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MULBERRY MANOR	612 EAST DAVIE STREET, BOX 88 ANNA, IL 62906

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Z 000	COMMENTS Complaint Investigations: #2356217/IL162512 #2356242/IL162545 #2356269/IL162577	Z 000		
Z9999	FINDINGS Statement of Licensure Violations 350.620a) 350.3240b) 350.3240c) 350.3240d) 350.3240f) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.3240 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident prohibited by Section 2-107 of the Act shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident prohibited by Section 2-107 of the Act shall immediately report the matter by telephone and in writing to the resident's representative, and to the Department. (Section 3-610(a) of the Act)	Z9999		

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Z9999	Continued From page 1 d) Any person may report a violation of Section 2-107 of the Act to the Department. (Section 3-610(a) of the Act) 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. (Section 3-612 of the Act) These regulations were not met as evidenced by: Based on observation, record review and interview, the facility failed to prevent sexual abuse, and to thoroughly investigate an allegation of sexual abuse occurring on two separate occasions for one of one individuals in the sample of three, (R1). The facility also failed to the facility failed to implement their policies regarding abuse for one of one individuals in the sample of three, (R1), potentially affecting 15 other individuals outside the sample residing at the facility. (R6-R20). Findings include: The facility's policy regarding resident-to-resident investigations revised 6-23-2009, documents sexual misconduct is defined as, "Any intentional or knowingly touching or fondling by one person, either directly or through clothing of the sex organs or anus of the other person for the purpose of sexual gratification or arousal of either person." The policy defines sexual abuse as, "Any contact, however slight, between the sex	Z9999		

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Z9999	Continued From page 2 organ of one person and the sex organ, mouth, or anus of another person, or any intrusion, however slight, or any part of one person or of any animal or object into sex organ or anus of another person, including but not limited to cunnilingus, fellatio, or anal penetration." The abuse and neglect policy, revised 11-1-21 documents, "It is the policy of this facility to provide a safe environment for the individuals served that is free from abuse, neglect, and exploitation" and further documents, "The facility will provide evidence that all alleged violations are thoroughly investigated and will prevent further potential abuse while the investigation is in process. If the alleged violation is verified, appropriate corrective action will be taken. When an investigation of a report of suspected abuse of a consumer indicates, based upon credible evidence, that another consumer of the facility is the perpetrator of the abuse, that consumer's condition will be immediately evaluated to determine that most suitable therapy and placement for the consumer, considering the safety of that consumer as well as the safety of other consumers and employees of the facility." The resident-to-resident investigations policy revised 6-23-2009, regarding sexual abuse and misconduct documents, "During the initial investigation, charge personnel will review the resident sexual assessment to ensure the client was capable of understanding choices and ability to consent." Resident roster dated 7-3-23, identifies the following female residents: R7, R13, R14, R16, R17, R18 as functioning in the Mild Range of Intellectual Disabilities. R11, R15, R19, R20 as functioning in the Moderate Range of Intellectual	Z9999		

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Disabilities. R6 and R10 as functioning in the Severe Range of Intellectual Disabilities. R8, R9 and R12 as functioning in the Profound Range of Intellectual Disabilities.

Physician assessment dated 7-24-23, documents R1 functions in the Mild Range of Intellectual Disabilities with additional diagnoses of Prader-Willi syndrome.

R2's ISP (Individual Service Plan) dated 12-27-22, identifies R2 as functioning in the Mild Range of Intellectual Disabilities with additional diagnoses of ADHD (Attention Deficit Hyperactivity Disorder) and Autism.

R1's admission information packet dated 6-14-23, identifies R1 as requiring 24 hour supervision in a safe setting and as being easily influenced and vulnerable in relationships.

Interview with E8/LPN (Licensed Practical Nurse) on 8-15-23 at 1:00 PM, E8 states R1's guardians (Z1 and Z10) came to pick up R1 at around 2:00-3:00 PM on 7-29-23 and went shopping. E8 states R1's guardians never returned R1 to the facility that day.

Progress note entry by E19/LPN dated 7-29-23 at 9:39 PM, documents while still on an outing with family, R1 informed Z1 that she was inappropriately touched by another unknown client in the facility courtyard and behind the facility. Z1 contacted the facility by phone and notified E19 of the allegation. E19 then notified E1/Administrator and E3/DON (Director of Nursing) at 9:43 PM.

Interview with Z1/Guardian on 8-16-23 at (8:09 AM) and (6:04 PM), Z1 states she picked up R1

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for an outing on 7-29-23, when she was informed by an unknown staff that R1 said she had been touched inappropriately, but that R1 recanted. Z1 then took R1 to a local store where Z1 notified R1 what the unknown staff told to Z1. R1 then explained to Z1 that a fellow resident took her to an outside courtyard on 7-26-23 and behind the facility on 7-25-23 and put his "pee pee in her pee pee hole and it hurt." Z1 states R1 has been highly guarded her whole life living at home and has always been protected from the details about sex due to her maturity level. Z1 explains it was very alarming to hear R1 speak in this manner as she has never done so before. Z1 reports initially, R1 notified her of bleeding on Wednesday 7-26-23 and the facility had R1 get a pelvic ultrasound on 7-28-23. Z1 states she thought R1 may have had a UTI and reports she has never received the results of the pelvic ultrasound to this day. Z1 reports R1 stated R2 was only a friend and did not want R2 to do this to R1, but R2 persisted even though R1 told him not to. Z1 explains R1 was taken to an area hospital where a forensic exam was done and a rape kit test collected. Afterwards, Z1 states R1 was taken to the local police department where statements were obtained and a police escort provided to collect R1's belongings to permanently remove R1 from the facility. Z1 states R1 should have been under supervision due to R1's diagnosis of Prader-Willi syndrome. Z1 reports R1 stated an unknown staff allowed her to go outside knowing R1 wears an alert bracelet to prevent elopement on 7-25-23 and that's how the first incident occurred behind the facility. Z1 states while collecting R1's belongings on 7-30-23, E1 was present at the time and stated, "We hate to see (R1) go," but that not much else was said or asked by E1.

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Z9999	Continued From page 5 Emergency hospital note dated 7-29-23, verifies R1 received the diagnosis of sexual assault of an adult and includes, "Per (Z1), patient has been at the facility from three weeks, patient called (Z1) on Wednesday and reports that one of the residents at the facility 'stuck his pee pee in my upper butt or pee spot and then I started bleeding.'" The patient's history of assault: "Patient is unsure of time on 7-25, states that on 7-26 was before dinner. The location and/or physical surroundings of assault: "Residential facility, Tuesday was during a walk. Wednesday was behind a bench. Assailant name, (R2) who is a fellow resident at the facility." The note includes a forensic exam with a diagram to indicate a perforated hymen, erythema and tenderness to the labia. The patient's description of the event includes, "One of the people I live with at the facility, we were friends, but then twice, he thought it would be a fine idea to put his wee wee part in my pee pee hole. Twice. And I asked him to stop and he didn't. And then he also touched my boobs as well, but I told him not to, both times he did it where he couldn't be seen. Once he asked them if we could go for a walk because he knew a place where there weren't any cameras, and he did it there. And once he did it behind the bench. Both times he inserted it multiple times for a while and I kept asking him to stop and he wouldn't." R1 was asked how did R2 stop what he was doing to her. R1's response to this includes, "After a while I hit him with my foot and told him he was hurting me." R1 was asked if she was experiencing any symptoms, R1 replied, "My peepee hole burns and burns and diaper rash cream and petroleum jelly doesn't help it. There was just a little blood on Wednesday, but I can't have a period. The doctor said that I wouldn't." Police report dated 7-30-23, indicates at 1:44 AM,	Z9999		

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Z9999	Continued From page 6 Z2/Police Officer was instructed to contact an area hospital to speak with Z12/RN regarding a possible sexual assault and was informed R1 was at the hospital for a sexual assault exam and was asked to retrieve the physical evidence and recovery kit. At 6:35 AM, Z2 collected R1's recovery kit and physical evidence and met with R1 and Z1 to obtain statements at the local police station. R1 reported to Z2 she had been sexually assaulted by R2 at the facility on two separate occasions, 7-25-23 and 7-26-23. Z1 states a staff person asked her how she felt about R1 having a boyfriend and that R1 had been hanging around a boy, R2, in the common areas, but R1 reports she was only friends with R2 and Z1 refused R1 to have a boyfriend type of relationship with R2. Z1 reports while during an outing on 7-29-23, R1 informed Z1, "(R2) stuck his pee pee in my front butt and put it in and out." Z1 reports R1 was to never be left alone without staff present due to medical issues. R1 reported one incident occurred in a fenced in area when R2 followed her and once when they went walking on the facility grounds without a staff present. R1 was further questioned about the first incident to which R1 stated she asked R2 to stop, but that he didn't and stated he wanted to hurry up and get it over with so that they wouldn't be caught. R2 was again asked about the second incident and R1 stated R2 took her behind a bench because he knew cameras would not be able to see them. R1 states she told R2 she wanted him to stop, but R2 said in response, "I don't care." Z1 brought R1 to an area hospital emergency room to be examined and it was determined R1's statement was accurate. Z1 reports due to R1's maturity level, R1 had been protected from the details about sex. Z1 states she was going to withdraw R1 from the facility. Z2 and Z11/Police Officer accompanied Z1 to collect R1's personal effects.	Z9999		

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Prior to leaving, Z11 received a call from E1 who stated R1 had been very promiscuous towards R2 and reported R2 denied doing anything to R1 when questioned by staff. E1 reported R1 had been having issues with following rules at the facility since arriving.

Observation on 8-16-23 between 1:30-1:45 PM, during a tour of the facility grounds and in the presence of E4/QIDP (Qualified Intellectual Disabilities Professional), E4 identified the courtyard as being just off from a dining room in the facility. In the courtyard were numerous sitting areas, some including bench style seating. At the far end of the courtyard is an enclosed fence where a bench sat with the back of the bench facing the courtyard fence. The fence has a gated entryway leading to the north side of the facility grounds. E4 then opened the fenced gate entry and walked to the east side of the facility and identified this area as behind the facility. E4 confirmed there are no cameras in these locations.

Interview with R2 on 8-1-23 at 3:00 PM in the presence of E2/Executive Director, R2 defined sex as, "When a penis goes in a vagina." R2 states he thought R1 was his girlfriend until she started talking to one of his friends that lives in a different facility. R2 confirmed having sexual intercourse with R1, but that it was one time behind a bench in the courtyard and that she wanted to have sex. R2 states he knew R1 was okay with having sexual intercourse because R1 told R2 that if he tried to have sex with her, she wouldn't say no to him. R2 then states he placed his penis in R1's vagina and not long after this, R1 told him to stop and he immediately done so. R2 states they began talking about music afterwards. R2 denied telling R1 to not tell about

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the incident and states no staff or any other residents were present during the encounter with R1. During a tour of the outside furthest end of the courtyard where an enclosed fence was located, sat a bench. In the presence of E2, R2 pointed to the area between the fence and the bench and stated, "This is where we did it, behind this bench."

Interview with R1 on 8-16-23 at 6:04 PM, R1 states, R2 placed his "pee pee in my pee pee hole." R1 reports that it hurt, that she told him to stop, but he didn't and said he didn't care. R1 states she never said it was ok for him to do that. R1 states he did this on Tuesday and Wednesday. 7-25 and 7-26. R1 states the first time was behind the facility and the second time was behind a bench in the courtyard. R1 states she considered R2 just as a friend and did not tell R2 she wanted to have babies with him. R2 states she noticed bleeding after wiping herself with a tissue on 7-26-23 and notified Z1 and a nurse. R1 reports during both incidents, no staff or other clients were present. R1 confirmed she notified LPNs E8 and E18, E13/DSP (Direct Support Person) and E17/RN (Registered Nurse), but that they said they didn't believe her. R1 states she asked an unknown staff to walk outside because R1 knew she wore an alert bracelet and that the alert bracelet would make a noise if she tried to walk outside. R1 states the unknown staff let her and R2 take a walk outside where R2 led R1 behind the facility because R2 knew there were no cameras present and reports that is where the first incident occurred. R1 states having to kick R2 during both incidents and telling him stop before R2 had quit.

Interview with E18/LPN on 8-24-23 at 7:55 AM, E18 confirmed R1 wore an alert bracelet that

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notified facility staff if R1 attempted to walk outside. E18 states if R1 wanted to go outside, a staff would be with R1.

Interview on 8-1-23 at 1:15 PM, E2 confirmed no safety measures were currently in place to protect the remainder of the female residents residing at the facility due to R1 no longer being in the facility. In the same interview, E2 verified sexual assessments were not completed for either resident and to this date, a sexual assessment has not been completed for R2.

The investigation dated 8-3-23, includes facility cameras were reviewed back to 7-26-23, which revealed at 4:52 PM, R1 and R2 were seen walking out the door that leads to the courtyard and walking back into the facility from the courtyard multiple times. E1 and E2/Executive Director interviewed R2 on 7-30-23 at 11:15 AM who confirmed going into the courtyard with R1 during the time in question, but denied any inappropriate sexual touching. In the same interview, R2 admitted to having sexual intercourse with R1 behind a bench in the courtyard, but stated it was consensual. The report does not include evidence the allegation of inappropriate touching occurring behind the facility was investigated.

Interview with E2 on 8-16-23 at 1:00 PM, E2 was asked if the allegation of inappropriate touching that occurred behind the facility was investigated as reported by R1. E2 states he was under the impression that the courtyard and the reference to behind the facility were the same areas and did not clarify with E19 regarding his documented note from 7-29-23, where it lists two areas on facility grounds where R1 was allegedly inappropriately touched.

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