STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014419	A. BUILDING: _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS (ELK GROVE)	1940 NERGE ROAD ELK GROVE VILLAGE, IL 60007

(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 Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 4) 330.780b)c) 330.1110g) 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. Section 330.1110 Medical Care Policies g) At the time of an accident, immediate	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 treatment shall be provided by personnel trained in medically approved first aid procedures. This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure a resident received prompt medical treatment (X-Ray) after a fall with injury and failed to ensure a resident injury was reported to the state agency for 1 of 5 residents (R1) reviewed for incidents in the sample of 6. Findings include: R1's face sheet shows he has diagnoses including: Alzheimer's disease and dementia. R1's active service plan (plan of care) initiated on 3/10/22 shows he is at risk for falls and requires staff assistance with his activities of daily living (ADL's). A facility incident report completed on 1/19/23 at 8:13 AM, shows that R1 had a fall at the facility. R1's nursing progress notes from 1/19/23 to 1/24/23 relative to the fall and injury are as follows: A post fall note dated 1/19/23 at 2:01 PM, shows R1 had a fall at the facility on the morning of 1/19/23. On 1/19/23 at 11:53 PM, R1 was experiencing pain in his left shoulder and hospice was called for pain management. On 1/20/23 at 8:38 AM, a late entry for 1/19/23 was written in R1's nursing progress notes stating, "Resident [R1] had unwitnessed fall in the living room at 3:15 AM. Assessed for injury. Noted redness and abrasion on his left shoulder & complained of	S9999		

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S9999	Continued From page 2 pain, was able to raise his arm up but with pain." On 1/20/23 at 9:08 AM, "Hospice called to come and assess resident of [sic] his left shoulder complain [sic] of pain & inability to move the arm up without assist." On 1/20/23 at 2:47 PM, "Hospice nurse [from a local agency] was here and gave the written X-ray order to left shoulder 2 views. They have their own company that they use and they will sent it out to the facility." A Physician's Order Form dated 1/20/2023 shows that R1 had an order for an X-ray of his left shoulder. On 1/21/23 at 7:30 AM, "awaiting left shoulder X-ray [for R1]." On 1/22/23 at 10:11 PM, "[R1] complaining of right [sic] shoulder pain. Still waiting for the X-ray ordered by hospice." The X-ray was not completed until 1/23/23. On 1/24/23 at 1:00 PM, "Hospice nurse reports that resident lt. [left] shoulder X-ray concludes lt. clavicle fracture." On 2/23/23 at 8:10 AM, V1 (Administrator) said if a resident has a fall that results in a fracture it should be reported to the Department/Regional Office. On 2/23/23 at 10:00 AM, V4 (Hospice Nurse) said, "[R1's] X-ray was delayed because the company they contract with did not come out to do the X-ray when they were supposed to and canceled without telling anyone. The X-ray should have been done much sooner, usually within 24 hours but 48 hours would be the maximum." On 2/23/23 at 11:23 AM, V3 (Licensed Practical Nurse) said, "If there was a delay for a resident to get an X-ray done the nurses should call the doctor, call the X-ray company and if needed send that resident to the emergency room to get it done. If an X-ray is not done timely it could delay treatment."	S9999		

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S9999	Continued From page 3 On 2/23/22 at 11:30 AM, V2 (Director of Nursing) said, "[R1's] X-ray should have been done much sooner. The facility has procedures to call for an X-ray if there is any delay in obtaining one through hospice. I don't think there is a single nurse here who does not know how to do it, how to order an X-ray." V2 also stated, "From what was reported to me, no, the state agency was not notified of R1's fracture. I was not the Director of Nursing when this happened, and I was told someone spoke with the former Director of Nursing and she thinks R1's injury may have slipped through the cracks. There was a delay between [R1's] fall and when his X-ray was done which confirmed he had a fracture and so reporting it may have been overlooked." A copy of R1's reportable incident that was supposed to be sent to the Department and Regional Office was requested by this surveyor and was not able to be provided during the survey. (B) Statement of Licensure Violations (2 of 4) 330.1155b) Section 330.1155 Unnecessary, Psychotropic, and Antipsychotic Drugs b) Psychotropic medication shall not be prescribed without the informed consent of the resident, the resident's guardian, or other authorized representative. (Section 2-106.1(b) of	S9999		

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S9999	Continued From page 4 the Act) Additional informed consent is not required for reductions in dosage level or deletion of a specific medication. The informed consent may provide for a medication administration program of sequentially increased doses or a combination of medications to establish the lowest effective dose that will achieve the desired therapeutic outcome. Side effects of the medications shall be described. This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure informed consents were obtained for residents receiving psychotropic medications. This applies to 3 of 4 residents (R2, R4, R5) reviewed for psychotropic medications in the sample of 6. The findings include: 1. R2's Physician Order Sheets dated February 2023 shows orders for lorazepam (antianxiety) 0.25 mg every 4 hours as needed for anxiety (order date of 1/11/23). R2's medical record showed no consent was obtained. 2. R4's Physician Order Sheets dated February 2023 shows orders for alprazolam (antianxiety) 0.25 mg every morning and twice a day as needed (order date 12/14/22); Quetiapine (antipsychotic) 12.5 mg at 1:00 PM (order date 12/2/22); and Quetiapine 50 mg in the evening (order date 4/27/22). R4's medical record showed no consents were obtained. 3. R5's Physician Order Sheets dated February 2023 shows orders for Fluoxetine (antidepressant) 20 mg daily (order date	S9999		

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S9999	Continued From page 5 11/16/22). R5's medical record showed no consent was obtained. On 2/23/23 at 11:20 AM, V2 (DON) said she's been at the facility for 3 weeks. V2 said she looked through the consent binder and could not find the psychotropic consents for R2, R4, and R5. V2 said nursing staff should obtain the consents when they receive the order and place them in the medical chart. The facility's Antipsychotic Medication Policy undated Policy states, "Use of antipsychotic medication requires a discussion with the resident, if possible and the family as to use and effects of the medication. A signed consent by the responsible party may be required as per state regulations." (C) Statement of Licensure Violations (3 of 4) 330.1160a)b)c)d) Section 330.1160 Vaccinations a) A facility shall annually administer or arrange for a vaccination against influenza to each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention that are most recent to the time of vaccination, unless the vaccination is medically contraindicated or the resident has refused the vaccine. Influenza vaccinations for all residents age 65 and over shall be completed by November 30 of each year	S9999		

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S9999	Continued From page 6 or as soon as practicable if vaccine supplies are not available before November 1. Residents admitted after November 30, during the flu season, and until February 1 shall, as medically appropriate, receive an influenza vaccination prior to or upon admission or as soon as practicable if vaccine supplies are not available at the time of the admission, unless the vaccine is medically contraindicated or the resident has refused the vaccine. (Section 2-213 of the Act) b) A facility shall document in the resident's medical record that an annual vaccination against influenza was administered, refused or medically contraindicated. (Section 2-213 of the Act) c) A facility shall provide or arrange for administration of a pneumococcal vaccination to each resident in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility unless the resident refuses the offer for vaccination or the vaccination is medically contraindicated. (Section 2-213 of the Act) d) A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, refused, or medically contraindicated. (Section 2-213 of the Act) This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure residents were offered vaccinations against pneumococcal pneumonia	S9999		

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S9999	Continued From page 7 and influenza. This applies to 3 of 5 residents (R2, R4, R5) reviewed for vaccinations in the sample of 6. The findings include: 1. R2's face sheet shows she was admitted to the facility on 12/16/22. R2's electronic medical record showed no immunizations records for influenza or pneumonia. 2. R4's face sheet shows he was admitted to the facility on 10/31/21. R4's electronic medical record showed no immunization record for pneumonia. 3. R5's face sheet shows she was admitted to the facility on 11/15/22. R5's electronic medical record showed no immunizations records for influenza or pneumonia. On 2/23/23 at 11:20 AM, V2 (DON) said she's been at the facility for 3 weeks. V2 said residents should be offered the vaccinations upon admission to the facility and yearly for the influenza. Staff should document in the medical records the dates received and with the consent and education provided to each resident. V2 said she could not find the immunizations reports for R2, R4 and R5. The facility's Immunizations Policy dated 6/2021 states, "All residents will be offered the influenza immunization on move in and annually based on seasonal information. Pneumococcal Immunization will be offered upon move in ...if the immunization section is not completed in the Medical Evaluation form of state form upon move-in, it is the responsibility of the Resident Services Coordinator to contact the physician and	S9999		

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S9999	Continued From page 8 obtain/verify the resident's immunization history ...The Resident Services Coordinator offers the Influenza and Pneumovac immunizations if the resident in not already immunized and obtains a physician's order. (B) Statement of Licensure Violations (4 of 4) 330.4220f) Section 330.4220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure physician orders were implemented for 2 of 5 residents (R3, R4) reviewed for physician orders in the sample of 6. The findings include: 1. R3's Face Sheet shows that he was admitted to the facility on 12/4/22. R3's Physician's Order dated 12/8/22 shows, "PT [Physical Therapy] Eval and Tx [evaluate and treat] dx [diagnosis] safety issues." R3's Physician's Order dated 1/22/23 shows, "PT Eval and Tx."	S9999		

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S9999	Continued From page 9 On 2/23/23 at 11:44 AM, V7 (R3's spouse) said that they had talked about physical therapy when he first came in but she does not believe he ever received it. V7 said that she would have approved it if he needed it. On 2/23/23 at 12:30 PM, V3 (Licensed Practical Nurse) said that R3 had an order for physical therapy when he first came in but then he got COVID on 12/10/22 so the order was not carried through. V3 said that R3 has never had physical therapy and is now on hospice care so therapy can not be initiated. R3's Incident Reports show that he fell on 1/6/23, 2/4/23, 2/9/23 and 2/10/23. R3's Fall Service Plan initiated on 12/6/22 shows an intervention of: Evaluate for PT/OT/SLP (physical therapy/occupational therapy/speech therapy). The facility's Fall Prevention Policy dated 6/2021 shows, "Consult with Physical Therapy and/or Occupational Therapy for evaluation of functional mobility, bed mobility, transfers, gait, Activities of Daily Living and impairment as appropriate." 2. R4's face sheet shows he is an 85-year-old male with diagnoses including vascular dementia, major depression, anxiety, Alzheimer's and heart disease. R4's Physician Progress note dated 1/25/23 documents R4 was seen for "complaints of increasing confusion and agitation noted by staff and difficult to re-direct ...mostly between 5:00 to 8:00 PM ...he is intrusive to other residents, becomes disruptive and has moderate to severe	S9999		

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S9999	Continued From page 10 cognitive deficits .... Medications reviewed with nursing staff will increase Seroquel 12.5 mg to 25 mg in the afternoon." R4's NP (Nurse Practitioner) Psychiatric Evaluation progress note dated 1/26/23 documents "[R4] recently with increased sundowning behavior. Seems to start around dinner when he becomes increasingly anxious, restless, and agitated. Sometimes he shouts and pounds his fist on the table. He gets also very close to the face of other residents. ...We will increase Seroquel to 25 mg at 2:00 PM and okay to change scheduled alprazolam from morning to 5:00 PM for anxiety ...discussed with staff and with the Director of Nursing." R4's Physician Orders Sheets (P.O.S.) for February 2023 shows orders for Seroquel 12.5 mg at 1:00 PM and Alprazolam 0.25mg at 7:00 AM. The P.O.S. shows the orders did not get changed. On 2/22/23 at 8:53 AM, R4 was observed wandering the halls. On 2/23/23 at 9:15 AM, V6 (caregiver) said, "He is "tricky" and he has a lot of behaviors. He gets aggressive, speaks loudly, you have to be careful how you approach him. His behaviors increase in the afternoon." On 2/23/23 at 11:15 AM, V3 (LPN) said R4 has increased behaviors after lunch and that it could be related to sun downing. V3 said that R4 gets aggressive and anxious. On 2/23/23 at 12:00 PM, V2 (Director of Nursing) said she's been the DON at the facility for about 3 weeks. When the physician has new orders, they	S9999		

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S9999	Continued From page 11 should transcribe them on an order form and enter the new order. "To be honest I don't look at the physician progress notes." V2 said that R4's medication should have been increased and that she was not sure what happened. (B)	S9999		