STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014419	A. BUILDING: _____ B. WING _____	C 05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS (ELK GROVE)	1940 NERGE ROAD ELK GROVE VILLAGE, IL 60007

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S 000	Initial Comments Investigation of Facility Reported Incident of 4/23/25/IL191856	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710a) 330.4240e) 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. Section 330.4240 Abuse and Neglect 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 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). These regulations were not met as evidenced by: Based on interview and record review the facility	S9999		

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S9999	Continued From page 1	S9999		

failed to follow their policy to immediately report an allegation of abuse and failed to ensure residents were provided a safe and secure environment when an allegation of employee-to-resident abuse was reported, and the employee was allowed to continue working with residents.

This applies to all 42 residents residing in the facility on April 23, 2025.

The findings include:

The facility's Daily Census Report dated April 23, 2025 shows the facility census was 42 residents on April 23, 2025.

On April 23, 2025 at 1:30 PM, the facility submitted the following reportable incident to IDPH (Illinois Department of Public Health): "A staff member reported observing an employee strike [R1] on the right hand with a spoon while stating, "I said no," as the resident reached over in an attempt to take another resident's dessert."

The EMR (Electronic Medical Record) shows R1 was admitted to the facility on October 31, 2021 with multiple diagnoses including Alzheimer's disease, major depressive disorder, vascular dementia, and anxiety disorder.

R1's Annual Clinical Evaluation dated March 17, 2025 shows R1 is alert to person only, is independent with eating, transfers between surfaces, and bed mobility and requires assistance by facility staff with all other ADLs (Activities of Daily Living). R1 fluctuates between continence and incontinence of bowel and bladder.

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On May 12, 2025 at 10:33 AM, R1 was sitting up in the chair in the dining room. R1 was not able to answer any questions due to his cognitive status. R1 did not have any visible lacerations or bruises on his hands.

On May 13, 2025 at 10:43 AM, V4 (RC-Resident Caregiver) said, on April 23, 2025, V3 (RC) was serving food to residents and appeared overwhelmed. V3 approached R1, with a serving spoon in her hand. R1 was reaching for another resident's food. V3's back was to V4 at the time and V4 said she saw V3 use the serving spoon to hit R1's hand and correct him for trying to take food from the other resident by hitting him and telling him "No." V4 continued to say she did not report the alleged abuse right way and waited until after lunch to report it to her immediate supervisor.

V4 said she did not report the allegation of abuse to V1 (ED-Executive Director/Abuse Coordinator).

V4 also said she saw V3 remained working in the facility after she reported the allegation of abuse.

On May 13, 2025 at 12:16 PM, V3 (RC) said, "On April 23, 2025, I worked from 7:00 AM to 3:30 PM. I was not sent home. I punched out at the end of my shift, and I went home. I was scheduled to work on April 26, 2025. They called me on Friday, April 25, 2025, and talked to me and told me I couldn't come to work the next day because someone reported I abused a resident. On the day that this happened, no one told me to go home early. I was able to work my whole shift."

V3's timecard dated April 23, 2025 shows V3 started work at 7:11 AM and clocked out of work

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S9999	Continued From page 3 on April 23, 2025 at 15:36 (3:36 PM). On May 13, 2025 at 1:38 PM, V1 (ED-Executive Director) said the timeline of events for the allegation of abuse on April 23, 2025 were as follows: 12:40 PM - V4 (RC) witnessed V3 (RC) use a spoon to slap the back of R1's hand. 1:05 PM - V4 (RC) reported this to her supervisor V9 (Activities Director) 1:10 PM - V9 (Activities Director) notified V1 (ED) and V2 (RSS-Resident Service Supervisor) 1:11 PM - Investigation initiated 1:15 PM - V4 (RC) interviewed by V1 (ED) and V2 (RSS) 1:20 PM - V9 (Activity Director) interviewed by V1 (ED) 1:25 PM - Head-to-toe skin assessment performed by V2 (RSS) V1 (ED) stated V4 (RC) should have immediately reported the allegation of abuse to V1. V1 said, "Part of our general orientation includes abuse training. The curriculum is part of the general orientation. One of the first things I discussed with [V4] (RC) was that she was supposed to report the abuse to me immediately, and how important it is to come to me directly to prevent further delay. She wasn't sure if she should report it. We want our staff to report suspected abuse. I would have expected her to report this to me right away." V1 (ED) continued to say the timeline does not show V3 (RC) was sent home during the abuse investigation. When V1 was asked why V3 was allowed to continue working after the allegation of abuse was made, V1 replied, "That's a good question. Why did we allow her to work the rest of the day? I don't have a good answer. There	S9999		

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was some unclarity as to what the suspension process would have looked like. I guess the suspension should have happened immediately. Mentally, it took us a while to realize we were doing an abuse investigation. [V3] (RC) worked until 3:36 PM that day."

The facility does not have documentation to show V3 (RC) was immediately removed from resident care, and the facility does not have documentation to show R1 or any other residents were removed from contact with V3 (RC).

The facility's policy entitled Resident Protection, revised on "02/2024" shows, "Policy: 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 restrain not required to treat the resident's medical symptoms. Purpose: The community will adopt and operationalize an abuse prevention system that includes screening and training of employees, protection of residents, identification, and investigation of allegations of abuse, and reporting and responding to the appropriate individuals or agencies. Procedure: ...3. The community provides employees orientation and ongoing education about the prohibition of abuse such as: How to immediately report suspicions or allegations of abuse (including injuries of unknown origin), neglect, exploitation, mistreatment, misappropriation of resident property, or a crime against a resident. How to report knowledge related to abuse allegations without fear of reprisal. 4. Employees are educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse, neglect,

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S9999	Continued From page 5 exploitation, mistreatment, misappropriation, or crime against a resident. 5. The Executive Director is the designated Abuse Prevention Coordinator." The facility's policy entitled Resident Protection, revised on "02/2024" shows, "Policy: 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 restrain not required to treat the resident's medical symptoms. Purpose: The community will adopt and operationalize an abuse prevention system that includes screening and training of employees, protection of residents, identification, and investigation of allegations of abuse, and reporting and responding to the appropriate individuals or agencies. Procedure: ...18. Resident protection actions include: Immediately removing the resident from contact with the alleged abuser. ...Provide a safe and secure environment for residents." (B)	S9999		