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 12/03/2019

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

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S 000	Initial Comments Complaint Investigation 1995639/IL114492	S 000		
S9999	Final Observations Statement of Licensure Violations 330.710a) 330.780b) 330.780c) 330.4240f) 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 330.780 (b) (c) 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 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

Section 330.4240 Abuse and Neglect
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)

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to assess and evaluate 1 of 6 residents (R1) identified with aggressive behaviors towards other facility residents (R2, R3, R4, R5 and R6) to determine the most suitable therapy and placement, in an effort to ensure the safety of other residents. The facility failed to notify the Department of serious incidents and/or accidents that had the potential to result in resident injury for 2 of 6 residents (R3 and R6) as a result of the aggressive behavior of R1.

Findings Include:

Per record review of incident reports, on 3/14/19 at 10:30 AM, R1 was punching R4 in the arm in the common hallway.

On 5/9/19 at 7:00 AM, R1 was aggressive and hit two caregivers.

On 6/12/19 at 4:40 PM, R1 was in another house and was grabbed and held by another resident for fooling with the TV. When R1 was released he hit

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S9999	Continued From page 2	S9999		

a third resident R2 in the left chest and left cheek.

On 7/11/19 at 6:00 PM, R1 pushed R5 causing her to fall on her buttocks.

On review of the incident report dated 7/24/19 at 8:00 AM, "R1 hit R3 in the eye during an altercation in the dining room at breakfast time."

On 9/17/19 at 6:30 PM, per caregiver and administrator, R6 yelled for help and R1 was observed leaving R6's room. R6 was on the floor bleeding from the back of the head. (R1 history of pushing others down) per incident report.

On 12/3/19 at 11:29 AM, V3 (Caregiver) stated sometimes R1 is aggressive and is now a two person assist for care. When V3 tries to provide care to R1, R1 fights. When R1 is in the hallway R1 tries to flip other residents out of their wheelchair, so V3 has to watch him. V3 stated R1 is more calm now; R1 is under hospice care.

At 11:42 AM, V4 (Licensed Practical Nurse) stated R1 is more aggressive when the staff is providing care. R1 sun downs and gets very anxious. No changes in his behavior since he was admitted.

At 11:55 AM, V5 (Family Member) stated R1 had no recent changes in behavior. He thinks R1 is declining but hopes hospice will help.

At 12:00 PM, V6 (Caregiver) stated R1 is equally aggressive with both staff and other residents. V6 stated, "R1 punched R3 in the eye and she's scared of him. R1 is a two person assist for care because one person can't take care of him. R1 will stand behind residents and push them, even in front of staff and the administration does

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S9999	Continued From page 3	S9999		

nothing."

At 1:12 PM, R2 stated, "R1's behavior is about the same or a little worse. R1 kicked me in the chest when I was trying to break up a fight with him and another guy. R1's not getting any help here. They're just babysitting. If you don't be conscious about locking and closing your door R1 will be in there. R1 will open your room door. I've witnessed R1 being aggressive with staff and other residents all the time. R1 does the same thing over and over and the staff just yell at him. Nothing is done."

At 1:28 PM, R3 stated, "I'm not the only one R1 picks on. I tell one of the staff but sometimes he just hits. He'll stop you from walking in the hall. I make sure when I walk through the halls he's not there. I don't want to deal with him."

At 3:16 PM, V7 (Caregiver) stated, "R1 has had many incidents. R1's too aggressive with everybody. No changes in his behavior. R1 pushed a resident down to the floor in front of corporate staff and the administrator did not do anything. R1 goes into other resident's rooms. R1 took R3's walker and he punched her in the eye. I tell other residents to stay away from him."

On 12/4/19 at 11:15 AM, V2 (Resident Services Coordinator) stated, "R1 started to show behavioral symptoms by becoming difficult and was referred to the psychiatrist. No one has expressed to me that they are scared of R1." V2 acknowledged R1's multiple incidents stating she did not believe he was a danger to others. V2 stated, "If it were something really bad we would transfer him to the adult psych unit. Physically harming someone is abuse, resident to resident. You have to be careful with the word abuse

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S9999	Continued From page 4	S9999		

because both these residents have Alzheimers's. We generally don't send people out. With our residents it depends on the severity of the thing. If someone is recurrently being aggressive and we think it's becoming extreme we talk to the family and call the medical doctor." V2 stated it was V1's (Senior Executive Director) responsibility to report incidents and accidents to the state. V2 stated, "If it is extreme or someone was hurt then we would report that of course. I'll have to look up the regulation on abuse."

At 12:59 PM, V1 (Senior Executive Director) stated the incident on 7/24/19 was R1 being the perpetrator of the assault against R3. V1 also stated he was aware of R1's aggressive behavior a week after his admission. V1 acknowledged that some of the other residents worry about R1's behavior and the intervention used is to separate and monitor R1.

V1 stated he did not report the resident-to-resident abuse and acknowledged that he probably should be reporting a lot more things. V1 stated he typically reports any resident with dementia that is sent out to geriatric psych. V1 stated, "We don't send the resident out unless they totally lose control. We are a social model, not a medical model. It's the executive director's responsibility to do the service plans and interventions."

Per record review of R1's service plan, there was no documentation in the clinical record to support that the resident was evaluated or that the resident's aggressive behaviors were addressed. The facility failed to conduct an assessment to determine appropriate placement.

On review of the revised August 2009 Resident

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S9999	Continued From page 5 Abuse policy it states: 2. The Executive Director notifies the state agency of the suspected resident abuse situation according to state regulations. On 12/4/19, review of the revised August 2009 Injuries and Occurrences policy states: 4. Documentation of incidents and occurrences is completed per facility policy. The Executive Director and/or designee will complete State mandated reporting. (B)	S9999		