STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015424	A. BUILDING: _____ B. WING _____	C 05/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS (GENEVA)	2388 BRICHER ROAD GENEVA, IL 60134

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S 000	Initial Comments Investigation of Facility Reported Incident of April 25, 2022/IL146592	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710 a)c)3)A)B)C)F) 330.3620 g) Section 330.710 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. c) The written policies shall include, but are not limited to, the following provisions: 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers, taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs. B) Education of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care workers during resident handling. C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment. F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. Section 330.3620 General Building Requirements g) Have each exterior door equipped with a signal that will alert personnel in the area if a resident leaves the building. Any exterior door that is supervised during certain periods during the day or night may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to identify and minimize hazards related to resident movement and failed to have external door locks in place at all times to prevent potential elopement. This applies to 4 of 4 residents (R1-R4) reviewed for accidents/incidents in a sample of 4. The findings include: Face sheet, undated, shows R1 was admitted to the facility on 7/8/21 and R1's primary diagnoses was dementia. Progress notes dated 4/30/22 and 5/1/22 show R1 wandering and pacing at the facility.	S9999		

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S9999	Continued From page 2 Service plan, dated 7/8/21, shows R1's challenging behaviors include actively seeking ways to leave the facility, frequently asking how to leave the facility, following people through doors, and walking the outdoor fence line and pushing on gates. Police report, dated 4/25/22, shows on 4/25/22 at 5:00 PM the police department was notified that R1 was located at the personal residence in Geneva, Illinois sitting in the driver's seat of a vehicle parked in the driveway of the residence. The report shows R1 believed he was sitting in his own vehicle and was very confused. The property owner stated she did not know R1 and did not see him enter the vehicle. The report showed it was apparent R1 suffered from memory loss. The report shows R1's family was contacted and, simultaneously, the facility contacted the police department to report R1 missing. The report shows the facility staff noticed R1 was missing from the facility at approximately 5:10 PM when they were unable to locate R1 for dinner. The report shows R1 was returned to the facility by the police. The approximate walking distance from the facility to the location R1 was found sitting in the community member's car was 1.5 miles. The approximate time it would take R1 to walk the distance between the locations was 28 minutes. On 5/9/22 at 11:36 AM, V6 (Maintenance) stated on the afternoon of 4/25/22 the facility unlocked the gates for the landscapers to mow the courtyard lawn. V6 stated he punched out of work at 4:30 PM. V6 stated he left the building at approximately 4:40 PM which was when he checked to see if the landscapers locked the gate and found the gate unlocked. V6 stated he	S9999		

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S9999	Continued From page 3 locked the gate and left to go home. V6 stated R1 must have left the courtyard out of the unlocked gate prior to his locking the gate at 4:40 PM. Investigation Report, dated 4/25/22, shows V6 (Maintenance) stated on 4/25/22 he unlocked the courtyard gate for the landscapers at approximately 2:00 PM. Facility Incident Report, dated 4/26/22, shows on 4/25/22 at 5:10 PM, facility staff were unable to find R1 in the facility. The report shows the facility searched for R1 and then contacted 911 at 5:30 PM to report R1 missing. The report shows while on the phone with 911, the facility was told by police that R1 was found. The report shows R1 was returned to the facility by the police officer. Investigation report, dated 4/25/22, shows on 4/25/22 at approximately 2:00 PM a landscaping staff requested the east side gate to be unlocked. At approximately 3:30 PM the landscaping truck was seen leaving the facility property. At 4:20 PM, R1 was seen outside in the courtyard. At 4:40 PM, V6 (Maintenance) noticed the gate was not locked and V6 locked the gate. At 5:10 PM, facility staff were unable to find R1. Investigative report, dated 4/29/22, shows R1 left the property through a closed but unlocked gate that led from the courtyard to the property on the east side of the property. The report shows the staff were unaware the gate was unlocked. The report shows by the time a staff member was aware that the landscapers had left, and the gate was unlocked, it was too late and R1 already left the facility property.	S9999		

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S9999	Continued From page 4 Investigative Report, dated 4/25/22, shows V4 (Caregiver) stated on 4/25/22 R1 refused to come inside and R1 was looking for his wife. On 5/5/22 at 3:06 PM, V4 (Caregiver) stated the last time they performed hourly checks on 4/25/22 was at 4:15 PM. V4 stated R1 was inside the facility during the check. V4 stated after the hourly check, she saw R1 walking back and forth between the facility and the courtyard and putting on additional shirts. On 5/5/22 at 12:27 PM, V1 (Administrator) stated R1 and R2 were identified as elopement risk residents at the facility. V1 stated R3 and R4 were residents who walk independently and "who ask for the door." Employee meeting document, dated 4/28/22, shows, "Immediate changes - Landscapers will be locked inside the courtyard when they are doing any type of work whatsoever. Whenever landscapers are on the property it will be announced over the walkie talkies so that all staff know they are present on the property regardless of courtyard doors being unlocked or not." Facility phone list indicating staff who received employee training regarding procedures regarding landscapers, updated 5/2/22 and provided on 5/5/22 by V1, shows only 23 of the 48-facility staff were trained on locking landscapers inside the courtyard while working in the courtyard at the facility. On 5/9/22 at 11:04 PM, V1 stated no additional staff were in serviced regarding the new procedures for landscapers and locking gates since the list was provided on 5/5/22.	S9999		

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S9999	Continued From page 5 Facility Safety and Security of Residents Procedure, dated 2021, shows the facility "provides a safe and healthy living environment for all its residents to the maximum extent possible...." The document shows, "C. All fences in courtyards should be at least eight (8) feet high." The document does not specify that exit doors in the courtyards were to be locked at all times or how those door locks were to be operated/monitored when needing to be opened." The document shows, "5. Courtyard Monitoring Guidelines A. Courtyard monitoring guidelines are utilized to provide for the ongoing supervision and safety of residents... Weather permitting residents are permitted the freedom of independent movement throughout the secure outdoor area.... General consideration: All staff responds to door alarm immediately to determine which resident is outside and redirect back into community." The facility policy fails to include which staff are responsible for monitoring and overseeing the external courtyard doors when unlocked. The document shows the facility inspects and tests security systems only weekly. 2. Face sheet, undated, shows R2 was admitted to the facility on 4/30/22. Clinical Evaluation, dated 4/30/22, shows R2's diagnoses included dementia with behavioral disturbance and Alzheimer's disease. The evaluation shows R2 was not identified as having an exit seeking history and not identified as verbalizing the desire to exit the facility. Progress notes dated 4/30/22 shows R2 was pleasantly confused and ambulates independently with a steady gate. The note shows R2 went outside in the courtyard multiple times and was re-directed back inside the facility.	S9999		

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S9999	Continued From page 6 Progress note, dated 5/1/22, shows R2 was identified digging under the fence in the facility courtyard and R2 was redirected inside the facility. The note shows R2 later returned that day R2 again went out in the courtyard, but staff were unable to redirect R2 back into the facility. The clinical record failed to show a service plan was developed for R2 to address his elopement risk since his admission. On 5/9/22 at 11:04 PM, V1 stated she had not yet had time to complete R2's service plan. 3. Clinical Evaluation, dated 5/14/21, shows R3's diagnoses include dementia with behavioral disturbance, sleep deprivation, and epilepsy. The evaluation shows R3 was identified as having seeking history and verbalizing a desire to exit the facility. Psychological Biography, undated, shows R3 had a history of elopement, exit seeking behaviors, and paranoid behaviors prior to admitting to the facility. Service plan, dated 5/17/21, shows R3's challenging behaviors included exit seeking and packing her clothes. 4. Clinical evaluation, dated 5/17/21, shows R4's diagnoses included vascular dementia with behavioral disturbance. The evaluation shows R4 was identified as having exit seeking behavior and verbalizing a desire to exit the facility. Service Plan, dated 5/18/21, shows R4's challenging behaviors included exit seeking behaviors and asking to go home.	S9999		

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S9999	Continued From page 7 Psychological Biography, undated, shows R4 had a history of elopement prior to admitting to the facility. Progress notes, dated 4/18/22, show R4 began to cry, ask to go home, and wished to see her parents. "B"	S9999		