

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL5108581	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2025
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NAME OF PROVIDER OR SUPPLIER WOODLANDS AT CANTERFIELD (THE)	STREET ADDRESS, CITY, STATE, ZIP CODE 901 ANGLE TARN WEST DUNDEE, IL 60118
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(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 295.3000b) 295.3030e)1)2) Facility Reported Incident IL193060 295.6000a)13)	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: General Violation Section 295.3000 Personnel Requirements, Qualifications and Training 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. This requirement was not met, as evidenced by: Based on record review and interview, the establishment failed to 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. This failure affects all residents, visitors, and staff members who do not have Do Not Resuscitate orders. Findings include:	A3000		

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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A3000	<p>Continued From page 1</p> <p>CPR certification documents for the night shift caregivers were requested from the establishment on 6/30/2025 at 12:00 PM.</p> <p>Valid and current CPR certifications for E10(CNA), E11(Resident Care Assistant), and E12 (Resident Care Assistant) were provided on 6/30/2025 at 12:47 PM.</p> <p>On 7/02/2025 at 10:45 AM the surveyor reviewed the establishment's May and June staffing schedule. There were 3 night shifts where E10, E11, and E12 were not present. These dates were 5/9/2025, 5/10/2025, and 6/12/2025. It was found that E5 (Resident Care Assistant), E6(CNA), and E7(CNA) were working on those days. The facility was unable to provide CPR certifications for E5, E6, and E7.</p> <p>During interview with E4 (Business Office Manager) on 7/2/2025 at 11:18 AM they stated, "E5 no longer works here and we do not have a CPR card for them. E6 doesn't have one either. E7's CPR card is expired."</p>	A3000		
A3030	<p>Section 295.3030 Initial Health Eval for Dir Care and FS empl</p> <p>This Regulation is not met as evidenced by: Type 2 Violation</p> <p>Section 295.3030 Initial Health Evaluation for Direct Care and Food Service Employees</p> <p>e) Each employee shall have a tuberculin skin test in accordance with the Control of</p>	A3030		

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A3030	<p>Continued From page 2</p> <p>Tuberculosis Code (77 Ill. Adm. Code 696). The test must meet one of the following time frames:</p> <ol style="list-style-type: none"> 1) The test must be completed no more than 90 days prior to the date of initial employment in the establishment; or 2) The test must be commenced no more than ten days after the date of initial employment in the establishment. <p>This requirement was not met, as evidenced by:</p> <p>Based on record review and interview, the establishment failed to ensure that employee TB testing was completed no more than 90 days prior to the date of initial employment in the establishment; or commenced no more than ten days after the date of initial employment in the establishment. This failure involves 3 of 8 employees reviewed for this requirement (E13, E14, & E15).</p> <p>Findings include:</p> <p>During record review on 6/30/2025 at 11:42 AM it was found that E13 (Server), with a hire date of 5/21/2025, had only 1 step of 2 step TB skin testing completed. The first step was administered on 5/16/2025.</p> <p>During record review on 6/30/2024 at 11:48 AM it was found that E14(LPN), with a hire date of 6/12/2025, had only a QuantiFERON TB test completed on 10/26/2023. This is outside of the 90 days prior to employment testing window.</p> <p>During record review on 6/30/2025 at 12:04 PM it was found that E15 (Resident Care Assistant), with a hire date of 3/17/2025, had only a Chest</p>	A3030		

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A3030	Continued From page 3 X-ray that was performed on 7/6/2024 in their employee file. This is outside of the 90 days prior to employment testing window. During interview with E4 (Business Office Manager) on 7/02/2025 at 1:09 PM they stated, "E13 forgot to come back to have their 2nd step read. They have restarted the process of having a 2 step done and have already had the 1st step administered. I sent E14 to have a chest X-ray. I will send E15 for a chest X-ray."	A3030		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: General 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: 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 record review and interview, the establishment failed to ensure that residents were free from neglect. This failure involves 1 of 3 residents reviewed (R1).	A6000		

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A6000	<p>Continued From page 4</p> <p>Findings include:</p> <p>On 5/20/2025 the Illinois Department of Public Health (IDPH) received a report from the establishment. The report stated, "On 5/19/25, resident's daughter reported that she had reviewed surveillance footage from 5/16/25 through 5/19/25. She noticed that on 5/16/25 overnight shift and 5/18/25 overnight shift, safety checks were not performed for resident."</p> <p>During record review on 6/30/2025 at 12:27 PM the establishment's internal investigation of the incident documents were reviewed. E1 was identified. All documentation and interviews corroborate the report that was sent to IDPH. E1 was immediately suspended when the establishment was informed of the incident.</p> <p>During record review on 7/02/2025 at 9:12 AM R1's service plan was reviewed. R1's service plan was updated to address increased safety and continence checks between 2-5 AM. The service plan was also updated to address increased monitoring for potential abuse and neglect.</p> <p>During record review on 7/02/2025 at 9:23 AM R1's progress notes were reviewed. These progress notes stated that R1's POA was satisfied with the actions of the establishment concerning the incident.</p> <p>During interview with E3 (Resident Services Director) on 7/02/2025 at 12:06 PM they stated, "The incident was brought to our attention from the resident's family. They had an electronic monitoring device in R1's room. The family wanted to talk to me and E9 (Navigate Manager). The family said, "Everyone is always so great with R1. Everyone always checks on R1 multiple</p>	A6000		

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A6000	Continued From page 5 times a night but the other night R1 was not checked on from 9 PM until the morning shift. Don't you guys do safety checks?" We asked the family to share the video footage with us. R1 is supposed to be repositioned. E1 admitted they were assigned to R1 that night. E1 stated that they did check on R1. The camera is positioned so that you can see if anyone even opens the door to come in the room. There was no movement on the camera that night shift. We gave our team education about continence checks, safety checks, and repositioning. Everyone was going in to check on R1 at least every 2 hours. I don't know what was going on with E1 that night."	A6000		