Illinois Department of Public Health

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 11/06/2023

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 October 9, 2023/IL165874 Investigation of Facility Reported Incident of October 12, 2023/IL165876	S 000		
S9999	Final Observations Statement of Licensure Violations I of II: 330.710a) 330.710c)3)A)B)C) 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	S9999	**Attachment A** Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling.

C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review the facility failed to ensure a resident with dementia and exit seeking behaviors was monitored to prevent the resident from eloping. This failure resulted in R102 exiting the facility, unbeknownst to staff, on 10/12/23. R102 was found walking on facility property by the main entrance of the facility. This failure applies to 1 of 4 residents (R102) reviewed for safety/supervision in the sample of 4.

The findings include:

A facility incident report dated 10/12/23 showed R102 was found by staff, outside of the facility, on a sidewalk by the front entrance, at 1:45 PM. Facility staff walked R102 back into the facility, via the secured front door. R102 received no injuries from this incident. The report showed the facility could not confirm exactly how R102 got out of the facility but showed, "we assume that (R102) followed (V8 Caregiver) out a (secured) door to the outside, (V8) unaware (she was followed by R102)."

R102's admission risk agreement form dated 1/10/23 showed R102 had "exit seeking behaviors at previous facility."

R102's current service plan showed R102 was

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cognitively impaired related to her diagnosis of dementia. The plan showed R102 required safety checks every 30 minutes due to her behavior of wandering throughout the secured area of the facility. The service plan showed R102 resided in a secured, memory care area, in a sheltered care facility.

R102's safety check record dated 10/12/23 showed R102 was last seen in the facility at 1:30 PM (15 minutes prior to the incident).

On 11/6/23 at 9:45 AM, V8 (Caregiver) stated she had never taken care of R102 prior to the incident on 10/12/23. V8 stated, "I didn't know anything about (R102). I don't work on the unit where she lives. On that day, I was taking the garbage out. I went out through the locked, side door, by the main entrance. I was in a hurry. I used the code on the keypad and went out. I didn't look behind me. I don't remember hearing if the door closed behind me. I don't recall seeing (R102) anywhere around me before I went out. I threw the bag in the garbage (on the east side of the building). When I turned around, I saw (R102) walking down the sidewalk towards me. I thought she looked like one of our residents. I went up to her and walked her back into the building. I am not exactly sure how she got out." V8 stated no door alarm sounded during the incident.

On 11/2/23 at 9:20 AM, V3 (Caregiver) stated, "(R102) will try to open or get out exit doors about 5-10 times per day. All our doors are alarmed but the alarms don't stop her. We have to watch her closely. She has dementia. She likes to go outside to the courtyard."

On 11/2/23 at 9:35 AM, V4 (Licensed Practical Nurse) stated, "(R102) is very exit seeking. She

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has made multiple attempts to get out before. If we can't find her, she's probably gotten out the door to the courtyard ..."

On 11/2/23 at 1:05 PM, V2 (Director of Nursing) stated, "I was here when (R102) was found outside on the sidewalk. We don't have cameras, so we aren't exactly sure how she got out because all our exit doors are locked and alarmed. Staff must punch in a code, on the keypads, to open the doors. We are assuming (R102) snuck out when (V8 Caregiver) was taking the garbage out. Either (V8) didn't see (R102) behind her or the door didn't close securely after (V8) walked out. (R102) has a history of exit seeking behavior. She will attempt to exit any door. Door alarms don't even stop her. Staff are to respond immediately if they hear a door alarm. Staff need to look for residents prior to going out an exit door. We need to make sure our residents are safe. They all have dementia and have no safety awareness."

On 11/6/23 at 12:15 PM, V9 (Physician) stated R102 is ambulatory with a history of exit seeking behaviors. V9 stated, "All of the doors in the facility are locked but elopement prevention is really a 2-step process. The first is that all exit doors are locked and require a code via a keypad to open them. The second is staff observation. We have staff seated at the front desk, monitoring the entrance doors. Staff also need to make sure no residents are around them when they leave the building."

The facility's Safety and Security of Residents policy dated 6/2021 showed the facility "provides a safe and healthy living environment for all its residents to the maximum extent possible. In support of this objective each community is

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responsible for: Identifying members of the resident population who are prone to wandering and/or elopement ... Installing and maintaining resident monitoring/security devices at high-risk locations identified during the community risk assessment ... Maintaining the community's readiness for potential resident elopement incidents through employee training and routine system checks ..."

"B"

Statement of Licensure Violations II of II:
330.710a)
330.4240a)
330.4240e)

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 330.4240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) (A, B)

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact

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with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

This REQUIREMENT is not met as evidenced by:

Based on interview and record review the facility failed to ensure a resident was free from abuse which resulted in R101 being physically abused by a hospice staff member. The facility failed to immediately intervene/stop the alleged perpetrator from providing cares to R101. These failures apply to 1 of 4 residents (R101) reviewed for abuse in the sample of 4.

The findings include:

A facility incident report dated 10/9/23 showed facility staff reported witnessing a hospice CNA/Certified Nursing Assistant (V6) "forcefully jerking (R101) up by the arm, to get her to stand up" and "pushing (R101's) buttocks, with her (V6) hands, to get her to stand up and walk." The report showed R101 asked V6 to "stop" multiple times. The report also showed facility staff allowed V6 to continue to care for R101 (after the incident) as V6 took R101 into the bathroom for a shower. The report showed R101 was assessed for injuries, post-incident, with no injuries found. The report showed V6's hospice agency was notified. V6 was no longer allowed in the facility per direction of facility administration. The report showed the local police department was not notified of the incident.

R101's current service plan showed R101 was cognitively impaired with a decreased ability to make her needs known related to her diagnosis of dementia. The service plan showed R101 was

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a hospice resident that resided in a secured, memory care area of a sheltered care facility.

On 11/2/23 at 9:50 AM, V3 (Caregiver) stated she was seated in the dining room with R101, on 10/9/23, when V6 (Hospice CNA) arrived. V3 stated, "(V6 Hospice CNA) was already mad at us (staff) because we had gotten (R101) up out of bed and brought her to breakfast. (V6) walked over to (R101), grabbed the back of (R101's) chair and pulled the chair away from the table as (R101) was actively eating breakfast. (R101) looked scared. She asked (V6), "Hey what are you doing." (V6) put a walker in front of (R101). (V6) then grabbed (R101's) left arm and yanked her up to a standing position, by her arm. (V6) then forcefully wrapped (R101's) hands around the handles of the walker. (V6) then tapped her hands on (R101's) butt to get her to walk forward. (V6) then stated, "We aren't doing this today. I don't have time for this." (R101) kept saying "no' and "wait a minute". (R101) looked scared. I immediately reported this to the nurse. I was concerned about the way she grabbed (R101's) arm. I didn't like the way (V6) talked to (R101). I was shocked and numb. I had never seen someone treat a resident like this before. I should have intervened then. I should have asked (V6) to leave but I didn't." V3 stated V6 proceeded to take R101 into the bathroom for a shower.

On 11/2/23 at 10:55 AM, V10 (Caregiver) stated she was in the dining room with R101 on 10/9/23. V10 stated, "(V6 Hospice CNA) walked over to (R101) and said, "let's go." (R101) was eating her breakfast. She didn't want to go anywhere. (V6) grabbed (R101) under her arm, put her other hand on (R101's) butt, and then jerked (R101) up to stand. (R101) kept saying, "No, stop!" She

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looked scared and was getting agitated. She had no idea what was going on. (V6) then pushed (R101) on her butt to get her to start walking forward. I reported it all to the nurse right away. I was concerned that she might have hurt (R101). I also didn't like the way (V6) was talking to her. I should have intervened right away, but I didn't." V10 stated V6 proceeded to take R101 into the bathroom for a shower.

On 11/2/23 at 11:30 AM, V9 (Physician) stated, "(R101) has severe dementia. I would say she is pleasantly confused. Yanking someone up by their arm is not appropriate. The expectation is that no resident is touched against their will. I think (R101) would have enough cognition to know if she was being hurt or mistreated. By her saying, "stop, don't do this", she's telling you she doesn't want to be touched or forced to do anything."

On 11/2/23 at 1:05 PM, V2 (Director of Nursing/DON) stated, on 10/9/23, V3 and V10 (Caregivers) reported, to her, an allegation of physical and verbal abuse related to the incident between V6 (Hospice CNA) and R101. V2 stated, "It was reported to me that (V6) had forcefully grabbed (R101's) arm and made her stand up ...If a resident is forced to do something against their will, that is a form of abuse ...I didn't make a police report because (R101) was not hurt ...I did have to do some staff education, after the incident, since they (staff) didn't intervene immediately. (V6) should not have been allowed to continue to care for (R101) and shower her ... (V6) is no longer allowed in the facility ... We are responsible for any cares an outside agency provides in our facility ..."

On 11/2/23 at 1:35 PM, V6 (Hospice CNA) denied

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S9999	Continued From page 8 verbally or physically abusing R101. The facility's Resident Protection policy dated 11/2021 showed, "The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation ...Resident protection actions include: Immediately removing the resident from contact with the alleged abuser ..." "B"	S9999		