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S 000	Initial Comments Facility Reported Incident of March 7, 2025 /IL00189068 - 330.4240 Facility Reported Incident of March 16, 2025 IL00189069 - 330.710, 330.4220	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 330.710c)3)F)H 330.4220f) Section 330.710 Resident Care Policies c) The written policies shall include, but are not limited to, the following provisions: 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: 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. H) Fostering and maintaining resident safety, dignity, self-determination, and choice. (Section 3-206.05 of the Act) Section 330.4220 Medical Care f) All medical treatment and procedures shall be	S9999		

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administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

This requirement was NOT MET as evidenced by:

Based on interview and record review the facility failed to follow their policy and failed to provide adequate supervision for one (R1) of five residents reviewed for accidents and supervision. The failure resulted in R1 being burned with hot coffee and experiencing pain, redness, and blisters that formed on her right arm, upper thigh, and right abdomen. Also, based on observation, interview, and record review the facility failed to follow its policy on providing wound care and follow doctors' orders for one (R1) of five residents reviewed for wound care and following doctors' orders.

Findings include:

R1 is a 94-year-old resident initially admitted to the facility on 1/24/2025 with diagnoses including but not limited to: weakness, malnutrition, osteoarthritis, gait disturbance and Diabetes Mellitus type II.

Service plan for R1 dated 2/3/2025 documents in part: Personal hygiene - provide physical, reminders and repetitive verbal cues, and daily supervision of all grooming activities. Bathing - Assistance required (transfers in/out, steadying, cueing to wash self, cueing to dry self, shampooing/rinsing/drying hair, applying lotion).

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Dressing - Attempts to dress/undress self but may need assistance with appropriateness. Nighttime care - Provide set up assist with verbal reminders/cueing to get ready for and into bed. Dining and Eating - Provide encouragement to eat meals, and drink beverages of choice. Memory Loss/Cognition - Provide direction/guidance/prompts to surroundings throughout the day.

On 4/1/2025, at 12:12 PM, V10 (Program Service Assistant) stated, I was here the day R1 had the spill with the coffee. I placed the coffee on the table with 3 other resident's coffee at the front table right by the door. By the time I set the coffee down, I turned around and she was alert. When I turned around and I heard V12 (LPN) say R1 spilled her coffee. Coffee did not have a lid on it. It was a full cup. I did not let it (the coffee) cool before giving to R1. Most of the time they (the residents) wait because they know it is hot. R1 was not wearing any apron or clothing protector or anything like that. I did not take a temperature of the coffee before serving to the residents. We did not have a thermometer at that time, we have one now. V12 moved R1 to her room to go assess her. I blinked and it happened that quick. I know she was wide awake when I served it.

On 4/1/2025, at 12:05 PM, V12 Licensed Practical Nursing (LPN) stated, I was here when R1 had got coffee spilled on her and was burned. I was just walking down the hall and the activity aide (V10) called me and said R1 spilled coffee. I looked at R1 and her clothes were wet. I took her to her room and went to go check her out. We had to change her clothes. I did an assessment. R1 had redness to right arm, upper thigh, and right abdomen. There were no blisters at that time it was just slightly red. I cleaned the area and

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put ice on there and protective cream. I called the hospice on call person. I did not speak to any doctor as it was time for me to leave. I relayed in report what happened to the next nurse.

Progress note dated 3/16/2025 at 9:38 PM documents: Note Text: While changing clothing, care giver noted blister just below right antecubital region of right forearm. Noted blister is 1.5 x 1 inch, fluid filled, intact. R1 is not demonstrating any distress at this time. Noted surrounding area of forearm is red with soft tissue swelling and multiple less than 1 cm intact blisters. Area covered with non-stick foam dry dressing and wrapped with kerlix for protection. Called family and spoke to power of attorney (POA). All questions answered. Contacted Hospice and spoke to Hospice registered nurse (RN) who will notify assigned nurse to evaluate patient (R1) 03/17/25 at facility. Family is aware. Will continue to monitor. VS stable at this time, resting comfortably with eyes closed in bed.

Progress note dated 3/16/2025 at 2:11 PM documents: Note Text: Activity staff noted resident's clothing was wet with her coffee cup sitting on her lap. R1 was assessed by writer. Red areas noted to resident's right outer arm, upper right thigh and lower right quadrant. Skin is intact. Resident denies pain. Area cleansed and cream applied. Son made aware during his visit to pick up resident's hearing aids. MD made aware of incident.

Progress note dated 3/18/2025 at 2:45 PM documents in part: Note Text: Treatment orders carried out for right forearm burn. Site cleansed and dressed per resident service coordinator (RSC) (V2). Two smaller blisters ruptured- skin remains intact. Larger blister previously ruptured

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noted with skin sloughed off and open. Res tolerated dressing change well.

Progress note dated 3/24/2025 at 5:30 AM documents in part: Note Text: Knocked on the R1 door. She was asleep I had to wake her by sound and touch. I explained that I was her nurse and that I was in to change the dressing to her right arm. I removed the old dressing noted medium amount of serosanguineous. I cleansed the area with wound cleanser and pat dry. The wound measure to be 13cm long and 5cm wide appears red in color. I applied ABT (antibiotic) ointment and then covered with two 3X4 inch antibacterial nonstick pads. I wrapped the pads with gauze bandage and used a paper tape to keep dressing in place. R1 tolerated dressing change well. Bed placed back in lowest position and resident comfortably resting.

On 3/31/2025, at 9:59 AM, R1was noted to be in reclining chair at table in dining area. Surveyor asked if R1 could be taken to her room for interview. Facility staff wheeled her down to her room. Surveyor spoke to resident privately. When surveyor asked R1 about burns on her arm, she could not remember. R1 stated right arm hurts when she touches it.

On 4/1/2025, at 11:09 AM, V2 Director of Nursing/Resident Service Coordinator (DON/RSC) stated, I was not here for R1 burns from coffee incident. That happened on a weekend. Surveyor asked V2 how coffee is usually served to vulnerable residents. V2 stated, so usually the residents that are not as stable with coffee sit up at the table. The other residents they just pour and give the coffee in the community center. Coffee should be below 180 degrees F. It temps at 160 degrees out of the dispenser. They

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have initiated lids on the cups and letting the coffee sit and cool prior to giving to the residents and not filling it up all the way. I think the reason it burned her so bad is that it spilled on her sweater. It (the coffee) sat there for a while. She did not have any expression. The sweater was removed immediately when it was noticed. I do not know how long she had been sitting there with coffee spilled on her sweater. I think the sweater must have trapped the heat and adding to the severity of the burns. They were also talking about buying the refrigerated creamer to help bring down temperatures. That is something we are looking to put in place. The community center has 2 staff except for weekends and evening and then it has one staff. When R1 had her coffee spill it was the weekend and only had one staff member in the community center. I feel there should be 2 staff in there (the community center) at all times and this never should have happened.

On 4/1/2025, at 12:52 PM, surveyor askd V14 Nurse Practitioner (NP) how hot the coffee had to be to cause burns/blisters. V14 stated, the water could have been on the warmer side and if it stayed on her sweater for extended period of time it would have burned /blistered as if it were hotter liquid. For that reason, I am unsure what the temperature would have been. R1 is alert and oriented to self. R1 knows her name but pretty unaware of her surroundings other than that. I know they have coffee all the time, they are pretty safe with it they give 3/4 cups of coffee, they don't serve it boiling.

Hot Beverage Safety Policy dated November 2019 documents in part:
Safety Considerations
Review the following safety considerations for various situations when serving hot beverages:

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S9999	Continued From page 6 Identifying patients at risk for accidental spills and considerations for safe service Determine patients functional and cognitive ability to manage hot beverages Dispensing of hot beverages in the kitchen Fill cups less than full, do not overfill Consider the temperature range of 150-155 degrees F as an approximate guide for hot beverages leaving the kitchen; record the temperature taken on the Food Temperature Log Decant hot beverages from insulated large urns to smaller containers allowing for cooling Keep hot beverages uncovered as long as possible before serving to the patient Pre-pour hot beverages into mugs and allow to cool uncovered before start of the serving line Dispense servings of hot beverages to staff to serve to patients, rather than directly to patients Serving hot beverages to patients Serve hot beverages once the patient is seated; if in a wheelchair consider a cup holder with a sealed cup Serve hot beverages in a mug with a spill-proof drinking lid, if clinically indicated Cover disposable cups with a spill-proof drinking lid Place beverage away from the edge of the table Place beverage in the patient's field of vision Encourage the patient to consume cold beverages Allow hot beverages to cool before serving. Treatment administration record dated 3/18/2025 documents: Cleanse right forearm with wound cleanser and pat dry. Apply Silvadene 1% and cover with non-stick pad and wrap with kerlix daily on 11 p.m. - 7 a.m. shift. Treatment administration record has this scheduled at 6	S9999		

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a.m. Treatment administration record has blank spaces on 3/27/2025 and 3/30/2025 indicating treatment was not completed.

On 3/31/2025, at 9:59 AM, R1 was noted to have gauze bandage to right forearm dated 3/28/2025, indicating the bandage had not been changed for three days (3/29/2025, 3/30/2025, 3/31/2025).

On 3/31/2025, at 10:06 AM, V3 Licensed Practical Nurse (LPN) stated, the night shift nurse does the wound treatments. Surveyor asked V3 how often the treatments are ordered for R1, V3 stated, the treatments are to be done every day at 6am. V3 stated, the treatment was signed out as being done for today already. Surveyor asked V3 to look at date on dressing and tell me the date. V3 stated, the date on there (dressing) is 3/28/25.

On 4/1/2025, at 10:36 AM, V11 (LPN) stated, regarding the dressing changes for R1 I just forgot to do it on 3/30/2025 and I forgot to circle my signature after I signed it out ahead of time 3/31/2025. We are not supposed to sign before doing dressing change. We have to put date and time on dressing when we do them.
On 4/1/2025, at 11:09 AM, V2 Director of Nursing (DON) stated, my expectation of wound care and dressing changes is that they should be done according to the order. Wound dressings should be signed and dated after changing. The nurse V11 was going to do the dressing change (on 3/31/2025) for R1 and seen the hospice nurse who said they would do it. V2 stated, the hospice nurse never ended up doing dressing change before surveyor seen it and V11 forgot to go back and circle that she did not do the dressing change. V11 said, she just forgot to do the dressing change the day before. I am unsure why V9 (LPN) did not do the dressing change on

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3/29/2025 as she charted. Staff is supposed to sign and date all dressing changes. IDPH surveyor informed V2 (DON) that there was no date or time on dressing for R1 today (4/1/2025). V2 stated, I do not know why there was no date on the dressing today for R1.

On 4/2/2025, at 12:52 PM, 4/1/2025 12:52 PM V14 Nurse Practitioner (NP) stated regarding R1, I gave orders to change dressing daily. I do not have the computer in front of me right now for the exact orders. My expectation is that nurses follow the orders as given.

Dressing Change: Non-Sterile (Clean) Policy dated 6/2021 documents in part:
PURPOSE: Dressing changes are performed according to physician's orders. Non-sterile (clean) dressing changes are appropriate for select wounds such as chronic and acute wounds to clean and protect the wound.
PROCEDURE:
1. Verify physician's order
16. Apply dressing per physician's orders. (If physician's order requires application of topical ointment or cream apply with applicator)
17. Apply tape to secure dressing and label with date, time and initials.
(B)

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330.4240f)

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

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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 interview and record review the facility failed to protect three (R2, R3 and R4) out of five residents reviewed for resident-to-resident abuse. This failure resulted in R3 having a scratch, left wrist and hand swelling and sent out to urgent care for x-ray to left hand and R4 sent out to emergency room and receiving 3 staples to back of head for a laceration.

R3 is a 72-year-old resident initially admitted to the facility on 12/10/2024 with diagnoses including but not limited to dementia and hypertension.

R3's Progress note dated 3/7/2025, at 3:23 PM, documents: Note Text: At approximately 10:45, R3 was sitting in the chair in CC (community center), another res (R2) walked behind him (R3) and hit R3 in the face. This led to a physical altercation, ending up with both men on the floor swinging their arms and grabbing one another. Both residents (R2 and R3) were separated and taken into separate areas and assessed for pain and injuries. Small scratch noted to R3 left hand. Site cleansed and band aid applied. Message left by V3 Licensed Practical Nurse (LPN) for POA (power of attorney) to return call. R3 was seen by NP (nurse practitioner) V14 today around 12n (noon). No orders received. R3 denies pain and does not remember what happened earlier. R3 in

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S9999	Continued From page 10 no distress at this time. Functioning @ baseline. R2 is an 81-year-old resident initially admitted to the facility on 3/26/2024 with diagnoses including but not limited to neurologic cognitive disorder, hypertension and dementia. R2's Service Plan dated 6/27/2024 documents: Need: Memory Loss/Cognition Goal: Resident's daily routines will be supported as needed throughout the community environment. Supports/Support Actions: Monitor socially intrusive behavior, can become agitated if someone wanders into his room, Monitor territory/space intrusions, Provide additional encouragement/direction, Provide direction/guidance/prompts to surroundings throughout the day, Provide information on daily routine, Use personalized, lifestyle biography information to connect and engage in conversations, and/or important, meaningful events. R2's Progress note dated 3/7/2025 at 3:06 PM documents: Note Text: Res was observed by staff, walking behind another res (R3) as he was sitting down, and hit R3 in the face. This led to a resident-to-resident physical altercation between the two gentlemen (R2 and R3) ending up on the floor. Both residents were observed swinging their arms, trying to hit and grab each other. Both residents were separated and redirected into other areas until calm and assessed for injuries and pain. Scratches and swelling noted to left wrist. R2 was given first aid, and later seen by V14 (NP) who suggested that R2'a daughter be notified and previous psychiatric med change order be implemented, V2 Director of Nursing/Resident Service Coordinator	S9999		

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(DON/RSC) spoke with R2's daughter who is agreeable to increasing Seroquel to 50mg po BID, and is taking R2 to urgent care for x-ray of left hand/wrist at this time.

R2's Progress note dated 3/7/2025 at 4:42 PM documents: Note Text: Res returned home from urgent care with results negative for FX. Resident calm and functioning at baseline. Denies pain.

On 4/1/2025, at 12:40 PM, V15 housekeeper stated, I was here for the incident with R2 and R3. I was on my way to put my housekeeping cart into the closet. I seen an employee who no longer works here who was an activity aide (V16) saying they (R2 and R3) are fighting. I asked her to go get the nurse. In the meantime, I went in the community center to see what was going on. When I went inside, I seen R2 on the floor and R3 on top of R2. They were both on the floor. I started to talk to R3 to please get off him (R2) and R3 got up and we went to the chairs in front of the community center. Now when I got R3 to sit down and calm down I noticed R3 had a cut or scrape on one of his hands. I think it was the left but I am not sure it was by the wrist. As I was talking to R3, R2 came out of the community center trying to talk to R3. At that time, I stood between them. I also checked R2 his and face hands. R2 said his hand was hurting. I do not recall which hand, but it was swollen. I did not notice anything on R2 face. After that the nurse V3 came in and she took over from there.

On 4/1/2025, at 11:09 AM, V2 (DON/RSC) stated, I was here for the altercation between R2 and R3. It was a Friday because V14 our NP was here and looked at both of them (R2 and R3) as well. So, from what the activity aide (V16) told me R3 was sitting facing forward, R2 was sitting in the

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row behind R3 and R2 stood up and hit R3 in the face unprovoked. It ended up with R3 on top of R2 on the floor. The activity aide (V16) ran out to get help. V16 was relatively new and never had encountered that. This happened in the community center. The community center usually has two staff in there. I am not sure if there was another person in there.

On 4/1/2025, at 12:52 PM, V14 Nurse Practitioner (NP) stated regarding R2 and R3, I was aware of the altercation. One had the cane and the other started throwing punches. There was no rhyme or reason. R2 does not have any history of aggression that I am aware of. This is the first incident I am aware of, but he is a more recent move in.

R4 is an 83-year-old resident initially admitted to facility on 3/1/2025 with diagnoses including but not limited to: dementia, hypertension, and thoracic aortic aneurysm without rupture.

R4's progress note dated 3/21/2025 at 3:15 PM documents: Note Text: Resident was in his room when another resident (R5) entered and started to rummage through R4's items per R4's statement. Per V13 (Caregiver), she heard a commotion and when V13 arrived to R4's room, residents (R4 and R5) were pulling at a white shirt of R4's. Per V13, R5 was still swinging, trying to hit R4, and V13 had to redirect R5 out of room. R4 noted with 0.5cm laceration to back of head and a small scrape to forehead. Per R4, he believes that he must have hit his head on the floor at some point during the altercation. First aid administered by V2 Director of Nursing/Resident Service Coordinator (DON/RSC). POA (power of attorney) and MD (Medical Doctor) notified and R4 to be transferred to hospital for further

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	IL6014989	A. BUILDING: _____ B. WING _____	C 04/03/2025

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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evaluation.

R4's progress note dated 3/21/2025 at 10:51 PM documents: Note Text: Resident returned from hospital @10:05pm. Stitches at back of head, no complain of pain or discomfort noted at this time. No new orders need follow up.

R4's progress note dated 3/24/2025 at 11:52 AM documents: Note Text: 3 Staples in place- error stitches.

R4 hospital records dated 3/21/2025 documents: Diagnosis laceration of scalp, initial encounter.

On 3/31/2025, at 10:18 AM, surveyor asked R4 if he had any altercations with other residents here (facility). R4 stated, I had to go to hospital to get staples in my head. I still have them in there. Some guy (R5) came in my room and banged me in the head. He (R5) is kind of a nutcake. I haven't seen him (R5) since. I do not know what they did with him (R5). I do feel safe living here. I am going to lock my door when I get in here at night. I do not know who it was that hit me. Surveyor did not observed any dressing to back of head. Staples x3 observed.

R5 is a 72-year-old resident initially admitted on 12/13/2024 with diagnoses including but not limited to: altered mental status, bipolar, psychotic.

R5's service plan dated 1/5/2025 documents:
Need: Dementia-related behavior
Goal: Provide opportunities to minimize potential socially inappropriate or intrusive behavior so it does not interfere significantly with lives of self or others
Supports: Provide a calm, safe environment, i.e.

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hourly checks, Report behaviors as dictated by state regulations, and Revise approaches as needed.

R5's progress note dated 3/21/2025 at 3:51 PM documents: Note Text: Resident wandered into another resident room (R4) and started to remove items from R4 room. Per caregiver (V13), when V13 arrived to (R4) room, V13 saw them (R4 and R5) pulling on R4's white shirt and R5 was still swinging at R4 trying to hit R4. Both residents (R4 and R5) were redirected, and V2 DON/RSC notified. When V2 tried to assess R5, R5 became combative, with fists in a ball, and slammed door in threatening manor. Medical doctor notified and orders to transfer to hospital for further evaluation received. POA (power of attorney) aware of POC (plan of care). Awaiting ambulance. Resident under close observation by caregiver staff until transfer. R5 now in another resident room, refusing to leave. (Other resident (R4) not in room at this time).

R5's progress note dated 3/27/2025 documents: Note Text: Resident remains at hospital at this time.

On 4/1/2025, at 10:55 AM, V13 caregiver stated, I was here when R4 and R5 got into an altercation. I discovered R5 was missing from the living room. I was trying to keep R5 around me. I heard a noise. As I got up and ran to R4's room I discovered R5 pulling a white shirt from R4. R4 was telling R5 to get out. R4 said R5 knocked me in the head. R5 was still trying to be aggressive. I told R5 to please come with me and I can show you where your room and clothes were. R5 did come with me. I notified the V2 (DON/RSC) as soon as I separated them (R4 and R5). After the nurse (V2) and I checked on R4 we discovered

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R4 was bleeding from the back of his head. V2 called the ambulance and R4 got sent out to the hospital. I believe R5 got sent out (to hospital) as well. They (R4 and R5) were not on the same living unit. R5 had just moved to this hall 2 hours before the incident. Before that R5 was on another hall. R5 was on Dockside (hall) and R4 was on Berry Ridge (hall). R4 got moved to Dockside after he came back from hospital and R5 stayed on Berry Ridge. When this happened, they (R4 and R5) were on the same hall. R5 is pretty aggressive. I believe there are other reports of R5 being violent. R5 had never been violent with R4 before. We would have R5 on 30-minute checks and it is unspoken that we keep R5 near a caregiver at all times to prevent something like this.

On 4/1/2025, at 11:09 AM, V2 (DON/RSC) stated, I was here for the incident for R4 and R5. I came in on the end of that. When I appeared they (R4 and R5) were separated but R5 was still trying to get back into the room. I tried to redirect R5. R5 tried to slam the door in my face with his fist balled. I was trying to assess R5 because I had already seen that R4 was bleeding from the head. R5 would not let me assess him so we sent him out (to hospital). I sent R4 out to emergency room as well. R4 came back with 3 staples. V2 further stated, R5 does refuse care every now and then but nothing to this degree. R5 has not hit anyone else that we are aware of. Sometimes they just do stuff out of the blue for no reason. R5 when he came back he was on 30 minute checks, not prior to that. When R5 is agitated, caregivers know to keep an extra eye on him. That is pretty much with everyone.

On 4/1/2025, at 12:52 PM, V14 Nurse Practitioner stated regarding R4 and R5, R5 has not had any

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aggressive behavior previously that I am aware of. My expectation that abuse does not occur in the facility, and everything done to prevent it.

Resident Protection Policy dated 11/2021 documents in part:
POLICY: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.
Seven Key components of the abuse prevention system:
2. Train
3. Prevent
6. Protect
Procedure:
The community screens potential new move-ins to determine if the resident has a personal history of or is at risk for developing abusive actions or aggressive behaviors toward others. If the resident has such a history or presents such a risk, the community reviews the resident's status to determine if the resident is appropriate for move in and the community can meet the residents needs.
The community provides employees orientation and ongoing education about the prohibition of abuse such as:
Prohibition and preventing all forms of abuse, neglect, misappropriation and exploitation.
Ways to deal with aggressive behaviors.
Residents have the right to be free from abuse that may occur from the unauthorized taking of pictures or recordings that are demeaning or humiliating. New employee orientation and annual abuse prevention education includes:
Abuse prevention
Resident protection actions include:
Provide a safe and secure environment for residents.

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