STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014500	A. BUILDING: _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF NORTHMOOR	5831 NORTH NORTHWEST HIGHWAY CHICAGO, IL 60631

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S 000	Initial Comments Complaint Investigation #1987538/IL116577	S 000		
S9999	Final Observations Statement of Licensure Violations. 300.610a) 300.3240a) Section 300.610 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 by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations were not met as evidenced by: Based on interview and record review the facility failed to follow its policy to keep one of three residents (R1) who was at risk for abuse free from sexual assault by an employee. This failure resulted in R1 being transferred to the emergency	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 room with a diagnosis of sexual assault and the employee being arrested and charged with aggravated criminal sexual assault. Although R1 showed no negative response to the incident of 7/12/2019, using the reasonable person concept it is likely this vulnerable person who is unable to defend herself could experience fear and anxiety, when the facility failed to protect her from being sexually assaulted by V16. Findings include: On 10/15/19 at 9:25AM, R1 noted up in a wheelchair in front of nursing station. She is well groomed, clean and neat. She is alert x1 (oriented to person), no verbal response, making eye contact, and smiling and giggling. On 10/15/19 at 10:02AM, V1 (Administrator) and V2 (Director of Nursing - DON) stated they reported sexual abuse allegation of R1 to the state agency on 7/12/19. V1 stated V7 (Registered Nurse) saw V16 (Housekeeping aide) in R1's room with his hand inside her brief when she was passing her evening medications. V7 informed V2 who is still in the building at that time and reported the abuse. V2 called V1 and was advised to remove V16 from the floor. V2 instructed V7 to do head to toe assessment of R1. V16 stayed in his car until police officer arrived. V1 and corporate manager came to the facility. Police were called and abuse report filed. V7 notified R1's family and physician. R1 was sent out to the hospital for evaluation as ordered by physician. The family requested to be with R1 when transferring to the hospital. R1 came back with family the following morning. R1 was transferred to room closer to nursing station. No male staff assigned to work with R1. V16 was suspended pending investigation and eventually	S9999		

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S9999	Continued From page 2	S9999		

was terminated. V1 stated he did not communicate with V16 after he was terminated.

On 10/15/19 at 10:52AM, V7 (Registered Nurse) stated on 7/12/19 she worked double shift 7-3 and 3-11 shift. She was passing her evening medication near 8:00PM when she observed V16 (Housekeeping aide) standing next to R1's bed with his hand inside R1's disposable brief. V7 stated before she could speak to V16, he was defensively explaining he was only picking up a diaper inside the trash bin and immediately left the room before she could ask him more questions. V7 called another nurse to watch R1 while she reported the incident to the V2 (DON) who was still in the facility. V2 called V1 (Administrator) to report the incident. Police were called. Head to toe assessment was done of R1. Family and Physician was notified. R1 was sent out to the hospital for evaluation.

On 10/16/19 at 1:42PM V16 (Housekeeping aide) refused to be interviewed and stated he is not allowed to talk to anyone about the case.

On 10/17/19 at 3:11PM, V31 (Police Detective) stated she followed up with V30's (Police Officer) initial report on 7/12/19. The State's attorney gave the approval for release of warrant for arrest and the case was filed for aggravated criminal sexual abuse against V16 (Housekeeping aide). V16 was arrested on 7/26/19.

R1's incident report dated 7/12/19 documented by V7 (RN) indicated during evening rounds, V7 went inside R1's room to give medication. V7 noted V16 (Housekeeping aide) touching R1 inappropriately in her private area. Immediately separated staff from resident. Head to toe assessment performed with no visible injury, no

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trauma and denies any pain or discomfort. Informed V2 DON and V1(Administrator), with pending investigation. Facility protocol followed. Physician informed by DON with orders to send to hospital ER for evaluation. POAs (Power(s) of attorney) were both notified by DON and had been aware of transfer. Ambulance called for transfer.

Hospital record dated 7/12/19 to 7/13/19 reads R1 is 34 year old female with history of Multiple Sclerosis, anxiety and depression who presents to emergency room with chief complaint of sexual assault. R1 is here with mom and aunt, POA, who is and for concern of sexual assault. R1 lives at a nursing home due to her MS and per nurses at the nursing home she saw a male employee inappropriately touching R1. Male employee is immediately removed from the room and was reported, and family immediately brought the patient here. Per R1, she is unsure exactly of the events that happened however family wants to make sure there is no trauma to the genitalia area or bruising to the body. R1 herself has waxing and waning memory and cannot always recall events accurately, cannot remember the exact event that is in question. Laboratory test for Hepatitis B, HIV and Hepatitis C were sent off. At this time R1's mom and aunt are making medical decisions for R1. R1 is on a good amount of medication for MS. They do not want HIV prophylaxis or gonorrhea chlamydia treatment at this time. They are aware these are options. Evidence kit was collected. R1 does have a Urinary Tract Infection (UTI). Bactrim will be given. Physical exam indicated: Genito urinary: Vaginal discharge found. Whitish vaginal discharge. No lesion to the vaginal walls or the cervix. R1 has small vaginal wall polyps. No active bleeding in the vagina. Labia minora and

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majora without signs of bruising, bleeding, tears or lesions. Laboratory data 7/12/19: Urinalysis (UA) results: Bacteria - Many; Pregnancy Test-Negative.

Emergency Room diagnosis: UTI without hematuria and Sexual Assault of adult.

R1's sexual abuse initial report on 7/12/19 indicated Nurse on duty reported to the administrator she witnessed V16 (Housekeeping aide) with his hands inside R1's brief. V16 was suspended pending investigation notified. Police notified, POA (Power of Attorney) and Physician notified. Investigation initiated. Final report to follow.

R1's sexual abuse final report on 7/17/19 at 4:20PM indicated an investigation was initiated. V7 (RN) nurse on duty was going to pass medications in R1's room when she saw the housekeeper with his hand inside R1's brief. R1 was sent to the hospital for evaluation and returned with treatment for a UTI (Urinary Tract Infection). Other residents were interviewed that have their room regularly cleaned by V16 and no residents voiced any concerns with V16. Staff were interviewed, and no staff members voiced concerns about V16. V16 is no longer employed at the facility.

R1's safety/abuse assessment dated 2/4/18, 10/4/18, 5/13/19 and 7/12/19 indicated R1 is at risk for abuse.

R1's care plan indicated she is at risk for abuse related to diagnosis of severe mental illness and/or dementia and has an episode of verbal aggression/threats towards others. R1 is confused and forgetful at times, may use foul

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S9999	Continued From page 5 language and may have tangential thinking and may have looseness of thought during conversation as related to bipolar disorder and pseudobulbar effect. Facility's Abuse Policy dated 6/2019 indicated: The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. The facility will report reasonable suspicion of crime. This facility therefore prohibits mistreatment, neglect or abuse of its residents and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment neglect or abuse of our residents. Definitions: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. Sexual abuse is non-consensual sexual contact of any type with a resident. This includes, but not limited to sexual harassment, sexual coercion or sexual assault. (A)	S9999		