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 _____	C 12/31/2025

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 Investigation of Facility Reported Incident of 10/27/2025/IL00198625 - 330.4240a), 330.1710a), 330.1710b), 330.1720a)1)2)3)4)5)6)7)8)9)10)11)12)13)14)15)16), 330.780a)	S 000		
S9999	Final Observations Statement of Licensure Violations: (1 of 2) 330.4240a) Section 330.4240a) 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) This REQUIREMENT was now met as evidenced by: Based on interview and record review, the facility failed to prevent staff-to-resident mental abuse. This failure affected one resident (R1) of three residents reviewed for abuse. Findings include: R1's physician progress notes (10/31/2025) documents in part diagnoses, including but not limited to: dementia with behavioral symptoms, recurrent UTIs, major depressive disorder, congestive heart failure, anemia, hypothyroidism and hypertension. Facility reported incident to the state survey agency documents in part, on 10/27/2025 at 4:40	S9999		

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PM, V2 (Former Life Enrichment Coordinator) alleged that V3 (Former Licensed Practical Nurse) was "pushing" R1 from behind and felt that V3 was being forceful. After the investigation was completed, V3 was terminated.

Review of V3's witness statement (10/27/2025) documents in part, "As I am waiting (on the floor) with (R1) for (V3) to come and assist after (R1) fall, (V3) is yelling, pointing in (R1's) face to "stop it and get up!". (V3) grabs (R1) and pulls (R1) up aggressively to (R1's) feet. I noticed the aggressiveness (could feel the aggressiveness as I am holding on to (R1)) and I continued to hold on to (R1) afraid (R1) might fall again. As I am walking with (R1), (V3) is behind us and (V3) begins to push (R1's) back (full palm) forward to where I can feel the force. Then we get to (R1's unit), (R1) was holding on to the handrails and (V3) tells (R1) to "Stop holding on!" and was swatting (R1's) hand off the railing. Physically swatting (R1's) hand off the railing aggressively..."

On 12/24/2025 at 12:38 PM, V2 explained that V3 no longer works at the facility. V3's witness statement was reviewed with V2 and V2 affirmed that the statement was accurate. V2 stated V3 was being very physically aggressive towards R1 and reported the incident to the abuse prevention coordinator (V1, Executive Director).

Facility employee handbook (undated) documents in part, " ...Work Rules - Critical/Type A Violations of Critical/Type A work rules are considered severe and will result in suspension, subject to termination, pending a final review, for the first occurrence. Under these work rules, YOU AGREE TO: ... 12. Never verbally, physically or sexually abuse a resident ..."

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V3's termination documentation indicates that V3 violated Type A # 12, Never verbally, physically, or sexually abuse a resident.

V3's employee file documents in part multiple corrective actions given to V3 for similar behavior, including, but not limited to, V3 being rude to hospice staff (11/28/2023), being too loud when communicating to residents/family members/not meeting expectations of being helpful/caring (10/10/2023), being inpatient/rude towards residents and yelling at them (10/5/2023), yelling at residents and roughly took a book out of a resident's hands whom was reading (9/16/2023).

On 12/24/2025 at 12:01 PM, V1 (Executive Director) affirmed that V1 is the abuse prevention coordinator and completed the investigation between R1 and V3. V1 explained that V2 observed V3 be rough with R1, so V3 was suspended pending investigation. During the investigation, facility administration felt V3 was being rough, so they "aired on the side of caution" and terminated V3. V1 affirmed that V3 has a history of "being gruff" with the residents and families and affirmed there were multiple corrective action documents, performance improvement plans, and performance evaluations that document V3's lack of patience for the residents. V1 stated, "I don't think what (V3) did was abuse, but it does not meet our standards of care so (V3) was terminated. I don't think (V3) wanted to hurt the residents, I think (V3) was trying to hurry (R1) on and get on with (V3's) day. (V3) has no regard for the residents". V3's termination document was reviewed with V1 that identifies V3 abused a resident and was terminated. V1 replied, "we put it under abuse because we didn't know where else it would fit. Corporate HR told us to put it there". V1 affirmed

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that residents have the right to be free from abuse and neglect.

On 12/30/2025 at 10:06 AM, V11 (Receptionist) affirmed that V11 was familiar with V3 and recalled that V3 would often yell at the residents and be very aggressive with them.

On 12/30/2025 at 10:10 AM, R1 was observed sitting in the dining room. R1 was unable to answer questions due to cognitive deficits.

On 12/30/2025 at 12:20 PM, V10 (Regional HR Director) affirmed that V10 was involved and recalled the incident. V3's disciplinary action was reviewed with V10 and V10 stated, "If (V3's) file says that (V3) was fired for abuse, then yes, the final outcome of the investigation determined abuse occurred".

Facility policy titled, "RESIDENT PROTECTION" (5/2025) documents in part, "Policy: The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms."

"B"

(2 of 2)

330.1710a)
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330.780a)

Section 330.1710 Resident Record

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Requirements
a) Each facility shall have a medical record system that retrieves information regarding individual residents.

b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives.

Section 330.1720 Content of Medical Records
a) No later than the time of admission, the facility shall enter the following information onto the identification sheet or admission sheet for each resident:
1) Name, sex, date of birth and Social Security Number,
2) Marital Status, and the name of spouse (if there is one),
3) Whether the resident has been previously admitted to the facility,
4) Date of current admission to the facility,
5) State or country of birth,
6) Home address,
7) Religious affiliation (if any),
8) Name, address and telephone number of any referral agency, state hospital, zone center or hospital from which the resident has been transferred (if applicable),
9) Name and telephone number of the resident's personal physician,
10) Name and telephone number of the resident's next of kin or responsible relative,
11) Race and origin,
12) Most recent occupation,
13) Whether the resident or the resident's spouse is a veteran,
14) Father's name and mother's maiden

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name,
15) Name, address and telephone number of the resident's dentist, and
16) The diagnosis applicable at the time of admission.

Section 330.780 Incidents and Accidents
a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.

These REQUIREMENTS were not met as evidenced by:

Based on interview and record review, the facility failed to obtain/retain facility medical records and failed to create an admission record/identification sheet upon admission. These failures affected three (R1, R2 and R3) residents of three residents reviewed for medical records and has the potential to affect all 54 residents that reside within the facility.

Findings include:

Facility census (12/24/2025) documents in part that 54 residents reside within the facility.

R2's move in record (6/9/2025) does not document R2's previous address, race, birth place, most recent occupation, information for the resident's dentist, father/mother's maiden name, and diagnosis applicable at admission.

R3's move in record (6/9/2025) does not document R3's previous address, race, birth

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place, most recent occupation, information for the resident's dentist, father/mother's maiden name, and diagnosis applicable at admission.

R1's "senior resident detail report"documents in part that R1's moved in on 10/10/2025. It does not contain R1's sex, social security number, marital status, state or country of birth, home address, religious affiliation, name, address and telephone number of any referral agency, state hospital, zone center or hospital from which the resident has been transferred (if applicable), name and telephone number of the resident's personal physician, name and telephone number of the resident's next of kin or responsible relative, race and origin, most recent occupation, whether the resident is a veteran, father's name and mother's maiden name, name, address and telephone number of the resident's dentist, and the diagnosis applicable at the time of admission. The move in record for R1 was requested and not recieved prior to the exit of the survey.

Review of R1's medical record was completed and there was no progress notes in R1's records from before 12/22/2025. R1's health record did not include an identification record or admission record that meets the regulatory requirement. There is no documentation that the incident on 10/27/2025 was recorded in R1's progress notes.

On 12/30/2025 at 12:23 PM, V4 (HR Manager) affirmed that V4 is the currently the manager of the facility while V1 is absent. V4 stated that R1 did not have a move in record because they had no electronic health record when R1 moved in. R2 and R3 did have records but the old electronic health record is not accessable and the facility is in "black out". V4 explained that all charting is being done on paper, the facility has no access to

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the medical records prior to the black out, and that the facility was supposed to print out all the medical records prior to the system going permanantly down. V4 stated, "if I haven't provided any documents that you requested, it is because we do not have them".

On 12/30/2025 at 1:02 PM, V6 (Licensed Practical Nurse) explained that a few months ago, the old electronic health record was staff were no longer able to access the old records for all of the residents. V6 affirmed there was no facesheet for R1 or progress notes prior to 12/22/2025. V6 stated, "if we did have documentation of the incident, it would be in the old system, which we no longer have access to. We cannot access any of the resident's old records since the old system went down. If records you are looking for are not in the medical record or the stack we gave you, we don't have them or don't have access to them anymore".

On 12/30/2025 at 12:38 PM, V4 affirmed at the exit conference that the facility did not have a policy on retaining of medical records or creating move in records.

"C"