Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014989	A. BUILDING: ______ B. WING ______	C 07/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS (SOUTH HOLLAND)	2045 EAST 170TH STREET SOUTH HOLLAND, IL 60473

(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 Facility Reported Incident of March 27, 2021/IL132802-330.4240a)b)f) Facility Reported Incident of April 4, 2021/IL132808-330.4240a)b)f) Facility Reported Incident of April 6, 2021/IL132809-no findings	S 000		
S9999	Final Observations Statement of Licensure Violations Section 330.4240 Abuse and Neglect 330.4240a) 330.4240b) 330.4240f) a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) 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.	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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(Section 3-612 of the Act)

These regulations are not met as evidenced by:

Based on interview and record review, the facility failed to ensure the safety of residents and prevent R1 from physically abusing three of five residents (R2, R3 and R6) reviewed for abuse.

Findings include:

The Facility Reported Incident (FRI) dated 3/27/21 documents staff found R3 laying on the floor and R1 was on top of her hitting on her chest. R3 was given Tylenol for chest pain. R3's primary Medical Doctor (MD) was notified, family and hospice also notified. Resident was redirected. R1's primary MD and family notified.

The FRI dated 4/4/21 documents Caregiver observed R1 slap R2 in the face. R1 was redirected and MD and Family notified.

The FRI dated 4/6/21 documents R3 was pushed to the floor by R1. Medication administered to R1 (clonazepam administered after further review).

The FRI dated 4/22/21 documents R1 was observed hitting R6 on the arms, back and core of her body with a closed fist. R1 also grabbed R6 by her right arm and twisted it. R1 was redirected and separated from R6 to avoid further injuries/incidents.

On 7/18/2021 at 1:08 pm V2 (LPN) stated (in regards to 3/27/2021 incident with R1) "the caretaker told me what happened. I did not witness it. I went to do assessments on both them. There were no injuries. R3 got Tylenol for

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pain. R1, I sent her to her room. I redirected her. She had not been at the facility for long when she started fighting everyone. It was only about 2 weeks. I'm not sure of where she came from or she had a history of violence. After the incident we redirected her. We tried to keep eyes on them and give as needed medicine for anxiety and agitation. The second incident 4/4/2021 R1 with R2 I wasn't there. I heard that R1 was fighting with R2. I believe we contacted the doctor to ask to adjust medications. The third incident on 4/6/21 R1 with R3 again. I assessed them again. We keep R1 sometimes by herself and kept watch on her. We give medicine. I do not believe she had changes to medications at this time. Don't remember what the doctors orders were. On the 4th time R1 with R6 on 4/22/21. I heard about all of incidents. If it happen on my shift, I would do follow ups and I heard about it. We redirected R1. I don't remember the plan of care after this one."

On 7/19/21 11:54 AM V2 (LPN) stated she contacted the Psych Doctor regarding R1 incidents. V2 she states she does not remember if the doctor gave her any recommendations for any of the incidents, but if he had she would have put it in progress notes in PCC.

On 7/17/2021 12:34PM V3 (LPN) states "V7 (Caregiver) said R1 hit R2. I did not witness the incident. This incident was the only one I was present for. I was the nurse at the time." Surveyor asked, what was done to protect other residents from potential violence from R1. V3 stated she "redirected R1, removed her away from other residents, had the caregiver sit with her and calm her down. R1 has as-needed medication. We give it to her for anxiety. I do not remember any recommendation from the doctor

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when I called. "

On 7/18/2021 at 1:28 PM Surveyor asked V1, after all incidents with R1 should her care plan be updated. V1 stated, "after any situation the care plan should be updated. The Care plan should be updated but no it wasn't. We update the Resident Information (RIB) book with any incidents that happen." Surveyor asked if we can walk over together at this time to look at the RIB book for R1. We looked at the RIB book for R1 and observed there is no mention in the RIB regarding R1's history of violence. Surveyor requested copies of RIB. Looked at RIB book with V1 and at 1:40PM V1 confirmed there was no mention of R1's history of violence.

On 7/18/2021 at 11:57AM, V5 (Caregiver) had abuse training on the computer and in-services. "If we see abuse we separate them and call the nurse. We write it in in our "RIB" book. Every house has one. We put anything unusual in the RIB like falls, someone not eating, or any incident." V5 stated she witnessed the incident with R1 and R3. "R3 was on the floor and R1 was kneeling over her. R3 was saying 'get me away from that lady.' I took R3 and separated them. I called the nurse and did an incident report."

Review of R1's Care Plan is absent of any information related to her history of violence. Progress notes from March and April are absent of any notes by R1's physicians related to her violent incidents.

On 7/19/2021 at 3:43 PM, V1 stated via email: that there are no doctor's notes for R1 in March or April.

On 7/19/2021 at 4:04 PM, V1 stated via email

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S9999	Continued From page 4 and during exit conference: "I just spoke with V9 (Psychiatrist) and he has put the notes in priority mail." The facility's Abuse and Neglect and Exploitation policy documents the following: The residents of HCR Manor Care have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. (B)	S9999		