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 04/30/2025

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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 Incidents of 4/15/2025/IL190892, and 4/17/2025/IL190965.	S 000		
S9999	Final Observations Statement of Licensure Violations 330.710a) 330.4210a)2)A)B) 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. 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	S9999		

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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:

Based on interview and record review, the facility failed to follow their policy to ensure that residents are free from abuse and that a resident (R3) was protected after the incident.

This applies to 2 of 4 residents (R2 and R3) reviewed for abuse, in the sample of 4.

The findings include:

1. R1's EMR (electronic medical records) included diagnoses of Alzheimer's disease, unspecified, unspecified fracture of head of left femur, initial encounter for closed fracture, repeated falls, dizziness and giddiness.

R2's EMR included diagnoses of dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance, other Alzheimer's disease, other recurrent depressive disorders, generalized anxiety disorder, Stevens-Johnson syndrome.

FRI (Facility Reported Incident) report included as follows:
Initial Report to IDPH on April 15, 2025.
Date of incident April 15, 2025, 5:30 AM.
Summary of incident: R2 stated that R1 was roaming in her room and was trying to crawl into

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her bed. R2 said to R1 "This is not your room." That is when R1 punched R2 in her face. R2 has a bruise on her face (around eye) with red and purple discoloration.

On April 28, at 10:29 AM, V1 (Administrator) stated that the incident happened at 5:30 AM and was unwitnessed. V1 stated that she was notified by V2 (Director of Nursing) within an hour of the incident. V1 stated that R1 and R2's rooms are adjacent to each other and she has not received any previous reported incidents with R1 and R2. V1 stated that R2 yelled when this incident took place and V5 (Caregiver) responded. V1 stated that when V5 responded, R2 was leading R1 out of the room. V1 stated that R2 told V5 what happened and V5 got the nurse. V1 stated that the nurse was from Agency and she addressed R2's bruise.

On April 28, at 3:14 PM, V5 stated as follows in summary: The incident happened around 5:30 AM as I was doing my hourly checks and getting people (residents) up. I did not witness per se. I was in the area and heard R1 scream and I peaked out of the room and saw R2 push R1 out of the room. R1 was attempting to go back into the room. I got myself down there and R2 said that R1 punched her in the face. I saw that R2's face on the right side of her face was swelled up and it was purple the next day. I was trying to de-escalate the situation and trying to tell R1 that she is in the wrong room. R1 and R2 were in the hallway. I did not have to call the nurse as I alerted her when she came to the house (unit) about 5 minutes later. She is from Agency and she notified V2 (DON). I put R1 in her room and R2 was in the kitchen and the nurse examined her. R1 usually has a private care giver but she wasn't there that night. A few hours prior to that

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R1 had gone into another resident's (R5) room across the hall and tried to get into bed with her and I tried getting her (R1) back into her room. She wasn't sleeping and I tried many times. I let her stay on the couch (in the living room) and I did not see her walk down the hallway to go to R2's room. She might have gone from her room to R2's room.

2. R3's EMR included diagnoses of dementia in other diseases classified elsewhere with behavioral disturbance, Alzheimer's disease with late onset, unspecified hearing loss, bilateral, generalized anxiety disorder.

R4's EMR included diagnoses of vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, major depressive disorder, single episode, insomnia.

FRI report included as follows:
Initial Report to IDPH on April 17, 2025.
Date of incident April 17, 2025, 7:35 PM.
Summary of incident: Caregiver reported she witnessed R3 put her finger in R4's face. R3 did not touch R4 and R4 held up her fist and told R3 to get away from her and slapped R3 on the right side of the face.

On April 28, 2025 at 10:38 AM, V1 stated that the above incident was reported to her within 1-2 hours of the incident by V7 LPN (Licensed Practical Nurse) who works the second shift. V1 stated that R3 has had some incidents in the past and hit couple of residents because of her state of mind [Dementia] or if someone touches her. V1 stated that R3 is not aware of anything and talks to herself all the time. V1 stated that R3 has been seen by Psychiatry and medications have been

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adjusted in the past few months and she has had significant improvements. V1 stated that R3 has been recently admitted to Hospice. V1 stated that R4 is more alert but also has been declining. V1 stated that R4 is fiercely independent and likes her personal space and has a lock on her door. V1 stated that R3 was in her area and she told her to get away and when she did not, she slapped R3 on the cheek. V1 stated that the incident was witnessed by V6 (Caregiver) who works the second shift.

On April 28, 2025 at 2:50 PM, V7 (LPN) stated the following in summary: I was working the second shift and V6 reported to me that she witnessed R3 pointing at R4's face and then R4 slapped R3 on side of face. It happened in the living room. I was in another house. V6 came to get me. Her partner was on break I believe. When I came to the house, R3 was walking around the living room and R4 was seated in the recliner chair in same living room (about a couple feet from each other). No one was with them. When I asked R4 (about slapping R3) she said "No I didn't do it." She has Dementia.

On April 28, 2025 at 3:32 PM, V6 (Caregiver) stated the following in summary: I was changing a resident and R3 and R4 were in the hallway. R3 was holding her baby doll and and put her finger in R4's face and R4 said to get away and slapped R3. I couldn't get to them as I was holding the garbage in my hand from another resident's room. I separated them and put R4 in her room and R3 in the living room. I don't remember if I closed the door to R4's room. Then I went and got V7 who was in another house. My partner was on break. This was after dinner. This was happening at dinner table also and we separated them.

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S9999	Continued From page 5 Facility Abuse policy and procedure titled "Resident Protection" (Revised February 2024) included as follows: Policy: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.... Purpose: The community will adopt and operationalize an abuse prevention system that includes screening and training of employees, protection of residents, identification and investigation of allegation of abuse, and reporting and responding to the appropriate individuals or agencies. Note: For the purpose of this policy, abuse includes all types of abuse, neglect, exploitation, mistreatment and misappropriation of resident property. Seven (7) key components of abuse prevention system: 3. Prevent 6. Protect... 18. Resident protection actions include: Immediately removing the resident from contact with the alleged abuser.. "B"	S9999		