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 07/09/2025

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 2595596/IL194902 - Section 330.780 a) b) c) cited	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.780a) 330.780b) 330.780c) Section 330.780 Section 330.780 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. 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	S9999		

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S9999	Continued From page 1	S9999		

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.

This requirement was NOT MET as evidenced by:

Based on interview and record review, the facility failed to initiate and report a serious incident that caused injury to the resident for one of one resident (R1) reviewed for incidents and accidents in a sample of 4.

Findings include:
R1 moved in the facility on 06/03/2022 with diagnoses of not limited to Alzheimer's disease and Crohn's disease.

R2 moved in the facility on 03/10/2025 with diagnoses of not limited to other Alzheimer's disease and Anxiety disorder.

On 07/09/2025 at 12:36PM during interview with V6 (Licensed Practical Nurse/LPN), V6 stated that she was orienting at the time the incident happened, but she was preparing to pass medications just outside the TV room when R2 stood up from the chair and appeared to be starting to get agitated. V6 stated that when R2 saw V7 (Caregiver), R2 grabbed V7 by the arm. V6 stated that V7 was able to calm R2 down and brought back R2 to the TV room. V6 stated that R2 stood up again and grabbed V6 on her right shoulder. V6 stated that they were about to bring R2 to his room when R2 pushed R1 who was

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standing right across V6 out of nowhere. V6 stated that upon R1's assessment, R1 complained of pain on his right hip, and R1 was unable to stand up, so they sent R1 to hospital for further evaluation.

On 07/09/2025 at 11:46AM during interview with V5 (Caregiver), V5 stated that he was sitting on the couch with R2 and R2 got up and walked towards R1, who was standing in the hallway, and pushed R1 out of nowhere.

On 07/09/2025 at 10:25AM during interview with V4 (LPN), V4 stated that she was called by V6 and was told that R2 pushed R1 and R1 fell on the floor. V4 stated that during R1's assessment, R1 was unable to stand up and move his right lower extremity so they sent him out for evaluation. V4 stated that the incident between R1 and R2 is considered an allegation of abuse, and she should have reported it to V1 immediately since V1 is the abuse coordinator. V4 stated that she just followed the chain of command that's why she did not inform V1.

On 07/09/2025 at 12:10PM during interview with V2 (Resident Care Coordinator), V2 stated that she was informed by V4 of the incident that happened between R1 and R2, and that incident is considered resident-to-resident incident and an allegation of abuse. V2 stated that she informed V1, who is the abuse coordinator, immediately of the incident after she was informed, and the incident should have been reported to the state within 24 hours.

On 07/09/2025 at 1:40PM during interview with V1 (Executive Director), V1 stated that if R2 pushed R1, it is considered a resident-to-resident incident and should have been reported to the

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State within 24 hours. V1 stated that she was not aware that the hospital informed the facility that R1 sustained a right femur fracture the same day R1 was sent out to the hospital. V1 stated that the nurse who received the information should have initiated an incident report. V1 stated that V2 does the incident report, then she will receive an email notification that there is an incident. V1 stated that when she reviews the email notification and sees that it is incident with injury or resident-to-resident, she will automatically initiate a report to be sent to the State within 24 hours. V1 stated that in the case of the incident between R1 and R2, she did not receive any email notification, the reason why there is no report that was sent to the State.

Review of facility's Illinois Department of Public Health Reportables from April to July 2025 did not indicate any incident report for R1 and R2 resident-to-resident incident.

Facility was unable to provide facility incident report for R1 and R2 resident-to-resident incident.

Review of facility's policy entitled Resident Protection revised 02/2024 indicated the following:
Purpose: The community will adopt and operationalize an abuse prevention system that includes screening and training of employees, protection f residents, identification and investigation of allegations of abuse, and reporting and responding to the appropriate individuals or agencies.

Procedure:
5. The Executive Director is the designated Abuse Prevention Coordinator.
6. The Executive Director is responsible for

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S9999	Continued From page 4 investigating, reporting and coordination of the investigation process of any alleged or suspected abuse regardless of the source of the concern. 15. Any allegation requires an investigation. 18. Resident protection actions include: - Reporting allegations of abuse to other agencies or law enforcement. "C"	S9999		