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	IL6001895	A. BUILDING: _____ B. WING _____	C 09/23/2022

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S 000	Initial Comments Complaint: 2287568/IL151449	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.690a)b)c) 300.1210b) 300.3210t) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. 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 300.695, 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These Regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed protect the resident's (R7) right to be free from sexual abuse reviewed for abuse. R7 was grabbed by R1 in the crotch area, and R1 went to R7's room while R7 was undressing. The facility also failed to ensure 1 resident (R1) was provided interventions to	S9999		

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prevent recurrence of sexually inappropriate behavior. These failures resulted in R7 feeling violated per the reasonable person concept.

Findings include:

Facility's abuse policy dated 3/2022 in part reads: The facility affirms the right of our residents to be free from verbal, physical, sexual, mental abuse, neglect, exploitation, misappropriation of property, involuntary seclusion, or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. The purpose of this policy is to assure that facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. This will be done by: Establishing an environment that promotes resident sensitivity, resident security and prevention. Identifying occurrences and patters of potential mistreatment. Implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences. Filing accurate and timely investigative reports.

R1 is 40 years old with medical diagnosis of Schizophrenia, Manic episodes and Psychoactive Substance Dependence. R1 was initially admitted on 5/7/2013. R1's brief interview for mental status dated 9/2/2022 scored 15 which means that R1's cognition was intact. R1's functional status on the same assessment documents that he needs minimal supervision in all categories except for personal hygiene where he needs assistance.

R7 is 31 years old with medical diagnosis of

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Schizoaffective Disorder, Bipolar Type and Schizophrenia. R7 was initially admitted on 6/22/2022 and transferred to hospital on 6/24/2022. No brief interview for mental status was available for R7.
(R7 was not at the facility during investigation)

On 9/21/2022 at 10:25 AM, R1 was first seen in the dining room and agreed to go to his room. R1 can independently ambulate, was alert and able to express his thoughts. R1 seemed withdrawn during the interview. R1 denied having recollection about when he was transferred to the hospital, also denied remembering going into another residents' room or acting inappropriately with female residents. R1 said, " I don't remember going to the hospital or going inside another resident's room. I don't need those girls. It maybe another resident that did those things." When R1 was asked what he meant when he said, " those things." R1 did not respond. R1 was seen earlier on the 1st floor in different areas without supervision. Random residents on the 5th floor, R5 and R6 were also reviewed. At 10:50 AM, V2 (Licensed Practical Nurse) said, " V6 (Psychiatrist Rehabilitation Service Director) called her from the 2nd Floor, and told her that R1 was sexually inappropriate with staff and female peers. V2 said, " 2nd floor has lots of female residents compared to the 5th floor, and R1 was also seen on the bed with another resident. V6 did not inform me (V2) about the name and room number of the resident that R1 was being inappropriate with. R1 was redirected to the 5th floor then became aggressive. R1 was sent to the hospital after doctor ordered to transfer R1. The incident happened around 10:30 AM to 11:30 AM. V7 (Psychiatrist Rehabilitation Service Counselor) who spoke to me about the incident after R1 was sent to the hospital." At

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11:00 AM. V6 (Psychiatrist Rehabilitation Service Director) was informed that per V2's statement, she (V6) called her (V2) that R1 was on the 2nd Floor and was sexually inappropriate. V6 replied, " I am not sure about V2's statement. I don't know that he (R1) went into another resident's room. I was not aware that there was an issue that R1 was sexually inappropriate with another resident. I was with a new orientee (V10). I can't remember what R1 told or didn't tell me at that time. V5 (Psychiatrist Rehabilitation Service Counselor) is assigned to R1. I don't remember him (R1) going inside any resident's room in the past. I think I remember that R1 went to R2's toilet to urinate. He (R1) insisted in going to the toilet, but he did not go into R2's bed. He only used the toilet, and nobody was there. As far as I know, R1 does not have any problem with sexually inappropriate behaviors in the past. He (R1) has behavioral issues, but it was not sexual. At 11:30 AM. V5 (Psychiatrist Rehabilitation Service Counselor) said that she was assigned to R1, and said that she knew about R1's behavioral problems but not of sexual inappropriate behavior. V5 admitted that she was not aware that there was documentation that R1 was sexually inappropriate with staff or female peers. At 11:40 AM. V7 (Psychiatrist Rehabilitation Service Counselor) said, " I did not know because I am not R1's social worker. What I heard that R1 went into another resident's room. That is all I can say." V7 did not name the person who told her about R1 going inside another resident's room. " At 12:02 PM. V1 (Administrator) said, "I was not informed about R1 having sexually inappropriate behaviors here in the facility. We had a meeting, and nobody told me that R1 had sexually inappropriate behaviors. I just learned that R1 had sexually inappropriate behavior while at the hospital. That was the reason that I sent a initial report on 9/16/2022

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when I learned from the hospital. I did not know that there was a note about R1's sexually inappropriate behavior. If I would have known I would have reported and investigated the allegation on 9/8/2022. Yes, I agree staff should have reported to me that there was an issue of R1 being sexually inappropriate to staff or peers. Because they did not inform me it was reported late. The focus of my investigation was R1's behavior in the hospital because I thought I had nothing to work on with his behavior here in the facility. "

Facility Reported Incident dated 9/16/2022 documents the following:
In re: R1 perpetrator / victim unknown
It was reported to the Administrator (V1) by the hospital that resident (R1) was physically inappropriate towards others while in their care.

On 9/21/2022 at 12:30 PM. Random residents on the 2nd floor was reviewed including R2, R4 and R5 on the 2nd Floor. At 1:32 PM. V6 (Psychiatrist Rehabilitation Service Director) said that the allegation of R1's sexually inappropriate behavior should have been investigated and reported to V1 being the Administrator and Abuse Coordinator. But it may have been a misunderstanding or miscommunication with V2 (Licensed Practical Nurse). To address the problem, she (V6) made a care plan addressing sexually inappropriate behavior of R1. Upon review of R1's care plan it was documented that a focus problem of R1's sexually inappropriate behavior was initiated 9/8/2022. V6 was asked why she recognized R1 has a problem related to sexual inappropriate behavior on 9/8/2022, but now she is saying that it was a misunderstanding or miscommunication with V2. V6 said, "I just put it there to make it uniform as to R1's other behavioral concerns." V6

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was then asked that since it was initiated on 9/8/2022 did it mean that sexually inappropriate behavior was already an identified problem since 9/8/2022. V6 said, " Yes." Upon further review, it was seen on R1's clinical record that the care plan for sexually inappropriate behavior was entered by V6 on 9/21/2022 which is the day of interview. V6 then said, "I did not know that you would dig deeper into the care plan. I admit I just entered it today. R1 did not have care plan to address sexually inappropriate behaviors until today." At 4:44 PM. V10 (Psychiatrist Rehabilitation Service Director) was called and left a message but no return call was received.

R1's care plan history documents that a care plan for sexually inappropriate behavior has created date of 9/21/2022 although the date initiated was back dated to 9/8/2022 and entered by V6.

On 9/22/2022 at 9:53 AM, with V1 (Administrator) and V3 (Regional Director of Nursing / Director of Nursing), V1 (Administrator) stated that, "All allegations of sexual abuse should have been investigated. My staff should inform me if things like sexually inappropriate behaviors happen. I don't have any updates on the investigation of R1 dated 9/8/2022. I understand where you are coming from, but you and I know that the hospital said that R1 was entering another resident's room in the hospital. If I only knew about R1's sexual inappropriate behaviors I would have investigated it. I didn't know about other sexually inappropriate behaviors R1 has had in the past. " V1 was asked why she was investigating an incident that happened in the hospital instead of in her facility. V1 said, " What can I say my focus was at the hospital. " V1 was requested to present R1's progress notes dated 6/22/2022. V1 came back and said, " I was mistaken, there was an incident

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dated 6/22/2022, regarding R1 being sexually inappropriate with R7 but it was fully investigated. "

Facility Reported Incident dated 6/22/2022 documents the following:
In re: R7 victim and R1 Perpetrator
Administration was notified that a resident stated another resident touched her inappropriate(sic) on the evening of 6/22/2022. Per R7 attached signed document it reads: I (R7) was walking down the stairs and he (R1) grabbed my crotch. R1 walked into my room while I (R7) was naked. R1's attached signed document reads: I (R1) got out of the elevator, and went down the hallway and I (R1) opened the door. I (R1) saw a girl undressing. I just closed the door. The door was cracked and not closed all the way. V13 (Nurse) notes and signed document reads: During medication pass, R7 walked up to her (V13) to complain of a co-peer (R1) touching her inappropriately. R7 stated that the incident happened in the staircase of 2nd floor close to the hallway. V13 (Psychiatrist Rehabilitation Service Counselor) in her progress dated 6/22/2022 documents that R7 informed her that R1 touched her inappropriately while in the staircase. V11 Both R8 and R9 said that R1 goes inside their rooms.

On 9/22/2022 at 11:15 AM. V3 (Regional Director of Nursing/Director of Nursing) said, " R1 was living on the 5th Floor but he goes to the 2nd floor because social service office is on the 2nd floor. I cannot answer why R1 went into another's resident room while a resident was undressing. But if you ask me, if someone touched me in my private parts without my consent I would slap the h#*l out of him! I would be angry and violated! I cannot justify those actions. " At 11:35 AM, V6

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was asked again if there was prior incident involving R1 having sexually inappropriate behaviors. V6 said, " No, besides the incident dated 9/8/2022. R1 does not have any incident of sexually inappropriate behaviors. V6 was informed about the documented incident dated 6/22/2022 between R1 and R7. (V6) documented in the progress notes about R1's sexually inappropriate behavior. V6 then said, " Oh yes, but that incident was reported and investigated. " V6 documented on the progress notes dated 6/24/2022 for R1 that reads: R1 has had a behavioral incident. Behavior exhibited were yelling/screaming, delusions, sexually inappropriate. V6 further stated, " Of course, if someone would touch me inappropriately I would feel mad the same way as if someone watched me undressing or naked without my consent. I would feel that person invaded my privacy. " V6 after multiple requests presented R1's Petition for Involuntary/Judicial Admission which documents: R1 has a diagnosis of Schizophrenia, and other Manic episodes, which affects his behavior as evidenced by him (R1), being verbally and attempting to be physically aggressive towards staff. R1 displayed some socially inappropriate behavior towards co-peers by going to the female rooms and sleeping on their beds for sexual purposes. R1 continues to exhibit belligerent behaviors, becoming increasingly aggressive and not receptive to redirections which put him at risk to himself and others. An immediate hospitalization is ordered by the psych physician for evaluation. Signed by V2 and witnessed by V6. V6 was asked again if there was direct physical act that R1 did on 9/8/2022 that would be considered as sexual towards his female peers, V6 again denies having knowledge. At 12:07 PM V1 (Administrator) was asked for an update on the investigation of the incident dated 9/8/2022.

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V1 reiterated that her focus on the incident dated 9/8/2022 was on R1's behavior while he was in the hospital not for the allegation of sexual inappropriate behavior in the facility. Per V1, as a result, there is no update on investigation. V1 was then asked about the incident that happened on 6/22/2022. V1 stated that she was focused on investigating what happened on the staircase that she failed to investigate R1's signed document of him (R1) watching a female resident undressing. V1 further stated that she cannot say what R7 felt during the incident that happened on 6/22/2022. Asked V1 if it happens to a female person who has no mental illness would that person will feel angry and violated, V1 said, " I cannot really say what R7 felt but if you are asking me what would I feel if another person touches me without my consent or watching me undress or naked without my consent. Of course, I would be angry. Yes, also violated. "

On 9/23/2022 at 10:25 AM, V13 (Registered Nurse) said, " Yes, I was the nurse on the 2nd floor when the incident between R1 and R7 happened. R7 told me that R1 touched her butt, buttocks when she was on the staircase. R1 was there on the staircase when I went to find him. I informed V11 (PRSC) about what happened. That was during initial admission of R7, she insisted to take a smoke. So, she (R7) used the staircase. R1 then went to the 2nd floor and was redirected. I told R1 that this is her (R7's) floor not his (R1's) floor. I knew both R1 and R7 has diagnosis of mental illness. But if it happened to me, I will really feel bad. Yes, a male resident touching a female resident on the buttocks is sexual abuse. That is why, I reported it right away to V1 (Administrator/Abuse Coordinator). No man has the right to do that to a woman. That's not right. V11 had to redirect R1 to go back to the 5th floor.

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S9999	Continued From page 10 If R1 tells you that he does not go to the 2nd floor that is not true. R1 does that, sometimes. It is hard to get information from him (R1). " At 10:51 AM. V11 (Psychiatrist Rehabilitation Service Counselor) said, " After V13 informed me, I went to see R1. I asked him (R1) what happened. And he (R1) told me, I just touched the resident. R1 was referring to R7. " I stayed with R1 and V13 stayed with R7. Yes, if someone will touch me inappropriately, I will feel bad and would and to stop. " (B)	S9999		