STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510504	A. BUILDING: _____ B. WING _____	C 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETTY'S GARDEN MEMORY CARE	141 ACORN ST SOUTH KEWANEE, IL 61443

(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
A 000	Initial Comment Original investigation of FRI IL 181887. 295.4060 h) 3) A) Cited	A 000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Section 295.4060 Alzheimer's and Dementia Programs h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who: A) May wander VIOLATION Based on observation, record review, and interviews, the establishment failed to ensure that one of three sampled residents did not elope unsupervised from the building. (R1) Findings include: R1's current service plan notes that R1 was admitted to the establishment on 11/25/24, has Dementia, and is a high risk for elopement. Progress notes on 11/26/24, 11/27/24, 11/28/24 and 11/29/24 notes "Exit seeking behaviors" by going to the doors and pushing on them. Due to	A4060		

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A4060	Continued From page 1 R1's dementia, R1 is unable to answer questions appropriately. Establishment incident report reads, "At 11:42 A.M. 11/30/24, Wellness Director (E2) was alerted that tenant (R1) was last seen on North unit at approximately 11:20 A.M. At time of call to Wellness Director (E2), staff was unable to locate (R1). Staff looking throughout apartments on unit and outside grounds area of community. Wellness Director instructed that staff continue to look for (R1) and have a staff member get into vehicle and widen search area. Wellness Director contacted Executive Director (E1) who both immediately came to community to aide in search. (R1) is alert with confusion and ambulates with a steady gait. Prior to this event, (R1) is a known pacer who would go to the unit doors and push on doors. Once the door alarm sounds, (R1) would walk away from the doors. At 11:55 A.M., (R1) was noted to be at a local factory parking lot ambulating with a steady gait. (Approximately half mile away) Executive Director (E1) was able to get (R1) into vehicle and returned safely back to community. Assessment of (R1) noted small abrasion to 3rd knuckle of right hand. (R1) alert with confusion per baseline, pleasant and cooperative. P.O.A. for (R!) was notified of elopement. Primary care physician was notified via fax of elopement and request for medication review for (R1's) exit seeking behavior and anxiety. Wellness Director (E2) and Executive Director (E1) reviewed community cameras. At 11:00 A.M., (R1) was seen in front seating area of unit, 11:10 A.M. (R1) was seen being assisted to apartment with aide, 11:15 A.M. (R1) is seen seated in chairs with staff in seating area on unit, 11:25 A.M. (R1) is seen going out patio door to fenced in area of patio and then walking to the right of the patio area out of sight	A4060		

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A4060	Continued From page 2 of camera. Wellness Director and Executive Director assessed patio area and noted patio chairs and table were lined against the fencing. Director's contacted maintenance to remove furniture from patio area. Upon further investigation, it was noted that the alarm was deactivated to the patio area. All alarms on unit were tested for functionality and all were noted to be in working order. Staff immediately educated to not deactivate alarm system at any time on the units of the community. (R1) was also placed on 15-minute checks for 72 hours. (R1) will be reassessed in 72 hours to identify continued exit seeking behaviors. If behaviors continue, (R1) will remain on 15-minute checks and if he is not demonstrating exit seeking behaviors, 15-minute checks will be eliminated." On 12/6/24 at 10:20 A.M., E2 (Wellness Director) confirmed that R1 did elope from the facility on 11/30/24. E2 stated that through their investigation they found out that the alarm for the patio door on the North unit was deactivated. E2 stated that none of the staff would admit to deactivating it but it had to be a staff member. E2 stated that when reviewing the camera footage, they noted R1 going out the patio door at 11:25 A.M.. R1 went out of view on the patio and must have used the furniture to go over the fence. E2 stated that they did find R1 at the local factory at 11:55 A.M. and he had just a small abrasion on his right hand. E2 stated that they educated all staff on the need to keep the door alarms on at all times. E2 stated that R1 was wearing long pants, shoes and a long sleeve shirt at the time of the elopement. Accuweather noted that the temperature on 11/30/24 at 11:30 A.M. was approximately 25 degrees Fahrenheit.	A4060		

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