

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 12/13/2025
NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (SOUTH HOLLAND)			STREET ADDRESS, CITY, STATE, ZIP CODE 2045 EAST 170TH STREET SOUTH HOLLAND, IL 60473		
(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 Investigation of Facility Reported Incident of December 9, 2025/IL 199042	S 000			
S9999	Final Observations Statement of Licensure Violations: 330.785a)1)3) 330.785b)3) 330.785c)1)2)3)4)5) 330.1140a)1)2) 330.1140b) 330.1140c) 330.4240a) 330.4240f) Section 330.785 Contacting Local Law Enforcement a) For the purpose of this Section, the following definitions shall apply: 1) "911" ? an emergency answer and response system in which the caller need only dial 9-1-1 on a telephone to obtain emergency services, including police, fire, medical ambulance and rescue. 3) Sexual abuse ? sexual penetration, intentional sexual touching or fondling, or sexual exploitation (i.e., use of an individual for another person's sexual gratification, arousal, advantage, or profit). b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 3) Sexual abuse of a resident by a staff member, another resident, or a visitor; c) The facility shall develop and implement a policy concerning local law enforcement	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 notification, including: 1) Ensuring the safety of residents in situations requiring local law enforcement notification; 2) Contacting local law enforcement in situations involving physical abuse of a resident by another resident; 3) Contacting police, fire, ambulance and rescue services in accordance with recommended procedure; 4) Seeking advice concerning preservation of a potential crime scene; 5) Facility investigation of the situation. Section 330.1140 Care and Treatment of Sexual Assault Survivors a) For the purposes of this Section, the following definitions shall apply: 1) Ambulance Provider - an individual or entity that owns and operates a business or service using ambulances or emergency medical services vehicles to transport emergency patients. 2) Sexual Assault - an act of nonconsensual sexual conduct or sexual penetration, as defined in Section 12-12 of the Criminal Code of 1961, including, without limitation, acts prohibited under Sections 12-13 through 12-16 of the Criminal Code of 1961. b) The facility shall adhere to the following protocol for the care and treatment of residents who are suspected of having been sexually assaulted in a long term care facility or elsewhere (Section 3-808 of the Act): c) The facility shall take all reasonable steps to preserve evidence of the alleged sexual assault, and not to launder or dispose of the resident's clothing or bed linens until local law enforcement	S9999		

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S9999	Continued From page 2 can determine whether they have evidentiary value, including encouraging the survivor not to change clothes or bathe, if he or she has not done so since the sexual assault. 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) 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: 1.) Based on observation, interview and record review, the facility failed to immediately notify law enforcement after staff witnessed resident to resident sexual abuse/assault and failed to develop and implement a policy concerning local law enforcement notification. This failure affected one (R1) of three residents reviewed for abuse and has the potential to affect all 58 residents that reside within the facility. 2.) Based on interview and record review, the facility failed to take reasonable steps to preserve evidence of an alleged sexual assault including but not limited to, disposing/laundering resident	S9999		

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S9999	Continued From page 3 clothes, linen, briefs. This failure affected one of three residents (R1) reviewed for care of sexual assault survivors. 3.) Based on observation, interview and record review, the facility failed to evaluate R1's condition to determine appropriate therapy for R1 after being assaulted by another resident and failed to ensure the safety of other residents residing in the facility. Applying the reasonable person concept due to R1's severe cognitive impairment, a reasonable person would have experienced severe psychosocial harm from the incident which may include, but is not limited to, depression, traumatic stress, anger, and pain. These failures affected one of three residents (R1) reviewed for care and safety after sexual assault. Findings include: Facility provided census (12/12/2025) documents in part that 58 residents reside within the facility. Report to the state survey agency dated 12/10/2025 documents in part, on 12/9/2025, V3 (Caregiver) entered R2's room and observed what "appeared to be sexual intercourse between (R1) and (R2). (R2's) pants were below the knees and (R1's) pants/pull ups were pulled below (R1's) hips. (R2) was kissing (R1) in the mouth and moving in a sexual manor and stood up and got out of the bed and (R2's) penis was erect." R2's progress notes document in part, on 12/9/2025 at 10 AM, V2 (Resident Services Coordinator, Registered Nurse) documented that R2 was "trying to escort (R3) into (R2's) room.	S9999			

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S9999	Continued From page 4 Both residents were separated and (R2) was placed on 30 min checks for closer observation ... On 12/9/2025 at 12:30 PM, V2 documented that R2 was observed by V3 (Caregiver), "having sexual intercourse with another resident (R1) as (V3) was completing (V3's) 30-minute check. Both (residents) separated (at) that time and assessed by (V2). No abnormal findings noted ...". No progress notes indicate that evidence was preserved after the incident. On 12/10/2025 at 12 AM, V2 documented that the police officer was at the facility to interview the resident. No other documentation of notification to the law enforcement was noted. R1's face sheet documents diagnoses including but not limited to, Alzheimer's disease, abnormal weight loss, osteoarthritis, and asymptomatic varicose veins. R1's progress notes document in part, on 12/9/2025 at 12:30 PM, V2 documented that V3 entered R2's room and "Observed (R2) having sexual intercourse with (R1)". V2 completed a body skin assessment with no concerns noted. V1 (Executive Director) notified V7 (Family Member) about the incident and V7 requested R1 to not be sent to the hospital for evaluation and requested V6 (Nurse Practitioner) to assess. No progress notes indicate that evidence was preserved after the incident. R1's examination note (12/10/2025) completed by V6 (Nurse Practitioner) documents in part V6 evaluated R1 due to "inappropriate sexual behavior". Per nursing staff, on 12/9/2025, (R1) was noted to be having intercourse with another	S9999			

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S9999	Continued From page 5 resident (R2). Staff separated the residents, and resident was taken for physical assessment. Patient is mostly non-verbal secondary to Alzheimer's Disease..." Review of R1's service plan does not indicate any history of sexual behaviors. R2's examination note (12/10/2025) completed by V6 documents in part that R2 was being evaluated due to "inappropriate sexual behavior". On 12/9/2025, resident (R2) was seen trying to verbally guide another resident (R3) into (R2's) room. Staff interfered with the behavior and (R2) was put on frequent monitoring rounds every 30 minutes. Per nursing staff, during reassessment, (R2) was observed having sexual intercourse with another resident (R1) ... Review of symptoms was limited due to baseline mental status...". Additionally, V6's listed R2's diagnoses as inappropriate sexual behavior, moderate dementia associated with alcoholism, and encounter for holiday relief care. On 12/12/2025 at 9:35 AM, V3 (Caregiver) recalled that on 12/9/2025 in the morning, R2 had grabbed R3's hand and was trying to lead R3 into R2's room. Staff were concerned about this behavior, so R2 was placed on 30-minute checks. V3 went to go do R2's 30-minute check and noticed R2 was no longer in the dining room where V3 was feeding other residents. V3 went into R2's room and found R2 on top of R1 on R2's bed with both (R1 and R2's) pants down and R1's brief pulled back. R2 was kissing R1 on the mouth and had (R2's) pants pulled down. V3 was unsure if R2's penis was penetrating R1 but R2 was erect, "doing the movements" and recalled R1's brief being "half-down". V3 affirmed that V4 (Caregiver) was with V3 when the incident	S9999			

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S9999	Continued From page 6 occurred, and both staff yelled for R2 to get off R1 and they separated the residents. V3 described R1 as "not knowing anything, severely impaired. You can't even hold a conversation with (R1)". V3 believed R1 could not consent to sexual behavior due to R1's severe cognition impairment. V3 affirmed that V4 notified V2 of the incident after the residents were separated. V3 denied that either resident was sent to the hospital for evaluation and stated, "the police did not come until the day after (12/10/2025)". V3 denied that any evidence of the incident was saved for law enforcement and recalled throwing away their briefs, laundering their clothes/linen, and recalled R1 had a shower before law enforcement arrived the next day. On 12/12/2025 at 9:50 AM, V4 (Caregiver) recalled the sexual assault that occurred between R1 and R2 on 12/9/2025. V4 explained that it was after lunch time when the incident happened. V3 was feeding other residents and V4 was washing dishes so there was no staff watching R1 and R2 in the dining room. When V3 went to do the 30-minute checks, V3 noticed that R2 was not in the dining room so V4 went with V3 to R2's room to do the check. When V3 and V4 went inside the R2's room, V4 recalled that R2 was on top of R1, and their pants/pull-ups were down or pulled to the side. V4 stated that it appeared R2's penis was erect and humping rubbing R2's erect penis on R1's pubic area. V4 did not believe there was penetration. V4 affirmed neither resident is capable of consenting to sexual activity due to their cognitive impairment, and stated, "(R1) barely can have a conversation. (R1) might whine but (R1) wouldn't even know that tomorrow is tomorrow. (R2) is in-and-out with his dementia but I (V4) don't think (R2) could verbalize that he	S9999		

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S9999	Continued From page 7 would want to have sex with you". V4 denied that the residents would remember the incident occurred due to their cognitive status. V4 recalled that the police did not come the day of the incident, V4 stated, "I think it was the day after". V4 denied any of the residents' clothes, linen or other related articles/evidence was preserved for law enforcement. On 12/12/2025 at 10:04 AM, V2 (Resident Services Coordinator, Registered Nurse) affirmed that V2 was familiar with the incident that occurred between R1 and R2 and was the staff member responsible for completing the investigation. V2 recalled that V4 "was frazzled" and reported the incident between R1 and R2. When V2 arrived in the room, R1 and R2 had been separated and R2 was in the room. V2 assessed R2 and R2 stated, "(R1) was in my bed, I (R2) did what (R1) wanted me to do". V2 affirmed that R2 denied having sexual intercourse with R1. V2 recalled assessing R1 for injuries/care needs and there were no obvious signs of injury. V2 affirmed that R1 was unable to express what happened or any emotional duress because R1 is non-verbal and has a baseline flat affect or crying. V2 believed "(R2) was capable of initiating sexual activity" and recalled that R2 "knew what the year was, (R2's) name, but nothing else, didn't know where (R2) was. Couldn't remember conversations. (R2's) short term memory was gone". V2 stated based on the statements, V2 was unsure if sexual penetration actually occurred but did affirm that based on statements that some form of sexual assault did occur. V2 stated R2 was placed on 1:1 monitoring until R2 left the following day. V2 stated that R1 was not evaluated in the emergency room because R1's POA requested not to be sent to	S9999		

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S9999	Continued From page 8 hospital. V2 affirmed that R1 "absolutely could not consent to sexual activity". V2 stated that the police were not called until the following morning after the incident when "corporate told us to". When asked how soon law enforcement should be notified, V2 replied, "We didn't really know what to do. We told our corporate regional support of the incident on 12/9/2025 but they never told us to call the police. We were not told to call the police until the following day (12/10/2025) at 10 AM when we had another meeting about it. It was a gray area because they have dementia." V2 affirmed that R1 "absolutely could not consent to sexual activity". V2 affirmed that the facility did not keep relevant evidence including briefs, linen, clothes for law enforcement. On 12/12/2025 at 10:48 AM, facility tour was conducted with V2. R1 was observed in the hallway and was unable to be interviewed/answer questions due to severe cognitive impairment. On 12/12/2025 at 11:31 AM, V1 (Executive Director) affirmed that V1 is the abuse prevention coordinator and that residents have the right to be free from abuse. V1 recalled when the incident occurred, that V1 was not in the facility. V2 had called V1 and stated that R1 was found underneath R2 in R2's room having "a sexual encounter" and that V2 had initiated/was responsible for the abuse investigation. V1 recalled that the police came, and a police report was filed on 12/10/2025, but it was not completed yet. V1 affirmed that the regulatory requirement is that law enforcement is notified immediately of any allegation of sexual abuse. V1 stated, "in hindsight, we really should have called immediately. We notified regional support on the day of the incident and at that time, it was not	S9999			

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S9999	Continued From page 9 recommended to us by them to call 911. We had a trigger call due to the incident the following day and that was when we were notified that we needed to call 911. V5 (Regional Director of Operations) was one of the corporate people we spoke with on 12/9/2025". V1 was unsure if the facility had a policy on when to notify law enforcement. No policy was provided on when to notify law enforcement by the facility prior to the exit of the survey that meets the regulatory requirements. V1 affirmed that the facility did not save any evidence of the incident that could have been provided to law enforcement, stating, "we (facility staff) should have saved it (the evidence)". Facility policy for care of sexual assault providers was requested from V1 and no policy was received prior to the exit of the survey. On 12/12/2025 at 12:03 PM, V5 (Regional Director of Operations) stated that V5 was not in the facility when the incident occurred, but that V5 was made aware of it on the day of the incident (12/9/2025) by V2. V5 confirmed that there was a second call with "more senior leadership" on 12/10/2025 and they were informed that the facility had not notified the police. They instructed them to call the police on 12/10/2025. V5 was unsure when law enforcement is to be called based on the facility policy. V5 reviewed the regulation and affirmed the facility should have notified law enforcement immediately. V5 affirmed that the facility abuse policy does not specify when to notify the police. V5 was unsure if there was a facility policy that was developed to notify law enforcement that meets regulatory requirements. V5 stated, "I'm sure we have something, I will send it to you." No policy was provided on when to notify law enforcement by the facility prior to the exit of the survey that	S9999			

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S9999	Continued From page 10 meets the regulatory requirements. On 12/12/2025 at 1:22 PM, V6 (Nurse Practitioner) affirmed that V6 was familiar with both R1 and R2 and completed examinations for both residents after the incident. V6 recalled V6 was made aware of the incident "shortly after it occurred". V6 explained that V6 was told about R2 "luring" another resident (R3) into R1's room so staff put R2 on 30-minute checks. When staff went to do the follow up check, they found R2 engaging in sexual intercourse with R1. Staff intervened, deescalating the situation and the RN (V2) assessed the residents who had no visible injury. V6 was told by staff that R1's family was ok with R1 not being sent to the hospital and having V6 assess the following day. V6 recalled examining both residents, that R2 was pretty coherent in the morning but denied the incident occurred. R1 was examined and R1 did not appear in distress and did not appear to have any visible injuries. V6 affirmed that both residents were severely cognitively impaired and "definitely could not consent to sexual activity". V6 stated the purpose of the rape kit is "to prove intercourse had occurred. It would just confirm that the act was committed but it (R1 being raped by R2) was seen (by staff)." V6 explained that after sexual assault occurs, victims can have both negative physical and negative psychosocial outcomes, including pain, depression, anger, crying, and edema (swelling) to the genital area. On 12/13/2025 at 3:47 PM, V2 affirmed that potential outcomes of sexual assault include, but are not limited to, emotional trauma, traumatic stress/flashbacks, physical pain, bruising, and abrasions. Facility policy titled, "Resident Protection", dated 5/2025, documents in part, "Purpose: The	S9999			

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S9999	Continued From page 11 resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation... 18. Resident protection actions include... reporting allegations of abuse to other agencies or law enforcement." This policy lacks the following regulatory requirements: 1) Ensuring the safety of residents in situations requiring local law enforcement notification; 2) When to contact local law enforcement in situations involving physical/sexual abuse of a resident by another resident; 3) when to contact police, fire, ambulance and rescue services in accordance with recommended procedure; 4) when/how to seek advice concerning preservation of a potential crime scene; 5) notification of law enforcement of facility investigation of the situation. No other policies that meet this regulatory requirement were provided prior to the exit of the survey. Facility policy titled, "Resident Protection", dated 5/2025, does not document or instruct staff on how to care for sexual assault survivors, including reasonable means such as encouraging residents not to shower or preserving evidence. "A"	S9999			