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 11/18/2024

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

(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
S 000	Initial Comments Facility Reported Incident Investigation. FRI of 9.28.24 / IL179879- 330.4240(f)	S 000		
S9999	Final Observations Statement of Licensure Violations Section 330.4240 Abuse and Neglect 330.4240f) 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) Based on interview and record review the facility failed to protect the resident right to be free from physical assault by another resident. R2 physically assaulted R1 by scratching and striking R1 in the face. R1 subsequently noted with scratches to left shoulder, left thumb, left inner arm, large bruise noted to R1 right hand, and a nickel size bruise to left outer hand. This affects 1 of 3 residents (R1) reviewed for abuse prevention. Findings include:	S9999		

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S9999	Continued From page 1	S9999		

R1 is physician order sheet shows diagnosis of dementia, and severe hearing loss.

Facility final report to the department dated 10/1/24 denotes in part date of incident 9/28/24, caregiver observed R2 standing over R1 holding R1 by both of her arms. R1 has scratches to left shoulder, left thumb, left inner arm, large bruise noted to R1 right hand, and a nickel size bruise to left outer hand. No injuries to R2. Both residents redirected by staff, first aid administered to R1. Assessed for further injuries-non noted to either resident. Both residents denied pain. Families and MD (Medical Doctor) aware. R2 remained agitated and was Tx (treated) to in-patient psych facility for further evaluation. R2 returned to facility on 9/29/24 with new orders for ABT (antibiotics), Dx (diagnosis) UTI (urinary tract infection).

On 11/16/24 at 11:50am V1 (caregiver) said on 9/28/24 R2 was having behavior episodes. V1 said R2 hit, scratched, and kicked her and 2 other staff when they were getting her (R2) dressed the morning of the incident. V1 said they walked R2 to the lounge and when they turned to leave, R2 had grabbed R1 hands and was digging her nails into R1. V1 said they heard R1 screaming "help". V1 said R2 was separated from R1 and R2 attacked R1 again by hitting R1 in the face and scratching her (R1) shoulders. V1 said R1 did nothing to R2. R1 did not provoke R2. V1 said she summons the Nurse after R2 attacked R1 the. V1 said she did not inform the Nurse that R2 was having behaviors when R2 attacked them that morning. V1 said the Nurse never address R2 behaviors towards the staff, that's why she didn't report that R2 attacked the staff.

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S9999	Continued From page 2	S9999		

On 11/16/24 at 11:41am V2 (caregiver) said on 9/28/24 R2 was having behavior episodes. V2 said R2 had kicked and hit her when she was helping R2 get dressed. V2 said she help escort R2 to the lounge room and when they turned to leave R1 screamed "help". V2 said R2 attacked R1 digging her nails into R1's hands, V2 said R1 was separated from R2, and R2 attacked R1 again, hitting R1 in the face. V2 said she did not report R2's behavior to the nurse prior to R2 attacking R1.

On 11/16/24 at 12:07pm V3 (Assistant Executive Director) said she's the abuse coordinator, and she substantiated abuse to R1 by R2. V3 said the staff should have notified the Nurse of R2's behavior prior to R2 attacking R1. V3 said the staff should not have brought, R2 to the area where there were other residents when R2 was experiencing behaviors and physical aggression. V3 said the physical assault to R1 could have been avoided. V3 said the staff should have notified the Nurse for interventions.

Facility policy Titled "Resident Protection" denotes in part the resident has the right to be free from abuse, neglect, misappropriation of resident's 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 residents' medical symptoms. The community will adopt and operationalize an abuse prevention system that includes screening and training of employees, protection of resident, identification, and investigation of allegations of abuse, and reporting and responding to the appropriate individuals or agencies. The community provides employees orientation and ongoing education about the prohibition of abuse such as prohibition

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S9999	Continued From page 3 and preventing all forms of abuse, neglect, misappropriation, and exploitation. Recognizing signs of abuse, neglect, exploitation ways to deal with aggressive behaviors. Employees are educated upon hire and annually on abuse prevention program including the immediate reporting of any suspicion of abuse, neglect, exploitation, mistreatment, misappropriation, or crime against a resident. (B)	S9999		