STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510179	A. BUILDING: _____ B. WING _____	C 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENTREE AT MT VERNON	208 ZACHARY ROAD MOUNT VERNON, IL 62864

(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 Incident Investigation to Incident dated 7/12/25 / IL196428 Violation cited: 295.9040 a)	A 000		
A9040	Section 295.9040 Environmental Requirements This Regulation is not met as evidenced by: TYPE 2 VIOLATION Section 295.9040 Environmental Requirements a) The establishment shall be kept in a clean, safe and orderly condition and in good repair. Based on interview and record review the facility failed to ensure residents with dementia are provided a safe and secure environment to prevent unsupervised exit from a secured dementia facility. This failure creates a substantial probability of harm to residents, placing residents at risk for accidents, assault, heat or cold exposures, dehydration or being struck by a motor vehicle. Findings include: R1's Incident Report Investigation dated 7/12/25 documents, "Resident exited facility and walked down the street to (drive-in fastfood restaurant). Resident was returned to facility. Resident assessed, no signs or symptoms of distress or injury noted. Resident's daughter, administrator and wellness director notified of incident.. Resident placed on every hour checks."	A9040		

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A9040	Continued From page 1	A9040		

R1's record documents R1 is a resident of the Memory Care unit, has primary diagnosis of dementia, and is an elopement risk.

R1's Service Plan dated 2/26/25 documents, "Wandering/Elopement - Supervision. Directions: Provide supervision and redirection to avoid and prevent wandering episodes. Resident Needs/Preferences: To receive full supervision and redirection from staff to avoid and prevent wandering episodes. Staff to notify the nurse, Resident Care Coordinator, and administrator immediately of any increase in concerns with wandering and/or safety. On 7/12/25 - Elopement. 1 hour checks put in place right away.

On 7/23/25 at 9:45 AM, E2 (Director of Nursing) stated that on 7/12/25 at around 9 AM, R1 was brought in by a lady in a car from the drive in restaurant next door, a 1-2 minute walk from the facility, R1 had asked her for a ride. Camera footage were reviewed and showed R1 exited the MC unit thru the North East door at 8:50 AM at which time all the staff and all the residents were gathered in the living room situated at the south end of the building. Nobody heard the alarm sounding nor any of their pagers alerting that an alarm door was opened. E2 stated E4 (Maintenance Director) arrived and reset the doors, made sure every exit door was properly functioning and all pagers would alert to the North East door opening.

On 7/23/25 at 10:10 AM, E3 (Certified Nursing Assistant) stated she worked at the Memory Care unit on 7/12/25 from 6 AM to 2 PM and upon arrival observed R1 already started pacing from door to door, saying she wanted to go home, refused to sit down and have breakfast, and all staff took turns trying to redirect her with no

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A9040	Continued From page 2	A9040		

success. E3 stated she checked on R1 every hour because of her behavior and the others were keeping an eye on R1 too. E3 stated that all residents ate and gather at the south end of the facility for activities because of low census. E3 stated the last time she saw R1 was around 8:30 AM when she observed E5 (Licensed Practical Nurse) trying to offer R1 medication to calm her down and R1 refused and walked away. E3 stated all staff gets a pager at start of shift and she always checks if the pager she is using is connected to the door alarm at the beginning of her shift and she did not do it that morning or she would have notified E4 that her pager was not connected to the alarm doors.

In a signed statement dated 7/24/25, E4 stated he received a call on 7/12/25 at around 9:05 notifying him about an issue with the pager system and came in to work and reprogrammed the zone panel box for that area and the pagers worked.

On 7/23/25 at 9:55 AM, E1 (Administrator) stated that upon investigation it was found out the pager system did not work to alert the North East door that morning. All the alarms were working but the pagers were not alerted to the North East door when it opened as it should have done. All staff were at the south end of the building and could not hear the alarm sounding from the North East door when it opened. After the incident, all Memory Care doors were placed on 2 -hour checks to ensure proper function and external audible alarms were installed on the doors to help alert staff to the door opening. The vendor was contacted to diagnose why the door did not alarm to the pagers and make sure it will not happen again.

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A9040	Continued From page 3 The Facility Elopement Evaluation and Missing Resident Policy revised dated 4/2022 documents, "Policy: Residents are evaluated for risk upon move in; team members receive training regarding wandering prone individuals, and missing person protocols are established. Purpose: The greater the degree of the resident's cognitive impairment, the greater the risk for wandering and elopement behavior. The purpose of this policy is to prevent and/or minimize the risk of resident elopement. Team Education: 7. The care team will be alert at times of critical opportunity for a wandering or elopement incident (i.e.Change of shift, end of visiting hours and emergency situations)."	A9040		