

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6015101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/23/2025
NAME OF PROVIDER OR SUPPLIER ARDEN COURTS (NORTHBROOK)		STREET ADDRESS, CITY, STATE, ZIP CODE 3240 MILWAUKEE AVENUE NORTHBROOK, IL 60062		
(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 November 10, 2025/IL199027 - licensure findings Investigation of Facility Reported Incident of November 28, 2025/IL199028 - No findings	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.4210a)2)A)B) Section 330.4210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by State or federal law based on their status as a resident of a facility. 2) Residents shall have their basic human needs, including but not limited to water, food, medication, toileting, and personal hygiene, accommodated in a timely manner, as defined by the person and agreed upon by the interdisciplinary team. A) A facility shall treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life, recognizing each resident's individuality. B) A facility shall protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to keep a resident (R3) free from physical abuse from another resident (R2) for one out of three residents reviewed for abuse in a total	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 sample of five. R2 punched R3 in the mouth causing R3 to lose three teeth from R3's dentures. Findings Include: R2 is a 64-year-old with the following diagnosis: Alzheimer's disease and benign neoplasm of the prostate. R3 is a 77-year-old with the following diagnosis: dementia, congestive heart failure, bipolar disorder, and chronic obstructive pulmonary disease. On 12/18/25 at 12:34PM, R3 was sitting on R3's bed in R3's room. R3 was alert and oriented times two. R3 reported having a physical altercation with another male resident. R3 was unable to give the name/description of the other resident but reported staff knew who it was. R3 was unable to give a timeframe when the incident occurred. R3 stated R3 was sitting at a table in the dining room and R2 walked by R3 and punched R3 in the mouth without being provoked. R3 denied talking with R2 right before the incident. R3 denied knowing why R2 punched R3. R3 reported R2 hit R3 in the mouth with a closed fist. R3 stated R2 hit R3 hard enough to knock out "three to four teeth." R3 then showed the surveyor the missing teeth in R3 's mouth. The missing teeth were on the upper left side, and it appeared to be three missing teeth. R3 denied going to see a dentist and has no update on when R3 will be getting new teeth. R3 stated R3 now has trouble eating food that needs to be chewed more. R3 reported R3 's mouth was sore for a couple days but now has no pain. R3 stated R3 feels safe as long as R3 doesn't see R2 in the	S9999			

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S9999	Continued From page 2 building. R3 reported that R2 still lives in the facility but they have not had any other contact with each other. R3 reported R3 had seen R2 reach and "swat" at people in the past when people are in R2's way. R3 stated staff were around when the altercation occurred and saw the whole incident. On 12/18/25 at 12:42PM, V2 (Caregiver) stated R2 was walking through the dining room and grabbed R3's napkin. V2 reported R3 tried to pull the napkin back, but R2 then punched R3 in the mouth. V2 reported R2 and R3 didn't speak before the altercation. V2 stated R3 had a couple teeth come off R3's denture. V2 reported that the police were called and R2 was sent to the hospital. V3 stated R2 doesn't talk but if R2 feels threatened then R2 will push other out of R2's way. On 12/18/25 at 12:48PM, R2 was sitting at a dining room table with eyes closed and head drooping over. The surveyor went over for an introduction, and R2 picked up R2's head and opened R2's eyes then continued to droop his head and close eyes. R2 was only alert and oriented to self. R2 was able to state R2's name. When asked any other question, R2 responded with "Mhmmm." R2 was unable to answer any questions due to mental status. On 12/18/25 at 1:45PM, V4 (Director of Nursing/DON) stated V5 (Nurse) told V4 that R2 walked into the dining room and grabbed something off R3's table. V4 reported R3 attempted to grab the item back, and R2 took R2's other hand and punched R3 in the mouth. V4 stated R3 was very upset and yelling but R2 was unable to answer questions due to mental	S9999			

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S9999	Continued From page 3 status. V4 reported R2 was sent to the hospital for a psych evaluation and upon return R2 had an antipsychotic medication increased to help with anxiety. On 12/18/25 at 1:59PM, V5 stated R2 and R3 got into a fist fight during lunch. V5 reported V2 told V5 what occurred that R2 got too close to R3 so R2 hit R3 in the face. V5 stated R3 had two or three teeth knocked out of R3's dentures. V5 reported asking R3 what happened and R3 told V5 that R2 hit R3 in the mouth for no reason. V5 denied that R2 was able to give any details about the incident. V5 stated R2 will get frustrated and mad with others if they get too close to R2. V5 could not expand more on R2's behavior of being frustrated or mad. A General note dated R2 was sent to the hospital for assaulting another resident. R2 will be moved to a different room upon return from the hospital. A General note dated 11/20/25 documents that another resident punched R3 in the face and R3 lost three teeth from the dentures. A General note dated 11/11/25 documents R3 was agitated with the incident that happened the prior day. R3 was missing three teeth from top dentures. No new injuries noted. R3 did complain about the pain at about 7:15 AM and was given pain medication with no further complaints. The Hospital Records dated 11/10/25 document R2 was sent to the emergency department for agitation. R2 was discharged back to the facility the same day. The State Incident Report dated 11/10/25 documents R2 hit R3 in the mouth. Teeth were missing from the front partials. R3 was upset and yelling. R2 walked away after the incident. R2 was unaware of what happened. R2	S9999			

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S9999	Continued From page 4 was sent to the hospital for a psych evaluation. The police were notified. The psych nurse practitioner was notified when R2 returned and adjusted R2's medication. The Police Report dated 11/10/25 documents police were dispatched to the facility for a facility altercation between two residents. The police officer spoke with V4 (DON) who told the officer that R2 struck R3 but does not have the capacity to understand R2's actions. The Officer spoke with V2 (Caregiver) who said R2 was walking back and forth around R3's table when R3 told R2 to go away. V2 said R2 then punched R2 in the mouth. The police officer then spoke with R3 who stated R2 grabbed R3's fork and spoon so R3 tried to stop R2 but R2 punched R3 in the mouth. R3 reported this caused teeth to fall out of R3's dentures. The police officer spoke with R2 at the emergency department but R2 was only able to state R2's name. No arrests were made due to R2 not having the mental capacity. The Service Plan dated 1/27/25 documents R2 has memory loss/cognition with communication challenges. Interventions include providing additional encouragement and prompts throughout the day and observing body language. This service plan also documents R2 has a habit of wandering. An intervention is to provide rest periods. The Service Plan dated 6/8/20 documents R3 has a behavior of wandering. An intervention includes providing cueing and orientation. The policy titled, "Resident Protection," dated 05/2025 documents, "Policy: The resident has the right to be free from abuse, neglect, misappropriation of resident of property, and exploitation. This includes but is not limited to	S9999		

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S9999	Continued From page 5 freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint 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 investigations of allegations of abuse, and reporting and responding to the appropriate individuals or agencies." "B"	S9999			