STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510046	A. BUILDING: _____ B. WING _____	C 03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVONLEA COTTAGE #2/ QUAD CITIES	2025 E 1ST ST MILAN, IL 61264

(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 Complaint investigation #2522621/IL188836	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) Violation Based on observation, interivew and record review, the establishment failed to secure the appropriate services/level of care for one of three residents (R1) reviewed in a sample of three. Findings include: R1's 2-23-25 progress notes document "Resident exited AL (Assisted Living) per self at 1530 (3:30 pm) and walked to parking lot. Staff assisted confused resident back to AL. Nurse notified. DON (Director of Nursing) notified. Resident brought to locked memory care unit for remainder of awake time today."	A2000		

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A2000	Continued From page 1 On 3-21-25 at 12:40 pm, E3 (Caregiver) stated on 2-23-25, somewhere between 3:30 and 4:00 pm, she was taking out the trash and saw R1 on the sidewalk near the memory care unit. E3 was unsure how long R1 had been outside. E3 stated R1 is not safe to be outside by himself as he is confused and could wander off. E3 stated R1 is confused and will sometimes go to the exit door stating he needs to get in his car and "do stuff." On 3-23-25 at 5:50 pm, E4 (LPN/Licensed Practical Nurse) stated R1 was found outside on 2-23-25 in the parking lot. E4 was concerned for R1's safety so she had R1 stay on the locked memory care unit until his family could come. E4 stated R1 gets very confused in the afternoons, exit seeking and not knowing where he is. If R1 is exit seeking in the afternoon/evening time, they will with lock the Assisted Living doors or call family to come in. E4 stated she would never want R1 outside by himself due to his confusion and what might happen to him. On 3-21-25 at 11:20 am, R1 was up in the dining room. R1 stated he did not "live here" but lived down the street. R1 did not answer any more questions. R1's 10-31-24 Physician Health Assessment Form documents R1 has dementia. R1's undated SLUMS (The Saint Louis University Mental Status) documents R1 has a score of 9 out of 30 indicating dementia. Progress notes dated 2-3-25 and 3-17-25 document R1 is "an elopement risk" and "exit seeking." R1's 11-1-24 service plan documents R1 needs assistance with activities of daily living and has "poor ability to mae judgement" and poor ability to make decisions."	A2000		

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A2000	Continued From page 2 On 3-21-25 at 10:20 am, E1 (DON/Director of Nursing) stated they were thinking R1 should be admitted to their Memory Care unit but family wanted him in the Assisted Living unit. E1 stated if R1 has increased confusion and exit seeking, we lock the front door or call family.	A2000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Section 295.4010 Service Plan 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). Type 3 Violation Based on interview and record review, the establishment failed to revise R1's service plan after exit seeking behaviors for one of three residents (R1) reviewed in a sample of three. Findings include: R1's 2-23-25 progress notes document "Resident exited AL (Assisted Living) per self at 1530 (3:30 pm) and walked to parking lot. Staff assisted	A4010		

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A4010	Continued From page 3 confused resident back to AL. Nurse notified. DON (Director of Nursing) notified. Resident brought to locked memory care unit for remainder of awake time today." R1's 11-1-24 service plan documents R1 needs assistance with activities of daily living and has "poor ability to make judgement" and Poor ability to make decisions." There is no mention of R1's exit seeking behavior or elopement episode. On 3-24-25 at 1:10 pm, E2 (Office Manager) stated yes we should have revised that.	A4010		