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 12/04/2024

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 12, 2024/IL181693. 330.4210a)2)A)B)	S 000		
S9999	Final Observations Statement of Licensure Violations 330.4210a)2)A)B) Section 330.4210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by State or federal law based on their status as a resident of a facility. 2) Residents shall have their basic human needs, including but not limited to water, food, medication, toileting, and personal hygiene, accommodated in a timely manner, as defined by the person and agreed upon by the interdisciplinary team. A) A facility shall treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life, recognizing each resident's individuality. B) A facility shall protect and promote the rights of the resident. This REQUIREMENT was NOT met as evidenced by:	S9999		

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Based on interview and record review, the facility failed to follow their policy to ensure residents (R1, R3, R4) were free from physical abuse.

This applies to 3 of 4 residents (R1, R3, R4) reviewed for resident-to-resident physical abuse.

Findings include:

1. R1's Medical Record (MR) showed an admission date of 10/01/2020 with multiple diagnoses including dementia with behavioral disturbances, Alzheimer's disease, and generalized anxiety disorder.

On 12/3/2024 at 12:40 PM, V3 (Caregiver) said on 10/12/2024 at 9:30 AM she witnessed R2 all of a sudden becoming upset and started yelling at R1 in the living room area to "Get out!". V3 said then R2 slapped R1 in the face. V3 said she separated them but R2 remained very aggressive towards R1 and her. V3 said she was very scared for R1 and herself and screamed for help.

V2 (Director of Nursing/DON) documented on 10/12/2024 in R2's Medical Record (MR), "Caregiver reported that she saw [R2] slapping another female and yelling "Get out!" Caregiver ran and separated the two residents and guided the other resident out of the living room. [R2] continued to yell at both of them as she opened the dining room door "Get out!" Noted: PRN (as needed) Ativan 0.5/ml (milliliers) cream applied to skin at 9:45am for agitation. She did try to bite and kick me as I applied cream with the help of the caregiver. Note: I did approach her in a calm manner and she was agitated and yelling NO."

On 12/3/2024 at 12:10 PM, V2 (Director of

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Nursing/DON) said she assisted in the investigation on 10/12/2024 involving R1 and R2. V2 said it was substantiated that R2 slapped R1. V2 said R1 did not sustain an injury. V2 continued to say since R2's discharge from the facility the unit was much calmer. V2 said R1 had also been involved in prior incidents with other residents including R3 and R4 where she was the aggressor. V2 said it was not normal for R1 to be involved in so many physical incidents with other residents.

On 12/3/2024 at 9:00 AM, R1 was confused and incoherent. R1 was unable to be interviewed. V7 (Caregiver) said R1 had behaviors of confusion, repetitive speech, and hallucinations. V7 said R1 was very defensive about her therapeutic dolls because she believed they were her real children. V7 said R1 had been involved in multiple resident-to-resident incidents including with R2. V7 said R2 also had dementia and had a history of "clashing" with R1.

R1's Service Plan with a last revised date of 6/20/2023 said she had challenging behaviors with a goal to "minimize potentially socially inappropriate or intrusive behavior so it does not interfere significantly with lives of self or others." The Service Plan showed an intervention to "Help identify and avoid anxiety producing situations for [R1]."

R2's MR showed an admission date of 5/17/2024 with multiple diagnoses including dementia and adjustment disorder with mixed anxiety and depressed mood. R2's MR showed she had been experiencing increased agitation and psychosis during her stay at the facility. R2's Medical Record showed she was discharged from the facility on 11/16/2024.

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2. On 12/3/2024 at 2:40 PM, V5 (Caregiver) said on 10/11/2024 at 7:00 PM, she witnessed R3 trying to take R1's therapeutic doll. V5 said then R1 slapped R3 on the right side of the face. V5 said R1 tended to get aggressive when others tried to take her dolls. V5 said she separated them and notified V6 (Licensed Practical Nurse/LPN).

On 12/3/2024 at 2:30 PM, V6 (LPN) said she completed the investigation on 10/11/2024 involving R1 and R3. V6 said it was substantiated that R1 slapped R3. V6 said R3 did not sustain an injury. V6 said R1 was very protective of her dolls and had increased behaviors in the evenings because of her dementia. On 10/11/2024 at 10:48 PM, V6 documented in R3's MR, "At 7 PM caregiver reported that she witnessed [R1] holding her baby doll, [R3] tried to grab [R1's] baby doll and [R1] slapped [R3] on the right side of her face. Caregivers were able to separate both Residents." V6 also documented on 10/11/2024 in R1's MR, "[R1] slapped [R3] on the right side of her face ...[R1] appeared anxious. PRN Lorazepam 0.5mg (milligrams) PO (by mouth) given for increased anxiety."

R3's MR (medical record) showed an admission date of 5/17/2021 with multiple diagnoses including vascular dementia with behaviors and major depressive disorder.

3. V6 (LPN) continued to say R1 had also slapped R4 on 8/7/2024. V6 said at approximately 6 PM, R1 became upset when R4 grabbed her arm and responded by slapping her across the face. V6 said R4 did not sustain an injury. V6 said R1 was given an anxiolytic for her anxiety and agitation.

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On 8/7/2024 at 11:31 PM, V6 documented in R4's MR, "At 5:55 PM Caregiver reported that [R4] grabbed [R1's] arm and telling her to get out to the courtyard [R1] slapped [R4] across the face." V6 also documented on 8/7/2024 in R1's MR, "[R1] slapped [R4] across the face ...PRN Lorazepam 0.5mg PO given for increase anxiety/agitation. Monitored closely." R4's MR showed an admission date of 6/05/2024 with multiple diagnoses including dementia and major depressive disorder.

On 12/3/2024 at 2:00 PM, V1 (Executive Director) said the facility cared for residents with dementia and often they had disagreements with each other which resulted in altercations. V1 said R1's involve resident-to-resident physical altercations reportable incidents on 10/12/2024, 10/11/2024, and 8/7/2024 were investigated and substantiated. V1 said they were doing the best they could for R1 and continued to have her on 30-minute checks. V1 said the facility did not have behavioral management policies but had "Behavior Crosswalks" guidelines to help them manage residents with behaviors.

The facility's policy titled Resident Protection dated 11/2021 said: "The resident has the right to be free from abuse ...The community will adopt and operationalize an abuse prevention system that includes screening and training of employees, protection of residents, identification and investigation of allegations of abuse, and reporting and responding to the appropriate individuals or agencies ...The community provides employee orientation and ongoing education about the prohibition of abuse such as ...Recognizing sings of abuse ...Ways to deal with aggressive behaviors ...The community creates

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S9999	Continued From page 5 and maintains a proactive approach for identifying events that may constitute or contribute to abuse. When investigating whether abuse has occurred, the community identifies and considers events such as behavioral changes ...Investigation process is a three (3) step framework to provide a consistent standardized process for the identification and investigation of near miss situations, concerns/grievances, incidents, and trigger events. The purpose of the investigation process is to reduce resident risk, mitigate harm, identify root cause and associated factors, and minimize the opportunity of recurrence ...PLAN ...GATHER EVIDENCE ...RESPOND Analysis of findings, Complete paperwork, Formulate and implement recommendations. Resident protection actions include ...Provide a safe and secure environment for residents ...Additional actions may include...Resident room changes ..." (B)	S9999		