STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510143	A. BUILDING: _____ B. WING _____	C 01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDEN RETIREMENT CENTER, INC	300 S STATION RD GLEN CARBON, IL 62034

(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 Facility Reported Incidents IL199301 & IL199411- Violations cited: 295.4010 d) e) (repeat) 295.6000 a) 13)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 1 Violation Section 295.4010 Service Plan REPEAT VIOLATION d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). Based on interview, observation and record review, the establishment failed to update resident service plans to reflect the current resident's conditions/risks (R1, R2 and R4). This failure creates a substantial probability of severe harm to a resident or residents. Findings include:	A4010		

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A4010	Continued From page 1	A4010		

1. R1's Resident Service Plan dated 12/4/2025 documents R1 requires no assistance with transfers or mobility (walks short distances with wheeled walker and uses an electric wheel chair for all distances outside room).

R1's Service Plan dated 12/20/25 documents, "Additional Services to be provided: Has had a decline in health. Needs occasional checks when weak. Resident is over 110 (years old) and starting to sleep more often. At times he needs more help with ADLs (Activities of Daily Living).

Neither one of R1's Service Plans document R1 is a fall risk or any fall prevention measures.

R1's Progress Notes dated 12/22/2025 at 9:51 (am) documents staff reported R1 needed total assistance with dressing "this weekend" and R1 reported "falling out of bed" on 12/20/2025 to a resident assistant, coughing up phlegm and being more tired than usual. It continues to document R1's daughter was updated on R1's change in condition.

R1's Progress Notes dated 12/23/2025 at 16:24 (4:24 PM) documents a resident assistant reported R1 had fallen while attempting to stand up and use his walker. It continues to document R1 stated he got "twisted up" with the walker and fell on his bottom.

R1's Progress Notes dated 12/23/2025 further documents R1 was educated on taking his time standing up and getting his balance and also when R1 gets unsteady, to sit down on his rollator seat. It further documents, "12/20/25- resident had an unwitnessed fall, was placed on 72 hour checks and R1's nurse/POA was informed of R1's decline in health.

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A4010	Continued From page 2 R1's Progress Notes dated 12/26/2025 documents R1 had fallen at 12:28 AM while attempting to self-transfer from his recliner to his electric wheelchair. It further documents R1 complained of lower back pain and stated he couldn't move and it was painful. R1 was taken to the local hospital at 8:20 AM. R1's Progress Notes dated 12/26/25 documents R1 was admitted to a hospital for a "L1" vertebrae fracture (lower back fracture). 2. R2's Resident Face Sheet documents R2 has a diagnosis of mild vascular dementia. The Establishment's untitled form dated 1/3/2026 documents on 1/3/26 at 6 PM, R2 was eating in the dining room then seen walking towards the front desk. It continues to document by 8 PM staff could not find R2 when they went to complete a safety check and assist R2 with her bedtime medication. It continues to document the local police department called the establishment at 8:20 PM to report they found R2 at a residential house (located 0.3 mile away from the establishment) and would bring R2 back to the establishment. It further documents R2 did not have a coat on. R2's Mini Mental State Examination dated 9/4/25 documents R4 scored 22/30, indicating a mild cognitive impairment. The Establishment provided R2's Resident Service Plan dated 9/4/25 and hadn't been updated to include a history of elopement. On 1/5/2026 at 10:45 AM, R2 stated she did not recall leaving the building and stated, "I don't	A4010		

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A4010	Continued From page 3	A4010		

even know where I am". At this time, Z1, R2's son stated R2 has had memory issues for "a couple of years".

The Establishment's Elopement/Missing Person Policy and Procedure documents, "Policy: To provide direction to staff when a resident is determined to be missing or has eloped. Elopement means a situation in which a resident leaves the building and/or premises with the facility's knowledge and supervision, if necessary. Generally, a situation in which a resident with decision-making capacity leaves the facility intentionally would not be considered an elopement unless the facility is unaware of the resident's whereabouts." It further documents, " 17. Determine approaches needed to decrease risk of future occurrence and update service plan."

3. The Establishment's Fall/Safety Interventions Form documents R4 exited the building on 1/3/26. There are no interventions listed.

On 1/5/2026 at 12:15 PM, E2 , Assisted Living Manager stated R4 just exited the front door and was stopped by the front desk staff.

On 1/5/2026 at 12:45 PM, R4 stated she was instructed to take her shot records to another building, but then was scolded by staff when she did.

On 1/5/2026 at 2:15 PM, E3 stated, "I don't think she's (R4) in her right mind. She doesn't know where she is. She is new."

R4's Resident Face Sheet documents R4 was admitted to the Establishment on 12/19/2025.

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A4010	Continued From page 4 On at 1/5/2026, E2 stated, "They can walk outside. They aren't prisoners. I just made it an incident (on the Fall/Safety Interventions Form) to keep it in my mind. She didn't sign out (on the resident sign in/out form). R4's Resident Face Sheet documents R4 has a diagnosis of dementia, psychotic disturbance, mood disturbance and anxiety. R4's Mini Mental State Examination dated 11/13/25 documents R4 scored 23/30, indicating a mild cognitive impairment. R4's Service Plan does not address R4's mild cognitive impairment or potential exit seeking behavior. On 1/5/2026 at 1:51 PM the progress notes for R2's and R4's elopements/exit seeking behavior were requested and E2 stated she had not completed them yet but she was "working on them when you (surveyor) walked in" and was "trying to get (R2) 'out' (admitted to the memory care unit)".	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an	A6000		

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A6000	Continued From page 5	A6000		

establishment, nor shall a resident forfeit any of the following rights:

13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor;

Based on observation, interview and record review, the Establishment failed to provide a secure environment and provide adequate monitoring and supervision to prevent resident elopement (R2). This failure has the substantial probability of severe harm to a resident (or residents)

Findings include:

R2's Resident Face Sheet documents R2 has a diagnosis of mild vascular dementia.

The Establishment's untitled form dated 1/3/2026 documents on 1/3/26 at 6 PM, R2 was eating in the dining room then seen walking towards the front desk. It continues to document by 8 PM staff could not find R2 when they went to complete a safety check and assist R2 with her bedtime medication. It continues to document the local police department called the establishment at 8:20 PM to report they found R2 at a residential house (located 0.3 mile away from the establishment) and would bring R2 back to the establishment. It further documents R2 did not have a coat on.

The Local Police Departments Report dated 1/3/2025 documents the Police Department received a call about an older famale observed on a door ring camera of a residence, the police department responded and found R2 to be confused, unaware of where she was. It continues to document R2 mentioned the

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A6000	Continued From page 6	A6000		

establishment, the officer called and verified R2 was a resident of the establishment and transported R2 back to the establishment.

R2's Mini Mental State Examination dated 9/4/25 documents R4 scored 22/30, indicating a mild cognitive impairment.

The Establishment provided R2's Resident Service Plan dated 9/4/25 and hadn't been updated to include a history of elopement.

On 1/5/2026 at 10:45 AM, R2 stated she did not recall leaving the building and stated, "I don't even know where I am". At this time, Z1, R2's son stated R2 has had memory issues for "a couple of years".

On 1/5/2026 at 12:30 PM, E2 was asked to describe the weather outside on 1/3/26 to which she answered, "clear, but cold."

On 1/5/2026 at 3:00 PM, the location of the residential home R2 was found at was observed. There was a community lake/pond adjacent to the property that is 0.3 miles away from the establishment.

The Establishment's Elopement/Missing Person Policy and Procedure documents, "Policy: To provide direction to staff when a resident is determined to be missing or has eloped. Elopement means a situation in which a resident leaves the building and/or premises with the facility's knowledge and supervision, if necessary. Generally, a situation in which a resident with decision-making capacity leaves the facility intentionally would not be considered an elopement unless the facility is unaware of the resident's whereabouts." It further documents, "

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A6000	Continued From page 7 17. Determine approaches needed to decrease risk of future occurrence and update service plan." The Establishment's Resident Rights Policy was provided and is the 295.6000 code.	A6000		