| 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 11/30/2023 |

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

| (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 |
|---|---|---|---|---|
| S 000 | Initial Comments<br><br>Investigation of Facility Reported Incident of October 27, 2023/IL166439 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations: 330.4210a)<br><br>Section 330.4210<br>a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law based on their status as a resident of a facility. (Section 2-101 of the Act) (A, B)<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on interview and record review, facility failed to ensure a safe environment to their residents. This applies to 4 of 4 residents (R1, R2, R3, R4) reviewed for client abuse.<br><br>Findings Include:<br><br>According to their face sheets, R1 and R3 have unspecified dementia with behavior disturbance and R2 has vascular dementia. R1-R3 can walk around independently. R4 expired prior to the survey.<br><br>1. The facility's 10/27/23 State Report of Patient Incident showed R2 was in R1's room, and a Caregiver heard yelling. The Caregiver witnessed R1 grab R2 by her right arm and swung her against the wall. R2 hit the back of her head and her back on the wall but did not fall. No injuries were noted to R1 or R2. | S9999 | **Attachment A**<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br><br>On 11/29/23 at 10:20 AM V1 Executive Director (ED) of the facility stated that when R1 was out of his room, R2 was going through R1's closet. When R1 saw this, R1 swung R2 against the wall. On 10/19/23 R2 hit her head and her back to the wall.<br><br>On 11/29/23 at 3:04 PM V4 (Caregiver) was interviewed and stated V4 remembered the incident. V4 stated she heard yelling or arguing and saw R1 holding R2's right arm and R1 swing her to the wall. V4 stated R2 hit her back on the wall. V4 stated she couldn't reach them fast enough to separate them. V4 stated R2 hit R1 back and she stood there and said 'ouch' and then R2 walked away. V4 stated neither resident had any injuries.<br><br>On 11/29/23 at 3:25 PM V2 (LPN/Licensed Practical Nurse) stated one of the Caregivers called me and stated R1 was combative towards R2. R2 was in R1's room and R1 didn't want her in his room. V2 assessed both residents there were no injuries and now the facility is doing close monitoring and keeping them away from each other.<br><br>2. The facility's 10/19/23 State Report of Patient Incident showed R3 and R4 had a physical altercation at 7:30 PM on that day. The report showed R4 was screaming in the living room around 7:30 PM and R3 came out of his room and punched R4 on the left side of his face. Caregiver noticed R4 going towards R3 and stopped him from further conflict and separated them. The Report showed the nurse assessed both residents and there were no injuries.<br><br>On 11/29/23 at 10:20 AM V1 Executive Director | S9999 | | |

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| S9999 | Continued From page 2<br>(ED) stated that R3 punched R4 without any apparent reason and residents have been checked every 30 minutes for the past two months.<br><br>On 11/29/23 at 3:15 PM V3 (Caregiver) was interviewed and stated she remembered R3 was confused. It was nighttime and R4 was yelling in the TV room and R3 came out of his room and punched R4 in the face. V3 saw R3 was going towards the TV room and V3 ran down. V3 stopped R3 and talked to him and brought him back to his room and informed the nurse about the incident. V3 stated there were no injuries and R4 didn't complain of any pain.<br><br>The facility's 11/2021 Resident Protection policy showed "POLICY: The resident has the right to be free from abuse..."<br><br>"B" | S9999 | | |