IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

February 4, 2019

Stephen Sher, Registered Agent
Gardenview Manor, LLC
5750 Old Orchard Road, Suite 420
Skokie, Illinois 60077

RE:	Complaint #:	IL 107669
	Survey Date:	December 6, 2018
	Docket #:	19-C0019
	Violation Type:	B Violation with Fine

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Gardenview Manor.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Enclosure
cc: Administrator
File
Gardenview Manor/December 6, 2018/19-C0019/RegAgent/kk

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: GARDENVIEW MANOR COMPLAINT #: 0107669
LIC. ID #: 0052456
DATE COMPLAINT RECEIVED: 11/30/18 11:02:00

IDPH Code	Allegation Summary	Determination
104	NEGLECT	2
105	IMPROPER NURSING CARE	1
113	IMPROPER PHYSICIAN CARE	1
313	SPECIAL DIETS NOT FOLLOWED	2

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. GARDENVIEW MANOR, LLC, D/B/A, GARDENVIEW MANOR, Respondent.	)))))))))	Docket No. NH19-C0019

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS;
NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint Investigation conducted by the Department on December 6, 2018, at Gardenview Manor, 14792 Catlin-Tilton Road, Danville, Illinois 61834. On February 4, 2019, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.

2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$2,200.00**, as follows:

- **Type B violation** of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b), 300.1210d)6) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)6) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

Plan of Correction, Hearing Requests and Waivers can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Dated this 4th day of February ,2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. GARDENVIEW MANOR, LLC, D/B/A, GARDENVIEW MANOR , Respondent.	))))))))))	Docket No. NH 19-C0019

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); Notice of Plan of Correction Required; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Stephen Sher
Licensee Info:	Gardenview Manor, LLC
Address:	5750 Old Orchard Road, Suite 420 Skokie, Illinois 60077

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 4th day of February, 2019.

Sammye Geer

Sammye Geer
Administrative Assistant I
Long Term Care – Quality Assurance
Office of Health Care Regulations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009567	A. BUILDING: _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

(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 Complaint #1867764/IL107669 A partial extended survey was conducted.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)d)6) 300.3240a) Section 300.610 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 by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b)The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6)All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 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)

THESE REQUIREMENTS WERE NOT MET EVIDENCDED BY:

Based on record review, observation, and interview, the facility failed to ensure that the facility's electronic monitoring system was properly deployed in a manner and pursuant to facility policy to alert staff if a resident leaves the building. As a result, R2 a resident with severe cognitive impairment, and assessed as being at high risk for elopement (leaving the building unnoticed), left the facility and grounds without

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S9999	Continued From page 2	S9999		

staff knowledge. R2 is one of three residents reviewed for elopement in the sample of five. This failure resulted in R2 leaving the facility and property undetected at night, being subjected to cold outdoor conditions, and finally being returned by law enforcement hours later, uninjured.

Findings include:

The facility Physician Order Sheet for R2 dated December 2018, includes the following diagnoses: Altered Mental Status, Dementia and Adult Failure to Thrive.

R2's Plan of Care dated July 2018 through December 2018 documents a problem area of "Elopement High Risk related to wandering." The following interventions are documented as "1:1 (one on one) until further notice, 15 minute checks, Follow steps of elopement protocol. Photo placed in Elopement Book, (safety alert wrist band) in place and check placement and function every shift."

The Treatment Administration Record dated 11/29/18 documents R2's safety alert wrist band was functioning on 11/29/18 and is signed off on all three shifts.

The facility 15 minute check monitoring tool, undated for R2 documents 11/16/18 as the last documented monitoring check for R2.

The Minimum Data Set dated 10/23/18 documents R2 as being severely cognitively impaired and requiring one assist for ambulation on and off the unit.

A facility document titled "Elopement Risk

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S9999	Continued From page 3	S9999		

Observation" dated 9/19/18 documents R2 with a high risk for elopement score of 6. The report documents 4 and above as high risk.

On 12/6/18 at 10:40 am, V11 Co- Maintenance Director acknowledged the facility utilizes an electronic monitoring system comprised of door sensors, and bracelet devices which trigger audible alarms to alert staff when high risk individuals leave the building. The system is installed at the front facility entrance and the back facility entrance. Two separate wrist bands are needed for each door and are coded separately, one for the front door and one for the back door. Residents who are deemed high risk for elopement need to have two bracelets in place for each door to sound when exited.

A facility policy dated 7/2/10 documents "It is the policy of this facility that wandering residents shall be fitted with alarm bracelets, so that staff will be alerted to the elopement of observed residents. Wandering sheets will be used in conjunction with alarms"

On 12/4/18 at 11:30 am V1, Administrator stated R2 was witnessed to exit the front door at around 7:00 pm on 11/29/18. No alarm sounded at the door due to R2 having been fitted with a safety alarm wrist band coded for the back door only. R2 did not have a second safety alarm wrist band in place for the facility's front door and should have.

The facility policy titled "Elopement of Resident" dated 6/22/10, directs staff to perform the following: "It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the charge nurse/supervisor promptly. Any resident who is unable to be located once a thorough

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S9999	Continued From page 4	S9999		

search of the building and grounds is completed is deemed to be missing. Should a resident be observed attempting to leave the premises (an observed elopement), the following procedures shall be implements: Attempt to prevent the departure by orientation, distraction, or diversion; Should the attempt fail, obtain assistance from other staff members in the immediate vicinity; Instruct another staff member to inform Charge Nurse/Supervisor and/or Director of Nursing that a resident has left the premises; Be courteous in preventing departure and in returning the resident to the facility; If the resident leaves the facility grounds, or any injury occurred, complete an Incident/Accident Report according to procedure. Should you discover that a resident is absent from the section: Determine if the resident is out on authorized leave or pass; If the resident is not out on a pass, the nurse will page over the intercom system for the resident to return to the section; All staff will look in their immediate areas for the resident; When the resident is located, call the appropriate nursing section and inform them of the resident's locations. Make arrangements for assisting the resident to return to the section, if needed. If the resident is not located within a reasonable length of time, the nurse will repeat the page, all staff are to make a concerted search of the entire facility and outside grounds: Search all rooms including locked areas; Face Check all residents in bed; Check all bathrooms and shower rooms; All available staff will assist in search efforts; Check outside grounds, fields, roadways and walkways leading to (local nearby towns). Review photograph album with descriptive information regarding resident. Notify the Sheriff's department; Provide a complete description of resident: height, weight, clothing he/she is wearing, etc.; Notify the Administrator and the Director of Nursing; Notify the attending

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S9999	Continued From page 5	S9999		

physician."

A facility incident report dated 9/19/18 documents that R2 left the facility and grounds at 12:00 pm without the facility's knowledge. R2 was later returned to the facility uninjured.

Another facility incident report dated 11/29/18 documents "(R2) was seen lying on bed during rounds, 15 minutes later (R2) was gone from bed". Staff started searching, it was determined (R2) had left the building. (R2) found on facility property and brought back inside. (R2) noted to be dressed appropriately with flannel shirt, sweatpants, shoes and coat. Assessment was completed, no injury noted, no complaints of discomfort, vital signs within normal limits. Administrator, DON (Director of Nursing), and (R2's) family were notified. This report does not document the time of the incident, where R2 went, or when R2 was returned to the facility. There is no signature of who completed the report.

On 12/4/18 at 11:30 am, V1 Administrator stated when the "11/29/18 elopement incident was investigated there was a totally different story uncovered". V1 stated R2 left the building at 6:56 pm per video camera footage. V1 stated R2 went out the front door and V6, Laundry Aide and Door Monitor for the evening of 11/29/18, had been interviewed and stated V6 had seen R2 go out the door but did not know he was an elopement risk. V1 stated R2's safety alert wrist band did not sound as R2 exited the front door. V1 stated the alarms had been updated and some of the electronic monitoring devices were not working properly on the day of the incident (11/29/18). V1 again stated that R2 should have had two safety alert wrist bands on due to the change in the

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S9999	Continued From page 6	S9999		

alarm monitoring systems at the back, and front door exits in the facility. R2 had only one safety alert wrist band on that was coded for the back door.

On the above same date and time, V1 stated R2 was not identified as missing until approximately 9:00 pm and V1 and V2, DON (Director of Nursing) were not notified until 9:30 pm by V4, Licensed Practical Nurse. V1 stated R2 did not return to the facility until approximately 10:30 pm. V1 stated R2 had been picked up by the police walking down the side of a two lane county highway and had been taken to the neighboring town and dropped off, R2 then was transported later by a different police officer and taken to R2's old home neighborhood in the neighboring city of Danville. V1 stated V3, Registered Nurse would have the accurate timeline of events.

On 12/4/18 at 4:30 pm V3 stated at approximately 9:05 pm on 11-29-18, a code 2020 (resident missing) was called on the overhead speakers. V3 stated V3 went outside to look around and saw two police cars with one police officer in each car parked over at the southwest corner of the elementary school (off facility property). V3 stated V3 came back inside and went around asking if R2 had been located yet and found out that R2 was still missing. V3 stated this was approximately at 9:25 pm. V3 stated he got in a vehicle and drove back around and stopped and asked the police officers if they had seen anyone walking (this was at approximately 9:30pm). V3 stated the officers stated they had taken a man to the neighboring town and dropped the man off. The officers stated the man had been taken around 7:20 pm. V3 stated one of the officers called on the radio and asked about R2 and was told R2 had been picked up in the neighboring

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S9999	Continued From page 7	S9999		

town at 8:10 pm and that R2 had told the police that R2 was trying to go home. V3 stated R2 told the police officers he lived at an old address that R2 had not lived at for quite a while and the police officer had dropped R2 off in R2's old neighborhood. V3 stated the neighborhood is located in a bad area. V3 stated V3 then returned to the facility and called dispatch to let the police know that R2 was a missing resident from the facility. V3 stated the police returned to the neighborhood in which R2 had been dropped off and was found wandering on the streets at about 10:15 pm and was brought back to the facility at 10:35 pm. V3 stated V3 was present when R2 returned through the front door and R2 was not wearing a coat. V3 stated R2 had a flannel shirt on, pants, and shoes. V3 stated V3 reviewed R2's 11-29-18 monitoring documentation and 15 minute checks had not been done on R2 for 11/29/18.

A web-based weather history application for the nearest reporting station documents the temperature in the area on 11-29-18 to be between 28 and 41 degrees Fahrenheit, winds up to 10 miles per hour, and relative humidity above 70%.

On 12/5/18 at 8:35 am, R2 was not interviewable, had mixed words, expressed no recall of the incident, and could not follow the conversation.

On 12/5/18 at 8:40 am, R2 was ambulating down the hall with a slow shuffling gate.

On 12/5/18 at 10:30 am, video camera footage viewed and narrated by V2 Director of Nursing and V13 Business Office Manager confirmed R2 leaving the facility (on 11-29-18) at 6:56 pm and not returned until 10:35 pm when accompanied

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S9999	Continued From page 8	S9999		

by police. In the video footage, R2 had a flannel shirt, pants, and shoes on, R2 did not have a coat on. The video footage also documents that it was 9:22 pm before staff exited the building at the front door to search for R2.

On 12/5/18 at 11:30 am, V6 Laundry Aide/Door monitor on the night shift of 11/29/18, stated V6 did see R2 exit the building and stated V6 did not know R2 was an elopement risk. V6 stated when R2 left the building there was no alarm sounding. V6 acknowledged V6 had not looked at the Elopement Photo Album, identifying residents in the facility that are high risk for elopement.

On 12/5/18 at 3:30 pm, V2 stated there has been so many stories told about what happened the night of 11/29/18 when R2 went missing. V1 stated V10, CNA (Certified Nursing Assistant) that was assigned to R2 on 11/29/18 stated V10 had seen R2 at 9:00 pm lying in bed. V2 stated "we know that is not true because we see (R2) leaving the building at 6:56 pm (per video evidence) and the police telling us where, and what time they saw (R2). We really don't know what happened."

On 12/5/18 at 4:00 pm, V1 Administrator acknowledged that 1:1 (staff to resident) monitoring had not been done with R2 and V6 had not identified R2 as an eloping resident when exiting the front door of the facility at 6:56 pm. V1 also acknowledged 15 minute check monitoring had not been done after 11/16/18. V1 acknowledged the Plan of Care had not been followed for R2.

On 12/5/18 at 4:30 pm, V2 Director of Nursing acknowledged that the door alarms had been updated with a new system and R2's safety wrist

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009567	A. BUILDING: _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

(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
S9999	Continued From page 9 band did not work at the front door, but worked at the back door exit. V2 stated other residents have two safety alert wrist bands on, one for the front door, and one for the back door. V2 did not know why R2 had only one safety alert wrist band on. On 12/6/18 at 10:00 am, V8 Nurse Practitioner and Clinical Specialist for R2 stated "Absolutely at no time is (R2) safe outside wandering around independently. (R2) is severely cognitively impaired and has no concept of what is safe for (R2). (R2)'s elopement had the potential for tragedy." (B)	S9999		