STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510516	A. BUILDING: _____ B. WING _____	10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF YORKVILLE	4040 CANNONBALL TRAIL YORKVILLE, IL 60560

(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 Annual Licensure Survey 295.2000 c) 11) 295.2040 c) 3) d) e) g) h) 295.2050- a)b) 295.3000 a) b) e) 2) A) f) 1) 2) 3) 295.3020 b) 5) d) 1) 295.3040 295.4060 B) 295.6000- a)2)13) 295.6010- a)1) 295.9000 a) Entity Reported Incidents Investigation IL00170052- Substantiated, 295. 6000- a)2)13), 295.6010- a)1) IL00173360- Substantiated, no deficiency cited. IL00173938- Substantiated 295.2050- a)b) IL00174530- Substantiated 295.2050- a)b) IL00177390- Substantiated, no deficiency cited.	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 3 Violation Section 295.2000 Residency Requirements c) A person shall not be accepted for residency if: 11) The person is a diabetic requiring routine insulin injections unless the injections are self-administered or administered by a licensed health care professional; This requirement is not met as evidenced by:	A2000		

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A2000	Continued From page 1 Based on interview and record review the establishment failed to ensure residents meet residency requirements for two residents (R3,R9) requiring sliding scale insulin. This deficient practice affected two (R3,R9) of seven residents reviewed for residency requirements. Findings include: R6's medical record showed R6 moved into the establishment on 4/10/2025, resides in the Assisted Living Unit, and has multiple diagnoses, including but not limited to Pressure Ulcer of Buttock, Type 2 Diabetes Mellitus, Hyperlipidemia, Atrial Fibrillation, Chronic Systolic (Congestive) Heart Failure, Arthritis, Chronic Kidney Disease, Stage 3. R6's Physician Order Sheet indicates the following: HUMALOG KWIK INJ 100/ML Subcutaneous (inject, under skin) Active as of 09/15/2025 at 07:01 AM Inject 10 Units Subcutaneously Before Meals + Sliding Scale: if Bg (blood glucose) Inject 10 Units Subcutaneously Before Meals + Sliding Scale: if Bg (blood glucose)175-200= 1 Units 201-225= 2 Units 226-250 3 Units 251-275= 4 Units Over 275= 5 Units Maximum Is 45 Units Review of R6's Medication Administration Record (MAR) for September 2025 and October 2025, it indicated R6 received Humalog insulin per sliding scale parameters. According to R9's face sheet, R9 moved into the establishment on 1/30/25. R9's diagnoses include but not limited to Type 2 Diabetes Mellitus and Anemia in Chronic kidney Disease. R9's Physician Order sheet listed HUMALOG	A2000		

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A2000	Continued From page 2 KWIK INJ 100/ML Initial Start: 07/30/2025, Last Updated: 09/25/2025 at 08:01 AM Inject 3 Times a Day With Meal With Sliding Scale 2 U (unit)=141-180 3 U=181-220 6 Units= 221-260 8 Units =261-300 10 U=301-350 Call Md >351 Maximum 30 Units Review of R9's Medication Administration Record (MAR) for October 2025, it indicated R9 received Humalog insulin per sliding scale parameters. On 10/29/25 at 11:47am, E18 (Licensed Practical Nurse) confirmed both residents are on sliding scale insulin.	A2000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: Type 1 Violation Section 295.2040 Disaster Preparedness c) At least six drills shall be conducted per year on a bimonthly basis. At least two of the drills shall be conducted during the night when residents are sleeping. All drills shall be held under varied conditions to: 3) Evaluate the effectiveness of disaster plans, procedures and training. d) The establishment shall conduct a tornado drill on each shift during February of each year for employees.	A2040		

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A2040	Continued From page 3 e) Drills shall include residents, establishment personnel, and other persons in the establishment. g) Drills shall involve the actual evacuation of residents to an assembly point as specified in the emergency plan and shall provide residents with experience using various means of escape. If an establishment has an evacuation capability classification of impractical, those residents who cannot meaningfully assist in their own evacuation or who have special health problems shall not be required to participate in the drill; however, other requirements of the Life Safety Code will apply. h) A written evaluation of each drill shall be submitted to the establishment manager and shall be maintained for one year from the date of the drill. The evaluation shall include the date and time of the drill, names of employees participating in the drill, and identification of any residents who received assistance for evacuation. This requirement was not met as evidenced by: Based on record review and interview the facility failed to ensure fire drills were conducted on a bimonthly basis, ensure tornado drills were conducted on each shift in February, ensure fire drills include residents, ensure fire drills include date and times of drills, and ensure fire drills include identification of any residents who received assistance for evacuation. This failure has the substantial probability to cause sever harm or death to a resident or residents. Findings include:	A2040		

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A2040	Continued From page 4 On 10/28/2025, at 10:48 AM, Fire drills and tornado drills were provided to surveyor. Fire drill documentation as follows: 1/21/2025 - fire safety in-service. No times listed. Time could be more than 13 minutes. No residents listed. No list of residents needing assistance out of the building. 2/7/2025 Fire safety. No times listed. Time could be more than 13 minutes. No residents listed. No list of residents needing assistance out of the building. 2/21/2025 Fire safety in-service. No times listed. Time could be more than 13 minutes. No residents listed. No list of residents needing assistance out of the building. 2/24/2025 Fire safety in-service. Start time 12 noon. No end time. Time could be more than 13 minutes. No residents listed. No list of residents needing assistance out of the building. 2/26/2025 Fire safety meeting. 2pm-3pm. Time is more than 13 minutes. No residents listed. No list of residents needing assistance out of the building. 3/13/2025 Fire safety monthly meeting. No times listed. Time could be more than 13 minutes. No residents listed. No list of residents needing assistance out of the building. 9/2/2025 Fire safety meeting/in-service. 10:30 am-11:36 am. Time is more than 13 minutes. No residents listed. No list of residents needing assistance out of the building.	A2040		

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A2040	Continued From page 5 9/3/2025 Fire Safety Meeting/Inservice. 2 pm - 3 pm. Time is more than 13 minutes. No residents listed. No list of residents needing assistance out of the building 9/12/2025 Fire safety meeting/in-service. 10:30 pm - 11:30 pm. Time is more than 13 minutes. No residents listed. No list of residents needing assistance out of the building. 10/28/2025, at 11:19 PM Tornado drills reviewed and are as follows: 2/20/2025 Tornado Drill in-service. Start time 2:30 pm with no end time. 8/21/2025 Disaster (Tornado) Drill. No start time or end time. On 10/29/2025, at 12:44 pm, Fire drills reviewed. No fire drill documentation provided from 3/13/25 - 9/2/2025. On 10/28/2025, at 10:50 AM, E11 Maintenance Director stated I have not been here a complete year yet. When I came in, I was playing catch up, but I am doing fire drills at the rate of one a month whether it is fire, elopement, disaster. The fire drills you have are all the fire drills that were done. So, we are trying to do 12 fire drills a year. On 1/21/2025 that was not an actual fire pull drill it was a walk through. There were residents who participated but we did not take them outside. On 2/7/25, I was not present for that one, so I am not sure what that was it looks like it was a meeting for a fire safety talk. On 2/21/2025, that looks like it was just a fire safety in-service. On 2/24/2025 was an in-service walk-through drill. On 2/26/2025, that was just a meeting	A2040		

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A2040	Continued From page 6 talking about fire safety. On 3/13/2025, that was an actual fire drill. We did do 3 actual fire drills in the month of September on 3 different shifts. We do have a list of residents in each area and a list of bedridden residents. We do not attach a list of who needs assistance out of the building to each fire drill. Prior to September this year we have not been doing fire drills every other month on different shifts on a consistent basis as I am assuming we should have been doing. I think they went several months without a Director of Maintenance before I came here. I do not attach a list of residents who participates in drills to the drill. I cannot answer why the times are not listed on the drills I did not run. On the drill for 9/12/2025 I probably just forgot to write in the time on the first page, but it is on other page. Fire drills should take I believe 35 minutes from when the alarm is pulled to everybody out. From the time I start pulling the alarm to the time I get the last signature is the time I put on the report. I try to do tornado drills once a month, whether it be an in-service or a walk through.	A2040		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: Type 3 Violation Section 295.2050 Incident and Accident Reporting a) An establishment shall report to the Department any serious incident or accident. For the purposes of this Section, "serious" means any incident or accident that causes physical or	A2050		

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A2050	Continued From page 7	A2050		

emotional harm or injury to a resident. A change in an individual's (resident's) condition that is due to health or medical decline is not a reportable incident or accident.

b) The report shall be made by contacting the Department of Public Health Division of Assisted Living via email at DPH.LTCAL@illinois.gov or as requested by the Department within 24 hours after the occurrence of the incident or accident.

(Source: Amended at 47 Ill. Reg. 13264, effective August 30, 2023)

These requirements are not met as evidenced by:

Based on interview and record review the establishment failed to ensure incident reports were submitted to the department for two (R3, R5) of four residents reviewed for incident reporting.

Findings include:

According to R3's face sheet, R3 moved into the establishment on 4/4/2024. R3's diagnoses include but not limited to Hyperlipidemia, Depression, Anxiety Disorder, Primary Osteoarthritis, Muscle Weakness, Difficulty in Walking, Repeated Falls. Cognitive Communication Deficit, Need for Assistance with Personal Care, History of falls.

R3's document titled "Confirmation- Facility Reported Incident" reflected the date of 5/28/24 4:08PM. This document stated in part;
Date of occurrence: 5/24/24
Incident Description: Nursing alerted to resident apartment due to reported severe back pain

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A2050	Continued From page 8 ...Resident stated he was making an attempt to get out of recliner but unfortunately lost his balance causing him to fall backward and hitting the back of his head ...transported to (local hospital) ... Initial: Yes According to R5's face sheet, R5's diagnoses include but not limited to Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits , Syncope and collapse. R5's document titled "Confirmation- Facility Reported Incident" reflected the date of 6/6/24 3:57PM. This document stated in part; Date of occurrence: 6/4/24 Incident Description: . ...observed resident lying on the floor. The resident was observed on her back, between her kitchen table and the small closet ...doing something at the kitchen lost balance and fell backwards, acknowledge hitting head on the floor ...Transported to (local hospital) ... Initial: Yes Both of these incidents were not reported to the Department within 24 hours of the incidents' occurrence. On 10/29/25 at 8:55am, E1 (Executive Director) said, Incident report is sent to state within 24 hours.	A2050		

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A3000	Continued From page 9	A3000		
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) b) The establishment shall have on duty at all times at least one direct care staff person who has obtained cardiopulmonary resuscitation (CPR) training specific to adults, which includes a demonstration of the individual's ability to perform CPR, and who has current certification in CPR. e) A file shall be maintained for each employee containing the following: 2) Documentation of: A) Freedom from pulmonary tuberculosis; f) In addition to the information required in subsection (e) of this Section, the file for each direct care employee shall contain documentation of: 1) Current certification in CPR, if applicable;	A3000		

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A3000	Continued From page 10 2) Initial health evaluation; 3) Compliance with the Health Care Worker Background Check Act; and This requirement was not met as evidenced by: Based on record review and interview the facility failed to: ensure all nurses were correctly CPR certified (E5, E6, E22, E23, E24, E25, and E26), ensure a CPR certified staff was in the establishment at all times, ensure personnel files contained documentation of being free from tuberculosis for 2 of 8 employees reviewed (E5 and E8), ensure personnel files contained documentation of CPR certification status for 8 of 8 employees reviewed for CPR, ensure initial health evaluation was completed and in files for 3 of 8 employees reviewed for initial health evaluations (E5, E6, and E8), ensure compliance with the Health Care Worker Background Check Act (E4, E8, and E10) for 3 of 8 employees reviewed, These failures have the substantial probability to cause severe harm or death to a resident or residents. Findings include: 10/28/2025, at 11:15 am Employee files reviewed. Review of files indicated the following: No Healthcare Worker Background Check in files for E4 Dining Services Director, E8 Resident Assistant, and Health Care Worker Background Check for E10 was approximately 7 months late. No document showing employee being free of tuberculosis for E5 Licensed Practical	A3000		

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A3000	Continued From page 11 Nurse/LPN, or E8 Resident Assistant/RA. No cardiopulmonary resuscitation certificate in file for E5 LPN, or E6 LPN. No initial health evaluation noted in personnel files for E5 LPN, E6 LPN, or E8 RA. 10/29/2025, at 9:50 am, CPR certifications reviewed. No CPR certifications noted for the following nurses: E5 LPN, E22 LPN, E23 LPN, E24 LPN, E6 LPN, E25 LPN, and E26 LPN. On 10/30/2025, at 11:17 AM Staffing schedules reviewed with employee list of CPR certified staff. Documentation shows on 10/24/2025, from 10:00 PM - 6:30 AM there was not a correctly certified CPR employee in the establishment. On 10/28/2025, at 1:49 PM E29 Business Office Manager/BOM stated I do not have the background checks for E4 Dining Services Director or E8 RA. I do not have the TB test for E5 LPN or E8 RA. I do not have initial physician assessment for E8 RA. I will look for E5 LPN and get back to you. I do have a printout of CPR certified individuals, but I do not have CPR cards in their files. On 10/28/2025, at 2:35 pm, E1 Executive Director/ED stated I do not have a policy for CPR, background checks or initial health assessment for employees. For CPR we just follow regulations and have 1 person trained in building per shift. For Background checks my expectation is that we complete before employees first day on floor. For initial health assessment it is also completed before first day on floor. I am not sure why we do not have an initial health for E5 LPN, E6 LPN, and E8 RA.	A3000		

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A3000	Continued From page 12 On 10/29/2025, at 9:38 am, E29 BOM stated if staff gives me CPR cards I will put in their file. I know going forward I need to be better about that. Yesterday it took me awhile to get the list of recent CPR trainings because I reached out to the nurse who did the trainings to give me a list. I am not sure if that list is all inclusive. I do not have an accurate list of who has CPR in the building. For E5 LPN, I do not have TB, intial health, or CPR. I am not sure if we require nurses to have current CPR. I will provide you with a nursing job description. E6 LPN does not have initial health or CPR. E7 Certified Nursing Assistant/CNA does not have CPR. For E8 RA I do not have her Background checks, TB, initial health assessment, or CPR. For E10 Dining Server, I realized she did not have the healthcare worker background checks in her file so I ran it on 8/26/25 so it was late as she was hired on 1/13/2025. On 10/29/2025, at 10:00 am, E29 BOM provided more CPR certifications. She stated these are all the CPR certifications I have on file aside from the list of the ones I gave to you yesterday. Files reviewed. No CPR certifications noted for the following nurses: E5 LPN, E22 LPN, E23 LPN, E24 LPN, E6 LPN, E25 LPN and E26 LPN. On 10/29/2025, at 11:05 AM, E2 Director of Nursing/DON Assisted Living/AL stated we do require all nurses to have CPR certification. E29 BOM is in charge of making sure that is kept on file in their personnel record. There is 24-hour nursing so there is a nurse here at all times and all nurses are required to have CPR certification current. I am unaware of any nurses that do not have CPR certification. Nurses having CPR certification is a professional standard of care that	A3000		

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A3000	Continued From page 13 we want to continue providing. On 10/29/2025, at 11:34 am, E29 BOM provided online CPR certification for E6 LPN with exp. date of 8/8/2027. Surveyor informed E29 online only CPR certification is not acceptable. I do not have CPR certifications for E5 LPN, E22 LPN, E23 LPN, E24 LPN, E6 LPN, E25 LPN and E26 LPN.	A3000		
A3020	Section 295.3020 Employee Orientation and Ongoing Training This Regulation is not met as evidenced by: Type 1 Violation Section 295.3020 Employee Orientation and Ongoing Training b) Each employee shall also complete orientation within 30 days after the starting date of employment that includes: 5) CPR and emergency procedures for medical events, if applicable; and d) All training shall be documented with: 1) Date; This requirement was not met as evidenced by: Based on record review and interview the facility failed to ensure all nurses were correctly CPR certified (E5, E6, E22, E23, E24, E25, and E26) and ensure all training is documented with dates.	A3020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510516	A. BUILDING: _____ B. WING _____	10/30/2025

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CEDARHURST OF YORKVILLE	4040 CANNONBALL TRAIL YORKVILLE, IL 60560

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A3020	Continued From page 14 This failure has the substantial probability to cause severe harm or death to a resident or residents. Findings include: On 10/28/2025, at 11:15 am Employee files reviewed. Review of files indicated the following: No cardiopulmonary resuscitation (CPR) certificate in file for E5 LPN, or E6 LPN. No 16-hour dementia/orientation training noted in files for E5 Licensed Practical Nurse/LPN, and E8 Resident Assistant/RA. 16-hour dementia/orientation training noted in files for E6 LPN, E7 Certified Nursing Assistant/CNA, and E9 RA but all 3 documents are not dated. 10/29/2025, at 9:50 am, CPR certifications reviewed. No CPR certifications noted for the following nurses: E5 LPN, E22 LPN, E23 LPN, E24 LPN, E6 LPN, E25 LPN, and E26 LPN. On 10/29/2025, at 9:38 am, E29 Business Office Manager/BOM stated for E4 Dining Services Director, I do not have the 16-hour dementia training in her file. If staff gives me CPR cards, I will put in their file. I know going forward I need to be better about that. Yesterday it took me awhile to get the list of recent CPR trainings because I reached out to the nurse who did the trainings to give me a list. I am not sure if that list is all inclusive. I do not have an accurate list of who has CPR in the building. For E5 LPN, 16-hour dementia training. I am not sure if we require nurses to have current CPR. I will provide you with a nursing job description. E6 LPN her dementia training does not have dates on it. E7 CNA 16 hour dementia training does not have	A3020		

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A3020	Continued From page 15 dates or her last name on it. For E8 RA I do not have her CPR or 16 hour dementia training. For E9 RA her 16 hour dementia training does not have any dates on it. On 10/29/2025, at 10:00 am, E29 BOM provided more CPR certifications. E29 stated these are all the CPR certifications I have on file aside from the list of the ones I gave to you yesterday. Files reviewed. No CPR certifications noted for the following nurses: E5 LPN, E22 LPN, E23 LPN, E24 LPN, E6 LPN, E25 LPN and E26 LPN. On 10/29/2025, at 11:05 AM, E2 Director of Nursing/DON Assisted Living/AL stated we do require all nurses to have CPR certification. E29 BOM is in charge of making sure that is kept on file in their personnel record. There is 24-hour nursing so there is a nurse here at all times and all nurses are required to have CPR certification current. I am unaware of any nurses that do not have CPR certification. Nurses having CPR certification is a professional standard of care that we want to continue providing. On 10/29/2025, at 11:34 am, E29 BOM provided online CPR certification for E6 with exp. date of 8/8/2027. Surveyor informed E29 online only CPR certification is not acceptable. I do not have correct CPR certifications for E5 LPN, E22 LPN, E23 LPN, E24 LPN, E6 LPN, E25 LPN and E26 LPN. My expectation of filling out documentation would be that it is filled out completely, double checking documentation to make sure it is filled out completely and better communication with the resident care managers to make sure dates are correct.	A3020		

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A3040	Continued From page 16	A3040		
A3040	Section 295.3040 Health Care Worker Background Check This Regulation is not met as evidenced by: Type 3 Violation Section 295.3040 Health Care Worker Background Check An establishment shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code. Section 955.165 Fingerprint-Based Criminal History Records Check a) Educational entities, other than secondary schools, and health care employers are required to check the Health Care Worker Registry before allowing a student to enter a training program or hiring an employee to determine: 1) Whether a fingerprint-based criminal history records check has previously been conducted, which is indicated by the identifier of "FEE_APP" or "CAAPP". A) As long as the student, applicant or employee has had a background check and stays active on the Health Care Worker Registry, no further fingerprint-based criminal history record checks are required. (Section 33(g) of the Act) B) If the individual has disqualifying convictions and a waiver has not been granted pursuant to this Part, the individual is not allowed to work as a direct care giver for a health care employer or as an individual with access to	A3040		

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A3040	Continued From page 17 residents, the resident's living quarters, or the resident's financial, medical or personal records in a long-term care setting. This requirement was not met as evidenced by: Based on record review and interview the establishment failed to ensure health care worker background checks were completed on time for 3 (E4, E8, and E10) of 8 employees reviewed. This deficient practice has the probability to affect all residents. Findings include: On 10/28/2025, at 11:15 am, employee files were reviewed. Surveyor was not provided health care worker background checks for E4 Dining Services Director, E8 Resident Assistant and E10 Dining Server. 10/28/2025, at 1:49 PM, E29 Business Office Manager/BOM stated I do not have the background checks for E4 Dining Services Director or E8 Resident Assistant. On 10/29/2025, at 9:38 am, E29 BOM stated for E10, I realized she did not have the healthcare worker background checks in her file, so I ran it on 8/26/25 so it was late as she was hired on 1/13/2025. On 10/28/2025, at 2:35 pm, E1 Executive Director/ED stated for background checks my expectation is we complete before employee's first day on floor.	A3040		

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A4060	Continued From page 18	A4060		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 3 Violation Section 295.4060 Alzheimer's and Dementia Programs B) Direct care staff must receive 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. Training must cover: This requirement was not met as evidenced by: Based on record review and interview the facility failed to ensure 16-hour dementia training was completed or completed correctly for 5 out of 8 (E5, E6, E7, E8, and E9) employees reviewed. This deficient practice has the probability to affect all residents. Findings include: 10/28/2025, at 11:15 am Employee files reviewed. Review of files indicated the following: No 16-hour dementia/orientation training noted in files for E5 Licensed Practical Nurse/LPN, and E8 Resident Assistant/RA. 16-hour dementia/orientation training noted in files for E6 LPN, E7 Certified Nursing Assistant/CNA, and E9 RA but all 3 documents are not dated. On 10/29/2025, at 9:38 am, E29 Business Office Manager/BOM stated for E4 Dining Services	A4060		

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A4060	Continued From page 19 Director, I do not have the 16-hour dementia training in her file. For E5 LPN, do not have 16-hour dementia training. E6 LPN her dementia training does not have dates on it. E7 CNA 16-hour dementia training does not have dates or her last name on it. For E8 RA I do not have her 16-hour dementia training. For E9 RA her 16-hour dementia training does not have any dates on it. On 10/29/2025, at 11:34 am, E29 BOM stated my expectation of filling out documentation would be that it is filled out completely, double checking documentation to make sure it is filled out completely and better communication with the resident care managers to make sure dates are correct.	A4060		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 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: 2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment;	A6000		

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A6000	Continued From page 20 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to respect resident's dignity during care and ensure freedom from abuse. This deficient practice affected one (R1) of five residents reviewed for abuse .This failure resulted in R1 being physically abused by an employee (E13). This failure has the substantial probability to cause severe harm to all residents. Findings include: According to R1's hospice notes, R1 was admitted on hospice care on 12/8/23 with diagnoses that include but not limited to Chronic lymphocytic leukemia of B-cell type not having achieved remission, Aphasia following cerebral infarction, Hemiplegia and Hemiparesis following cerebral infarction. R1's progress notes indicated, R1's condition declined and passed away on 2/14/24. According to R1's face sheet, R1 moved to the Assisted Living unit on 5/16/22. R1 was 76 years old. Document titled "Confirmation- Facility Reported Incident" dated 2/19/24 10:41AM, stated in part; Date of Occurrence: 2/13/24 Resident/Victim/Perpetrator: (R1)/ (E13- Resident Assistant-Terminated) Incident Description: On 2/14/24 it was brought to the attention of the Executive Director (E1) that employee 1 (E12- Resident Assistant- Resigned)	A6000		

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A6000	Continued From page 21	A6000		

had witnessed employee 2(E13) giving care to resident (R1) that she felt was abusive. Employee 1 witnessed Employee 2 roughly wiping and pulling on the resident's genitals and turning the resident aggressively, Employee 1 reminded Employee 2 to be careful, Employee 2 stated 'the resident is going to die soon, he is on Morphine, he doesn't know what is going on."

Status of Perpetrator: Suspended

Initial (Report): Yes

Document titled "Confirmation- Facility Reported Incident" dated 2/19/24 4:02PM, stated in part;
Incident Description:
On 2/15 ED Interviewed 6 employees:
4 employees had no concerns, 2 employees brought concerns about the accused employee (E13).
It was determined that based on employee statements, that the abuse was substantiated. (E13) was terminated as of 2/16 due to substantiated abuse.

Final (Report): Yes

E1's incident investigation conducted on 2/14-2/15/(24) was reviewed. Part of the investigation documented E14's interview. On the interview, E14 was asked the question; Have you ever observed another team member providing care to a resident in a way that was concerning to you? (for example, being rough with a resident, saying inappropriate things to a resident, or being abusive in anyway), E14 answered "Just the way that (E13) speak to residents. Heard her say things like she is going to take resident to "potty", he needs cream for his "balls", "cooch", degrading terms when referring to residents and

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A6000	Continued From page 22 their care." On 10/28/25 at 12:42PM, E12 (Resident Assistant-Resigned) was interviewed over the phone. Per interview, on the date of incident E12 was working overnight in the Assisted Living unit, E13 (Resident Assistant- Terminated) radioed requesting for assistance with a resident. R1 was the resident. E12 said R1 was bed bound. E12 said E13 was aggressive during the provision of care. At one point, E13 shoved R1 so hard that R1's forehead hit the bed railing. E12 said, "Immediately I said "Hey, his face is hitting the railing, that was when she (E13) said, " He is half dead anyway, why does it matter." E12 said, E13 scared R1 so bad that R1 urinated on himself. E12 said, R1 was holding on E13's hands, E13 was aggressively telling R1 to let go, "she was flapping, or shoving his hands away." E12 said, "When she rolled him back, I remember I saw some bruising on his back side area. She was pinching and pushing him down aggressively, trying to hold him down so he cannot move." E12 said, E14 (Licensed Practical Nurse) the nurse on duty was immediately notified of E13's behavior. E14 advised E12 to report it to E1 (Executive Director). E12 said, E13 was relieved from duty. E12 also said, few residents "didn't like" E13 calling her "mean", "heartless". E12 said she had not witnessed any abusive behavior by E13 until that incident. On 10/28/25 at 12:34PM, E14 was interviewed over the phone. E14 said, she did not witness the abuse but E12 reported it to her. E14 said, she had not witnessed E13 getting abusive with residents however E14 was concerned with the words E13 used with residents such as "potty", "peepee" when they were escorted to the bathroom. E14 said, as a mandated abuse	A6000		

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A6000	Continued From page 23 reporter all abuse is reported, and keep residents safe. On 10/28/25 at 11:21AM, E1 said the abuse allegation (2/13/24) was substantiated based on (E12's) statement. There were also other people who had concern of E13's behavior. E1 said, E13 was interviewed, "she denied it of course." E13's document titled " Counselling Documentation Form," indicated E13 received two written warning due to behavior towards residents. The written warnings are the following: On May 4, 2023. It was reported by a resident and a resident's family member that (E13) was being rude and disrespectful to a resident ....The above statements do not meet customer service expectations and are direct violation of the (establishment's) Core Standards and the (establishment's) Mission. On 10/3/(23) it was brought to the attention of the Executive Director that there were concerns about a couple of interactions that (E13) had with various residents ... On 10/29/25 at 12:42PM, E1 was unable to recall exact behavior of E13 but it was not in line with core values of the establishment.	A6000		
A6010	Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr This Regulation is not met as evidenced by: Type 3 Violation	A6010		

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A6010	Continued From page 24 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: 1) Notify the Department within 24 hours after receiving the allegation, by contacting the Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report. These requirements are not met as evidenced by: Based on interview and record review the establishment failed to ensure allegation of abuse was reported within 24 hours as required. This deficient practice has affected one (R1) of one resident reviewed for abuse reporting. This deficient practice has the probability to affect all residents. Findings include: Document titled "Confirmation- Facility Reported Incident" dated 2/19/24 10:41AM, stated in part; Date of Occurrence: 2/13/24 Resident/Victim/Perpetrator: (R1)/ (E13- Resident Assistant-Terminated) Incident Description: On 2/14/24 it was brought to the attention of the Executive Director that employee 1 (E12- Resident Assistant- Resigned) had had witnessed employee (E13) giving care to resident (R1) that she felt was abusive. Employee 1 witnessed Employee 2 roughly wiping and pulling on the resident's genitals and turning the	A6010		

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A6010	Continued From page 25 resident aggressively, Employee 1 reminded Employee 2 to be careful, Employee 2 stated 'the resident is going to die soon, he is on Morphine, he doesn't know what is going on." Status of Perpetrator: Suspended Initial: Yes According to the Confirmation email the Abuse report was received five days after the incident. On 10/29/25 at 8:55am, E1 (Executive Director) said incident report is sent to state agency within 24 hours of incident.	A6010		
A9000	Section 295.9000 Physical Plant This Regulation is not met as evidenced by: Type 2 Violation Section 295.9000 Physical Plant a) The establishment shall comply with the residential board and care occupancies chapter of the National Fire Protection Association's (NFPA) Life Safety Code (Life Safety Code) 101, Chapter 32 for new establishments and Chapter 33 for existing establishments. This requirement was not met as evidenced by: Based on record review and interview the facility failed to ensure time constraints were met when conducting fire drills. This deficient practice has the probability to affect all residents.	A9000		

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A9000	Continued From page 26 Findings include: On 10/28/2025, at 10:48 AM, Fire drills and tornado drills were provided to surveyor. Fire drill documentation as follows: 1/21/2025 - fire safety in-service. No times listed. Time could be more than 13 minutes. No residents listed. No list of residents needing assistance out of the building. 2/7/2025 Fire safety. No times listed. Time could be more than 13 minutes. No residents listed. No list of residents needing assistance out of the building. 2/21/2025 Fire safety in-service. No times listed. Time could be more than 13 minutes. No residents listed. No list of residents needing assistance out of the building. 2/24/2025 Fire safety in-service. Start time 12 noon. No end time. Time could be more than 13 minutes. No residents listed. No list of residents needing assistance out of the building. 2/26/2025 Fire safety meeting. 2pm-3pm. Time is more than 13 minutes. No residents listed. No list of residents needing assistance out of the building. 3/13/2025 Fire safety monthly meeting. No times listed. Time could be more than 13 minutes. No residents listed. No list of residents needing assistance out of the building. 9/2/2025 Fire safety meeting/in-service. 10:30 am-11:36 am. Time is more than 13 minutes. No residents listed. No list of residents needing	A9000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF YORKVILLE	4040 CANNONBALL TRAIL YORKVILLE, IL 60560

(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
A9000	Continued From page 27 assistance out of the building. 9/3/2025 Fire Safety Meeting/Inservice. 2 pm - 3 pm. Time is more than 13 minutes. No residents listed. No list of residents needing assistance out of the building 9/12/2025 Fire safety meeting/in-service. 10:30 pm - 11:30 pm. Time is more than 13 minutes. No residents listed. No list of residents needing assistance out of the building. On 10/28/2025, at 10:50 AM, E11 Maintenance Director stated I cannot answer why the times are not listed on the drills I did not run. On the drill for 9/12/2025 I probably just forgot to write in the time on the first page, but it is on other page. Fire drills should take I believe 35 minutes from when the alarm is pulled to everybody out. From the time I start pulling the alarm to the time I get the last signature is the time I put on the report.	A9000		