STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014989	A. BUILDING: _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS (SOUTH HOLLAND)	2045 EAST 170TH STREET SOUTH HOLLAND, IL 60473

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S 000	Initial Comments Facility Reported Incident Investigation 04.03.24/IL172647 - 330.710(f) 05.04.24/IL173070 - 330.4240 (a)	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 330.710(a) 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 interviews and record reviews, the facility failed to follow its fall policy by not implementing effective fall interventions and supervision for one resident (R3) out of three residents reviewed for falls in a sample of 4. The facility also failed to follow its alert charting policy and perform increased monitoring of R3 every 30 minutes for 72 hours after an incident on 4/2/24. These failures resulted in R3 sustaining a one inch laceration and hematoma to right forehead after an unwitnessed fall on 4/3/24. R3 was transported to the hospital for further evaluation.	S9999		

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S9999	Continued From page 1	S9999		

Findings include:

On 6/27/24 at 1:40 PM, V4 (caregiver) stated that they have a house binder where the caregivers document 30 minute checks noting where the resident is and their initials. V4 stated that residents are monitored every 30 minutes for 72 hours after any incident occurs.

On 6/17/24 at 1:50 PM, V5 (caregiver) stated that on 4/2/24, R4 was having an episode, she walks a lot, and when R4 gets tired she walks very fast. V5 stated that V5 was holding onto R3's right arm and walking with her in the hallway. V5 stated that they were at a doorway near end of hall. V5 stated that R4 came from the opposite direction and R3 and R4 walked into each other and hit heads.

On 6/27/24 at 2:55 PM, V2 DON (director of nursing) stated that on 4/2/24, R3 and R4 collided into each other hitting each other in the head. V2 stated that R3 was sent to the hospital emergency room because R3 also twisted her ankle. V2 stated that R3 returned the same day with no new findings. V2 stated that R4 walks on her tip toes and leans forward when she is walking. V2 stated that R4 will run you over when she is walking fast. V2 stated that R3 was slower moving but was still ambulatory. V2 stated that R3 has a history of orthostatic hypotension (sudden drop in blood pressure that happens when standing up from sitting position). V2 stated that on 4/3/24, R3 was found lying on her right side on floor. V2 stated that R3 was transported to the hospital and then went to a skilled nursing facility for physical therapy before returning to this facility.

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S9999	Continued From page 2 On 6/28/24 at 10:30 AM, V2 stated that she can't find the 30 minute rounding log (alert charting log) for R3 that would have been initiated on 4/2/24. V2 stated that it could be because R3 went to the hospital on 4/2 and again on 4/3. On 7/2/24 at 1:05 PM, V8 (caregiver) stated that the nurse determines when a resident needs to be monitored more frequently. V8 stated that the nurse will inform the caregivers so the alert charting log can be initiated for the resident. V8 stated that an alert charting log would be initiated after a resident fall or any incident. On 7/2/24 at 3:00 PM, V3 LPN (licensed practical nurse) stated that she was not present when R3 and R4 collided into each other on 4/2/24. V3 stated that the nurse is expected to document the incident in the resident's medical record, notify the physician and resident's family, and send an incident report to the State Surveying Agency. V3 stated that R3 was sent to the hospital for evaluation on 4/2/24 due to hitting head with R4's head and injuring her left ankle. V3 stated that when R3 returned on 4/2/24, an alert charting log should have been initiated. R3's medical record notes R3 with diagnoses including, but not limited to, orthostatic hypotension, Parkinson's disease, and dementia. R3's program assessment and plan, dated 2/13/24, notes R3 wanders. Special precautions: R3 looks tired later in afternoon, offer her a seat and some coffee. she will rest for a while. R3's fall risk assessment notes R3 is at high risk for falls.	S9999		

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S9999	Continued From page 3	S9999		

R3's falls service plan, initiated on 12/5/23, notes observe for need rest periods. There is no documentation found noting R3's service plan was reviewed or updated after falls on 3/20/24 and 4/3/24.

R3's incident report, dated 4/2/24 at 3:30 PM, notes R3 ran into R4 and hit her head on the door frame and twisted her left foot. R3 was transported to the hospital for further evaluation. R3 returned to this facility later the same day.

There was no documentation found in R3's medical record noting an alert charting log was initiated upon returning from the hospital on 4/2/24.

R3's incident report, dated 4/3/24 at 7:30 PM, notes R3 was observed lying on the floor in the hallway of another residential area. V7 (nurse) assessed R3 head to toe. R3 was observed to have a one inch laceration to forehead above right eye and right eye hematoma. R3 was transported to the hospital for further evaluation.

R3's hospital record, dated 4/3/24, was not available for review during this survey.

This facility's falls prevention policy, dated 06/2021, notes the purpose is to 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. The guidelines guide staff through a structured process to screen and identify residents for predisposing risk factors or a history of falls. On-going follow-up: review, modify, and evaluate the effectiveness of the interventions.

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S9999	Continued From page 4 This facility's alert charting policy, dated 06/2021, notes the purpose is to provide a guideline for monitoring documentation that may be needed following a change in resident condition or status. The alert charting log is a tracking and communication system to alert licensed nurses to changes in a resident's condition that warrants continued observation. Examples of situations included on the alert charting log include, but are not limited to, accidents, changes in condition. Residents remain on the log for a minimum period of 72 hours. (B) 2 of 2 330.4240(f) 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 interviews and record reviews, the facility failed to protect one resident (R2) from being hit by another resident (R1) out of 4 residents reviewed for abuse in a sample of 4. On 5/4/24, R2 was shouting and R1 told R2 to shut up. R1 then walked directly up to R2 and	S9999		

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S9999	Continued From page 5	S9999		

smacked her in the mouth with an open hand while continuing to tell R2 to shut up.

Findings include:

On 6/27/24 at 1:35 PM, V3 (nurse) stated that she did not witness incident between R1 and R2 on 5/4/24, but was informed by caregiver. V3 stated that the caregiver was brushing R2's hair. V3 stated that R2 was shouting and R1 told R2 to shut up and then hit R2 in mouth. V3 stated that R1 and R2 are alert and oriented x 1 only. V3 stated that R2 did not sustain any injury.

On 6/27/24 at 1:40 PM, V4 (caregiver) stated that on 5/4/24, V4 was combing R2's hair while R2 was sitting in living room. V4 stated that R2 does not like getting her hair combed and was shouting. V4 stated that R1 walked over from the dining room and popped R2 in the mouth. V4 stated that R1 hit R2 with open hand, palm side. V4 stated that both R1 and R2 are alert and oriented x 1. V4 stated that R1 was re-directed out of living room.

This facility's incident report, dated 5/4/24 at 11:00 AM, notes R1 smacked R2 in the mouth. No injuries noted. V4's (caregiver) statement: V4 was brushing R2's hair in the living room. R2 began yelling she did not want her hair brushed. R1 told R2 to shut up from the dining room. R1 walked directly up to R2 and smacked her in the mouth while continuing to tell R2 to shut up. R1 was re-directed from the living room. An alert charting log was initiated and R1 and R2 were monitored every 30 minutes for 72 hours for behaviors.

This facility's resident protection policy, revised 02/2024, notes the resident has the right to be

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S9999	Continued From page 6 free from abuse, neglect, misappropriation of resident property, and exploitation. The 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. The executive director is the designated abuse prevention coordinator. The abuse coordinator interacts with the survey team to explain the community's resident protection process. 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. The community creates and maintains a proactive approach for identifying events that may constitute or contribute to abuse. Any allegation requires an investigation. 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, mitigate harm, identify root cause and associated factors, and minimize the opportunity of recurrence. (B)	S9999		