

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6015325	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/24/2025
NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (PALOS HEIGHTS)		STREET ADDRESS, CITY, STATE, ZIP CODE 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
S 000	Initial Comments Complaint Investigation: 2594541/IL192800 - no findings Facility reported incident of: 04/14/2025/IL191806 - 300.610a) and 300.4240a) cited	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710a) 330.4240a) 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 by a Resident Care Policy Committee consisting of at least 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. Section 330.4240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by:	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>Based on observations, interviews, and record review, the facility failed to protect a resident's right to be free from physical abuse from nursing staff for one of four (R2) residents reviewed for abuse. This failure resulted in R2 acquiring scratch, bruise, and swelling to his right hand.</p> <p>Findings include:</p> <p>R2 is a 87-year-old male admitted to the facility on 06/03/2022 with diagnosis including but not limited to Alzheimer's Disease, Unspecified; Crohn's Disease, Unspecified, With Unspecified Complications; And Basal Cell Carcinoma Of Skin Of Nose.</p> <p>According to R2's comprehensive assessment dated 03/05/2024, R2's Neuro/Emotional/Behavioral Status shows R2 is oriented to himself and forgetful. R2's Functional Status shows R2 is able to shower with intermitted assistance, supervision, encouragement, or reminder of another person.</p> <p>On 05/23/2025 at 10:15 AM Surveyor observed R2 sitting in the chair, in his room, clean and dressed appropriately. No bruise nor scratch noticed on R2's right hand/wrist/forearm area. R2 said, "I had a bruise on my right hand, but it was nothing, I bumped it into a chair. I bruise pretty easily. Staff is great here; I certainly feel safe."</p> <p>On 05/23/2025 at 10:22 AM V4 (Licensed Practical Nurse) said, "On the evening of 04/12/2025, V5 (Caregiver) reported to me that R2 had a very small scratch and bruise around it, on his right hand. V5 (Caregiver) said R2's bruising was there prior to the shower. Initially, R2 said he scratched himself in the shower. Then, on</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>the following Monday (04/14/25), R2 told his daughter that an aid was assisting him in the shower, R2 didn't want the help in the shower, but the aid insisted on helping him, so she grabbed his hand, and that's how R2 got scratched. R2 said it was a "big girl" but didn't know the aid's name. There was an internal investigation related to the incident, but I don't know the outcome of it."</p> <p>On 05/23/2025 at 10:52 AM V2 (Director of Nursing) said, " V5 (Caregiver) was providing care to R2 on 04/12/2025, she no longer works in the facility. V5 (Caregiver) was terminated 04/21/2025. R2 told his family member that V5 (Caregiver) was giving him a shower, sprayed water in his face and grabbed his right hand, leaving it scratched and bruised. We found out about the incident on 04/14/2025 when R2's family reported it to me and former executive director who was also an abuse coordinator. We immediately initiated abuse investigation. We interviewed R2, V4 (Licensed Practical Nurse), and V5 (Caregiver) who admitted to spraying water in R2's face and then grabbing his hand. V5 (Caregiver) was suspended on 04/14/2025 and later terminated. R2 had an x-ray related to the injury with a negative result. Nurse practitioner assessed it and recommended monitoring, so did wound care nurse, there were no new orders."</p> <p>On 05/23/2025 at 11:45 AM, at 12:18 PM, and on 05/24/2025 at 9:32 AM Surveyor attempted to call V5 (Caregiver), no answer, voicemail left. Per facility investigation report, V5 (Caregiver) who was providing direct patient care to R2 on 04/14/2025 stated that while she was giving R2 shower, R2 became combative. V5 (caregiver) sprayed R2's face with water trying to wash his face. V5 (caregiver) denied injuring R2's hand.</p>	S9999			

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S9999	<p>Continued From page 3</p> <p>On 05/23/2025 at 12:55 PM V1 (Executive Director/Abuse Prevention Coordinator) said, "I've been here since 05/19/2025, I started four days ago." Surveyor asked about general abuse investigation procedure, V1 said, "The abuse allegation investigation would be initiated with interviewing and documenting statements of perpetrator, victim, and Director of Nursing, to try to verify the allegation. I would then look for other witnesses' statements as well. In the meantime, we would perform any necessary assessments. The next thing would be to suspend the perpetrator. Call the emergency services, if necessary, then continue the investigation. Once we have the internal investigation completed, I would write a summary and submit it to regional director of operations and submit initial report to regulatory agency within 24 hours. The staff abuse training starts at new hire orientation and there will be monthly abuse in-service during all staff meeting that I'm going to initiate."</p> <p>Surveyor requested V5's (Caregiver) employee file including abuse training and background check.</p> <p>On 05/24/2025 at 9:45 AM Surveyor verified V5 (caregiver) background check with no concerns; no abuse training provided.</p> <p>Progress note dated 05/14/2025 written by V4 (Licensed Practical Nurse) reads in part, "Writer was made aware by caregiver (V5) that (R2) had a scratch to the right forearm. Upon assessment, (R2) noted with a very small scratch to the right forearm. A scant amount bleeding noted. Area was cleansed with NS, patted dry, TAO and band aid applied. No c/o pain noted. Bruising noted to the right hand. No swelling noted and able to move all fingers. (R2) stated he was scratched</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>during his shower. Writer asked caregiver (V5) what happen, and she stated that (R2) became combative while assisting him with his shower. Writer also asked if he hit his hand and was bruising present prior to his shower. Caregiver (V5) stated he didn't hit his hand, and the bruising was noted prior to the shower. (R2) was monitor throughout the shift for pain and distress."</p> <p>R2's Body Evaluation Tool dated 04/14/2025 shows right hand injury.</p> <p>R2's x-ray dated 04/16/2025 reads in part, "Procedure: Right hand (x-ray)/ Impression: No gross hand fracture."</p> <p>The facility "Resident Protection" policy last revised on 12/2024 reads in part, "The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint nor required to treat the resident's medical symptoms. Employees are educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse, neglect, exploitation, mistreatment, misappropriation, or crime against a resident."</p> <p>(B)</p>	S9999		