resident to explain to E2 and seconds later both he and E2 heard R1's alarm and a crashing sound and saw R1 on the floor bleeding. E3 stated R1 sustained a laceration above the left eye and was sent out to the ER.

On 3/16/26 at 10:50 AM, E4 (Resident Care Manager) stated he was working that day and heard her alarm go off but E3 and E2 reached R1 first. E4 stated that it is a common behavior for R1 to bend forward to reach/pick up something on the floor that's not there and R1 had a specialized alarm that gets triggered anytime the cord is pulled, like when she bends down and that's what he heard. E4 stated he would not have left R1 to get help when she was already leaning forward.

On 3/16/26 at 11:26 AM, E2 (Director of Wellness) stated she was in the office area when E3 called her for help to assist R1. E2 stated E3 should not have left R1 alone to get help. They both heard R1's alarm went off and ran towards R1 and found R1 on the floor bleeding from a laceration above her left eye. R1 was sent to ER and received sutures and returned to the community. E2 stated hospice ordered a Broda chair (durable medical equipment for positioning) for R1 right away to improve positioning, for safety and comfort while seated. E2 confirmed that staff should have called or waited for help without leaving R1's side.

The Facility Policy, undated, documents, "Upon move in to the Assisted Living Community and routinely according to state regulations and

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A6000	Continued From page 3 Assessment Policy and Procedures, each resident will be assessed for their fall risk. The Fall Risk Assessment will be completed by the Director of Nursing or Licensed Nurse. All Residents moving into the Memory Care Communities are identified at risk to fall. Interventions or a plan needs to be established and added to their plan of care."	A6000		