STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015523	A. BUILDING: _____ B. WING _____	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS (GLEN ELLYN)	2 SOUTH 706 PARK BLVD GLEN ELLYN, IL 60137

(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 Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 10 330.710a) 330.715a) 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 330.715 Request for Resident Criminal History Record Information a) a) A facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)	S9999		

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S9999	Continued From page 1 This regulation was NOT MET as evidenced by: Based on interviews and record reviews the facility failed to ensure background checks were initiated for newly admitted residents within 24 hours after admission. This failure applies to three of five residents (R6, R7, and R8) reviewed for background checks in a sample of 22 residents. The findings include: R6 is a 76-year-old male who was admitted to the facility 10/08/2025. R6's Criminal History Information Response Process (CHIRP) background check request was submitted by the facility 10/15/2025 and Illinois Sex Offender Registry and Illinois Department of Corrections background checks were reviewed by the facility 10/21/2025. R7 is a R7 is a 77-year-old female who was admitted to the facility 09/26/2025. R7's Criminal History Information Response Process (CHIRP) background check request was submitted by the facility 10/15/2025 and Illinois Sex Offender Registry and Illinois Department of Corrections background check requests were reviewed by the facility 10/21/2025. R8 is an 89-year-old female who was admitted to the facility 09/02/2025. R8's Criminal History Information Response Process (CHIRP), Illinois Sex Offender Registry and Illinois Department of Corrections background check requests were submitted and	S9999		

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S9999	Continued From page 2	S9999		

reviewed by the facility 09/10/2025.

On November 5, 2025 at 12:52 PM, V21 (Administrative Services Coordinator) said resident background checks should be completed within 24 hours of admission to the facility, R6, R7, and R8's background checks were completed more than 24 hours after their admission to the facility and he cannot recall why.

The Resident Protection Policy and Procedures provided by the facility 11/05/2025 states:
" The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.
" The community will adopt and operationalize an abuse prevention system that includes protection of residents.
" The community screens potential new move-ins to determine if the resident has a personal history of or is at risk for developing abusive actions or aggressive behaviors toward others. If the resident has such a history or presents such a risk, the community reviews the resident's status to determine if the resident is appropriate for move in.
(C)

Surveyor: Shawley, Cleofe

2 of 10

330.710a)
330.790c)1)

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

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S9999	Continued From page 3	S9999		

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 330.790 Infection Control

c) Depending on the services provided by the facility, each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, as applicable (see Section 330.340):

1) Guideline for Hand Hygiene in Health-Care Settings

This Requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that hand hygiene was implemented during medication administration.

This deficient practice applies to 12 of 12 residents (R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, and R19) observed during the medication pass.

The Findings include:

During medication pass observations conducted on November 4, 2025, from 12:00 p.m. to 1:05 p.m., and November 5, 2025, from 8:50 a.m. to 9:00 a.m., V3 (Licensed Practical Nurse) administered medications to 12 residents (R8-R19). During the medication administration

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process, V3 handled and poured medications into cups after touching used drinking and medication cups that had been handled by other residents. V3 did not perform hand hygiene between contact with contaminated items and clean medication supplies.

The facility's Hand Hygiene Policy, dated May 2025, states:
"Hand hygiene is the single most important measure for reducing the risk of the spread of infection. Hand hygiene is part of standard precautions."

This failure to perform hand hygiene between resident contacts and after handling contaminated items has the potential to contribute to cross-contamination and the spread of infection among residents.
(B)

3 of 10

330.710a)
330.792a)

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 330.792 Testing for Legionella Bacteria

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a) A facility shall develop a policy for testing its water supply for Legionella bacteria. The policy shall include the frequency with which testing is conducted. The policy and the results of any tests and corrective actions taken shall be made available to the Department upon request. (Section 3-206.06 of the Act)

These requirements were not met as evidenced by:

Based on interviews and record reviews, the facility failed to take corrective actions regarding Legionella test results per facility policy.

This failure has the potential to affect all 43 residents residing in the facility.

The findings include:

Facility Detailed Census Report, dated 11/4/25, showed there were 43 residents residing in the facility.

Facility policy Water Management Program Plan, dated 11/2024, shows, "The following are recommended remedial measure guidelines for positive sample results. Each circumstance should be evaluated independently. Isolated (less than 40% of samples analyzed) positive results of less than 10 CFU/ml. Replace fixture aerators or shower heads and hoses, flush lines, and retest locations. Individual (one or two) positive results of 10 CFU/mL or higher. Replace faucet and water supply lines or replace shower head and hose, flush lines, and resample. Test locations immediately upstream and down stream of each location with >10 CFU/mL and retest previous positive locations .... If resampling indicates persistent occurrence of bacterial in

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S9999	Continued From page 6 samples, consider chemical disinfection of water system. Consult with Plant Operations staff prior to conducting chemical treatment .... After remedial measures are completed, verification water samples will be collected one week after completion of remediation and six months afterward unless directed by the Water Management Team, Facility Consultants, por regulatory agencies based on specific circumstances .... System Maintenance ... Hot water tanks are drained and flushed once per year. Ice Machines - Ice machines are cleaned in accordance with manufacturer's recommendations twice per year. Should samples of water from ice machines exhibit positive legionella results after cleaning consideration should be given to removing charcoal or other filters .... Expansion Tanks - ...should be flushed periodically and installed with isolation valves .... Water Filters - Filters are changed by service contractors in accordance with manufacturer's recommendations. Shower Heads and Hoses - Shower heads and hoses at the Facility are cleaned or replaced every six months .... Aerators - Faucet aerators may be removed from faucets, cleaned, or replaced every six months .... The Water Management Team will keep a complete record of conditions, actions, monitoring and testing associated with implementation of the Water Management Program Plan ...." Review of the facility's Legionella lab test results showed the following: - 2/3/25 Clover, Room 25, sink, hot water - 13 CFU/mL (colony forming units per milliliter) Total legionella, 13 CFU/ml other Legionella species. The document shows the faucet was replaced and flushed. No further testing was noted to be performed at the time of the result.	S9999		

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- 3/24/25 Clover, Room 25, sink, hot water - 3 CFU/ml Total Legionella, 3 CFU/ml other Legionella species. No further action was taken by the facility.
- 2/13/25 Berry, Room 10, sink, cold water - 2 CFU/mL Total Legionella, 2 CFU/mL other Legionella species. No action was noted as being taken by the facility.
- 2/13/25 Berry, Room 10, sink, hot water - 3 CFU/ml Total Legionella, 3 CFU/ml Legionella pneumohila SG1. No action was noted as being taken by the facility.

- 2/13/25 Clover, shower room, sink, cold water - 10 CFU/ml Total Legionella, 10 CFU/ml other Legionella species. No action was noted as being taken by the facility.
- 2/13/25 Berry, Room 10, sink, hot water - 3 CFU/mL Total Legionella, 3 CFU/ml Legionella pneumophilia SG1. No action was noted as being taken by the facility.
- 2/13/25 Berry, Room 14, cold water - 15 CFU/mL Total Legionella, 15 CFU other legionella species. The document shows the faucet was replaced and flushed. No further testing was identified to be performed at the time of the result.

On 11/5/25 at 2:04 PM, V1 (Administrator) and V6 (Maintenance Director) stated they were not aware that Legionella lab test results below 10 CFU/ml required interventions. V1 and V6 both stated they were not aware that additional interventions were required for Legionella lab test results above 10 CFU/ml other than replacing the faucet, flushing and retesting. V1 stated her understanding was that she only needed to take corrective action regarding Legionella lab test results that were greater than 10 CFU/ml. V1 stated she was not sure where historical data

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regarding Legionella prevention measures/controls was located. V6 stated he drained and flushed hot water tanks often but did not keep a log as to when the work was performed. V6 stated he did not do any maintenance in the kitchen and did not monitor/change any water filters in the kitchen and was not aware of if/when the ice machines were being cleaned/tested. V6 stated he was not aware if any aerators in the facility were being removed/cleaned/replaced every six months and was not aware of the shower heads/hoses being replaced or the water filters being serviced in the facility.

During the survey, no documentation was provided that showed the facility was draining and flushing hot water tanks, monitoring/changing water filters, cleaning/testing ice machines, removing/cleaning/replacing facility aerators, or replacing shower heads/hoses, or water filters being serviced at the facility.
(B)

Surveyor: Broadnax, Teri

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330.760a)
330.911

Section 330.760 Personnel Policies

a) Each facility shall develop and maintain written personnel policies that are followed in the operation of the facility. These policies shall include, at a minimum, each of the requirements of this Section.

Section 330.911 Health Care Worker

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Background Check

A facility shall comply with the Health Care Worker Background Check Act [225 ILCS 46] and the Health Care Worker Background Check Code (77 Ill. Adm. Code 955).

This regulation was NOT MET as evidenced by:

Based on interviews and record reviews the facility failed to ensure background checks were thoroughly completed for newly hired staff prior to hire.

This failure applies to all 43 residents currently residing in the facility.

The findings include:

V2 (Director of Nursing)'s hire date is 06/03/2024. V2's Illinois Department of Financial and Professional Regulation Licensure status was reviewed 04/30/2025.

V11's (Caregiver) hire date is 09/04/2025. V11's National Sex Offender Registry background check reviewed by the facility 08/26/2025 shows the Nevada registry was temporarily unavailable at the time resulting in a recommendation to try again later.

V14's (Caregiver) hire date is 07/30/2025. V14's National Sex Offender Registry background check reviewed 07/30/2025 shows the Iowa registry was temporarily unavailable resulting in a recommendation to try again later.

On November 5, 2025 at 12:52 PM, V21 (Administrative Services Coordinator) said he was not aware that he could access the

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unavailable databases for the National Sex Offender Registry when he originally attempted to check them for V11 and V14, and he should have rechecked them timely to ensure there was no sex offender history for V11 and V14.

On November 5, 2025 at 2:29 PM, V21 (Administrative Services Coordinator) said as of 04/30/2025 when he reviewed V2's (Director of Nursing) files he did not find a copy of her license and also did not find it in the facility's system, he then printed it out and filed it.

The Criminal History Check for Employment Policy and Procedures provided by the facility 11/06/2025 states:
" It is the policy of (the facility) to conduct criminal background checks within the guidelines of specific state and federal laws. Job offers are made contingent upon successful completion of criminal background checks and other pre-employment checks and policies.
" Those locations in states with specific regulations and protocols must abide by those state-specific provisions.
" All locations will be responsible for checking the National Sex Offender Registry. A printed record of the results is to be placed in the employee's confidential file.

The Resident Protection Policy and Procedures provided by the facility 11/05/2025 states:
" The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.
" The community will adopt and operationalize an abuse prevention system that includes screening of employees.
" The community evaluates a prospective employee's experience in working with residents

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S9999	Continued From page 11 who have specific conditions and needs and seeks to identify and verify any history of abuse, neglect, exploitation, mistreatment or misappropriation of resident property. The community screens prospective employees to reduce the risk that no one is hired who is likely to abuse residents. (C) Surveyor: Shawley, Cleofe; (Frazer, Mimi) 5 of 10 330.710a) 330.1120a) 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 330.1120 Personal Care a) Each resident shall have proper daily personal attention and care including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. This requirement was not met as evidenced by: Based on observation, interview, and record review, the facility failed to assist residents identified as needing assistance with personal hygiene, grooming, and nail care.	S9999		

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This applies to 4 of 4 residents (R1-R4) reviewed for (Activities of Daily Living) ADL/personal care in the total sample of 22.

The findings include:

1. R3's Face sheet shows that R3, an 86-year-old male who has multiple medical diagnoses including unspecified dementia, Alzheimer's disease, and difficulty in walking.

On November 4, 2025, at 10:10 a.m. while observing activities being conducted in Central Station Room, R3 was observed sitting at an activity table with peers having an unshaven face and with hair coming out of his ears.

On November 4, 2025, at 11:57 a.m. V5 (Caregiver) stated that R3 was not independent with personal/ADL care and that he required assistance from staff.

On November 5, 2025, at 9:10 a.m. R3 was sitting in his living area and with an unshaven face and with hair coming out of his ears.

On November 5, 2025, at 11:50 a.m. V14 (Caregiver) stated that they usually do not shave R3 that since she started working there in August and V14 has always waited on R3's wife to shave him. V5 stated that she doesn't shave R3. V5 stated that since she started working there in April V5 has always waited on R3's wife to shave him.

R3's current service plan dated February 10, 2025, provided by V2 (Director of Nursing) states that R3 will be able to follow cues to meet grooming needs.

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S9999	Continued From page 13 2. R4's Face sheet shows that R4, a 95-year-old male who has multiple medical diagnoses including unspecified dementia, unspecified lack of coordination, and blindness right eye. On November 4, 2025, at 10:10 a.m. while observing activities being conducted in Central Station Room, R4 was observed sitting in a chair during activities and R4 was observed unshaven and with long, discolored nails and having brownish colored debris under his fingernails. On November 4, 2025, at 11:57 a.m. V5 stated that R4 was not independent with personal/ADL care and that he required assistance from staff. On November 5, 2025, at 9:10 a.m. R4 was sitting in his living area with wife at his side. R4 had been shaven and but nails remained long, discolored, and having brownish colored debris. R4's wife stated that she shaved R4 on Tuesday and usually shaves R4 on Tuesdays and Fridays if she is able to come. R4's wife stated that when R4 needs his nails cut she is not strong enough and not able to cut R4's fingernails and would like for someone to cut R4's fingernails. On November 5, 2025, at 11:50 a.m. V14 (Caregiver) stated that they usually do not shave R4 that since she started working there in August and V14 has always waited on R4's wife to shave him. V5 stated that she doesn't shave R4. V5 stated that since she started working there in April V5 has always waited on R4's wife to shave him. R4's current service plan dated July 7, 2025, provided by V2 (Director of Nursing) states that R3 will be able to maintain independence with grooming and hygiene.	S9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS (GLEN ELLYN)	2 SOUTH 706 PARK BLVD GLEN ELLYN, IL 60137

(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
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3. The Electronic Medical Records (EMR) showed that R1 is a 79-year-old female resident admitted to the facility on August 16, 2025. R1's diagnoses include, but are not limited to, Alzheimer's disease, unsteadiness on feet, dementia, major depressive disorder, and peripheral vascular disease.

On November 4, 2025, at 10:35 a.m., R1 was observed in the activity room participating in a group activity conducted by V9 (Activity Director). R1 appeared confused. She was noted to have approximately 2 inches of facial hair, and her fingernails were long, curled inward, and embedded with a black substance.

On November 5, 2025, at 11:35 a.m., interviews were conducted with V10 and V11 (Caregivers). They stated that R1 is confused and requires assistance with Activities of Daily Living (ADLs), including hygiene, personal care, and nail care.

The current service plan dated August 21, 2018, and provided by V2 (Director of Nursing) on November 5, 2025, at 10:05 a.m., indicated that R1 requires extensive assistance with grooming and hygiene.

4. The EMR showed that R2 is a 97-year-old female resident admitted to the facility on May 31, 2025. R2's diagnoses include, but are not limited to, Alzheimer's disease, major depressive disorder, atrial fibrillation, diabetes mellitus, and osteoarthritis.

On November 5, 2025, at 10:35 a.m., R2 was observed in a group activity conducted by V9 (Activity Director). R2 appeared confused. She was noted to have approximately 2 inches of facial hair, and her fingernails were long, curled

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S9999	Continued From page 15 inward, and embedded with a black substance. At 11:35 a.m. on the same date, interviews were conducted with V10 and V11 (Caregivers). They reported that R2 is confused and requires assistance with ADLs, including hygiene, personal care, and nail care. The current service plan dated May 29, 2024, and provided by V2 (Director of Nursing) on November 5, 2025, at 10:05 a.m., indicated that R2 requires total physical support and daily supervision for grooming and hygiene. The facility policy dated of May 2025 states: "The community goal is to maintain each resident's routine with personal care and activities of daily living, as specified in the Service Plan. If residents present with a hygiene or health concern, individualized approaches are developed to address those specific concerns. Resident services staff promote resident independence and self-care in these areas as practicable. Personal services include assistance with personal hygiene such as hair, nail, skin, and shaving." (B) Surveyor: Broadnax, Teri 6 of 10 330.1160f) Section 330.1160 Vaccinations f) A facility shall document in the resident's medical record that he or she was verbally screened for risk factors associated with hepatitis B, hepatitis C, and HIV, and whether or not the resident was immunized against hepatitis B.	S9999		

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S9999	Continued From page 16 (Section 2-213(c) of the Act) This regulation was NOT MET as evidenced by: Based on interviews and record reviews the facility failed to ensure residents were screened for a history, risk factors, or an immunization history for Hepatitis B or Human Immunodeficiency Syndrome (HIV). This failure applies to five of five residents (R1, R2, R3, R4, and R5) reviewed for immunizations in a sample of 22 residents and has the potential to affect all 43 residents currently residing in the facility. The findings include: R1 is a 73-year-old female with a diagnoses history of Alzheimer's, Tachycardia (Abnormally Fast Heart Rate), and Peripheral Vascular Disease who was admitted to the facility 08/16/2018. R2 is a 97-year-old male with a diagnoses history of Alzheimer's, Atrial Fibrillation, and Hypertension who was admitted to the facility 05/31/2024. R3 is an 86-year-old male with a diagnoses history of Alzheimer's, Chronic Kidney Disease, Nicotine Dependence, and Protein Calorie Malnutrition who was admitted to the facility 01/22/2025. R4 is a 95-year-old male with a diagnoses history of Dementia, Congestive Heart Failure, and Chronic Kidney Disease who was admitted to the facility 07/09/2025.	S9999		

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S9999	Continued From page 17 R5 is a 98-year-old male with a diagnoses history of Dementia, Atherosclerotic Heart Disease, and Type 2 Diabetes Mellitus who was admitted to the facility 08/04/2025. R1, R2, R3, R4, and R5's medical records reviewed from 11/04/2025 - 11/05/2025 between 9 AM - 4:00 PM did not include a screening for Hepatitis B or Human Immunodeficiency Virus. On November 06, 2025 at 1:04 PM, V1 (Executive Director) said the facility does not screen for Hepatitis B or HIV. During the course of the annual licensure survey from 11/04/2025 - 11/06/2025 the facility could not provide documentation of screening R1, R2, R3, R4, or R5 for Hepatitis B or HIV. (C) 7 of 10 330.710a) 330.1950b)1) 330.1950g) 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 330.1950 Meal Planning	S9999		

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S9999	Continued From page 18 Each resident shall be served food to meet the resident's needs and to meet physician's orders. The facility shall use this Section to plan menus and purchase food in accordance with the following Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. b) Meat Group: A total of 6 ounces (by weight) of good quality protein to provide 38 to 42 grams of protein daily. To ensure variety, food items repeated within the same day shall not be counted as meeting a required serving. The following are examples of one serving: 1) Three ounces (excluding bone, fat and breading) of any cooked meat such as whole or ground beef, veal, pork or lamb; poultry; organ meats such as liver, heart, kidney; prepared luncheon meats. g) Meals for the day shall be planned to provide a variety of foods, variety in texture and good color balance. The following meal patterns shall be used. These Requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to serve the facility menu as planned and approved by the facility dietitian to residents receiving mechanical soft and pureed diets. This applies to 3 of 3 residents (R5, R20 and R21) reviewed for texture modified diets in a sample of 22.	S9999		

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S9999	Continued From page 19 The findings include: 1. Facility Resident Dietary Information document, undated, shows R21 received a Mechanical Soft diet. Facility Week 4 Day 18 diet spreadsheets Lunch, Cycle R, show residents receiving regular diets were to be served 2 ounces of marinated pork roast and residents receiving mechanical soft diets were to receive one portion of ground marinated pork roast. Facility recipe Marinated Pork Roast 2oz (ounce), dated 8/20/25, shows 5 servings of ground pork was to be prepared using 5 - 2 ounce weight portions of regular pork roast and 1.25 cups of sauce and then ground. The recipe shows one serving of the ground pork was to be served using a #10 scoop (3/8 cup). On 11/5/25 at 10:08 AM in the kitchen during lunch preparation, V7 (Food Service Manager) stated the pork being served to residents at lunch was a 2-ounce weight portion. When preparing ground pork for Mechanical Soft diets, V7 placed approximately two cups of diced pork in a blender. V7 initially stated he used his judgement when he measured the diced pork and initially estimated he used a total of two 2-ounce weight servings of pork but later stated he placed a total of four 2-ounce portions of regular pork to prepare the ground pork. V7 then added thickener and 1 cup of sweet and sour sauce to the blender with pork and ground the mixture. V7 then placed the mixture back into the small pan and stated each resident receiving mechanical soft pork will receive a #16 scoop (1/4 cup or 2 fluid ounces) of the mixture at lunch.	S9999		

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On 11/5/25 at 12:00 PM in the Kitchen, V16 (Caregiver) stated the care staff follow the menu and the cook's instructions when serving the food items to the residents. V19 (Dietary Aide) plated a mechanical soft plate using a #16 scoop (1/4 cup or 2 fluid ounces) to place one serving of ground pork on the plate which was then served to R21. A second mechanical soft plate was served utilizing a #16 scoop to place a serving of ground pork on the plate. The plate was then served to R5. After the two servings of pork were served, V18 utilized the #16 scoop to portion the remaining ground pork from the pan on to a plate. There were an 6 additional #16 scoop servings of ground pork remaining in the pan.

On 11/5/25 at 1:40 PM, V20 (Corporate Dietitian) stated the facility should follow the serving sizes and preparation as planned on the facility recipes and menu spreadsheets when serving ground menu items.

Facility document Regular diet, dated May 2007, shows, "Guidelines for Daily Menu Planning - Meat, Poultry Fish, Dry Beans, Eggs and Nuts: 6 oz (ounces) of meat or equivalent servings: 2 oz at breakfast and 2 oz at the noon and evening meals ...."

Facility document Ground Meat, dated January 2007, shows "The menu for the diet ordered is followed except that most meats are served ground with gravy or sauce, entrees such as casseroles, pizza and soups with meat are prepared with ground meat." The document shows for information on preparation of ground meats, refer to the recipes for the menu item ...."

2. Resident Dietary Information, undated, shows

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S9999	Continued From page 21 R20 received a pureed diet. On 11/5/25 at 10:08 AM in the kitchen during lunch preparation, there was a plate with puree food molds on the counter and V7 (Food Service Manager) stated the facility utilized purchased, pre-formed frozen pureed food purchased from the food vendor when serving pureed diets. V7 stated all of the pureed diets are served the purchased frozen pureed food items for all meals. On 11/5/25 at 1:30 PM, V7 reviewed the pureed menus and stated that purchased, plain, pre-made pureed food molds were served for every pureed item served on the four week cycle. V7 stated if the menued pureed items was an item other than a plain piece of meat, V7 would serve the purchased pureed food mold that would most closely resemble the pre-planned menu item. Reviewing Week 1 and Week 2 of the approved facility menus, V7 stated the following purchased, plain pureed food molds would be substituted for the planned pureed menu items: Week 1 - Plain pureed egg mold for pureed Baked Egg Omelet - Plain pureed pork mold for pureed Breaded Pork Loin - Plain pureed beef and pureed bread molds for pureed Philly Cheese Steak Sandwiches - Plain pureed egg mold for pureed Egg Swiss Bake - Plain pureed beef and pureed pasta molds for pureed Spaghetti sauce with meat and pasta - Plain pureed turkey mold for pureed Roasted Sliced Turkey - Plain pureed chicken mold for pureed Crispy Ranch Chicken Breast - Plain pureed tilapia mold for pureed Baked	S9999		

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S9999	Continued From page 22 Fish - Plain pureed egg mold for pureed Scrambled Egg - Plain pureed turkey mold and plain broccoli mold for pureed Turkey Divan - Plain pureed pork mold for pureed Marinated Pork Cubes - Plain pureed egg mold for pureed Scrambled Egg - Plain pureed chicken and pureed bread for pureed Grilled Chicken on a Bun - Plain pureed egg mold for pureed Confetti Eggs (with peppers) - Plain pureed tilapia or salmon mold for pureed Grilled Salmon - Plain pureed tilapia mold and bread mold for pureed Tuna Salad on a Croissant - Plain pureed egg mold for pureed Bacon Omelet - Plain pureed chicken mold with no sauce for pureed BBQ Chicken Breast - Plain pureed pasta mold with melted shredded cheese for pureed Baked Four Cheese Pasta Week 2 - Plain pureed egg mold and pureed bread mix with cinnamon for pureed French Toast Strata - Plain pureed pork for pureed Apricot Pork Loin - Plain pureed beef and pasta molds for pureed Beef Stroganoff - Plain pureed egg mold for pureed Cheese Skillet Eggs - Plain pureed chicken mold for pureed Oven Fried Chicken Breast - Plain pureed turkey and bread molds for pureed Turkey Sandwich on Wheat - Plain pureed ham mold for purred Baked Glazed Ham - Plain pureed omelet mold for pureed Western	S9999		

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S9999	Continued From page 23 Omelet - Plain pureed tilapia mold for pureed Crab Cakes - Plain pureed chicken mold for Chicken Salad Sandwich - Plain pureed pork and pureed egg molds for pureed Scrambled Eggs and Ham - Plain pureed beef and pureed pasta molds for pureed Meatballs and Mushroom Sauce. V7 stated the use of the pureed entrée molds as substitutes for pureed entrees which were planned on the facility-approved menu was "repetitive." V7 stated the facility policy regarding serving the planned menu was to follow the diet spread sheets. On 11/5/25 at 1:22 PM, V20 (Corporate Dietitian) stated if the pureed diet spread sheet lists the food item as pureed, the facility should puree the actual food item on the menu as planned. V20 stated only if there was a plain meat item listed on the menu and the same items was available to be purchased as a frozen pureed mold. V20 stated the facility should serve pureed menu itemsas close to the items served on the regular diet as possible. Facility document Regular diet, dated May 2007, shows " ...The menus are written to incorporate a variety of foods which take into consideration color and appearance, acceptance and familiarity of foods, complementary combinations of foods, variety and frequency ...." The document shows, "Guidelines for Daily Menu Planning - Meat, Poultry Fish, Dry Beans, Eggs and Nuts: 6 oz (ounces) of meat or equivalent servings: 2 oz at breakfast and 2 oz at the noon and evening meals ...."	S9999		

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S9999	Continued From page 24 Facility document Ground Meat, dated January 2007, shows "The menu for the diet ordered is followed except that most meats are served ground with gravy or sauce, entrees such as casseroles, pizza and soups with meat are prepared with ground meat." The document shows for information on preparation of ground meats, refer to the recipes for the menu item ...." (B) Surveyor: Shawley, Cleofe 8 of 10 330.1510a) Section 330.1510 Medication Policies a) Every facility shall adopt written policies and procedures for assisting residents in obtaining individually prescribed medication for self-administration and for disposing of medications prescribed by the attending physicians. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These Requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with physician orders and established facility policies. During a medication pass observation, there were 26 opportunities with 2 medication errors, resulting in a 7.69% medication error rate. This failure applies to 2 of 13 residents (R9 and R10) observed during the medication pass in a sample of 22 residents.	S9999		

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S9999	Continued From page 25 The Findings Include: 1. On November 4, 2025, at 12:22 p.m., V3 (Licensed Practical Nurse) administered 9 units of Novolog Flex Pen insulin to R9. V3 used a prefilled insulin cartridge with an insulin needle and injected the insulin into R9's left upper arm at an approximate 15-degree angle, administering the insulin just under the skin. Review of R9's Physician Order Sheet (POS) for November 2025 showed an order for Novolog Flex Pen insulin to be administered subcutaneously. On November 4, 2025, at 10:45 a.m., V2 (Director of Nursing) stated that insulin injections given via the subcutaneous route should be administered at a 90-degree angle to ensure delivery into the subcutaneous tissue, not the dermis or just under the skin surface. 2. On November 4, 2025, at 12:54 p.m., V3 administered Quetiapine 50 mg (milligrams) orally to resident R10 as part of the scheduled noon medication pass. Review of R10's current POS revealed an additional order for Divalproex 125 mg, prescribed three times daily at 9:00 a.m., noon, and 5:00 p.m. Observation confirmed that Divalproex 125 mg was not administered during the noon medication pass. During an interview on November 4, 2025, at 3:00 p.m., V3 reviewed the Medication Administration Record (MAR) and confirmed that she missed administering the ordered Divalproex dose. The Facility Policy dated May 2025 regarding Insulin Injection Administration:	S9999		

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S9999	Continued From page 26 "Insulin injections shall be administered subcutaneously at a 90-degree angle to ensure proper delivery into subcutaneous tissue." The Facility Policy dated May 2025 regarding Medication Pass: "Purpose: To safely and accurately prepare and administer medication according to the physician's order." (B) Surveyor: Shawley, Cleofe 9 of 10 330.1530a) 330.1530b) 330.1530f) Section 330.1530 Labeling and Storage of Medications a) b) f) a) All medications shall be stored in a locked area at all times. Areas shall be well lighted and of sufficient size to permit storage without crowding. This area may be a drawer, cabinet, closet, or room. In those facilities where a licensed nurse dispenses medication to residents, medications may be stored in a locked mobile medication cart, which is made immobile when not in use by the nurse to dispense medication. b) The key to the medicine area shall be the responsibility of, and in the possession of, the staff persons responsible for overseeing the self-administration of medications by residents. f) The label of each individual medication container filled by a pharmacist shall clearly indicate the resident's full name; licensed prescriber's name; prescription number, name,	S9999		

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strength, and quantity of drug; date of issue; expiration date of all time-dated drugs; name, address, and telephone number of pharmacy issuing the drug; and the initials of the pharmacist filling the prescription. If the individual medication container is filled by a licensed prescriber from his or her own supply, the label shall clearly indicate all of the preceding information and the source of supply; it shall exclude identification of the pharmacy, pharmacist, and prescription number.

These Requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that prescribed medications were completely labeled to include expiration dates and that medications were stored securely and accessible only to licensed nursing staff.

This deficiency was observed in 13 of 13 residents (R4, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, and R19) during medication pass observations and has the potential to affect all 43 residents in the facility.

The Findings Include:

1. During the medication pass observation on November 4, 2025, from 12:00 p.m. through 1:05 p.m. with V3 (Licensed Practical Nurse), medications prescribed for R9, R10, R11, R12, R13, R14, R15, R16, and R17 were observed without expiration dates on the labels. V3 reviewed the medication labels and confirmed that the pharmacy-supplied medications did not include expiration dates. During the continued medication pass observation on November 4,

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	IL6015523	A. BUILDING: _____ B. WING _____	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS (GLEN ELLYN)	2 SOUTH 706 PARK BLVD GLEN ELLYN, IL 60137

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S9999	Continued From page 28 2025, at 3:30 p.m., V4 (Licensed Practical Nurse) administered medications to R4, R8, and R12, and the same issue was observed, the medication containers lacked expiration date labeling. 2. On November 4, 2025, at approximately 1:00 p.m., observation of the enclosed nurse's station revealed medications that were no longer in use stored unsecured under a counter cabinet. The cabinet contained a nearly full 64-ounce plastic container filled with multiple unused medications. The area was accessible to non-licensed staff. V3 stated that housekeeping staff have access to the enclosed nurse's station and that the station contains unused medications awaiting disposal. During interviews conducted on November 5, 2025, at 11:30 a.m., V12 and V13 (Housekeeping Staff) confirmed that they know the access code to the nurse's station and routinely enter the area without a nurse present to perform cleaning tasks. On November 4, 2025, at 2:00 p.m., V2 (Director of Nursing) stated that unused medications should be secured until disposal and verified that medication labeling must include expiration dates in compliance with facility policy and pharmacy standards. (C) 10 of 10 330.710a) 330.4210a)2)B) Section 330.710 Resident Care Policies	S9999		

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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 330.4210 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.

B) A facility shall protect and promote the rights of the resident.

This regulation was NOT MET as evidenced by:

Based on interviews and record reviews the facility failed to ensure the protection of resident's right to be free from abuse by not reporting an allegation of abuse to the state agency.

This failure applies to one of four residents (R17) reviewed for abuse in a sample of 22 residents.

The findings include:

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S9999	Continued From page 30 R17 is an 86-year-old female with a diagnoses history of Alzehimer's Disease, Severe Vascular Dementia, and Anxiety-Disorder who was admitted to the facility 01/22/2025. R22 is a 68-year-old male with a diagnoses history Signs and Symptoms Involving Cognitive Function and Metabolic Encephalopathy who was admitted to the facility 06/30/2025. On November 04, 2025 at 9:00 AM, in the hallway across from the activity room R22 grabbed and rubbed R17's buttocks while she stood in front of him holding her walker. R17 and R22 stated they didn't know where they were and could not state the name of the facility. On November 04, 2025 at 9:15 AM, Surveyor reported to V1 (Executive Director) that R22 fondled R17's buttocks in the hallway. On November 04, 2025 at 1:36 PM, V8 (Family Member) stated she was not ever aware of R22 touching or fondling R17's buttocks and although she is aware that R17 considers R22 her boyfriend the facility had not had a discussion with her or V15 (Family Member) regarding boundaries and limitations of their physical interactions. R17's Progress note dated 11/05/2025 1:05 PM shows the facility was informed the surveyor reported witnessing a male resident touching R17's backside. On November 04, 2025 at 2:55PM, V1 (Executive Director) said she did not report to the state agency the allegation she received regarding R22 fondling R17 and did not consider it reportable based on R17 and R22's relationship and family	S9999		

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approval of their relationship.

Email communication from V8 (Family Member) to the facility dated November 04, 2025 at 2:56 PM shows that V8 received a report that R22 had his hand on R17's buttocks while walking in the common area hallway and would like a follow up response to this information.

Facility communication reports dated November 04, 2025 shows V1 (Administrator) contacted V8 (Family Member) to inform her of the information she received that a male resident was rubbing R17's buttocks; V8 later communicated she was informed by a surveyor that R17 was fondled by R22 and V8 was startled by this information; R17 was interviewed and reported she and R22 are in a relationship, they share little kisses and hold hands sometimes but nothing more than that; R22 was interviewed and reported he and R17 kiss and hold hands and denied touching R17 inappropriately.

The facility's Resident Protection Policy and Procedures provided by the facility 11/05/2025 states:
" The resident has the right to be free from abuse.
" The community will adopt and operationalize an abuse prevention system that includes identification and investigation of allegations of abuse, and reporting and responding to the appropriate individuals or agencies.
" Key components of the abuse prevention system include: Report/Respond.
" The Executive Director is responsible for reporting and coordination of the investigation process of any alleged or suspected abuse regardless of the source of the concern.
" Communities can best support the detection

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S9999	Continued From page 32 and prevention of abuse by implementing a process that supports the immediate reporting of suspected abuse. " Resident protection actions include: Reporting allegations of abuse to other agencies. (B)	S9999		