STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510215	A. BUILDING: _____ B. WING _____	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF BREESE	13887 PROGRESS DRIVE BREESE, IL 62230

(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 Incident Report Investigation IL 200849 295.4060h)3)A)B) Technical Infraction: During this survey investigation, it was identified that the establishment did not have the appropriate number of staff for it's resident population. The regulations were reviewed with establishment managment, who verbalize understanding. While onsite, the establishment started taking steps to correct the concerns. No violation was cited. Technical infraction cited at 295.2000a)c)5 and 295.4060h)6	A 000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 2 Violation Section 295.4060 Alzheimer's and Dementia Programs h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who: A) May wander; and B) May need supervision and assistance when evacuating the building in an emergency; Based on record review and interview the establishment failed to develop and implement	A4060		

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A4060	Continued From page 1 policies and procedures that ensure continued resident safety. These failures resulted in R1 falling from an unlocked high backed wheelchair and sustaining injuries. This failure creast the substantial probability of harm to a resident or residents. Findings include: R1's 03-12-2026 Incident Report contains documentation that R1 had an unwitnessed fall. Documentation also includes that R1 was sitting in a high back wheelchair at a dining room table when staff heard a noise and observed R1 lying on the floor. R1 was observed on the floor face down on the right side. R1's wheelchair was against the table behind R1. R1 was transferred back into the wheelchair using a mechanical lift. R1 was observed to have a laceration with a hematoma above the right eyebrow, a laceration to the nose with bleeding from the right nostril, a skin tear to the right ring finger, and a skin tear to the right wrist. The lacerations and skin tears were treated and bandages applied. Documentation also includes that R1 had been leaning to the left in the wheelchair and was repositioned by staff twice during the meal. R1 was "fidgety and grabbing/reaching for items on table throughout meal." Documentation includes that R1's wheelchair wheels were not locked, no other injuries were noted, R1's legs are contracted, and that R1 does not stand. Documentation also includes that R1 was transferred to a local hospital. R1's progress notes were reviewed. The progress notes contain documentation that R1 has been receiving hospice services prior to this fall and that R1 is unable to reposition independently. Documentation also includes that	A4060		

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A4060	Continued From page 2 R1 has been using a mechanical lift and high back specialized wheelchair. R1's 03-13-2026 progress note contains documentation that R1 returned to the establishment from the local emergency room on 03-12-2026 at 9:30pm with sutures to the right 4th finger. Documentation also includes that R1 has a nondisplaced fracture of the nose. R1's 11-21-2025 service plan includes documentation that R1 requires a mechanical lift with transfers, receives a safety check every two hours, and utilizes a high back wheelchair for mobility. The same service plan also includes documentation that R1 is a high fall risk and includes fall interventions added on 03-12-2026. Documentation includes that staff are to ensure the wheelchair brakes are locked when the chair is stationary. On 03-26-2026, at approximately 2:15pm, E2 (Director of Nursing) states that R1 does scoot around at times and that they are unsure of how R1's fall occurred. E2 states that R1's fall occurred in a common area of the dining room and that staff were in the room. E2 states that staff were interviewed, and that R1's wheelchair was near the table, and that R1's wheelchair wheels were not locked. E2 also states that staff interviews reveal that the fall occurred quickly. E2 also states that she has asked staff to ensure R1's chair wheels are locked and that if R1 is agitated that staff lay R1 in bed.	A4060		