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 |
|---|---|---|---|
| | IL6015325 | A. BUILDING: ______ B. WING ______ | C 03/09/2022 |

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

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| S 000 | Initial Comments<br><br>Complaint:<br>2291832/IL144381- 330.710 cited<br><br>Facility Reported Incidents<br>FRI of 02/26/22/IL144276 - 330.710 cited<br>FRI of 02/09/22/IL144176 - 330.710 cited | S 000 | | |
| S9999 | Final Observations<br><br>#1 Statement of Licensure Violations:<br><br>330.710a)<br><br>SECTION 330.710 RESIDENT CARE POLICIES<br><br>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.<br><br>This requirement was NOT MET as evidenced by:<br><br>Based on observation, interview and record review, the facility failed to follow it's fall policy for 1 of 3 (R3) by not implementing any fall interventions after R3 had a fall sustaining a closed head injury with laceration to forehead requiring tissue adhesive repair.<br><br>Findings Includes | S9999 | Attachment A<br>Statement of Licensure Violations | |

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

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On 3/2/22 at 2:09pm, R3 said, I don't remember how I fell. R3's bed was observed against the wall on the right side, night stand was on the left next to the bed with a portion of the floor exposed, no fall interventions or specialized mattresses/low bed were in place.

On 3/3/22 at 1:20pm, V4 (nurse) said, I am aware that R3 had a fall, which resulted in bruising and an injury to his face. We would diligently monitor a resident after a fall. I'm not sure if R3 has a specific care plan.

On 3/3/22 at 2:58pm, V2 (resident service coordinator/ head nurse) said, R3 has dementia. If a resident has a number of falls we would put in interventions. I would check for dementia staging related to brain deterioration and complete a medication review. R3 rolled over out of bed. If a resident has a bunch of falls out of bed, I will get a high low bed so they are only 6 inches off the floor. We don't do any interventions for one fall.

On 3/3/22 at 3:42pm, V3 (nurse) said, V8 (caregiver) reported, R3 rolled out of bed. R3 hit his head on the floor above his left eye. R3 sustained a small laceration. I couldn't stop the bleeding. I called 911. I moved R3's bed against the wall, we don't have fall mats or rails. R3 is a fall risk related to unsteady gait, unsafe transfers and a fear of falling.

On 3/4/22 at 10:11am, V8 (caregiver) said, I was in the kitchen, I heard yelling. I went to R3's room. R3 rolled out of bed unto the floor.

On 3/8/22 at 8:32am, V7 (caregiver) said, I was called when R3 had his fall. Blood was everywhere. R3 said, he rolled out of bed on the left side and hit his head. R3's bed has always

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been against the wall on the right side. We don't do any fall interventions.

Fall risk evaluation tool dated 1/7/22 documents: R3 is a severe risk for falls.

R3 care plan initiated 2/7/22 documents: R3 will remain free of injury due to fall requiring hospitalization: Intervention: Nothing documented.

Incident report dated 2/9/22 documents: Caregiver was doing hourly check and observed R3 on the floor next to his bed. R3 appeared to have hit his head, 911 called.

Progress note dated 2/9/22 documents: Caregiver notified V3 (nurse) that R3 has fallen. V3 asked, R3 what happened. R3 stated, "I rolled out of bed and hit my left eye on the floor". V3 called 911. R3 was taken to the hospital.

Hospital paperwork dated 2/9/22 document: R3 states, he rolled out bed sustaining an injury head. R3 had a hematoma on the left side of forehead above the left eyebrow approximately 2 cm, abrasion noted with active bleeding. R3's diagnosis was closed head injury with laceration to forehead requiring tissue adhesive repair.

Fall prevention policy dated 6/2021 documents: Identify resident at risk or predisposed to falls and implement measure to attempt to prevent fall and minimize the risk that serious injury will result.

(B)

# 2 Statement of Licensure Violations:

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330.710a)

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.

This requirement was NOT MET as evidenced by:

Based on interview and record review, this facility failed to follow its resident protection policy for 1 of 3 (R2). This failure resulted in R2 being hit with a portable CD player sustaining facial contusion, laceration of the nose and a closed fracture left rib in a total sample of 6 reviewed for abuse.

Findings include:

On 3/2/22 at 2:12pm, R2 who was assessed to be alert and oriented to person, place and time, said, I awoke to R1 hitting me in the face on the right side, I turned over and R1 hit me directly in my face/nose. I tried to get up after the second hit, I got hit again on the side of my face and then my chest. I was frightened and sick. I wanted to get up and fight but I was being hit repeatedly. Staff came after the last hit.

On 3/3/22 at 2:58pm, V2 (resident service coordinator/head nurse) said, R1 was found in R2's room holding a cd player. R2 said, R1 hit me on the face. R2 had a little bump on his nose. R2

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| S9999 | Continued From page 4<br>complained of pain. R1 was high functioning and the aggressor.<br><br>On 3/3/22 at 3:42pm, V3 (nurse) said, V6 (caregiver) came, got me and said, R1 was very anxious. When I entered R1/R2's unit, I heard R2 yelling, help, help, help. R1 was standing over R2 with a radio in his hand. R2 was in bed with blood running down his face. R1 said, "I clobbered you good". I struggled to get the radio from R1. R2 had a small laceration across the bridge of nose. R2 complained of pain to the right side his face. R2 was in bed, shocked and wasn't trying to fight back.<br><br>Progress note dated 2/26/22 documents: R2 was alert alert/oriented times three. R2 had an unwitnessed altercation with another resident. R2 was heard screaming help me, help me. R1 was standing over R2 with an object raised up. R2 was noted with a small laceration on the bridge of his nose and some redness under his eye. R2 said, he was struck in the face. R2 was complaining of so much pain the paramedics had to take R2 to the hospital.<br><br>Incident report dated 2/26/22 documents: R2 was in bed when R1 hit him with an object in the face.<br><br>State report incident dated 2/26/22 documents: R2 was involved in an altercation with R1. R1 struck R2 with a portable CD player. Caregivers came in after the fact. X-ray at the hospital documents fracture of left, sixth rib was noted.<br><br>Hospital paperwork dated 2/26/22 documents: R2's diagnosis were facial contusion, laceration of the nose and closed fracture one rib (left side). R2 said, he was asleep, another resident hit him with a CD player in the face, nose and left chest. | S9999 | | |

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| S9999 | Continued From page 5<br><br>Resident protection policy dated 11/2021 documents: resident has the right to be free from abuse. Seven key components of the abuse prevention system: # 6 - protect.<br><br>(B) | S9999 | | |