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 09/08/2025

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 8/26/2025/IL197329 330.4210C) cited	S 000		
S9999	Final Observations Statement of Licensure Violations 330.4210C) Section 330.4210 General C) Residents have the right to reside in and receive services in the facility with reasonable accommodation of their needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This requirement was NOT met as evidenced by: Based on interview and record review, the facility failed to ensure a resident's feet were positioned on foot rests of a wheelchair before moving them, and failed to update service plans with new interventions after a fall. This applies to 1 of 3 resident (R1) reviewed for falls in a sample of 3. Findings include: On 9/6/25 at 9:22 AM, R1 was sitting in wheelchair with footrests attached. She was in activities. V3 (MOD-Manager on Duty/Activity Director) put R1's feet on the footrests and wheeled her into R1's room. R1 face was observed to be bruised, purplish in color. R1 was	S9999		

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confused. First, she stated she didn't recall the fall incident, but then she said she remembered a little bit of what happened. R1 stated a nurse pushed her wheelchair to be closer to the TV. R1 said her feet were on the footrests but her toes got caught in the wheelchair and she fell forward, hitting her face. R1 stated, "Then I went to the hospital. They took pictures of me. My toes got bent back. They fixed my forehead. Everything was ok. I haven't had any other falls. At least, I don't think I have."

On 9/6/25 at 10:13 AM, V3 (LPN-Licensed Practical Nurse) stated she was the nurse for R1 on 8/26/2025. She stated she works from 12 AM to 8:30 AM. She stated that R1 was displaying her typical behavior of yelling "Help! Help!" To preoccupy her, V3 moved her closer to the TV by pushing her in her wheelchair in the living room. While pushing her, R1 fell forward and hit her face. V3 stated that R1 had her footrests connected to her wheelchair, but she didn't position R1's feet on the footrests. She stated that V6 (Caregiver) toileted and dressed R1 and put her in her wheelchair. She said V6 forgot to put her feet in the footrest and then V3 pushed R1 and she didn't realize that R1's feet were not in the foot rests. V3 stated, "(R1) fell and had a bruise on the middle of forehead. I called 911." V3 stated R1 went to the hospital and she was brought back the same day and she had a bandaid on her forehead.

On 9/6/25 at 10:38 AM, V5 (LPN) stated she worked on 8/26/25. She said worked from 6:30 AM to 3 PM. V5 stated she was doing medications at the other houses, and she didn't see R1 fall. She stated that leg/footrests are supposed to be on the wheelchairs so some residents can use it to elevate their feet. She

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stated when you transfer residents, you need to put the feet on the footrests so the residents' feet don't get caught on the floor. She said footrests are used for safety and they are used to prevent falls.

On 9/6/25 at 11:15 AM, V1 (Executive Director) stated she discussed R1's fall incident from 8/26/25 with V2 (RN-Registered Nurse/ Resident Services Coordinator). V1 stated that last year R1 used a walker to ambulate but this year she's declined and is using a wheelchair. V1 was unable to verbalize any interventions that the IDT (Interdisciplinary Team) discussed. She stated that R1 had 3 prior falls. V1 stated she doesn't have any service plans for R1. She stated she is actively working on creating and updating all the residents' service plans.

On 9/6/25 at 11:51 AM, V2 (RN-Registered Nurse/Resident Services Coordinator) stated she didn't work the day R1 fell. In her opinion, she felt the wheelchair should have footrests and the wheelchair should be locked when not in use. V2 stated the residents' feet should be on the footrests. She said the purpose of the footrest is so the resident doesn't drag their feet on the floor and helps to prevent falls. She stated they are in the process of creating all service plans for all residents.

On 9/6/25 at 12:42 PM, V6 (Caregiver) stated that she was R1's assigned caregiver on 8/26/25. She said that she didn't see R1 fall because she was taking care of another resident in his room. She heard that V3 pushed R1 in her wheelchair and R1 fell. V6 didn't remember if R1 had her footrests on. V6 stated that staff should always put the resident's feet in the footrests when pushing them because the resident shouldn't

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drag their feet, and it can also cause a fall.

R1's face sheet shows the following diagnoses: Alzheimer's disease, dementia in other diseases, other specified anxiety disorder, and other reduced mobility. R1's incident report dated 8/26/25 at 5:58 AM shows the following: "(R1) had a witnessed fall and sent to the ER (Emergency Room) due to the fact that she was sat incorrectly on her wheelchair and it wasn't locked. When she asked for a blanket, I placed it on her. I wanted to move her closer to the TV , but she fell and hit her head on the floor." R1's progress note dated 8/26/25 at 1:15 PM shows, "Night nurse reported that at 5:58 AM, (R1) wheeled closer to the TV and she fell to the floor hitting her head, face down. Night nurse called EMS (Emergency Medical Services) and was transferred to the hospital. At 11 AM, did get a call from the ER nurse and no fracture upon x-rays taken. ER did do first aid to her face. No stitches needed."

Review of R1's other incident reports show that she had three prior falls. On 6/19/25, R1 was found on the floor on her right side. She was complaining of leg pain. R1 was sent to hospital and came back with no injuries. On 8/2/25, R1 was found on the floor. She stated she was trying to go to the bathroom but fell. There were no injuries. On 8/17/25, caregiver reported she heard a noised and found R1 lying on the floor in the dining room. Per R1, she hit the back of head on the floor. She complained of backache. Tylenol was given and cool compress applied to back of head. R1 refused to go to ER.

Review of R1's medical chart shows she had no fall service plans created with appropriate goals and fall interventions.

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Facility's policy titled Falls Prevention (5/2025) shows the following: "Process: Fall Prevention Guidelines guide staff through a structured process to screen and identify residents for predisposing risk factors or a history of falls. Whenever possible, the staff implements precautionary measures to reduce the risk of falls by individualizing resident needs. In the event that a resident is at risk for falls, interventions are incorporated into the resident's service plan; and a negotiated risk is initiated and signed by the resident, POA (Power of Attorney), guardian, or family member (as appropriate) ...interventions should be geared toward the interaction of all those contributing factors. Fall prevention is a team effort involving the resident, resident's family, and staff. Ongoing follow up-1. Staff to be notified of fall prevention plan ....2. Review, modify, and evaluate the effectiveness of the interventions. Keep staff and family informed of any changes.

Facility's policy Planning and Monitoring Services (6/2025) shows: "1 ....Identify and plan for the resident's service needs, requirements, and preferences. Develop the resident's service plan. 3. Residents are reassessed within 30 days and annually unless they experience a significant change for better or worse (change of condition) or per state requirement. Service plans are modified accordingly."

"B"