STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015325	A. BUILDING: _____ B. WING _____	R-C 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS (PALOS HEIGHTS)	7880 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463

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{S 000}	Initial Comments Licensure Post Visit to Facility reported incident of: 04/14/2025/IL191806 survey of 5/24/25 Citations: 330.710b) 330.710c)3)H) 330.780b) 330.780c)	{S 000}		
{S9999}	Final Observations Statement of Licensure Violations: 330.710b) 330.710c)3)H) 330.780b) 330.780c)	{S9999}		
	330.710 Resident Care Policies b) All of the information contained in the policies shall be available for review by the Department, residents, staff and the public. c) The written policies shall include, but are not limited to, the following provisions: 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following:			

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{S9999}	Continued From page 1 H) Fostering and maintaining resident safety, dignity, self- determination, and choice. (Section 3-206.05 of the Act) 330.780 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 330.785, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. This requirement was NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to have resident care policies readily accessible to staff. I also failed to follow its planning and service monitoring policy and properly document, investigate and track two incidents of resident injury for one resident (R2) in	{S9999}		

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{S9999}	Continued From page 2	{S9999}		

the sample. The facility also failed to provide adequate supervision and maintain for one resident's safety (R2) of three residents. As a result, R2 sustained two incidents of resident injury, one of which required R2 to be sent to the hospital on 12/2/25 for evaluation of right hand/wrist injury. The other resulted in R2 sustaining a dark purple discoloration to right eye on 12/4/25. The facility also failed to file an initial report within 24 hours for incidents resulting in serious injury for one resident (R2) out of 3 residents reviewed for falls involving serious injury in a sample of 3.

Findings include:

R2's medical record notes R2 with diagnosis including but not limited to stroke with hemiplegia affecting left dominant side.

On 12/5/25 at 11:20 AM, R2 was observed sitting in wheelchair in resident common area. R2's left hand is contracted. R2 has dark purple discoloration surrounding right eye.

On 12/5/25 at 11:20 AM, R2 stated that R2 fell and sustained a right black eye. R2's family members stated that R2 is not able to stand and walk to the bathroom unassisted. R2's family members stated that if R2 did fall, R2 would not be able to pick self-off floor.

On 12/5/25 at 9:55 AM V3 (caregiver) stated that V3 has worked at this facility for ten years. V3 stated that V3 does not recall the last time there was a resident protection in-service. V3 is not able to state where resident care policies are kept.

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{S9999}	Continued From page 3 On 12/5/25 at 10:02 AM, V4 (caregiver) stated that V4 started working at this facility in June 2025. V4 stated that V4 received resident protection training when hired. V4 denied any further in-service or training since then. V4 stated that V4 is not sure how to access resident care policies and procedures. On 12/5/25 at 10:15 AM, V5 (housekeeping) stated that V5 has worked at this facility for eight months. V5 denied receiving any resident protection in-service/training. On 12/5/25 at 10:25 AM, V6 (caregiver) stated that V6 has worked at this facility for 20 years. V6 stated that V6 has completed resident protection training on the computer but does not recall when the last training/in-service was. On 12/5/25 at 10:28 AM, V7 (caregiver) stated that V7 has worked at this facility for four years. V7 stated that the last resident protection training V7 attended was this past spring. On 12/5/25 at 11:24 AM, V7 stated that R2 sustained the black eye 1-2 days ago on the 3:00 PM-11:00 PM shift. V7 stated that V7 does not know any further details. V7 stated that R2 is on a toileting program and is assisted to the bathroom every 1 ½ hours around the clock. V7 stated that R2 will attempt to take self to the bathroom. On 12/5/25 at 10:34 AM, V8 (caregiver) stated that V8 has worked at this facility for two years. V8 stated that V8 believes V8 has received training on resident protection but could not state when it was. V8 stated that the resident care policies are located in the locked cabinet but does not have the key to access it.	{S9999}		

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{S9999}	Continued From page 4 On 12/5/25 at 10:40 AM, V9 (caregiver) stated that V9 has worked at this facility for eight years. V9 stated that V9 believes last resident protection training V9 attended was four years ago. V9 stated that the resident care policies are not readily accessible to staff. On 12/5/25 at 11:10 AM, V1 (executive director) stated that the resident service coordinator was expected to implement a resident care policy committee with staff. V1 stated that V1 had no idea what the resident service coordinator was doing; reason she no longer works at this facility. On 12/5/25 at 1:00 PM, V10 LPN (agency licensed practical nurse) stated that this is V10's first day working here. V10 stated that if a resident has a fall, the nurse is expected to complete a head-to-toe assessment, complete an incident report, and document in the resident's medical record and on the 24-hour report. R2's re-admission clinical evaluation, dated 5/20/25, notes R2 is alert and oriented to person and place. R2's ADL (activities of daily living) assessment notes R2 is dependent on staff for toileting, dressing, bathing, grooming, ambulation, bed mobility, and transfers. R2's POS (physician order sheet), dated 12/1/25 notes an order for an x-ray of R2's right hand and wrist. On 12/2/25, there is an order to send R2 to the hospital for evaluation of right hand. R2's hospital record, dated 12/2/25, notes R2 presented to the emergency room after a fall. Diagnoses include fall on same level from slipping, tripping, or stumbling, right hand pain, and right-hand sprain.	{S9999}		

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{S9999}	Continued From page 5	{S9999}		

There was no documentation in the nurses 24-hour report or medical record noting how R2 injured right hand/wrist on 12/1/25.

The nurses 24-hour report dated 12/4/25 at 11:00 PM, notes R2 with red-purple bruise around right eye. During 3:00 PM - 11:00 PM shift, both care givers came to nurse to report R2's eye very red and with purple discoloration. When asked what happened, R2 stated that nobody hit R2 and R2 hit eye on end table trying to go the bathroom. The care giver stated that R2 hit head but was not trying to get out of bed.

On 12/9/25 at 8:08 AM, V1 (executive director) presented an incident report, dated 12/1/25 at 11:00 AM. The report notes upon assessment, R2 complained of pain to touch to R2's right fifth finger. R2 stated she was trying to go to the washroom to use the toilet and fell over on the wall and hit her finger. R2's gait is weak, and she requires assistance with transfers.

On 12/9/25 at 8:08 AM, V1 presented an incident report that was created on 12/8/25 at 4:50 PM for an incident that occurred on 12/4/25 at 10:30 PM. The report notes it was reported by the nurse manager on duty on 12/4/25 that R2 was noted with a bruise to the right eye. Per nurse manager, R2 stated she hit her eye on the end table trying to go to the washroom.

V1 did not provide documentation that the incident on 12/1 or 12/4 were reported to the State Surveying Agency.
R2's service plan for falls, created on 3/4/2024 and last revision on 3/4/24, notes in part, prompted toileting regimen every two hours and as needed; safety checks every hour.

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{S9999}	Continued From page 6 R2's service plan for nighttime care, created on 3/4/2024 and last revision on 11/25/24, notes in part, to observe for and report episodes of sleep disturbance, family provided a video monitor to help staff keep aware of attempts to get out of bed alone to self-toilet. On 12/9/25 at 12:30 PM, V1 stated that R2 does not have a video monitor in her room; it has been gone for a long time. R2's service plan for ambulation and transferring, created on 3/4/2024 and last revision on 11/25/24, notes in part, R2's falls are most always related to R2 trying to transfer by herself, on and off the toilet. R2 is able to transfer/ambulate from wheelchair to bed with assist of one. Often does not want to wait for help to bathroom and will attempt self-transfer, often falls on transfer back to wheelchair. The facility's planning and monitoring services, dated 06/2025, notes residents' service needs, and requirements are identified, planned, implemented, monitored and reassessed on an on-going basis. Residents are reassessed annually unless they experience a significant change. Service plans are modified accordingly "B"	{S9999}		