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 11/06/2021

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 September 18, 2021/ IL138798	S 000		
S9999	Final Observations Statement of Licensure Violations 330.780b) 330.780c) Section 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. These regulations were not met as evidenced by:	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Based on interview and record review, the facility failed to ensure an injury of unknown origin was thoroughly investigated and failed to ensure the final investigation was reported to the Illinois Department of Public Health (IDPH) within 7 days. This applies to 3 of 3 residents (R1, R2, and R3) reviewed for incidents/injuries of unknown origin in the sample of 3. Findings include: 1. The facility's incident report for R3 dated August 17, 2021 shows, "Summary of Alleged Incident: Caregiver noticed a large bruise under resident left breast and scratch on top of breast." The documents reviewed, timeline of critical events, action taken during investigation, and conclusion were all left blank. No further information was on the incident report. The facility's state (IDPH) report for R3 from incident on August 17, 2021 shows, "Brief description of incident: caregiver noticed a large bruise under residents left breast and scratch on top of her left breast of unknown origin. Type of injuries: left breast and scratch. Late follow up report, 5-day follow up." The report shows it was faxed to IDPH on October 6, 2021 (50 days after incident). The facility did not provide any evidence of an investigation for R3's bruising or scratch on her left breast. 2. The facility's incident report for R1 dated September 18, 2021 shows, "Summary of alleged incident: writer noted unknown origin of swelling to residents upper lip with a small abrasion, scratch on nose and dried blood around both	S9999		

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S9999	Continued From page 2	S9999		

nostrils while giving AM medication." The documents reviewed, timeline of critical events, action taken during investigation, and conclusion were all left blank. No further information was on the incident report.

The facility's state (IDPH) report for R1 from incident on September 18, 2021 shows, "While giving AM medication writer noted a small abrasion, swelling to upper lip and a scratch across the nose with dried blood coming from both nostril all of unknown origin. Type of injuries: abrasion and swelling to upper lip, scratch across nose... Late follow up report, 5-day follow up." The report shows it was faxed to IDPH on October 7, 2021 (19 days after incident).

The facility provided 3 statements from staff that show, they didn't notice any swelling or abrasions prior to the R1's incident on September 18, 2021.

3. The facility's incident report for R2 dated October 12, 2021 shows, "Summary of alleged incident: Caregiver noted resident sitting upright in bed and drops of blood on the floor next to resident's night stand. While assisting resident with ADL's (activities of daily living), caregiver then noted a small hematoma (bruise) to the center top of resident's head and a nickel size skin tear to resident's outer right elbow, all of unknown origin." The documents reviewed, timeline of critical events, action taken during investigation, and conclusion were all left blank. No further information was on the incident report.

The facility did not provide any evidence of an investigation for R2's bruising and skin tear.

On November 6, 2021 at 12:40 PM, V3, Licensed

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S9999	Continued From page 3 Practical Nurse (LPN) stated, the nurses are all responsible for doing the investigations and sending the reports to IDPH. She interviews a few caregivers and sends the same information on the final/5 day follow up report as what is reported on the initial report. The initial report is sent within 24 hours and the final within 5 days. She didn't know what happened to R1, R2, or R3. (C)	S9999		