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	IL6015424	A. BUILDING: _____ B. WING _____	C 10/31/2022

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ARDEN COURTS (GENEVA)	2388 BRICHER ROAD GENEVA, IL 60134

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S 000	Initial Comments Investigation of Facility Reported Incident of October 17, 2022/IL152703	S 000		
S9999	Final Observations Statement of Licensure Violations I of II: 330.710a) 330.780a) 330.780b) 330.780c) 330.1110a) 330.1110f) 330.4240b) 330.4240d) 330.4240f) 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. Section 330.780 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 330.785, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. of each reportable accident or incident to the Department within seven days after the occurrence. Section 330.1110 Medical Care Policies a) The facility shall have a written program of medical services approved in writing by the advisory physician that reflects the philosophy of care provided, the policies relating to this and the procedures for implementation of the services. The program shall include the entire complex of services provided by the facility and the arrangements to effect transfer to other facilities as promptly as needed. The written program of medical services shall be followed in the operation of the facility. f) The facility shall notify the physician of any accident, injury, or unusual change in a resident's condition. Section 330.4240 Abuse and Neglect b) A facility employee or agent who becomes	S9999		

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S9999	Continued From page 2 aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter of the department. f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to protect residents from risk of harm by residents who had serious mental/emotional problems and a history of violent behaviors. The facility also failed to investigate and report an initial incident of a resident barricading residents in a resident room. This applies to 1 of 3 residents (R2) reviewed for abuse in a sample of 5. The findings include: 1. Facility Diagnosis Report printed 10/17/22 shows on admission date of 9/6/22, R2 had the following diagnoses: Schizophrenia, unspecified, major depressive disorder, recurrent, moderate, unspecified symptoms and signs involving cognitive functions and awareness, attention-deficit hyperactivity disorder, predominantly inattentive type, nicotine	S9999		

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S9999	Continued From page 3 dependence, unspecified uncomplicated, other developmental disorders of scholastic skills, problem related to housing and economic circumstances, unspecified. Facility physician note dated 9/7/22 shows R2 was seen as a new admission for assessment. The note shows R2's past medical history of diagnoses included schizotypal personality disorder, delusional disorder, dependent personality disorder, ADHD (attention deficit hyperactivity disorder), anxiety, cognitive disorder, depression, learning disorder, psychotic disorder with delusions. The progress note shows the physician visit diagnoses included cigarette nicotine dependence with withdrawal, schizotypal personality disorder, and dependent personality disorder. Geriatric Psychiatrist assessment dated 9/7/22 shows diagnoses included degenerative disease of nervous system, major depression disorder, developmental disorders of scholastic skills, ADHD, and Schizotypal personality disorder. Health concerns and risks include: "R2's personality profile suggests he can exhibit emotional lability, overactivity, moodiness, and impulsiveness which may cause difficulty for him. R2 suggests with instances of inadequate judgment. R2 may behave erratic at times and may be prone to mood swings. He may also exhibit some disorganization and difficulties interpersonally. R2's progress note dated 9/30/22 shows, "On the afternoon of 9/29/22, resident displaying agitation and behaviors abnormal for resident. Pacing halls, discussing calling police, aggressively approaching (staff); standing over (staff), approaching within personal space, noting "I	S9999		

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S9999	Continued From page 4 haven't touched you yet" while walking closer to (staff) as (staff) backed up. PT (Physical Therapist) noted to (staff) that resident had commented to her as well noting he would lock her up/call the police." On 10/27/22 at 11:30 AM, V4 (Caregiver) stated during the 10/13/22 incident, V4 was assisting R5 in R5's room when R2 walked into R5's room with R6 and R7 and closed R5's room door. V4 stated R5, R6 and R7 were all confused residents. V4 stated R2 walked toward R5 and told R5 to lay down on his bed. V4 stated R5 looked confused and seemed afraid of R2 by the look on R5's face. V4 stated R2 then looked at V4 and stated, "Get the f___ out!" R2 walked to the door, looked out and told V4 to look down the hall because there were people and police present. V4 stated she stepped outside to look and R2 closed the door to the room with R5, R6, and R7 remaining in the room with R2. V4 stated R2 would not open the door and V4 could not open the door. V4 stated she called the nurse on duty who came immediately, could not get R2 to open the door, and returned to the nursing station. V4 stated she remained by the door watching over residents in the hall to protect them. V4 stated eventually R2 opened the door and walked out. R6 walked out and began walking with V4 and stated, "He's gonna kill up a bunch of people!" V4 stated she did not respond to R6 but knew R6 was afraid of R2 because she knew R2 was angry. V4 stated in addition to reporting the incident to the nurse on duty, she discussed the incident with V2 (Director of Nursing). R2's progress note written by V4 (Caregiver), dated 10/13/22, shows R2 pushed his way into [R5's] room told caregiver to "get the F out." Resident opened the door and said look there are	S9999		

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S9999	Continued From page 5	S9999		

police down the hall and people. Resident closed the bedroom door and caregiver notified the nurse on duty. Nurse came right away to speak to R2, but he would not let the nurse in the room. "Resident told other resident he was going to kill."

On 10/27/22 at 11:55 AM, V1 (Administrator) stated she was informed of R2's 10/13/22 barricading incident on 10/14/22. V1 stated there was no facility investigation of R2's 10/13/22 incident and the incident was not reported to IDPH (Illinois Department of Public Health). V1 stated no further documentation regarding the incident existed other than the progress note written by V4.

On 10/26/22, V8 (Caregiver) stated on 10/17/22, she was walking with R1 and R2 "kind of had a hard grab on [R1] and was forcing her toward the room." V8 went to R2's room, knocked on the door, and heard R2 block the door with his body. V8 walked away to try to let R2 decompress, gathered other staff, and when she returned. R1 was lying on the ground by the closet door. R2 was pushing staff away from R1 and not letting staff assist so V5 (Building Services Coordinator) attempted to remove R2 from the room so staff could help R1. V8 stated R1 had a lump on her head. V8 stated R2 barricaded himself again in the room for approximately 15 minutes prior to the police coming to the facility. V8 stated R2 had a habit of inappropriately touching females and believes females at the facility are his wife. V8 stated she was scared for the residents and for R2.

On 10/26/22 at 2:23 PM, V9 (LPN- Licensed Practical Nurse) stated on 10/17/22 she was called to R2's room by V8 because R1 was barricaded in R2's room by R2. V9 stated they

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S9999	Continued From page 6 were able to open the door and saw R1 on the floor. V9 stated when they attempted to approach R1, R2 became violent. V9 stated R1 had a bump larger than a golf ball on the back of her head. V5 arrived and assisted blocking R2 so V9 could assist R1. V9 stated V9 was aware of R2's history of inappropriately touching a female resident on the pelvis as well as kissing R1. On 10/27/22 at 1:14 PM, V5 (Building Services Coordinator) stated on 10/17/22 he was asked to come to help with R2. When V5 arrived, R2 was locked arm and arm with a resident caregiver and R1 was on the floor in R2's room. V5 stated R2 believed R1 was his wife and R2 thought he needed to protect R1 from the facility staff. V5 stated he attempted to keep R2 away from R1 so the staff could safely assess R1 on the floor when R2 began telling V5, "I'm going to kill you!" V5 stated R2 dug his fingernails in V5's arm and continued to fight V5. V5 stated V1 (Administrator) arrived and R2 grabbed V1's glasses off her face and threw them. V5 attempted to hold R2 from hurting V1 and R2 began trying to grab V5's badge. V5 stated he backed R2 up into his room and R2 fell backward on his bed. R2 then began kicking V5. V5 retreated and R2 seemed to begin to calm down. R2 then walked out in the hall and began fighting with V5 again. After R2 calmed down again and stopped fighting, R2 went into his room and barricaded himself into his room. The facility called the police and R2 was taken to the hospital. V5 stated he was aware of reports that R2 touched R8 inappropriately. Facility incident report, dated 10/17/22, shows, "Resident took resident (R1) inside his room when caregivers tried to take resident, he became very aggressive to caregivers and nurse,	S9999		

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S9999	Continued From page 7 kicking and swinging hands, pushing staff. Resident barricades himself to front of his door, won't let staff to go outside his room. Resident was sent out 911 to ... hospital for behavior disturbance." Investigation Report, dated 10/17/22, shows "R2 took R1 to his room, they are in a family approved "relationship" however, in order to make sure nothing continues beyond kissing and hand holding a caregiver went to open his door so as to better supervise them. (R2) became defensive and upset and barricaded his door. Caregivers and the nurse supervisor tried to get the door open and when they did, they saw (R1) on the floor and went to help her. As staff tried to help (R1), (R2) had a catastrophic reaction and started pushing, shoving, and hitting them. Staff got (R1) out of the room and tried to redirect him away from her, they called for the (staff) to assist. However (R2) became violent with him at several times pulling him and pushing him around in attempt to go after (R1). After (R2) was in his room, (V1) made the decision to call 911 and get police assistance." Investigation conclusion shows, "(R2) had a catastrophic reaction to caregivers checking on him and R1 ('his wife'), he barricaded the door and (R1) fell to the ground and hit her head on the wall of the closet. He got defensive over caregivers taking 'his wife away.' He became violent and began pushing staff members in order to get to her, (R1) was taken away for safety and he continued to be physically violent towards other staff members and was unable to be redirected and calmed down. After successfully convincing him to stay in his room, police were called as he barricaded the door again. ...Police convinced him to get on the stretcher and the EMTs (emergency medical technicians) took him to (hospital) ER	S9999		

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S9999	Continued From page 8 (emergency room)." R2's progress note dated 10/17/22 at 11:46 PM, shows R2 returned from the hospital at 11:00 PM. The progress note shows R2 was pacing back and forth down the hallway and a new order from V6 (Physician) included an extra dose of olanzapine 2.5 mg (milligrams.) The progress note shows R2 received Ativan at the hospital to calm him down and R2 was being checked every thirty minutes upon return from the facility. On 10/26/22 at 12:20 PM, V1 stated when R2 returned to the facility from the hospital on 10/18/22 at approximately 12:00 AM, R2's behavior was only monitored by staff every 30 minutes. V1 stated the facility was not able to provide a 1:1 supervision until 10/18/22 at approximately 8:00 AM. V1 stated the 1:1 staff stayed until R2 left for the hospital on 10/18/22 at 11:50 PM. V1 stated R2 returned to the facility at approximately 5:00 AM on 10/19/22 and again only received visual supervision every 30 minutes from 5:00 AM - 12:00 PM when a caregiver arrived to begin providing 1:1 supervision. V1 stated R2 was discharged to a behavioral hospital on 10/19/22 where had had remained for treatment. V1 stated the facility would readmit R2 when discharged from the behavioral hospital. Facility 30-minute check form, dated 10/17/22, shows R2 began receiving checks every thirty minutes at 11:00 PM on 10/17/22. R2's progress note, dated 10/18/22 at 3:32 PM, shows V7 (Physician) provided orders to continue to provide 30-minute checks on R2 for safety. Facility 30-minute check form, dated 10/18/22, shows R2 began receiving monitoring every 30	S9999		

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S9999	Continued From page 9 minutes at 10:00 AM on 10/18/22. Facility 30-minute check forms, dated 10/19/22, shows R2 received 30-minute checks on 10/19/22 for all three shifts at the facility. R2's progress note, dated 10/18/22 at 4:17 PM, shows R2 was provided a male private duty caregiver. R2's progress note, dated 10/19/22 at 12:40 AM shows R2 was transferred to an emergency department. R2's progress note, dated 10/19/22 at 8:52 AM, shows R2 returned to the facility at 6:38 AM. The progress note fails to show R2 had any staff behavior monitoring in place. "B" Statement of Licensure Violations II of II: 330.720e)1)2)3) Section 330.720 Admission and Discharge Policies e) No person shall be admitted to or kept in the facility: 1) Who is at risk because the person is reasonably expected to self-inflict serious physical harm or to inflict serious physical harm on another person in the near future, as determined by professional evaluation; 2) Who is destructive of property and that destruction jeopardizes the safety of her/himself or others; 3) Who has serious mental or emotional problems based on medical diagnosis;	S9999		

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S9999	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow their admission screening policy to prevent the admission of a resident with serious mental/emotional problems. This applies to 1 of 3 residents (R2) reviewed for abuse in a sample of 5. The findings include: Facility Screening Guidelines for Move-In Memory Care Communities, dated 1/2022, shows diagnoses that are not likely appropriate for move-in to the facility include: "Primary mood, anxiety, personality, and psychotic disorders." The document shows, "Primary dementia (such as Alzheimer's disease) with psychotic symptoms is likely acceptable for move-in; longstanding psychosis with secondary dementia is likely not appropriate for move-in." Facility Move-In/Out Criteria, dated 6/2021, shows, "The community setting, and services may be appropriate for prospective residents who have been evaluated with the following: Have a diagnosis of Alzheimer's disease or a related dementia (see Screening Guidelines for Move-In.)" The document shows, "The community setting and services may no longer be appropriate for current residents who have been evaluated with the following: ...Those who exhibit behaviors that place them, other residents, staff or visitors at risk." Review of R2's clinical record showed R2 was admitted to the facility on 9/6/22. Facility Diagnosis Report printed 10/17/22 shows on admission date of 9/6/22, R2 had the following	S9999		

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S9999	Continued From page 11 diagnoses: Unspecified symptoms and signs involving cognitive functions and awareness, attention-deficit hyperactivity disorder, predominantly inattentive type, major depressive disorder, recurrent, moderate, nicotine dependence, unspecified uncomplicated, other developmental disorders of scholastic skills, problem related to housing and economic circumstances, unspecified, and schizophrenia, unspecified. R2's Facility physician note dated 9/7/22 shows R2 was seen as a new admission for assessment. The note shows R2's past medical history of diagnoses included ADHD (attention deficit hyperactivity disorder), anxiety, cognitive disorder, delusional disorder, dependent personality disorder, depression, learning disorder, psychotic disorder with delusions, schizotypal personality disorder. The progress note shows the physician visit diagnoses included cigarette nicotine dependence with withdrawal, schizotypal personality disorder, and dependent personality disorder. R2's Care plan created 9/6/22 and revised 9/14/22, shows R2 "has hallucinations/visions of things that are not there. Sometimes he can be disturbed by them but sometimes he sees them, and it doesn't bother him .... Due to these hallucinations, he often has much trouble sleeping. (R2) is also socially awkward, he says things that are inappropriate (particularly to females) but is redirectable, he also has a difficult time understanding personal boundaries or space intrusions, again usually re-directable." Dementia-Related Behavior care plan dated 9/6/22 shows, "Observe for and report to the nurse about physical interactions with other female residents. (R2) is very confused and	S9999		

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S9999	Continued From page 12 thinks that female residents are his wife. Redirect (R2) when/if necessary." Memory Loss / Cognition care plan, dated 9/6/22, shows "Monitor for socially intrusive behavior (R2) doesn't really understand personal space sometimes, re-direct when / if needed. Monitor territory/space intrusions. (R2) is confused and may think female residents are his wife. Redirect when/if needed." The care plan fails to address R2's serious mental illness diagnosis. On 10/27/22 at 2:35 PM, V1 stated she was not aware that residents with serious mental problems were prohibited from admission to sheltered care facilities. "C"	S9999		