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	IL6014989	A. BUILDING: _____ B. WING _____	C 09/08/2024

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ARDEN COURTS (SOUTH HOLLAND)	2045 EAST 170TH STREET SOUTH HOLLAND, IL 60473

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S 000	Initial Comments Complaint Investigation #2496412/IL176683 Facility Reported Incident of 8/11/24 #IL176743	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 330.4240a) 330.4240b) 330.4240c) 330.4240d) 330.4240e) 330.4240f) Section 330.4240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. 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. c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter of the department. e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome	S9999		

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of any further investigation, prosecution or disciplinary action against the employee.
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.

These Requirements were not met as evidenced by:

Based on interview and record review, the facility failed to prevent resident to resident abuse for two residents (R1, R2) and staff to resident abuse for one (R3) resident of three residents reviewed for abuse.

Findings include:

Facility reported incident of 8/11/24 exhibits a physical altercation that occurred between R1 and R2 that resulted in R2 sustaining bruises to the right eye and forearm as well scratches to the left forearm.

R1 is an 80 year old male who moved into the facility on 3/26/24. R2 is an 86 year old male who moved into the facility 2/28/24. Both residents are living in the facility with diagnoses that contribute to cognitive impairment.

R1 was observed on 9/6/24 at 11:52am walking without any assistive device in his room. R1 was noted to be conversive, however unable to appropriately answer questions and exhibited

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some confusion. R1 is alert to name, but unable to determine at the time of observation if he was alert to place, time, or situation. During this observation V7 Caregiver came to the room to encourage R1 to have lunch in the dining room. R1 looked at V7 and said, "I'm going to kick your ass" and laughed before turning away. V7 acknowledged R1's statement and dismissed it by walking away. R1 walked behind R7 towards the dining room but then turned around to go back into his bedroom to close the door.

On 9/6/24 at 12:47PM R2 was observed alert and walking with a cane after finishing lunch. R2 was conversive and was able to recall some information about his past, however was unable to recall the incident that occurred with R1. Although R2 said he was unable to recall the incident, R2 looked around at a resident who was walking slowly in our direction and said "be careful" in a low voice. When R2 was asked to explain or if he was fearful, R2 repeated "you just have to be careful around here." As the other resident got closer, R2 quickly shuffled away.

On 9/6/24 at 3:01pm V7 Caregiver said that they were on duty on 8/11/24. V7 said, at the time R1 and R2 had bedrooms that were positioned close to each other. V7 said that R2 is often wanders into other resident's rooms and on this day, R2 walked into R1's room and R1 doesn't react well to other residents entering his space. V7 said R1 "gets fidgety" when people come into his room and requires re-direction. V7 was completing documentation at the desk when they heard R1 and R2 arguing with each other. When V7 responded to the two residents they had already engaged in physically. V7 said they separated the residents and redirected R2 to his room. V7 sent R1 to go to participate in activities and informed

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the nurse on duty.

Further investigation of R1's behavior revealed that R1 and R2 had a previous physical altercation on 6/1/24. According to progress notes on 6/1/24, R1 "R1 was observed hitting [R2] in the face and head (with) a closed fist. Four areas of red marks (assessed) to [R2's] face. R1 was sent to the emergency room for a psychiatric evaluation and returned from the hospital later that evening without any further orders.

On 9/8/24 at 10:41am, V2 Resident Services Coordinator (RSC) said, after the first altercation between R1 and R2, both residents forgot about the incident, and we believed it was a one time occurrence. R1 was not sent to the hospital under emergency petition because we wanted to get him out of the facility immediately as to protect the other residents from him. When the second incident occurred, we changed R2's room because we determined that since the rooms were so close together, R2 would get confused and go into the wrong room. Now R2's room is on another unit, but he continues to wander the facility. R1 is currently being managed by psychiatry and we have discussed with the physician that if further behaviors occur, R1 would likely be admitted for an inpatient psychiatric evaluation and would have to be assessed if this setting is appropriate for him. We don't have the resources to maintain 1:1 monitoring or skills to treat advanced behavioral issues in this facility.

The census record for R1 and R2 were reviewed, and it was identified that their rooms were two doors from each other at the time of the altercation on 8/11/24. R2 was moved to a different unit on 8/12/24 with a progress note that

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said, "Res moved to another house for safety due to [R1's] continued signs of aggression towards him. Res moved to rm (#). No (signs and symptoms) of aggression or distress noted from R2."

The facility provided "Move-In/Move-Out Policy and Criteria" revised 8/22 which states in part; "[The facility] setting, and services may no longer be appropriate for current residents who have been assessed with the following: Those who exhibit behaviors that place them, other residents, staff, or visitors at risk."

R3 is 74 years old and moved into the facility 8/30/23 with diagnoses that contribute to cognitive deficit. R3 was observed 9/6/24 at 11:56am sitting in a wheelchair in the dining room. R3 was unable to converse during observation, did not appear to want to eat when presented lunch by caregiver and nurse on duty and appeared sleepy and slow to respond.

The facility initiated an abuse investigation on 8/5/24 when R3 notified staff that a caregiver harmed her earlier that morning.
On 9/7/24 at 3:30pm V9 Caregiver said, they started their shift at 7am on the morning of 8/5/24. V9 said that when they arrived to the unit, R3 was up, dressed and sitting in her wheelchair located in the dining room. V9 remembered serving R3 breakfast and sometime after breakfast, R3 called V9 over and informed V9 that V8 Caregiver "touched me down there". V9 said that they immediately informed V3 LPN (Licensed Practical Nurse).

On 9/6/24 at approximately 3:20pm, V2 RSC said that staff came to inform V1 Executive Director and V2 of R3's allegation the morning of 8/5/24.

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V2 said that when they went to assess R3, R3 was emotional- tearful and anxious at that time. R3 said V8 scraped her in the vaginal area and complained of pain. V2 said that they gathered information from R3 and involved staff members and it was determined that R3 required incontinence care while in bed. While V8 was providing the care, R3 was yelling at V8 to stop. V8 continued and dressed R3 and got her up for the day. V2 said that caregivers should ask another staff member for assistance when a resident is combative or refusing necessary care.

Written statement from V8 on 8/5/24 V8 said, R3 was not cooperating with incontinence care, however V8 continued to care for R3, got her dressed and brought her to the living room. During interview on 9/7/24 at 1:45pm V8 said there weren't any other staff available to help with caring for R3, and V8 continued to give care despite R3 yelling and screaming. Now, V8 does not provide any care for R3 since the incident, however, continues to be assigned to that unit.

When V2 assessed R3, V2 assisted to the bed, observed R3's vaginal area and provided incontinence care. Later that afternoon, R3 received visitors who insisted that R3 be evaluated at the hospital for sexual assault.

On 9/8/24 at 10:45am V2 said when R3 made a complaint against V8, V2 began an investigation to rule out sexual abuse, however, V2 also believed that R3 could have been suffering from a urinary tract infection that could have been causing pain or discomfort. There were no plans to transfer R3 to the hospital for further evaluation until the family requested.
V2 said that no other residents were questioned regarding the care they received from V8

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because many of the residents are nonverbal.

Progress note 8/5/24 at 3:41pm notes that R3 was transferred to the hospital for evaluation due to vaginal pain.

The facility abuse policy was requested. "Resident Protection" revised 2/24 states in part; "Policy: The resident has the right to be free from abuse, neglect, misappropriation of resident property, an exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion an any physical or chemical restraint not required to treat the resident's medial symptoms.

Procedure: The community screens potential new move-ins to determine if the resident has a personal history of or is at risk for developing abusive actions or aggressive behaviors toward other. If the resident has such a history or presents such a risk, the community reviews the resident/s status to determine if the resident is appropriate for move in and the community can meet the resident's needs.
4. Employees are educated upon hire and annually on the abuse prevention program including the immediate reporting of any suspicion of abuse, neglect, exploitation, mistreatment, misappropriation, or crime against a resident.
14. The community creates and maintains a proactive approach for identifying events that may constitute or contribute to abuse. When investigating whether abuse has occurred, the community identifies and considers events such as behavioral changes, bruising of residents, suspicious resident patterns, unexplained injuries, communication or social interaction changes and other trends that may signify abuse.

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S9999	Continued From page 7 18. Resident protection actions include: Immediately removing the resident from contact with the alleged abuser; Evaluation of the physical and psychosocial condition of the resident and providing emotional support to the resident during and after the investigation as needed; Provide a safe and secure environment for residents; Reporting the actual or suspicious event to the Abuse Prevention Coordinator; Reporting allegations of abuse to other agencies or law enforcement. Additional actions may include Resident room changes; Staff assignment changes; Staff, contractor, or visitor restrictions. The facility provided "Assisted Living New Employee General Orientation Facilitator Guide" revised 3/24 that defines Abuse: the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychological well-being. (B) Statement of Licensure Violation 2 of 2 Section 330.911 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act [225 ILCS 46] and the Health Care Worker Background Check Code (77 Ill. Adm. Code 955). This regulation was not met as evidenced by:	S9999		

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S9999	Continued From page 8 Based on observation, interview, and record review, the facility failed to comply with the Health Care Worker Background Check Act by not verifying employment annually. This failure has the potential to affect all residents currently in the facility. Findings include: On 9/8/24 V1 Executive Director said that the Health Care Worker Registry was updated upon hire and termination but not annually. The facility was unable to provide verification of annual employment verification for three care givers sampled for background checks of non licensed staff members. The Act states in part; (i) On October 1, 2007, or as soon thereafter, in the discretion of the Director of Public Health, as is reasonably practical, and thereafter, each direct care employer or its designee shall provide an employment verification for each employee no less than annually. The direct care employer or its designee shall log into the Health Care Worker Registry through a secure login. The health care employer or its designee shall indicate employment and termination dates within 30 days after hiring or terminating an employee, as well as the employment category and type. Failure to comply with this subsection (i) constitutes a licensing violation. A fine of up to $500 may be imposed for failure to maintain these records. This information shall be used by the Department of Public Health to notify the last known employer of any disqualifying offenses that are reported by the Illinois State Police. (C)	S9999		

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