

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014989	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/17/2025
NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (SOUTH HOLLAND)		STREET ADDRESS, CITY, STATE, ZIP CODE 2045 EAST 170TH STREET SOUTH HOLLAND, IL 60473		
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S 000	Initial Comments Complaint Investigation: 2597682/IL196997 - 330.4240a), 330.4240d) Investigation of Facility Reported Incident of June 30, 2025/IL196520 - 330.4240a), 330.4240f)	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 330.4240f) 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 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 is not met as evidenced by: Based on interview and record review the facility failed to protect one resident's (R2) right to be free from physical abuse by R1. This failure resulted in R2 being slapped in the face multiple	S9999		

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

TITLE

(X6) DATE

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S9999	Continued From page 1 times by R1. This affected one of three residents reviewed for physical abuse. Findings include: R2 with diagnosis not limited to: Cataract, Hyperlipidemia, Arthritis, Alzheimer's Dementia W/Behavioral Disturbance, Kidney Disease, HTN. On 8/16/25 at 10:50am V1 (caregiver) said she was taking care of another resident, she heard help and when she approached the living room, she observed R1 slapping R2. V1 said the two residents was sitting side by side of each other. V1 said she did not see any injures on R2. She notified the Nurse, and the nurse immediately separated the two residents. V1 said there were no staff in the room with the residents when she arrived and observed R1 hitting R2. V1's witness statement dated 6/30/25 denotes in-part I was in resident room when and heard help. When I came out to the living room, I witnessed the resident R1 smacking and other resident R2. I immediately went to report to the Nurse. The Nurse asked R1 if she smacked R2, and R1 stated "yeah I did but I didn't hurt her". I did not notice R2 having her shoes off. On 8/16/25 V3 (Administrator) said the residents have dementia she doesn't think they know what they're doing. V3 said staff should be monitoring the areas where the residents are sitting. V3 said she must determine what area that the incident occurred in. Facility final investigation to the department date 7/3/25 denotes in-part R1 was observed smacking R2 in the face three times back-to-back this morning in the dining room. Staff asked R1 why she did that. R1 stated I didn't hurt her. R1	S9999			

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S9999	Continued From page 2 later stated that R2 hit her with a shoe so she hit her back. Staff states that there was no shoe present/nearby the area where it took place. No injuries known. Facility policy titled, Resident protection dated 11/2021denotes in-part policy: the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but not limited to freedom from corporal punishment, involuntary seclusion and physical or chemical restraint not required to treat the residents' medical symptoms. "B" Statement of Licensure Violations 2 of 2: 330.4240a) 330.4240d) 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) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the department. (Section 3-610 of the Act) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility neglected to develop and implement an	S9999		

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S9999	Continued From page 3 individualized plan of care for one resident (R3) with exit seeking behaviors. This failure resulted in R3 eloping from facility and found by the police inside an unidentified vehicle with his belongings on 7/26/25. The facility neglected to implement their policy and procedures for elopement when R3 activated door alarms. This failure affected one of three residents (R3) reviewed for elopement. Findings include: R3's records show R3 has diagnosis of memory loss. R3 records shows R3 was admitted on 7/21/25. R3's care plan with created date of 7/27/25, shows wandering, resident will wander safely within the boundaries of the community. R3's Nurse Note dated 7//23/25 denotes in-part resident alert and oriented to self. Emulates well no complaints of pain made multiple requests to exit facility but easily redirected with two staff assists escort 2 unit. No further incident noted. On 8/16/25 at 10:32am V2 (Police Department) stated he responded to a call that someone when was breaking into a vehicle. V2 said when he arrived at the scene he observed a male, rummaging through a vehicle and the male stated that was his vehicle and that he was headed to work. V2 said the owner of the vehicle approached and informed him that that was his vehicle. V2 said the male who owned the vehicle was an employee at the nursing facility. V2 said he ran R3's name and R3 name came back associated to an address in (name of a city). V2	S9999			

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S9999	Continued From page 4 said the owner of the vehicle informed him that the belongings that was in his vehicle did not belong to him and that they belonged to the resident. V2 said the resident had a box of items, it was a lot of items, there were diapers, clothing. V2 said it looks as if R3 had cleared out a closet. V2 said as he and his partner were gathering information, two females casually walked up and stated Mr. ... (R3) what are you doing out here. V2 said that's when he identified that R3 was a resident of the Arden Courts Nursing facility. V2 said he asked the two females when the last time was they saw R3. V2 said he request to speak to the supervisor of the two female staff. V2 said he recall speaking with V6 (Licensed Practical Nurse/LPN). V2 said V3 called someone. V2 said himself and V3, and the two female staff went to the Arden Courts Nursing home, the staff was supposed to allow him to see the log for when the last time they checked on R2 but they left him in the lobby and did not return. V2 said R3 did not have any injuries, he was confused, it was evident that he had dementia, and so he and his partner left the scene and call the department of public health. V2 said he thought it was strange that R3 was able to leave that facility, the staff could not tell him what time they saw R3 last, so the report to the department was made. On 8/16/25 at 11:22am V3 (Administrator) said R3 was admitted to the facility for respite stay. V3 said, R3 has dementia, and she was notified of R3 eloping the facility on 7/26/25. V3 said R3 did elope the facility and was found in the parking lot trying to get into cars. V3 said there were multiple failures that night. V3 said, the staff did not follow the protocol for hourly checks, the staff did not follow the protocol for missing residents, and staff did not follow protocol for door alarms. V3 said an investigation was conducted and the conclusion	S9999		

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S9999	Continued From page 5 was that R3 left out the front door. V3 said she was aware that R3 had his belonging with him when he was found by the police. On 8/16/25 at 1:27pm V4 (Caregiver) said she arrived on duty at 7:00pm on 7/26/25, she was working the unit with V5 (Caregiver) and she was under the impression that V4 was doing the hourly checks for the unit at 9:00pm and prior. V4 said the door alarms was sounding a lot that night. V4 said maybe around 10:00pm or so, she was made aware that R3 was missing. V4 said R3 was having exit seeking behavior for a few days before he left the facility on 7/26/25. V4 said everyone was aware that R3 was walking around with his bag of clothes wanting to leave. V4 said they (herself and peers) do hourly round on the residents. V4 said she checked the lobby when looking for R3. V4 denied going out the entrance door to look for R3. V4 said she was under the impression that the entrance door could not be opened without being buzzed out or without using the code to get out. V4 said she don't know how R3 exited the facility. V4 said the facility gave her an in-service on elopement, and gave her some papers, but she has a lot of things going on and she can't recall what was reviewed with her during the in-service. On 8/16/25 at 1:58pm V6 (LPN) said she last saw R3 at 4-5pm when she was administrating medications. V6 said she was made aware that R3 was missing on 7/26/25, and they did a search for R3 around 10:00pm. V6 said staff informed her that R3 was located outside with the police. On 8/17/25 at 10:59am V5 (Caregiver) said was working with V4 and he last saw observed R3 in the facility in the hallway around 9:00pm. V5 said	S9999		

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S9999	Continued From page 6 around 10:00pm, he noticed that R3 was not in the facility. V5 said he looked for R3, he informed the Nurse that he could not locate R3 in the facility. V5 said he checked the courtyard multiple times during the search for R3. V5 said the courtyard is closed in and the residents are allowed to go out to the courtyard freely. V5 said he was made aware by a staff member that R3 was found outside the facility with the police. V5 said the staff brought R3 back into the facility. V5 said R3 was having exit seeking behaviors for days, and everyone knew. R3 would wandering around the facility with his bag of clothes, R3 would say he wanted to go home. V5 said R3 was on hourly checks. V5 said all residents are on hourly checks. V5 said he don't know how R3 got out the facility. V5 said the alarms was sounding a lot the evening. V5 said there were no open windows, R3 did not leave out a window. On 8/17/2025 at 12:09pm V7 (Director of Nursing) said she was made aware of R3 eloping the facility on 7/26/25. V7 said the incident was reported to the department. V7 said she was made aware that R3 was in the parking lot rummaging through someone's car. V7 said she was made aware that R3 had his belongings in the vehicle with him. V7 said the facility investigation determined that there were multiple failures. V7 said she believes that R3 followed a family member out of the facility. V7 said sometimes her visitors does not want to wait for staff to buzzed them out the facility and they will leave out without being assisted. V7 said the facility has two doors there's an entrance door, allowing entry into the lobby and there's an entry door that allows entry into the care unit. V7 said both doors have separate alarms, both door alarms have to be reset once activated. V7 said she has not determined who reset the door	S9999			

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S9999	Continued From page 7 alarm. V7 said her investigation revealed that staff did not complete hourly checks on the residents, V7 said R3 should have been placed on 30 minutes checks because he was new to the facility and he was displaying exit seeking behaviors, and the 30-minute monitoring was not implemented for R3. V7 said the staff did not announce a code yellow for missing resident. V7 said her expectation is that the staff place R3 on 30-minute monitoring upon admission for 72 hours, and complete 30-minute monitoring when R3 observed with exit seeking behavior of wanting to leave with his belongings, staff should conduct hourly rounds and document that the saw the resident during that time. V7 said hour rounds should be completed 5 minutes before or 5 minutes after the hour, if staff are not able to complete the hourly round within the time frame, they should circle the time and document the actual time the round was completed. V7 said if the staff does not visually observe the resident in the facility, they should immediately search the unit, if the resident is not found they should notify the Nurse, use the walkie talkie and announce a code yellow, extend the search onto the other units and to the courtyard. V7 said if the resident is not found they staff should retrieve the backpack (include search kit) and extend the search to the parking lot, searching the entire parking lot for the resident, if the resident is not found staff should call 911, notify herself and the administrator. V7 said the entrance door alarms are activated the staff should do a head count to ensure the residents are in the facility, staff should check outside of the entrance door to ensure that a resident did not leave the facility. V7 said staff should deactivate the alarms and not check for the residents. V7 said all staff are responsible for the safety and security of all the residents.	S9999			

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S9999	Continued From page 8 Request was made 8/17/25 at 10:44am during this survey to review R3 elopement risk assessment. The facility failed to provide R3 elopement risk assessment. On 8/17/25 V3 present a manilla envelope and stated that R3 chart was purged and that's all of his facility documents. There was no elopement risk assessment noted. V3 said all resident receives the same assessments regardless of if they are admitted for respite stay or permanent stay. Facility policy titled safety and security of residents last updated 7/2024 denotes in-part purpose, (Facility) senior services provides safe and healthy living environments for all its residents to be maximum extent possible. In support of this objective each community is responsible for identifying members of the resident population who are prone to wandering and or elopement. Performing a community specific risk assessment to identify ways in which disoriented residents may gain unauthorized access to the exterior of the community or areas within the community that are considered hazardous. Installing and maintaining resident monitoring security devices at high-risk locations identified during the community risk assessment. Using guidelines provided in this document developing a community specific plan for potential missing resident searches. Implementing procedures outlined in this document in response to a door alarm courtyard monitoring guidelines resident hourly checks and potential resident elopements. Maintaining the community's readiness for potential resident elopement incidents through employee training and routine system checks. "B"	S9999			