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S 000	Initial Comments Annual Licensure Survey Complaint Investigation: 2395423/IL00161556 - 330.710 2395847/IL00162072 - No Deficiency 2397980/IL00164779 - 330.911, 330.710, 330.4240 2398030/IL00164829 - 330.710 2398255/IL00165108 - No Deficiency 2491440/IL00170047 - 330.710 Facility Reported Incident of April 27, 2023/IL00159437 - 330.4240 Facility Reported Incident of August 20, 2023/IL00163560 - 330.710 Facility Reported Incident of August 21, 2023/IL00163562 - 330.710 Facility Reported Incident of August 31, 2023/IL00164216 - 330.710 Facility Reported Incident of September 13, 2023/IL00164328 - 330.710	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 6 Section 330.911 Health Care Worker Background Check	S9999		

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A facility shall comply with the Health Care Worker Background Check Act [225 ILCS 46] and the Health Care Worker Background Check Code (77 Ill. Adm. Code 955).

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to follow the facility Criminal History Background Check Policy. This failure affected one employee (V4) of 9 employee files reviewed for background checks.

Findings include:

On 4-11-24 at 8:46 AM, surveyor and V5 (Human Resources/ Business Office Manager) reviewed R4's employee file and could not locate V4's employee background checks.

On 4-11-24 at 11:19 AM, V1 (Administrator) said she reviewed V4's Employee file and did not see V4's background checks in the employee file. V1 said she will reach out to cooperate to verify if they have V4's background checks.

On 4-11-24 at 8:46 AM, V5 (Human Resources/ Business office) said V4 (Resident Program Coordinator) is a long-time employee since 2002. V5 said had V4 no documentation of any background checks in their employee file.

Criminal History Check Policy dated 1-14-13 documents: Policy Statement: It is the policy of HCR ManorCare to conduct criminal background checks within the guidelines of specific state and federal laws. All applicants who are offered employment will undergo a criminal background check.

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(C)

Licensure Violation 2 of 6

Section 330.710 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to follow the facility fall policy by not implementing effective fall interventions and supervision for three (R3, R4, R5) residents that had a fall. This failure resulted in: (R3) sustaining a nosebleed and bilateral bruising to both eyes, (R4) sustaining a small cut to her forehead, and (R5) sustaining a fall resulting in a rib fracture and a bruised and swollen finger.

Findings include:

Falls Prevention Policy documents: Purpose: Identify residents at risk or predisposed to falls. Evaluate the health, safety, and welfare of our residents and implement measures to attempt to prevent falls and minimize the risk that serious injury will result.

R5 dx not limited to Alzheimer's Disease,

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S9999	Continued From page 3 Dementia with behavioral disturbance, Chronic Back Pain (Falls Investigation Tool dated 8-13-23) On 4-10-24 at 1:00 PM, V2 (Resident Service Coordinator) said R5 is alert, confused, and able to make simple needs known. V2 said she does not believe R5 would be able to accurately report any incident or abuse. V2 said R5 is a fall risk due to confusion, dementia, could be impulsive, and not ask for help. V2 said on 8-31-24 after fall, hematoma to back of head however R5 was not sent to hospital. V2 said 72-hour neuro checks within normal limits and was stable at that time. V2 said family and MD were notified. V2 said R5 had complaint of pain that morning however no further complaint of pain or indication of rib pain or injury the day of the fall. V2 said nurse did head-to-toe assessment with no acute findings. R5's son said R5 was complaining of abdominal pain and brought R5 to urgent care for evaluation which found rib fracture. V2 said she believes the rib fracture could have been due to the previous fall. On 4-10-24 at 10:08 AM, V11 (Resident Care Giver) said R5 had a couple of falls at the facility. V11 said R5 was trying to walk with a boot and bilateral bad knees. V11 said R5 was alert and confused. V11 said R5 has dementia, confusion, and poor safety awareness. V11 said R5 requires frequent monitoring. V11 said at the time of the fall, R5 was in the house kitchen sitting next to V11. V11 said she was by herself because the 2nd Resident Care Giver was floating to other units. V11 saw R5 get up and fall backwards hitting her head. V11 informed R5's nurse who responded immediately. V11 does not recall if there was any injury or if R5 went to hospital. V11 said she is not aware of R5 having any rib injury at that time.	S9999		

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State Report dated 8-31-23 documents: Brief Description of Incident: Resident was observed by staff falling backwards to the floor hitting the back of her head. Immediate Action Taken By Center: Resident assessed by staff, Neuro checks initiated all WNL, resident observed x 72 hours per company policy. Family and MD made aware. Disposition: Resident was taken to urgent care by her son on 9-2-23 for complaints of lower abdominal pain. Per son, x-ray revealed a rib fracture. Resident had a fall on 8-31-23. Was observed by staff falling backwards onto the floor, hitting the back of her head. Resident denied pain at that time. Neuro checks were within normal limits. No complaints of pain prior to 9-2-23. Resident denies falling again.

Progress Note dated 8-31-23 documents (in part): Res was observed by CG standing in the dining room with her boot on her foot, talking to another resident, lost her balance, and fell backwards onto the floor, hitting her head. Res has a small hematoma to the back of her head. No break in skin or loss of consciousness. No changes in ROM. Res assisted off of the floor with assist x2, and placed into W/C. Boot removed, and leg elevated on chair in living room for closer observation. Neuro checks initiated. Res denies pain. Son, notified by writer of incident. Dr. ***** aware.

Progress Note dated 9-2-23 documents: Resident was c/o lower abdominal pain- moaning and guarding site. Son took her to urgent care for further eval. Positive rib fracture noted on x-ray. Resident had fall on 8/31/2023, and small hematoma was noted to back of head. Neuro checks were done- within normal limits. No complaints of pain or incidents noted until

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morning of 9/2/23 when resident complained of abdominal pain. Staff aware to keep res in common area as much as possible with boot on for closer observation and continue to observe for signs and symptoms of pain.

Progress Note dated 9-2-23 documents: Son returned with resident from urgent care visit. Closed fracture. Right side multiple fracture.

Radiology Report dated 9-2-23 documents: Clinical History: Right-sided rib pain after fall 2 days prior. Findings: Acute nondisplaced fracture of the right sixth rib laterally and the seventh rib anteriorly.

Nurse Practitioner Progress Note dated 9-8-23 documents: Assessment/ Plan: Rib fracture s/p fall New, Acute.

R3
On 4-10-24 at 10:39 AM, V2 (Resident Service Coordinator) said R3 is alert, oriented x1, and able to make simple needs known. When R3 had Covid, R3 became weaker and less coherent. V2 said upon R3's admission R3's initial nursing assessment documents no fall history or any risk for falls. V2 said R3 was on 30 minutes checks when hourly checks are the standard. R3 said all of the residents are unable to grasp the concept of call lights or asking for assistance. R3 was placed on 30-minute checks immediately. On 9-20-24, R3 was observed sitting on the floor with nosebleed and not acting per her baseline (increased confusion). V2 asked if she fell and R3 said she did not think so. R3's speech was slurred and had delayed responses. MD was notified and sent to hospital for evaluation. V2 said R3 did not return after transfer. V2 said R3's

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initial incident R3's right eye was worse than left. R3's 2nd incident, R3 had bilateral bruising. V2 said R3 was on 6:1 ratio (6 residents to 1 caregiver). R3's acuity was not high however Covid made R3 more confused and weaker.

On 4-11-24 at 2:19 PM, (Licensed Practical Nurse) V3 said R3 required 30-to-15-minute checks. V3 said staff would keep R3 in common areas and encourage activity. During the night RCG (resident caregiver) will do room checks. The facility is not equipped to provide one-to-one.

State Report dated 9-20-23 documents: Resident was noted sitting on the floor with nosebleed and both eyes swollen and bruised. Resident was in living room at time of incident and caregiver stated that resident has been getting on and off the floor today. RN asked resident if she fell and resident replied, "I don't know, I don't think so." Speech slurred and delayed responses noted. Resident usually responsive and ambulatory. Type of Injuries: Bruised eyes, swollen eye, bruised bridge of nose. Immediate Action Taken by Center: Assessed for further injuries- none noted. Primary MD noted. Family notified. Medical Director notified. Resident transferred to Northwestern Hospital for further evaluation- rule out head trauma. Disposition: Resident remain in hospital with facial fracture and brain bleed.

R4's Dementia Behavior Service Plan documents: Provide a calm, safe environment, i.e., hourly checks.

On 4-9-24 at 2:15 PM, surveyor observed R4 in central common area sitting on a chair with no staff present. Surveyor observed R4 stand up and start walking while dragging the chair behind her.

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S9999	Continued From page 7 On 4-10-24 at 11:30 AM, V2 (Resident Services Coordinator) said R4 is alert and unable to make her needs known. V2 said R4 would not be able to report any abuse or incident due to confusion. V2 said she noted blood on the door on the inside of a resident room. V2 believes R4 walked into the wall and would not be able to report this to any staff. V2 said R4 requires routine hourly checks. V2 said R4 has no safety awareness due to altered mental status and confusion. V2 said all residents are fall risk. On 4-9-24 at 12:27 PM, V6 (Resident Care Giver) said R4 is alert, confused, and unable to make her needs known. V6 said R4 will repeat what she is told and unable to effectively communicate. V6 said R4 will mimic the speaker. V6 said R4 is risk for abuse because R6 does not speak and R6 can aggravate other residents by wandering and entering other resident rooms. V6 said R4 requires frequent monitoring due to confusion, wandering behaviors, and poor safety awareness. On 4-10-24 at 9:55 AM, V8 (Resident Care Giver) said she saw R4 with bruised eye. V8 asked R4 what happened and R4 was unable to articulate what happened. V8 said she reported this to the nurse. V8 said R4 is confused and unable to make her needs known and has no safety awareness due to confusion. V8 said R4 would not be able to report abuse or any incident that occurred. V8 is not aware of any accident or incident that could cause R4's bruising. V8 said she has not seen any abuse by resident or staff towards R4. V8 said R4 is a fall risk because she is confused, gets up by herself, and wanders the facility. On 4-10-24 at 10:32 AM, V12 (Resident Care Giver) said R4 is confused with poor safety	S9999		

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awareness. V12 said R4 like to wander the units and will wear other resident's clothing, and sleep in other resident's beds. V12 said he would monitor R4 every 15 to 20 minutes during R4's waking hours (when not in bed or room).

Progress Note dated 8-21-23 documents: Staff heard another resident screaming that the resident has blooding on her left forehead.

State Report dated 8-21-23 documents: Staff heard another resident yelling out that resident (R4) was bleeding from her forehead. Type of Injuries: small cut 0.25 cm to forehead. Immediate Action Taken By Center: First aid administered. Assessed for further injuries- none noted. MD notified. Family notified. Disposition: No changes in level of consciousness. Neuro checks within normal limit Resident functioning at baseline. Ambulates independently.

(B)

Licensure Violations 3 of 6

Section 330.710 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part.

This regulation was NOT MET as evidenced by:

1. Based on interviews and record reviews the

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facility failed to follow their policy and procedures for discharging residents by not communicating with the resident or their representative the criteria for returning to the facility nor did the facility provide assistance with discharge planning and referrals after involuntarily discharging the resident due to aggressive behavior. This failure applies to one of three residents (R1) reviewed for involuntary discharges.

Findings include:

R1 was a 77-year-old male with a diagnoses history of Dementia without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, Anxiety, and Depression. who was admitted to and discharged from the facility 07/01/2023.

R1's progress notes dated 7/1/2023 document at 6:14 PM it was noted R1 moved in at 10:30am accompanied by his family members from Princeton Rehabilitation And Heath Care Center. R1 was alert but, very aggressive running after staffs, pushing on doors 911 was called, two Police officers came in at 11:45am one asked him if he hit anyone or did anyone hit him and he replied no; the two paramedics came in and said they know R1 from another facility and he doesn't do well with women. R1 likes to chase them around. R1 was taken to Ingalls Hospital for further evaluation; at 7:42 PM it was noted at 4:30pm V21 (Family Member) came and moved R1 out and took all his things.

On 04/11/2024 at 10:45 AM V1 (Executive Director) stated admission requirements depend on where residents are coming from. V1 stated if a resident is coming from a former facility or hospital a referral packet is required. V1 stated

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we need to see the resident's diagnosis and we need to determine if we can manage them at the facility. V1 stated there has to be a diagnosis of Alzheimer's or Dementia. V1 stated if there is any notation of any violent behaviors for prospective residents, V2 (Resident Care Coordinator/Registered Nurse) will review if they're on any antipsychotics or any other medications or behavior that would make it out of the facility's scope of care and they would not be admitted. V1 stated violent behaviors would exclude a resident from being admitted to the facility. V1 stated family's will withhold if the prospective residents have violent behaviors such as hitting caregivers. V1 stated the facility also obtains medical paperwork form prospective resident's physician 30 days prior to admission. V1 stated usually within the first 48 hours to 2 weeks the resident will exhibit behaviors and will have to be sent out for a psych evaluation and the family is contacted. V1 stated then the resident exhibiting these behaviors will usually have stay for a psych eval for about for 2 weeks to get them to a safe therapeutic level without behaviors and then they are able to return. V1 stated they do interview family regarding any behaviors but the families often don't report this information. V1 stated if families report violent or concerning behaviors our recommendation is to have the resident see a neurologist and then get them to a therapeutic level prior to admission. V1 stated she was informed that R1 tried to attack V21 (Licensed Practical Nurse) and they had to send him out for a psych evaluation. V1 stated she's not sure what was discussed with R1's family regarding his return to the facility but his family would have been advised on the procedures previously discussed and then they would have considered readmitting him. V1 stated referral packets usually contain face sheet, progress

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notes from previous care at previous facilities, diagnoses, medication list. V1 stated other required documents from family would include homework packet with information regarding the resident such as likes and dislikes and should be included in all resident's medical record.

On 04/11/2024 at 11:49 AM V1 (Executive Director) stated they do ask prior facilities about resident's behaviors and if they provide any information about concerning behavior it is documented. V1 stated if they observe anything that raises questions about the resident's behavior they will follow up with the former facility and ask additional questions.

On 04/12/2024 at 11:30 AM V20 (Family Member) stated basically a nurse from the hospital R1 was transferred to from Arden Courts informed her he was discharged from the facility illegally and they couldn't do that so they advised they would file a complaint. V20 stated prior to coming to Arden Courts R1 was at a hospital, then transferred to a skilled nursing facility when they found Arden courts. V20 stated they then transferred him to Arden Courts and within 2 hours of him being admitted he was sent to the hospital and not allowed to return. V20 stated she picked R1 up from the hospital and he never returned to the facility. V20 stated she came and picked up R1's belongings from the facility because he was not allowed back at the facility. V20 stated when she picked up R1's belongings from the facility they told her he could not return because he was aggressive. V20 stated she was not offered an option to return him and was even charged for the full day although he was only there for 2 hours. V20 stated we literally took him to the facility because they specialized in dementia. V20 sated R1 was aggressive prior to

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coming to Arden and the facility was aware as all this information was included in his records which the facility was aware of. V20 stated R1's medical records showed he had a history of aggression and that's why other facility's wouldn't take him, but Arden Courts assured they could take him in because they specialize in dementia.

R1's medical records did not include his referral packet or reports from the nursing facility or hospital he was in prior to admission to the facility and does not include documentation that R1 or V20 (Fa mily Member) were advised on the facility's return criteria or received assistance with discharge planning and referrals.

The facility's Move Out Criteria policy received/reviewed 04/10/2024 states:
"Arden Courts is committed to providing you and your loved one quality service for as long as it is possible and appropriate. However, there are needs that cannot be met at Arden Courts and may be better served in a different setting or with additional services."
"Our move-out decisions are made in consultation with the responsible party, family members and clinicians and are based on whether the community can continue to appropriately meet Resident's needs, as their care needs change with the progression of the disease."

The facility's Admissions Contract Move Out or Transfer policy received/reviewed 04/10/2024 states:
"If Arden Courts determines that the Resident needs services beyond those Arden Courts is licensed to provide, the Responsible Party will be notified that the Resident will be transferred to an appropriate care setting. Arden Courts will assist

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the Responsible Party with discharge planning and referrals.

The facility's Transfer Policy received/reviewed 04/12/2024 states:
"Transfers of residents whose condition requires more care than is available at the community are evaluated on a case-by-case basis and with the advice of a physician."

2. Based on interviews, observations, and record reviews the facility failed to follow their policy and procedures for fall prevention by not identifying risks for falls, not completing a fall investigation tool after each fall, not tracking fall patterns, not reviewing, modifying, or evaluating the effectiveness of fall interventions, and not providing adequate supervision for a resident who experienced multiple unwitnessed falls. This failure applies to one of three residents (R12) reviewed for falls.

Findings include:

R12 is an 81-year-old female with a diagnoses history of Dementia and Parkinson's Disease who was admitted to the facility 06/22/2023.

On 04/09/2024 from 12:31 PM - 1:14 PM Observed R12 use her rolling walker to ambulate herself to the Central Station Activity room, then observed R12 having difficulty placing herself in a chair at a table in the room. R12 stated she needs assistance. Observed R12 sit herself in a chair with her rolling walker next to the chair. Observed R12 with an abrasion on the right side of her nose. R12 stated she had a fall last Thursday and went to the hospital. R9 stated she hit her forehead when she fell, and no one was around when it happened. Observed R12 get up

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and walk back and forth from chair to chair with an unsteady gait without using her rolling walker. Observed no staff present throughout the course of this movement; at 1:14 PM Observed V4 (Program Services Coordinator) come and assist R12 out of the Central Station room.

R12's service plan for falls and wandering initiated 08/21/2023 documents interventions initiated 01/20/2024 including: Fall management interventions of encouraging resident to be in the community center with activities throughout the day in order to decrease falls; Hourly rounds daily; Evaluate for Physical/Occupational Therapy; and Observe for needed rest periods. R12's service plan does not include interventions addressing her trying to get up and do things on her own.

Incident report dated 10/19/2024 documents R12 was observed in her bedroom on the floor near her dresser with her back leaning on the dresser in a sitting position. Upon assessment R12 was initially observed with redness to her upper back side and three hours later observed with redness to right upper back.

A falls investigation form was not provided by the facility for her fall on 10/19/2023.

Incident report dated 10/26/2023 documents a caregiver observed R12 sitting on the floor in her room next to the door.

R12's progress notes dated 10/26/2023 documents a caregiver observed R12 sitting on the floor in her room next to the door.

R12's Falls Investigation Tool dated 10/26/2023 documents she has a diagnoses history of

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Dementia, Parkinson's, and is a fall risk; had a previous fall on 10/09/2023.

R12's progress notes dated 4/9/2024 at 11:38 PM documents R1 returned from hospital with no new order.

An incident report and falls investigation tool was not provided by the facility for a fall incident on 04/09/2024.

On 04/10/2024 from 1:30 PM - 1:45 PM V2 (Registered Nurse/Resident Services Coordinator) stated R12 went out on the morning of 04/09/2024 for a fall. V2 stated they found R12 face down in the bathroom and the right side of her face was a little pink and her pupils were not reactive to light so they sent her out. V2 stated R12 does need help going to the bathroom just for safety because she walks with a rolling walker but is incontinent and may spontaneously feel the urge to go to the bathroom so we try to toilet her every couple of hours. V2 stated she doesn't see R12 walking without her walker. V2 stated sometimes there will be some device neglect but R12 is pretty good with using her rolling walker. V2 stated R12 has lower extremity weakness, and an unsteady gait without her rolling walker. V2 stated if staff observe R12 does stop using her walker consistently they will remind her and potentially have to use her wheelchair depending on the circumstances. V2 stated R12 probably fell just trying to use the bathroom on her own. V2 stated she is not aware of R12 typically trying to use the bathroom on her own. V2 stated R12 does not roam and rather moves on request and will follow when lead. V2 stated it's rare you'll see R12 wandering and she likes to get somewhere and sit down. V2 stated if R12 does begin to start wandering without her walker it would be a safety

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concern but not if she is wandering around without her walker. V2 stated hourly checks are done so staff are aware of all resident's whereabouts. V2 stated for residents who do exhibit device neglect they try to keep a close eye on them and bring them in the common areas.

On 04/11/2024 at 12:20 PM V3 (Licensed Practical Nurse) stated risk factors for R12 falling includes her needing assistance. V3 stated most of the time when R12 fell she tried to get up herself, or when in her wheelchair tried to go to bed by herself, or tried to go to the bathroom by herself. V3 stated R12 tries to do things by herself. V3 stated R12 engages in these behaviors at any time of day even right after being toileted. V3 stated sometimes R12 misses the chair. V3 stated falls investigation tools are completed by nurses after each fall. V3 stated when risks for falls are identified V2 (Registered Nurse/Resident Services Coordinator) will revise resident's service plans with interventions to address those risks.

On 4-11-24 at 2:26 PM, V1 stated she would ask family to visit, hire a private sitter, discuss with family the possibility of skilled care, or discuss negotiated risks at the facility if a resident needs increased supervision. V1 stated residents need increased supervision when they have increased falls and behaviors that are beyond the facility's scope of care. V1 stated if residents have multiple unwitnessed falls there may be a need for increased supervision or they may need to be considered for skilled nursing services based on the progression of their disease. V1 agreed that supervision may not be adequate if residents sustain a fall while being supervised or have multiple unwitnessed falls. V1 stated if a resident has multiple falls or require 15 min checks, the

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resident may be considered for skilled nursing care. V1 stated the facility does not track fall trends.

The facility's Falls Prevention Policy received/reviewed 04/11/2024 states:
"Purpose is to Identify residents at risk or predisposed to falls. Evaluate health, safety and welfare of our residents and implement measures to attempt to prevent falls and minimize the risk that serious injury will result."
"Falls 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. There are multiple contributing factors when examining the reason, a resident falls and interventions should be geared toward the interaction of all those contributing factors."
"Identify any predisposing factors - physical, mental (psychological, cognitive) or environmental."
"Review, modify, and evaluate the effectiveness of the interventions. Keep staff and family informed of any changes."
"Track falls using a copy of the community's lay out to determine patterns. Possible pattens include: change of shift; employee's break time; same employee scheduled; orduring "Sun Downing" time."

3. Based on interviews and record reviews the facility failed to follow their policy and procedures for pneumonia immunization by not ensuring eligible residents received the pneumonia vaccine. This failure applies to two of five residents (R11 and R12) reviewed for immunizations.

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Findings include:

R11 is an 83-year-old resident whose Vaccine consent form dated 09/28/2023 documents she was consented to receive a flu, pneumonia, and COVID vaccine who received a flu and COVID Vaccine 10/18/2023 but has no record of receiving a pneumonia vaccine.

R12 is an 81-year-old resident whose Vaccine consent form dated 09/28/2023 documents she was consented to receive a flu, pneumonia, and COVID vaccine received a flu and COVID vaccine 10/18/2023, but has no record of receiving a pneumonia vaccine.

An email from V22 (Pharmacy Manager) dated 04/11/2024 11:10 AM documents residents immunization records were reviewed and R11 and R12 are both overdue for the Pneumonia vaccine.

The facility's Immunization Policy received/reviewed 04/10/2024 states:
"Pneumococcal Immunization will be offered upon move in."
"The Resident Services Coordinator reviews the resident's Medical Evaluation Form or state specific form for evidence of: Pneumovac Immunization in past 10 years."
"The Resident Services Coordinator offers the Pneumovac Immunizations if the resident is not already Immunized and obtains a physician's order.

4. Based on interviews and record reviews the facility failed to follow their policy and procedures for resident transfers and change in condition by not informing a family that a resident was

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transferred to the hospital for evaluation. This failure applies to one of three residents (R1) reviewed for transfers.

Findings include:

R1's progress notes dated 7/1/2023 document at 6:14 PM it was noted R1 moved in at 10:30am accompanied by his family members from Princeton Rehabilitation And Heath Care Center. R1 was alert but, very aggressive running after staffs, pushing on doors 911 was called, two Police officers came in at 11:45am one asked him if he hit anyone or did anyone hit him and he replied no; the two paramedics came in and said they know R1 from another facility and he doesn't do well with women. R1 likes to chase them around. R1 was taken to Ingalls Hospital for further evaluation; at 7:42 PM it was noted at 4:30pm V20 (Family Member) came and moved R1 out and took all his things.

On 04/12/2024 at 11:30 AM V20 (Family Member) stated within 2 hours of R1 being admitted he was sent to the hospital and not allowed to return. V20 stated the facility did not call her to inform her R1 was being transferred to the hospital because of has dementia and being aggressive.

On 04/12/2024 at 12:19 PM V1 (Executive Director) stated resident's family members or responsible party are informed if they are transferred to the hospital.

The facility's Admissions Contract Move Out or Transfer policy received/reviewed 04/10/2024 states:
"If Arden Courts determines that the Resident needs services beyond those Arden Courts is

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licensed to provide, the Responsible Party will be notified that the Resident will be transferred to an appropriate care setting. Arden Courts will assist the Responsible Party with discharge planning and referrals.

The facility's Change of Condition Policy received/reviewed 04/12/2024 states:
"Evaluate the seriousness of the issue."
"Determine whether a call to 911 is indicated."
"Document all interventions."
"Notify the Responsible Party."

(B)

Licensure Violations 4 of 6

SECTION 330.710 RESIDENT CARE POLICIES

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part.

This requirement was NOT MET as evidenced by:

Based on interview and record review, the facility failing to follow their policy to investigate any allegation of abuse. This failure resulted in the facility being unable to reduce resident risk, mitigate harm, identify root cause and associated factors, and minimize the opportunity for recurrence of abuse.

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S9999	Continued From page 21 Findings include: R7 is 75 years of age. Current diagnoses include but are not limited to Dementia unspecified severity, type whether behavioral, psychotic, or mood disturbance or anxiety, Alzheimer's Disease, Aggressive Behavior, Gout, and Hypertension. R8 is 83 years of age. Current diagnoses include but are not limited to Alzheimer's Disease, Left Knee Osteoarthritis, and Weight Loss. R9 is 86 years of age. Current diagnoses include but are not limited to Dementia. On 4/9/24 at 11:30 AM, V1 was asked to provide the resident to resident abuse investigation for R7 from 4/27/23 for review. On 4/11/24 at 12:19 PM, V1 was inquired of R7's incident on 4/27/23 and how a resident is screened for abuse upon being accepted into the facility. V1 said, "I am the executive director and I've been trained for abuse. After we receive the resident's paperwork from the hospital or transferring facility we communicate with the family and use all the information to put the service plan together. If we come up with a red flag for behaviors, we check if the resident's behaviors are controlled, and medication is being taken. If the resident is at a therapeutic level, we allow them to come into our community." How do you monitor a resident with behaviors? V1 said, "Everyone has hourly checks. If a resident is flagged for concerns, we take the checks down to 30-15 minutes." Was R7 monitored for behaviors? V1 said, "I'll check with nursing." Did R7 return to the facility when he was discharged from the hospital on 4/27/23? V1 said, "No, due to his violent behavior he wasn't readmitted to our community."	S9999		

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S9999	Continued From page 22 On 4/11/24 at 3:00 PM, V1 was asked again to review the grievance documentation. V1 said, "I'm going to be in trouble. I haven't been documenting any of the concerns or grievances." As of 4/11/24 V1 Executive Director did not provide the 4/27/23 facility reported abuse investigation regarding R7 for review as requested from 4/9/23. The revised 02/2024 Resident Protection policy states in part: Policy: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Purpose: The community will adopt and operationalize an abuse prevention system that includes screening and training employees, protection of residents, identification, and investigation of allegations of abuse, and reporting and responding to the appropriate individuals or agencies. Note: For the purpose of this policy, abuse includes all types of abuse, neglect, exploitation, mistreatment, and misappropriation of resident property. Procedure: 1. The community screens potential new move-ins to determine if the resident has a personal history of or is at risk for developing abusive actions or aggressive behaviors toward others. If the resident has such a history or presents such a risk, the community reviews the resident's status to determine if the resident is appropriate for move in and the community can	S9999		

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meet the resident's needs.
5. The Executive Director is the designated Abuse Prevention Coordinator.
6. The Executive Director is responsible for investigating, reporting, and coordination of the investigation process of any alleged or suspected abuse regardless of the source of the concern.
7. The Abuse Coordinator interacts with the survey team to explain the community's resident protection process.
8. Reporting of concerns may take several forms: concern form, incident report, and care line call.
9. The concern process is the community's designated grievance process.
10. The Executive Director is the designated grievance officer for the community.
11. Communities can best support the detection and prevention of abuse by implementing a process that supports immediate reporting of suspected abuse. The process should be available to residents, family members, advocates, employees, vendors to report abuse in a manner that elicits immediate attention without fear of retribution.
14. The community creates and maintains a proactive approach for identifying events that may constitute or contribute to abuse. When investigating whether abuse has occurred, the community identifies and considers events such as behavioral changes, bruising of residents, suspicious resent patterns, unexplained injuries, communication or social interaction changes and other trends that may signify abuse.
15. Any allegation requires an investigation.
16. Investigation process is a three (3) step framework to provide a consistent standardized process for the identification and investigation of near miss situations, concerns/grievances, incidents, and risk events. The purpose of the investigation process is to reduce resident risk,

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mitigate harm, identify root cause and associated factors, and minimize the opportunity of recurrence.
19. Investigation results will dictate the appropriate response, which may include corrective, remedial, or disciplinary action in accordance with applicable local, state, or federal law.

(C)

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SECTION 330.1510 MEDICATION POLICIES
a) Every facility shall adopt written policies and procedures for assisting residents in obtaining individually prescribed medication for self-administration and for disposing of medications prescribed by the attending physicians. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility.
1) Medication policies and procedures shall be developed with consultation from an Illinois registered professional nurse and a registered pharmacist. These policies and procedures shall be part of the written program of care and services.

4) If the facility elects to administer medications to some residents for control purposes, the medications shall be administered by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Medications shall not be recorded as having been administered prior to their actual administration to the resident.

This requirement was Not Met as evidenced by:

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Based on observation, interview, and record review,the facility failing to 1. follow their medication and treatment policy by documenting/signing each resident's medication administration record prior to administering the medication to each resident, and 2. failing to perform a blood pressure prior to administering a blood pressure medication in accordance with physician orders. This failure affects 4 (R12, R16, R17, and R18) of 4 residents reviewed during medication administration.

Findings include:

R12 is 81 years of age. Current diagnoses include but are not limited to Parkinson's Disease, Dementia, Hypertension, Gastroesophageal Reflux Disease, and Arthritis.

R16 is 87 years of age. Current diagnoses include but are not limited to Dementia, Alzheimer's Disease, Hypertension, Bradycardia, Transient Ischemic Attack, and Osteoarthritis.

R17 is 68 years of age. Current diagnoses include but are not limited to Alzheimer's Disease, Hypertension, and Osteoarthritis.

R18 is 86 years of age. Current diagnoses include but are not limited to Dementia, Alzheimer's Disease, Hypertension, and Hearing Loss.

On 4/10/24 at 8:21 AM, medication administration was observed with V2 RSC Resident Services Coordinator for R17. V2 prepared the following medications for R17.
1. Norvasc 5mg/ Valsartan 160mg (milligrams) 1 tab by mouth daily.
2. Loratadine 10mg give 1 tab by mouth daily.

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3. Cinacalcet 60mg give 1 tab by mouth daily.
4. Seroquel 25mg give 1 tab by mouth daily.
5. Vitamin D3 5,000 IU (international unit) give 1 tab by mouth daily.
6. Namenda 10mg give 1 tab by mouth daily.
V2 RSC signed each medication with her initials prior to administering the medication to R17.

On 4/10/24 at 8:26 AM, medication administration was observed with V2 RSC Resident Services Coordinator for R18. V2 prepared the following medications for R18.
7. Latanoprost 0.005% eye drops, instill 1 drop into both eyes daily.
8. Multivitamin give 1 tablet by mouth daily.
9. Lisinopril 20mg give 1 tablet by mouth daily.
10. Namenda 10mg give 1 tablet by mouth daily.
V2 RSC signed each medication with her initials prior to administering the medication to R18.

On 4/10/24 at 8:31 AM, medication administration was observed with V2 RSC Resident Services Coordinator for R16. V2 prepared the following medications for R16.
11. Norvasc 5mg give 1 tab by mouth daily. V2 did not check R16's blood pressure prior to administering the blood pressure medication.
12. EC (Enteric Coated) Aspirin 81mg give 1 tab by mouth daily.
13. Zyrtec 10mg give 1 tab by mouth daily.
14. Fluticasone 50mcg (micrograms) give 2 sprays in each nostril daily.
15. Vitamin D3 5,000 IU (international unit) give 1 tab by mouth daily.
16. Seroquel 12.5mg give 1 tab by mouth twice a day.
V2 RSC signed each medication with her initials prior to administering the medication to R16.
Review of R16's blood pressure monitoring flow sheet indicates the blood pressure was

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performed at 6:00 AM. V2 administered R 16's blood pressure medication 2 1/2 hours after the blood pressure monitoring was performed.

On 4/10/24 at 8:37 AM, medication administration was observed with V2 RSC Resident Services Coordinator for R12. V2 prepared the following medications for R12.
17. Multivitamin give 1 tablet by mouth daily.
18. Chewable Aspirin 81mg give 1 tab by mouth daily.
*19. Pantoprazole Sodium DR (delayed release) 40mg give 1 tab by mouth daily.
20. Sinemet 25/100mg give 1 tab by mouth twice a day.
21. Metoprolol 12.5mg give 1 tab by mouth twice a day.
V2 RSC signed each medication with her initials prior to administering the medication to R12.

On 4/10/24 at 12:35 PM, V2 RSC was inquired of concerns with the medication administration. When administering medication to residents when should the medication be documented? V2 said, "After the medicine is administered."

When are blood pressures monitored? V2 said, "Blood pressures are done around 6AM by the night nurse."

If a resident's blood pressure is taken at 6AM and the blood pressure medication is not administered until 8:30 AM which is 2 1/2 hours later, what would be the concern? V2 said, "The amount of time when the medicine is given. I'd have to check our policy. We only take blood pressures if the resident has orders for blood pressure parameters."

On 4/11/24 at 12:47 PM, V14 NP Nurse

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Practitioner was inquired of R16's blood pressure being performed for medication administration. V14 said, "The resident's blood pressure should be done thirty minutes to one hour before administering the blood pressure medication."

The 06/2021 Medication and Treatment Policy states in part:

Documentation:
Medications and treatments administered are documented immediately following administration or per state specific standards.

Vital signs are taken and recorded prior to the administration of vital sign dependent medications in accordance with medical practitioner's orders.

SECTION 330.1530 LABELING AND STORAGE OF MEDICATIONS

f) The label of each individual medication container filled by a pharmacist shall clearly indicate the resident's full name; licensed prescriber's name; prescription number, name, strength and quantity of drug; date of issue; expiration date of all time-dated drugs; name, address, and telephone number of pharmacy issuing the drug; and the initials of the pharmacist filling the prescription. If the individual medication container is filled by a licensed prescriber from his or her own supply, the label shall clearly indicate all of the preceding information and the source of supply; it shall exclude identification of the pharmacy, pharmacist, and prescription number.

h) The medications of each resident shall be kept and stored in their originally received

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containers. Medications shall not be transferred between containers.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failing to follow their policy for medication storage and labeling by medication in a clear cup found in the top drawer of a medication cart not stored in the original pharmacy packaging and a schedule IV controlled substance found with the original pharmacy label altered. This failure affects two (R15 and R19) residents reviewed during the medication storage and labeling task.

Findings include:

R15 is 76 years of age. Current diagnoses include but are not limited to External Ear Disease, Hypertension, and High Cholesterol.

R19 is 80 years of age. Current diagnoses include but are not limited to Hypertension, Alzheimer's Disease, Dementia, and Chronic Kidney Disease.

On 4/10/24 at 10:12 AM, medication storage and labeling was reviewed with V2 RSC Resident Service Coordinator. There is a clear medication cup with R19's name handwritten the outside with one pink colored pill inside in the top drawer of the medication cart. V2 RSC was inquired of the medication. V2 said, "The night nurse must have popped it out by accident and didn't want to waste it. I think it's her Synthroid, I'll waste it."

On 4/10/24 at 10:23 AM, R15's schedule IV controlled substance Lorazepam indicates 1mg (milligram) tablet by mouth BID (twice a day) per

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the original pharmacy packaging.

The schedule IV controlled substance Lorazepam medication shows handwritten directions on the pharmacy medication card and the controlled substance record which indicate 1/2 tab and circled.

V2 RSC was inquired of the controlled substance directions. V2 said, "Pharmacy told us to use the same prescription because they were scored. We just break them in half."

Review R15's physician orders indicate Lorazepam 1mg tablet take 1/2 tab= 0.5mg by mouth BID (twice a day) PRN (as needed) for anxiety dated 3/28/24.

Review of R15's 3/27/24 hospital discharge instructions indicate a change to the Lorazepam; take 0.5mg by mouth twice daily as needed for anxiety or agitation.

On 4/10/24 at 12:35 PM, V2 RSC was inquired of concerns with the medication administration, storage, and labeling. When a medication has been changed and a new order has been received from a physician how should the order be transcribed and processed? V2 said, "We have stickers for medication dose change we usually use. We fax the new order to the pharmacy. If we send it we usually get the new medication within 2 to 3 days unless we send it stat. We didn't get the new dose, pharmacy told us to use the same prescription because they were scored."

How should each medication be kept and stored prior to being administered to the resident? V2 said, "The medication should be in the bingo

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S9999	Continued From page 31 cards that come from pharmacy." Is it permissible by the pharmacy policy or the facility policy to transfer medication between containers outside of administration to the resident? V2 said, "No, it's to identify the medication." On 4/11/24 at 1:15 PM, the 09/01/2010 Changing Orders policy was reviewed. The pharmacy provides "change in direction" stickers to update the resident's medication administration record. There is no documentation of the pharmacy providing "change in dosage" stickers in the policy. The revised 06/30/23 Medication Labels policy states in part: Procedure 1. All medications, regardless of source, are labeled in accordance with state and federal laws and accepted practice standards. Only the pharmacist is able to modify or change information on prescription labels. 3. The community staff should not change or alter labels in any way- only the pharmacy can change a label. The revised 09/01/2010 Changing Orders policy states in part: Procedure 1. Any change to an existing order should be treated by the community as a new order. 1.1 Community staff should discontinue the previous order. 1.2 The physician/prescriber should write the new order/prescription with new directions and the community should enter the new order on the appropriate medication record forms. 2. The pharmacy must receive a discontinuation order before a new order that reflects a change is filled.	S9999		

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S9999	Continued From page 32 (B) Licensure Violations 6 of 6 SECTION 330.4240 ABUSE AND NEGLECT f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act). This requirement was not met as evidenced by : Based on interview and record review, the facility failing to protect two (R8 and R9) of two residents reviewed from abuse when R7 grabbed R8 by the neck and grabbed R9 by the shirt collar. This failure resulted in R8 sustaining redness to the neck area and R9 sustaining redness to the clavicle area. Findings include: R7 is 75 years of age. Current diagnoses include but are not limited to Dementia unspecified severity, type whether behavioral, psychotic, or mood disturbance or anxiety, Alzheimer's Disease, Aggressive Behavior, Gout, and Hypertension. R8 is 83 years of age. Current diagnoses include but are not limited to Alzheimer's Disease, Left	S9999		

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Knee Osteoarthritis, and Weight Loss.
R9 is 86 years of age. Current diagnoses include but are not limited to Dementia.

On 4/9/24 at 11:30 AM, V1 was asked to provide the resident to resident abuse investigation for R7 from 4/27/23 for review.

On 4/10/24 at 12:47 PM, V2 RSC Resident Services Coordinator was inquired of the resident to resident abuse by R7 towards R8 and R9. V2 said, "I don't remember if R7 had any previous aggressive behaviors. They were all in the living room area. I don't remember if I was there when it happened or was called to help out. R7 grabbed R8 by the neck. V13 Caregiver persuaded R7 to let R8 go. R7 turned around and grabbed R9 by her shirt. He was persuaded to let her go. R7 attempted to go after another resident but her husband was there visiting, and he stood in front of her and guarded her. V11 Caregiver walked R7 out to the courtyard and sat outside with him until 911 came. We sent him out for evaluation. The notes say he was still in the hospital the next day. After that he was sent to another facility." V2 was asked to provide the 4/27/23 incident report, investigation, resident assessments, and care plans for review.

On 4/11/24 at 10:00 AM, V11 Caregiver was inquired of the incident between R7, R8, and R9. V11 said, "I was working on the unit. R7 was in a rage. He was in the living room. When I got there everything was over. I didn't see what he did. I helped calm R7 down. I walked around with him outside on the porch until the paramedics came and got him. He kept saying some woman was taking his money from him. He didn't have any injuries." V11 was inquired of R8's care after the incident. V11 said, "I don't remember any

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concerns with her. R8 only had a little redness to her neck." On 4/11/24 at 10:00 AM, V11 was inquired of R9's care after the incident. V11 said, "V9 don't know if she had any concerns."

On 4/11/24 at 11:41 AM, V13 Caregiver was inquired of the incident between R7, R8, and R9. V13 said, "R7 was always aggressive from his admission. He was an officer previously. I don't know what caused him to do it. I walked out a room from caring for another resident. R7 was in the living area, and I heard screaming. When I was going there R9's sister was coming down the hall. I tried to get R7 off the first resident, then he went after another resident. There was a man that stood up in front of the other resident. R7 came after me, he was chasing me down the hall. I tried to hide in one of the rooms then V2 and V11 came, and they sent him out."

On 4/11/24 at 12:19 PM, V1 was inquired of R7's incident on 4/27/23 and how a resident is screened for abuse upon being accepted into the facility. V1 said, "I am the executive director and I've been trained for abuse. After we receive the resident's paperwork from the hospital or transferring facility we communicate with the family and use all the information to put the service plan together. If we come up with a red flag for behaviors, we check if the resident's behaviors are controlled, and medication is being taken. If the resident is at a therapeutic level, we allow them to come into our community." How do you monitor a resident with behaviors? V1 said, "Everyone has hourly checks. If a resident is flagged for concerns, we take the checks down to 30-15 minutes." Was R7 monitored for behaviors? V1 said, "I'll check with nursing." Did R7 return to the facility when he was discharged from the hospital on 4/27/23? V1 said, "No, due

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to his violent behavior he wasn't readmitted to our community."

On 4/11/24 at 3:00 PM, V1 was asked again to review the grievance documentation. V1 said, "I'm going to be in trouble. I haven't been documenting any of the concerns or grievances."

V1 was asked to provide all of R7's behavior monitoring from admission to current.

Review of R7's face sheet indicates he was admitted into the facility on 3/24/23. Review of the progress notes from 3/24/23 through 4/28/23 does not indicate any behavior concerns with R7 until the 4/27/23 incident.

R7's service plan documents Dementia related behavior. Support actions include monitor for symptoms of depression, such as fatigue and decreased energy, inability to fall/remain asleep, irritability, restlessness, overeating or decreased appetite, decreased interest in activities/interests, anxiety, sad mood, and tearfulness.

V1 provided R7's individual service notes. V11 LPN Licensed Practical Nurse documented on 4/27/23 at 8PM, hospital did not call for report. Resident came back very agitated. Staff resent resident back to the hospital for further evaluation. Family notified.

R7's 4/27/23 hospital after visit summary indicates a reason for the visit as a diagnosis of Dementia.

Review of R8's 4/27/23 progress note indicates she sustained redness to her throat from R7 grabbing her by the neck.

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Review of R9's 4/27/23 progress note indicates she sustained redness to her left clavicle from R7 grabbing her by her shirt collar.

R8 and R9 required staff to stay with them until they were calm after the abuse. R8 remained in the facility. R9 was discharged out of the facility after the abuse incident on 5/31/23.

As of 4/11/24 V1 Executive Director did not provide the 4/27/23 facility reported abuse investigation regarding R7 for review as requested from 4/9/23.

The revised 02/2024 Resident Protection policy states in part:

Policy: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms.
Purpose: The community will adopt and operationalize an abuse prevention system that includes screening and training employees, protection of residents, identification, and investigation of allegations of abuse, and reporting and responding to the appropriate individuals or agencies.
Note: For the purpose of this policy, abuse includes all types of abuse, neglect, exploitation, mistreatment, and misappropriation of resident property.
Procedure: 1. The community screens potential new move-ins to determine if the resident has a personal history of or is at risk for developing abusive actions or aggressive behaviors toward others. If the resident has such a history or

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presents such a risk, the community reviews the resident's status to determine if the resident is appropriate for move in and the community can meet the resident's needs.
5. The Executive Director is the designated Abuse Prevention Coordinator.
6. The Executive Director is responsible for investigating, reporting, and coordination of the investigation process of any alleged or suspected abuse regardless of the source of the concern.
7. The Abuse Coordinator interacts with the survey team to explain the community's resident protection process.
8. Reporting of concerns may take several forms: concern form, incident report, and care line call.
9. The concern process is the community's designated grievance process.
10. The Executive Director is the designated grievance officer for the community.
11. Communities can best support the detection and prevention of abuse by implementing a process that supports immediate reporting of suspected abuse. The process should be available to residents, family members, advocates, employees, vendors to report abuse in a manner that elicits immediate attention without fear of retribution.
14. The community creates and maintains a proactive approach for identifying events that may constitute or contribute to abuse. When investigating whether abuse has occurred, the community identifies and considers events such as behavioral changes, bruising of residents, suspicious resent patterns, unexplained injuries, communication or social interaction changes and other trends that may signify abuse.
15. Any allegation requires an investigation.
16. Investigation process is a three (3) step framework to provide a consistent standardized process for the identification and investigation of

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S9999	Continued From page 38 near miss situations, concerns/grievances, incidents, and risk events. The purpose of the investigation process is to reduce resident risk, mitigate harm, identify root cause and associated factors, and minimize the opportunity of recurrence. 19. Investigation results will dictate the appropriate response, which may include corrective, remedial, or disciplinary action in accordance with applicable local, state, or federal law. (B)	S9999		