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S 000	Initial Comments Annual Licensure	S 000		
S9999	Final Observations Statement of Licensure Violation 1 of 4 330.710a)3)A)F) 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. 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers, taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs. F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident.	S9999		

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S9999	Continued From page 1 This requirement was NOT MET as evidenced by: Based on interview and record review, the facility failed to provide adequate supervision and monitoring on a resident with cognitive impairment to prevent a fall for one (R2) of three residents reviewed for accidents and supervision. This deficiency resulted in R2 having an unwitnessed fall in the common area when she was observed face down on the floor, sent to the hospital and was diagnosed with closed odontoid fracture. Findings include: R2 is a 95-year-old, female, admitted in the facility on 02/14/25 with diagnoses of Hypertensive Heart Disease with Heart Failure; and Dementia with Behavioral Disturbance. Fall scale assessment dated 02/15/25 recorded a score of 55, which means R2 is high risk for falls. Progress notes dated 02/22/25 documented that R2 was observed face down in the living room. R2 was assessed for injuries and transferred back to wheelchair. Hematoma was noted to the left side of forehead and redness to the left cheek bone and near left eye. R2 was sent to the hospital as ordered for further evaluation and management. R2's Hospital Records dated 02/22/25 recorded: CT (Computed Tomography) Cervical Spine without Contrast - Impression: Minimally displaced type II odontoid fracture. R2's Service Plan/Care Plans documented the following:	S9999		

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Ambulation and Transferring, initiated 02/23/25: Interventions: Staff will provide verbal cues and prompts when resident attempts to get out of her wheelchair unassisted; able to transfer/ambulate (total level of assistance); staff will provide verbal cues when resident attempts to leave her wheelchair unassisted.
Fall, initiated 02/23/25: Interventions: Resident is on safety checks hourly.

On 03/03/25 at 10:50 AM, R2 was in bed, confused, mumbling with words. R2 did not respond when name was called. R2 unable to communicate when asked how she was doing. R2's bed was observed lowered.

On 03/05/25 at 10:35 AM, V10 Licensed Practical Nurse (LPN) was interviewed regarding R2's fall. V10 stated, "On 02/22/25, (V11 (Caregiver)) came to get me and told me that (R2) was observed on the floor in the television (TV) area, the common area. I assessed her, asked if she was in pain, we did lift her up because she fell on her belly on the floor. She was not able to tell what happened. We did assist her back to the chair and assessed her further. She was ordered to be sent out to the hospital. It was an unwitnessed fall. (V11) said, she stepped away to go to the laundry room, when she came back, (R2) was already on the floor." V10 was also asked regarding supervision and monitoring of residents in the common area. V10 verbalized, "When residents are in the common area, there should be a staff who monitors residents. We usually have another caregiver to float between the two houses and that caregiver could supervise the residents in the common area when one of the caregivers needs to step away."

On 03/05/25 at 11:02 AM, V11 was interviewed

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regarding fall incident involving R2 on 02/22/25. V11 replied, "I was the caregiver for her at the time. (R2) was still alert to self, she was sitting in the TV room watching TV, eyes open. I was told she is a fall risk so I always watch her. That day, I went to the kitchen, then to the laundry room, and took out the stuff out of the dryer. I came out and saw her (R2) on the floor. When I went to the laundry, there was no other staff monitoring the residents in the TV room. I guess there should be another staff who should be monitoring the residents in the TV room. When I was starting, there is always two caregivers in each house but recently, its only one staff and one float."

On 03/05/25 at 11:42 AM, V3 (Director of Nursing) was asked regarding prevention of falls. V3 stated, "There should be frequent monitoring of residents in the common area. If a staff needs to leave the common area, find coverage. For (R2), (V11) had to step away but she needs to ask another staff to be with the residents. It is a challenge to staff the community because it is a shelter and close to home like environment that monitoring and supervision is not actually emphasized. But clinically, residents on high fall risk should be monitored more frequently and should not be left alone in the area. With (R2), she never tried to get up before, that was the first. Close to (R2)'s fall incident, (R2) was observed with increased agitation like screaming, yelling, calling for family, saying vulgar things. She was declining more rapidly in terms of her cognition right before the fall."

Facility was asked if there was a care plan formulated for R2 regarding fall prior to fall incident on 02/22/25.

On 03/05/25 at 12:28 PM, V1 (Executive Director)

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stated "R2 does not have any fall care plans prior to fall."

On 03/05/25 at 1:28 PM, V12 (Physician) was interviewed regarding R2 and fall prevention. V12 stated, "(R2) is new, had a fall and went into the hospital. Each facility has their own protocol that needs to be followed. Residents should be monitored closely, I don't know how but there should be some kind of a plan for fall precautions. I am not sure if staff is aware of her (R2) baseline."

POLICY: Falls Prevention, 06/2021
Purpose: Identify residents at risk or predisposed to falls. Evaluate the health, safety and welfare of our residents and implement measures to prevent falls and minimize the risk that serious injury will result.
Process: Falls Prevention Guidelines guide staff through a structured process to screen and identify residents for predisposing factors or a history of falls. Whenever possible, the staff implements precautionary measures to reduce the risk of falls by individualizing resident needs.

(B)

Statement of Licensure Violation 2 of 4

330.790a)

Section 330.790 Infection Control

a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code and Control of

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S9999	Continued From page 5 Sexually Transmissible Infections Code. Activities shall be monitored to ensure that these policies and procedures are followed. This requirement was NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure blood glucose monitoring device (glucometer) was cleaned and sanitized in between residents' use for three (R10, R11 and R12) of three residents reviewed for infection control during medication administration. Findings include: R12 is a 61-year-old, female, admitted in the facility on 05/22/2024 with diagnoses of Unspecified Dementia and Type 2 Diabetes Mellitus. R12 has an order for blood glucose monitoring four times daily. On 03/03/25 at 4 PM, V7, Licensed Practical Nurse (LPN) took a glucometer from another medication cart. V7 did not clean it prior to use and performed blood glucose check on R12. After checking, V7 placed the glucometer on top of the cart, did not clean or sanitized it after use. R10 is a 68-year-old, male, admitted in the facility on 01/03/2024 with diagnosis of Dementia and Diabetes Mellitus. R10 needs blood glucose monitoring four times daily as prescribed. On 03/03/25 at 4:35 PM, V7 used the same glucometer used to check R12's blood glucose level without cleaning and sanitizing it prior to use. R11 is a 78-year-old, male, admitted in the facility on 01/22/2025 with diagnosis of Vascular	S9999		

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Dementia, Unspecified. R11's blood glucose is also monitored four times daily before meals and at bedtime as ordered. On 03/03/25 at 5:05 PM, V7 took the same glucometer that was not cleaned and sanitized prior to use to take R11's blood sugar level. Afterwards, V7 placed the glucometer on top of the medcart, without cleaning and sanitizing it.

On 03/04/25 at 10:39 AM, V3 (Director of Nursing) was asked regarding use of glucometer. V3 stated, "Glucometer should be cleaned and sanitized after each resident's use. We clean it by alcohol or wipes in the cart."

Facility's policy titled, "Glucose Blood Monitoring (Finger Stick Blood Sugar), dated 06/2021 documented in part but not limited to the following:
Procedure:
17. Clean blood glucose meter utilizing an EPA approved bleach wipe or approved germicidal disinfectant.

Facility presented the manufacturer's guidelines for the blood glucose monitoring system which documented in part but not limited to the following:
Cleaning and Disinfecting Procedures for the Meter
The meter should be cleaned and disinfected between each patient. The meter is validated to withstand a cleaning and disinfection cycle of ten times per day for an average period of three years. The following products have been approved for cleaning and disinfecting the meter.
(Brand Name) Disinfectant Towels with Bleach
(Brand Name) Bleach Germicidal and Disinfectant Wipes
(Brand Name) Bleach Germicidal Bleach Wipes

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S9999	Continued From page 7 (C) Statement of Licensure Violation 3 of 4 330.1510a)2) 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. 2) All medications taken by residents shall be ordered by the licensed prescriber directly from a pharmacy. If the facility has a licensed nurse who supervises the medication regimen of the residents, the nurse may transmit the licensed prescriber's orders to the pharmacy. This requirement was NOT MET as evidenced by: Based on observation, interviews and record reviews, the facility failed to administer medications as ordered; and failed to ensure medications are available during administration. There were 21 opportunities with three errors resulting in a 14.29% medication error rate. The errors involved three (R7, R8 and R9) of 9 residents reviewed for medications. Findings include: R7 admitted in the facility on 12/12/23 with	S9999		

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diagnosis of Dementia with Aggressive Behavior; Depression and Alzheimer's Disease. On 03/03/25 at 4:30 PM, V7 (Licensed Practical Nurse, LPN) was passing medication on R7. R7 has an order of ABH topical gel 1 ml (milliliters) topically to carotid area of neck or radial wrist area with gloved hand three times daily and every 4 hours, per POS (physician order sheet). The medication was not given at the time of medication pass because it was not available. V7 stated, she could not find it.

R8 admitted in the facility on 09/10/24 with diagnosis of Pulmonary Fibrosis and Glaucoma. R8 has an order for Restasis 0.05% eye emulsion, instill 1 drop into both eyes twice daily. On 03/03/25 at 5:00 PM, V7 opened the medication cart to look for R8's Restasis but it was not available during medication pass.

R9 admitted in the facility on 05/14/2017 with diagnosis of Unspecified Dementia and Secondary Hypertension. POS dated 04/10/24 recorded: Cholestyramine 4 grams powder packet dissolve 1 powder pack in 4-8 ounces of water or juice and drink by mouth twice daily. On 03/03/25 at 5:10 PM, V7 was observed looking for R9's Cholestyramine in the medication cart. V7 was not able to find it, and even asked the assistance of V3 (Director of Nursing) but Cholestyramine was not available at the time of medication administration.

On 03/04/25 at 10:10 AM, V1 (Administrator) was asked regarding process of ordering medications of residents. V1 replied, "We use (name) pharmacy. The nurse sends a fax for medication orders to pharmacy and pharmacy delivers the medications. The nurses are supposed to be reordering, when medications come, its supposed

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S9999	Continued From page 9 to be placed in the medication cart." On 03/04/25 at 10:39, V3 (Director of Nursing) was interviewed regarding medications availability during medication administration. V3 stated, "Nurses on the floor do the reordering of the medications of residents by faxing the order to pharmacy or they can go online to order the medication. Sometimes the pharmacy sends us notification which medications are on low via fax or phone calls to family. Nurses on the floor make sure that medications are available during medpass." Facility's policy titled, "Medication Administration: Medication Pass, dated 06/2021 stated in part but not limited to the following: Purpose: To safely and accurately prepare and administer medication according to physician order and resident needs. Documentation: Medications not administered according to medical practitioner's orders are reported to the attending medical practitioner and documented in the clinical record including the name and dose of the medication and the reason the medication was not administered The licensed nurse or medication aide is responsible for validating documentation is completed for any medication administered during the shift Facility was requested to provide a policy related to ordering of medications but nothing was presented. (B) Statement of Licensure Violation 4 of 4 330.2000	S9999		

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S9999	Continued From page 10 Section 330.2000 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Code". (Source: Amended at 49 Ill. Reg. 802, effective December 31, 2024) FDA Food Code 2022, Chapters 3: Food, 3-6 FOOD IDENTITY, PRESENTATION, AND ON-PREMISES LABELING . Website Link https://www.fda.gov/food/fda-food-code/food-code-2022 On-premises preparation Prepare and hold cold 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. This requirement was NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that cold food held in cold storage was properly dated and labeled with an "open and use by date" and failed to discard expired food after 7 day maximum. These failures have the potential to affect all 48 residents residing in the facility.	S9999		

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Findings include:

On 03/03/2025 at 10:00AM, surveyor observed the kitchen with V5 (Dietary Aide).

On 03/03/2025 at 10:30AM, surveyor observed in reach-in cooler, food items not properly labeled with "open and use by dates", food items past maximum 7-day storage and expiration date per facility policy

Bacon Bits - open date 02/21/25, no "use by" expiration date and past 7-day maximum storage per facility policy.
Shredded Cheese - open date 02/21/25, no "use by" expiration date and past 7-day maximum storage per facility policy.
Mozzarella Cheese - open date 02/21/25, no "use by" expiration date and past 7-day maximum storage per facility policy.
Pepper Jack Cheese - Not labeled with "open or use by" expiration date.
Heavy Whipping Cream - manufacture expiration date 02/21/2025, no open or "use by" expiration date and past 7-day maximum storage per facility policy.
Ham Lunch Meat - open date 02/21/2025, no "use by" expiration date.

On 03/03/2025 at 10:40AM, V5 (Dietary Aide) said, he's been trying to catch-up and clean out the reach-in cooler but guess he missed the expired food items. V5 said, food items should be labeled with an "open and use by" date to make sure they are discarded by the 7-day maximum. V5 said, items that are not opened or used they should still be discarded by the manufacture's expiration date and even though the heavy whipping cream was unopened it should have

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been removed from the shelves since it was past the manufacture's "use by" date.

On 03/04/2025 at 9:30AM, V1 (Administrator) said, she expects kitchen staff to properly label and date all food items with an "open and used by date" so they can be discarded according to the food storage policy.

Facility Policy (Revised: June 2013; June 2020) Food Storage Pantries Section III-Production & Controls documents in part:
All food products stored in the House pantries are stored in a safe and sanitary manner. Food products may be delivered, stocked and rotated by Food Service personnel or Resident Caregivers.
4. All food stock and products are stored in NSF approved sanitary storage containers that are covered, labeled as to contents, and dated.
Facility Policy (Revised: June 2013; June 2020) Food Storage Main Kitchen Section III-Production & Controls documents in part:
All food stock and food products are stored in a safe and sanitary manner. All food stock is dated and used on a first in, first out basis.
GUIDELINES:
There are many food safety aspects to consider regarding food storage. What is done with foods once deliveries are received, how they are labeled, how long they are stored, where they are stored and the temperature at which they are stored are just a few of the considerations.
One of the most frequently asked questions regarding the storage of food relates to the length of time foods may be kept, particularly those which have been opened or removed from original packaging. Storage times may vary for commercially processed foods dependent on the type of food, the processing or packaging and the

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ARDEN COURTS (PALOS HEIGHTS)	7880 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463

(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
S9999	Continued From page 13 conditions under which it is held. Many manufacturers provide instructions on labels concerning handling and storage of their food items. When there is doubt concerning food safety, foods are discarded and not served. PROCEDURES: 1. Inspect food deliveries for factors that pertain to food safety, such as proper labeling, 11. Some potentially hazardous foods under refrigeration at or below 41 degrees Fahrenheit for a maximum of 7 days, unless there is a different manufacturer's "use by" date specified. 12. Check storage time of unopened packaged foods. Vacuum-sealed, dairy products and commercially prepared ready-to-eat food vary in shelf-life. Check the expiration dates and rotate as needed. 15. Discard food that has exceeded the expiration date or when use-by date is unclear. (C)	S9999		