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 02/15/2025

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 of January 18, 2025/IL185371 - 330.4310, 330.4240	S 000		
S9999	Final Observations Statement of Licensure Violations 330.4310a)1)2)3)4)5)6 330.4240a) 330.4240b) 330.4240c) 330.4240d) 330.4240e) 330.4240f) a) A resident shall be permitted to present grievances on behalf of themselves or others to the administrator, the Long-Term Care Facility Advisory Board, the residents' advisory council, State governmental agencies or other persons of the resident's choice, free from restraint, interference, coercion, or discrimination and without threat of discharge or reprisal in any form or manner whatsoever. Every facility licensed under the Act shall have a written internal grievance procedure that, at a minimum: 1) sets forth the process to be followed; 2) specifies time limits, including time limits for facility response; 3) informs residents of their right to have the assistance of an advocate; 4) provides for a timely response within 25 days by an impartial and nonaffiliated third party, including, but not limited to, the Long-Term Care Ombudsman, if the grievance is not otherwise resolved by the facility; 5) requires the facility to follow applicable State and federal requirements for responding to	S9999		

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S9999	Continued From page 1	S9999		

and reporting any grievance alleging potential abuse, neglect, misappropriation of resident property, or exploitation; and
6) requires the facility to keep a copy of all grievances, responses, and outcomes for three years and provide the information to the Department upon request. (Section 2-112 of the Act) .

Section 330.4240 Abuse and Neglect

Section 330.4240a)
330.4240b)
330.4240c)
330.4240d)
330.4240e)
330.4240f)

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)
b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)
c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act)
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

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S9999	Continued From page 2	S9999		

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 regulation was NOT MET as evidenced by:

Based on interviews and record reviews the facility failed to follow their policy and procedures for abuse reporting by not investigating and reporting allegations of abuse received from a resident's family member to the state agency.

Findings include:

Grievance communication from V8 (Family Member) addressed to V1 (Executive Director) and V2 (Resident Services Coordinator/Registered Nurse) dated 01/08/2025 documents safety concerns regarding R3, an allegation of a staff member rough handling two residents during a birthday celebration on 11/02/2024, and an allegation of a staff member verbally berating a resident in the bathroom of their room on 12/27/2024.

On 02/14/2025 at 12:15 PM V1 (Executive Director) stated there were no other abuse investigation reports from November 2024 -

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S9999	Continued From page 3 February 2025 other than one for resident-to-resident abuse. On 02/14/2025 at 1:30 PM V1 (Executive Director) stated she is the abuse coordinator. V1 stated she does consider staff rough handling and verbally berated residents forms of abuse. On 02/14/2025 at 2:45 PM V1 (Executive Director) stated she did an informal partial investigation regarding V8's allegations of staff rough handling and verbally berating residents and did not submit a report of this to the state agency. V1 could not provide any documentation of an investigation of V8's allegations of staff abuse. The facility's Resident Protection Policy received 02/14/2025 states: "The resident has the right to be free from abuse." "The community will adopt an operationalize an abuse prevention system that includes identification of allegations of abuse, and reporting and responding to the appropriate individuals or agencies." "The Executive Director is the designated Abuse Prevention Coordinator." "The Executive Director is responsible for reporting of any alleged or suspected abuse regardless of the source of the concern." "Communities can best support the detection and prevention of abuse by implementing a process that supports immediate reporting of suspected abuse." (C)	S9999		