STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015325	A. BUILDING: _____ B. WING _____	C 03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS (PALOS HEIGHTS)	7880 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463

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S 000	Initial Comments Complaint Investigation 2592133/IL187949	S 000		
S9999	Final Observations Statement of Licensure Violations 330.780b) 330.780c) 330.4240d) 330.4240e) 330.4240f) Section 330.780 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 330.785, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.	S9999		

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S9999	Continued From page 1 Section 330.4240 Abuse and Neglect d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter of the department. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) 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 report abuse allegations related to injuries of unknown origin and to investigate and report an allegation of sexual abuse to the state agency for a resident who was found with multiple bruises and an abrasion on her head, who was sent to the hospital for evaluation. This failure	S9999		

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applied to one of three residents (R1) reviewed for abuse.

Findings include:

R1 is an 87-year-old female with a diagnoses history of Dementia, History of Falls, History of Multiple Fractures, Abnormalities of Gait and Mobility, Osteoporosis, Congestive Heart Failure, and COPD who was admitted to the facility 02/29/2024.

R1's progress note created by V4 (Licensed Practical Nurse) dated 3/8/2025 at 2:07 PM documents R1 was noted with a bruise and dry abrasion to the right side of the forehead near the scalp; R1 doesn't know what happen to her head or remember falling.

R1's progress note created by V4 (Licensed Practical Nurse) dated 03/09/2025 at 2:50 PM documents R1 was noted with bruising to both eyes and right arm. R1 stated that V9 (Family Member) beat her up last night. Order received to send R1 to the hospital for a psych evaluation.

On 03/11/2025 at 11:55 AM V8 (Family Member) stated she doesn't know what happened to R1 however she was observed with bruises on her eyes, hand, and head and this was the reason she requested a sexual assault investigation be performed.

On 03/11/2025 at 12:30 PM V8 (Family Member) stated the facility hasn't reached out to check on R1 or ask any follow up questions about her injuries.

On 03/11/2025 at 12:47 PM, V1 (Executive

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Director) confirmed she is the abuse coordinator. V1 stated nursing investigates bruises of an unknown source and this investigation would be included as part of an incident report. V1 stated she has not been reporting bruises of an unknown source to the state agency and asked if she should be. V1 stated in the case of injuries when nursing completes an incident report, they conduct an investigation to see if they can determine where the injury came from. V1 stated any reportable events should be reported to the state agency within 24 hours and either herself or V2 (Resident Services Coordinator/Licensed Practical Nurse) complete reportable events as soon as they become aware of them. V1 stated according to the facility's resident protection policy an injury of unknown origin would be a reportable event.

On 03/11/2025 at 1:47 PM V2 (Resident Services Coordinator/Licensed Practical Nurse) stated the facility started investigating if there were any falls or observations of bruises for R1 from Friday 03/07/2025 prior to the first observation of her bruising until 03/08/2025 when her bruises were originally identified. V2 stated the investigation for R1's bruises is still ongoing. V2 stated R1's bruises were first observed between 2 - 3 PM on 03/08/2025. V2 confirmed that the source of R1's bruising has not yet been identified. V2 stated on yesterday 03/10/2025 late last night a nurse from the hospital notified them that family members visiting R1 requested a sexual assault examination.

In response to the surveyors request on 03/11/2025 for reportable incident's from March 2025, the facility did not provide documentation of investigating or submitting a report to the state agency of R1's multiple injuries identified on

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03/08/2025 and 03/09/2025 or of investigating or submitting a report to the state agency of an allegation of sexual abuse for R1.

On 03/12/2025 at 12:51 PM V1 (Executive Director) stated V2 (Resident Services Coordinator/Licensed Practical Nurse) or any staff member that becomes aware of a serious incident or potential sexual abuse should notify her. V1 stated if she's not available nursing can inform V12 (Regional Director of Operations) of these concerns. V1 stated she wasn't notified until yesterday when the surveyor entered the facility about R1 going out to the hospital for injuries and that the hospital notified the facility that the family requested a sexual abuse evaluation. V1 stated when V2 informed her of these concerns they discussed that these concerns would have been considered to be reportable events. V1 stated if she isn't available V12 would have instructed V2 to report these concerns and initiate the investigation. V1 stated V2 could have notified her or V12 of these concerns. V1 confirmed the allegation of sexual abuse for R1 had not been reported to the state agency or investigated. V1 stated an initial investigation of abuse should be conducted by herself or V2. V1 stated an abuse investigation includes interviewing everyone that worked with the resident and other residents that may have witnessed the incident. V1 stated staff interviews would include all departments. V1 stated if the family member or resident identifies staff as the perpetrator, that person would be immediately put on administrative leave pending investigation and if a resident was identified as the perpetrator they would be sent out to the hospital. V1 stated the potential perpetrator should be identified as soon as the abuse investigation is initiated. V1 stated she would speak with staff or family to attempt to

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identify the potential perpetrator if the resident is unable to be interviewed. V1 stated R1 is interviewable sometimes.

The facility's Resident Protection Policy received 03/11/2025 states:
"The resident has a right to be free from abuse."
"The community will adopt and operationalize an abuse prevention system that includes protection of residents, 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 and preventing all forms of abuse;
How to immediately report suspicions or allegations of abuse (including injuries of unknown origin)."
"Employees are educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse."
"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."
"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 bruising of residents, and unexplained injuries that may signify 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 incidents and risk events. The purpose of the investigation process is to reduce resident risk,

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S9999	Continued From page 6 mitigate harm, identify root cause and associated factors, and minimize the opportunity of recurrence." "Resident protection actions include: Immediately removing the resident from contact with the alleged abuser; Reporting the actual or suspicious event to the Abuse Prevention Coordinator; Reporting allegations of abuse to other agencies or law enforcement." (B)	S9999		