STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011753	A. BUILDING: _____ B. WING _____	07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING - WINDSOR PARK	110 WINDSOR PARK DRIVE CAROL STREAM, IL 60188

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S 000	Initial Comments Annual Health & Complaint Survey: 2375558/IL161723	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements were not met as evidenced by: Based on interview and record review the facility failed to protect residents from further abuse by allowing an alleged perpetrator of sexual abuse to continue to work and care for residents in the facility for at least four and a half hours after the allegation was reported to the administrator. This has the ability to affect all 52 residents in the facility. The findings include: The Resident Census and Conditions of Residents report dated July 11, 2023, shows the facility census was 52 residents. On July 10, 2023, at 11:46 AM, R263 said a male employee sexually abused her. R263 continued to say he got on top of her and had sex with her. On July 10, 2023, at 12:12 PM, V8 (R263's Family) said R263 has a hard time talking about the sexual abuse. V8 continued to say R263 can be confused at times, but on July 6, 2023, when R263 was telling V8 about V3 sexually abusing her, R263 was lucid. On July 10, 2023, at 4:40 PM, V4 (Speech	S9999		

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S9999	Continued From page 2 Therapist) said during her therapy session with R263, R263 reported to V4 a male CNA sexually abused her. V4 continued to say V4 reported R263's sexual abuse allegation to V5 (Director of Rehab) immediately after her speech therapy session with R263, and they reported to V1 (Administrator). V4 said since R263 was first admitted to the facility she has been able to communicate better and has been more alert. On July 11, 2023, at 10:50 AM, V1 said on July 6, 2023, between 10:30 AM and 11:00 AM, V5 notified V1 of R263's sexual abuse allegation regarding V3. V1 continued to say V4 told V1, during R263's speech therapy session, R263 pointed to V3 walking in the hallway and R263 said he is dangerous, he will sexually assault you. V1 said R263 told V4 she had been sexually assaulted by V3. V1 said she went to speak with R263, but she was sleeping. V1 continued to say V3 is the only CNA who fits R263's description, he is the only male CNA. V1 said on July 6, 2023, after R263's allegation was reported to her, V3 told V1 he was not currently providing care to R263 but had been providing care earlier in the morning and the previous day. V1 said she told V3 to make sure he does not see R263 anymore today and if there is an emergency in R263's room, to make sure he is not in her room alone. V1 said R263's nurse performed a head-to-toe assessment and did not see anything on R263's external genitalia. V1 continued to say R263's physician was notified of R263's allegation and the facility's nurse practitioner was asked to examine R263, but the nurse practitioner was no longer in the facility on July 6, 2023. V1 said the nurse practitioner assessed R263 on July 7, 2023, and the nurse practitioner reported R263 told her the CNA put his fingers inside her vagina.	S9999		

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S9999	Continued From page 3 V3's timecard showed on July 6, 2023, V3 started his shift on July 6, 2023, at 6:43 AM and clocked out on July 6, 2023, at 3:38 PM. On July 11, 2023, at 3:25 PM, V1 said she did not suspend V3 immediately because she was waiting to interview R263. V1 continued to say she also did not immediately suspend V3 because V1 spoke with V7 (R263's Family) and V7 told V1 he did not have a problem with V3, he just didn't want V3 providing incontinence care to R263. V1 continued to say V7 called back later in the day and reported to V1 that V3 inserted his fist into R263's vagina, and V1 then suspended V3 at 3:38 PM. V1 said she also did not suspend V3 because the head-to-toe assessment completed on R263 did not show any external trauma. On July 13, 2023, at 11:11 AM, V2 (DON) said she was working on July 6, 2023, and V3 continued to provide care to residents after R263 made the sexual abuse allegation against V3. On July 13, 2023, at 10:02 AM, V14 (RN) said she worked on July 6, 2023, with V3 and was caring for some of the residents in R263's hallway. V14 continued to say V3 provided care to residents until he went home on July 6, 2023. V14 said V3 also assisted residents in the dining room during lunch on July 6, 2023. V14 continued to say in the afternoon on July 6, 2023, she saw V3 sitting in a chair in the hallway across from R263's room. V14 said she was unaware of R263's allegation against V3 until V2 told us V3 was getting sent home, then the staff knew something was going on. A progress note dated July 6, 2023, at 8:46 PM, by V15 (RN/Registered Nurse) showed,	S9999		

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S9999	Continued From page 4 "...Approximately 3:45 PM, thorough body check done, nothing unusual, with old bruises on both arms, left posterior hand and abdomen with various stages of healing; excoriation on peri area and buttocks ..." A progress note dated July 7, 2023, at 3:09 PM, by V6 (Nurse Practitioner) showed on July 7, 2023, the DON requested V6 to see R263 due to R263's sexual abuse allegation. The documentation continued to show V6 only assessed R263's external genitalia, and R263 was oriented times two to three. Facility documentation showed on July 6, 2023, at 5:19 PM, V19 (Regional Human Resources Director) interviewed V3 and V3 stated "That morning, after feeding her, she said 'Don't touch me. Someone else has to change me.' She didn't want me to change her. I did what the nurse said. I called my coworker like the nurse told me. I was beside my coworker when she was doing it." Facility documentation showed on July 7, 2023, at 10:00 AM, V19 interviewed V15 (RN) and V15 said, "I remember in the morning I was doing medication pass because my cart was [adjacent to R263's room] and [V3] was in [R263's room] and he told me 'Can you talk to the resident?' So I went in there and asked the resident, 'What's going on?' [R263] said, 'I don't want him.' I asked, 'Why?' [R263] said, 'I don't want him.' I say to her, 'Let me get another care giver because I'm passing medication.' [R263] said, 'No I want you to clean me.' I said, 'Ma'am I can't do that right now, but I can get another CNA to do that; I can get [V20 (CNA)].' And so I went out and I don't know if I was holding something and I went to the cart and [V20] came out. I told [V3]	S9999		

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S9999	Continued From page 5 also before I left the room that [R263] will exchange to [V20]. So I told [V20] that [V3] will have an exchange resident with you because [R263] doesn't want [V3]. Later on, I was in [R263's room] now when [V1] approached and said 'We have an allegation of abuse. For the meantime, don't have [V3] handle [R263].' I said, 'Ok.' She mentioned two persons should go in there all the time. So I told that to [V20] and I told to [V3]." The EMR (Electronic Medical Record) showed R1 was admitted to the facility on June 23, 2023, with multiple diagnoses including nontraumatic subarachnoid hemorrhage, aphasia, dysphagia, and diabetes. R1's MDS (Minimum Data Set) dated June 27, 2023, showed R1 had severe cognitive impairment. The MDS continued to show R1 required extensive assistance from facility staff for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. The facility's policy titled, "Abuse Prevention Program," dated October 15, 2022, showed, "Policy: The policy of [the facility] is zero tolerance of any form of abuse, neglect, or exploitation ... F. Investigation ... iii. Protect the resident or residents involved in a case of suspected abuse from potential additional harm during the investigation. If an employee is the alleged perpetrator, the administrator will take appropriate action, including suspending the employee pending investigation ..." (B)	S9999		