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S 000	Initial Comments Complaint Investigation 2475475/IL175472	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.690 c) 300.1210 b) 300.1210 c) 300.1210 d)3) 300.1220 b)3) 300.3210 t) 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 300.690 Incidents and Accidents 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	S9999		

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Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional 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.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the

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nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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 requirements are not met as evidenced by:

Based on interview and record review, the facility failed to reassess and update R1's capacity for sexual consent after a significant decline in her cognition; failed to timely report an incident of sexual abuse; failed to promptly conduct a thorough investigation of an incident of sexual abuse; and failed to update and revise a care plan after a resident's change in cognitive status and inability to consent to sexual activity. These failures resulted in the sexually inappropriate behavior between R1 and R2 in a public area. R1 is not able to consent to sexual activity due to her severe impairment in cognition and diagnosis of Dementia, and a reasonable person would not want to perform sexual acts without consent.

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This applies to 1 of 4 residents (R1) reviewed for sexual assault in the sample of 5.

The findings include:

Facility census report, dated July 9, 2024, showed R1, R2, R5-R9 resided on the secure behavioral unit.

R1's EMR (Electronic Medical Records) showed R1 was a 70-year-old female admitted to the facility on April 12, 2024, with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, Schizoaffective disorder, depressive type, need for assistance with personal care, mood disturbance, and anxiety, mixed obsessional thoughts and acts, and difficulty in walking, not elsewhere classified, other lack of coordination.

Social Service Assessment for Capacity for Sexual Consent, dated April 23, 2024, included R1 has capacity to consent to sexual relationship as she is able to describe what consent looks like, and states is able to spend time with anyone she would like.

R1's quarterly MDS (Minimum Data Set), dated June 25, 2024, showed R1 was severely impaired in cognition.

R1's care plan, initiated April 23, 2024, included R1 is able to exercise the right to engage in a sexual/intimate relationship and has received counseling, as appropriate, regarding sexual practice and behavior, boundaries, respect for roommates, healthy relationships, and only

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engaging in this type of relationship with a consenting party.
Interventions for this focus area included to provide individual counseling regarding safe sexual practices including education regarding transmission of sexually transmitted diseases, contraceptives, privacy issues, respect for one's roommates and respect for one's partner.

R1's care plan, revised July 10, 2024, included R1 is unable to exercise the right to engage in a sexual/intimate relationship, due to diagnosis of dementia and severe impaired cognitive function. No interventions were specified in the care plan for this focus area.

Facility Initial Reported Incident, dated July 11, 2024 at 10:49 AM, included as follows: Staff reported an interaction between R1 and R2 in the 3rd floor dining room on July 9, 2024 at approximately 7:00 PM. Staff intervened and separated both residents...Both residents stated that the interaction was consensual. Facility will conduct a thorough investigation.

Social Service Assessment for Capacity for Sexual Consent, dated July 10, 2024, included R1 is unable to consent due to diagnosis of Dementia and BIMS (Brief Interview of Mental Status) score of 5/15, indicating severely impaired cognition.

Nursing progress notes, dated July 9, 2024 at 6:45 PM, included R1's behavior noted at that shift was socially inappropriate, with R1 being sexually inappropriate with co-peer R2 in the dining room.

On July 11,2024 at 10:07 AM, R1 stated she got in trouble as a man pretended to be a cop and

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took her to the back of the room and wanted her to have oral sex on him, and he wanted to feel her in her private parts. R1 stated R2 had his pants down and so did she, and he wanted to have sex with her in the middle of the dining room. R1 stated she was wearing a Marilyn Monroe shirt, blue jeans, and a lacy pink bra. R1 stated R2 kept touching her private parts as she performed oral sex on him. R1 stated, "Two staff came in and said that I am in trouble. They were going to put me in jail as I did something obscene. I committed adultery. This man was married to some other black girl, and I cheated on his wife, and he got me involved in it. I consented to it, so unfortunately, it's my fault and I should go to jail." R1 continued to ramble about unrelated topics about a Rabbi and about diet cola and about the furniture in her room.

R2's EMR included R2 is a 29-year-old male, admitted to the facility on February 14, 2024, with diagnoses of Bipolar disorder, current episode depressed, severe, with psychotic features, attention-deficit hyperactivity disorder, unspecified type.

R2's quarterly MDS, dated May 17, 2024, showed R2 was moderately impaired in cognition.

Nurses progress notes, dated July 10, 2024, included R2 was seen by in house Psychiatric NP (Nurse Practitioner) related to sexually inappropriate behaviors and increased psychotic behaviors, and received new order for psychiatric hospitalization for psychiatric evaluation and treatment and R2 was discharged to affiliated hospital on the same day.

Social Worker Biopsychosocial Assessment dated March 15, 2024 included that R2 has

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pressured speech flight of ideas loose associations, mood disturbance, interpersonal relationship issues and sporadic bouts of depression and mania.

Residents (R5-R9) in the same unit were also interviewed on the above incident.

On July 11, 2024 at 11:00 AM, R5 stated she was in the dining room and saw R1 and R2 in the corner "Doing something they should not be doing in front of people. He (R2) had his zipper undone and he put it (his penis) in her (R1's) mouth and she was laughing. I was sitting right next to what happened. It was after dinner and two other residents were in the dining room. I notified the staff and told them about it." R5 identified one of the two witnesses as R6 and R7. R5 added no other staff including from Administration has talked to her about this incident after she reported it.

On July 11, 2024 at 12:19 PM, V5 (PRSC/Psychiatric Rehabilitation Social Service Coordinator) stated she started in May, 2024, and she did the (quarterly) assessment for R1 on June 25, 2024, and scored R1's BIMS (Brief Interview for Mental Status) score for cognitive status as 5/15, which shows R1 has severe cognitive impairment. V5 stated R1's initial Capacity for Sexual Consent was done by the previous Social Service coordinator, who is no longer at the facility. V5 stated the Capacity for Sexual Consent is updated when there is a change in cognitive status for the residents, or when the residents enter into a new relationship

On July 11, 2024 at 12:52 PM, R6 stated he saw, "A black man and an old lady wearing glasses doing something embarrassing in the dining

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room. I did not tell anybody about it."

On July 11, 2024 at 10:32 AM, R7 stated prior (about half hour) to the above incident, R7 saw R2 leaning towards R1 inappropriately and talking to R1. R7 she went up to V7 (Behavioral aide) and told him she thought it wasn't appropriate for R2 to talk to an elderly woman, because she knew about R2's history. R7 stated V7 just left and V6 (Behavioral Aide) was in the dining room. R7 stated R5 told her at a later time she saw R2 pull out his penis and R1 performed oral sex on him, and there were no behavioral aides in the dining room as they had left. R7 stated later that night, V7 told her R1 has had a wild sexual history and she was "into it" and it was consensual. R7 stated she told V7 that she disagrees because R1 has Dementia and she cannot consent. R7 added R2 was behaving in a bizarre manner for three days in a row in the dining room prior to the incident of R1 and R2.

On July 11, 2024 at 12:44 AM, R8 stated she heard R5 talk to V7 about R2 talking inappropriately to R1 in the dining room right after dinner.

On July 11, 2024 at 10:44 AM, R9 stated, "[R2] had an incident with me a month ago and requested to use my bathroom and he went in there and later bragged to his friend that he was thinking of f***king me as he was jacking off." R9 stated she told the administration about it. R9 continued (R2) was living on the second floor before and doesn't understand why the facility moved him up to the 3rd floor.

On July 11, 2024 at 1:29 PM, V6 (Behavioral Aide) stated on July 9, 2024 after dinner time, he was at the nurses station and R5 came and told

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the staff R1 is doing a hand job on R2 in the dining room. V6 stated he saw R2's pants were unbuttoned, and R1's hands on R2, and he separated them. V6 stated he and V4 talked to them and made it clear what they did was not appropriate, as it was a public space. V6 stated both R1 and R2 stated it was consensual. V6 added, "I still think it was not okay. I don't think both of them are in the right mind. [R1] is one of our new patients. She could be mentally persuaded."

On July 11, 2024 at 3:20 PM, V4 (Registered Nurse) stated on July 9, 2024, R5 came up to the nurses station at around 6:45 PM after dinner and told the staff present R1 and R2 were being sexually inappropriate in the in the dining room. V4 stated she told the behavioral aides to check on them, and they separated them. V4 stated she assessed R1. V4 stated, "I asked [R1] if she was consenting and she said 'yes'. [R2] is hyper and has a behavior of grandiosity." V4 stated she reported it to V1 (Administrator), and he asked her if R1 was able to consent, and she told him that she wasn't sure. V4 stated she was concerned about the age gap of R1 and R2, as R1 is around 70 and R2 is 29 (years old). V4 stated she felt it was inappropriate to mingle with someone at a younger age.

On July 11, 2024 at 3:20 PM, V4 (Registered Nurse) stated on July 9, 2024, R5 came up to the nurses station at around 6:45 PM after dinner, and told the staff present that R1 and R2 were being sexually inappropriate in the in the dining room. V4 stated she told the behavioral aides to check on them, and they separated them. V4 stated she assessed R1. V4 stated she asked asked R1 if she was consenting and she said 'yes'.

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On July 11, 2024 at 1:29 PM, V6 (Behavioral Aide) stated on July 9, 2024 after dinner time, he was at the nurses station, and R5 came and told the staff R1 is doing a hand job on R2 in the dining room. V6 stated =he saw that R2's pants were unbuttoned, and R1's hands on R2 and he separated them. V6 stated he and V4 talked to them and made it clear that what they did was not appropriate as it was a public space. V6 stated both R1 and R2 stated it was consensual. V6 added, "I still think it was not okay. I don't think both of them are in the right mind. [R1] is one of our new patients. She could be mentally persuaded."

On July 11, 2024 at 1:46 PM and on July 16, at 12:33 PM, V3 (Social Service Director) stated the facility's assessment tool to determine a Capacity for Sexual Consent is done initially when a resident shows interest in having sexual activity with another resident. V3 stated R1 was liking a resident sometime in April and on April 23, 2024 an assessment for Capacity for Sexual Consent was done that showed R1 had the capacity to say no to uninvited sexual contact. V3 stated R1's BIMS on admission was 11/15, which showed that she was moderately impaired in cognition and able to give consent, as she knew that resident by name and room number.V3 also added having a high BIMS score does not necessarily mean they have good judgement.V3 stated on June 25, 2024, during R1's cognitive reassessment, R1's was found to have severe cognitive impairment, and therefore R1 would not be able to provide consent to sexual activity. V3 added when a resident is not able to give consent, then they are identified at risk for sexual abuse, and the care plan should be updated. V3 stated the EMR will prompt the care plan

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interventions on the focused area of whether they are or not able to give sexual consent which are resident specific.

On July 12, 2024 at 1:53 PM, V7 (Behavioral aide) stated he did see R2 taking to R1, who was seated at the next table in the dining room. V7 stated he believes R7 said something about the behavior being inappropriate, but he could not recall the conversation exactly.

On July 11, 2024 at 11:32 AM, V1, Administrator, stated V4 notified him on 7/9/24 at 6:59 PM, that there was a witnessed promiscuous act between R1 and R2 in the dining room, and R1 and R2 were separated. V1 stated he asked V4 if any goods had been transferred for coercion and if it was consensual, and V4 was not sure. V1 stated V4 told him R1 was laughing and there was no distress. V1 stated he reviewed the Social Service Assessment [dated April 23, 2023] in EMR and it showed R1 had the capacity to consent. V1 stated if the incident is consensual, then it is not reported to IDPH (Illinois Department of Public Health). V1 stated since the act was in a public setting, he sensed something was off, and a behavioral note was done, and R1 and R2 were placed on safety checks. V1 stated the facility consulted a Psychiatrist, and Social Service was to check for any emotional distress or foul play. V1 stated both R1 and R2 were assessed on July 10, 2024 by a Psychiatrist, and R2 was sent out to the hospital for Psychiatric evaluation, as he was off in his behavior. V1 stated R1 was initially assessed after admission to have ability to consent to sexual relationships. V1 stated the Psychiatrist was questioning R1's capacity to consent, as R1 has Dementia and it's progressing. V1 stated the Psychiatrist suggested

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to get her off the 3rd floor and to a memory care setting. V1 stated V3 re-did the assessment for Capacity for Sexual Consent (on July 10, 2024) and assessed R1 does not have the capacity to consent. V1 stated he called his consultant this morning, and was advised to submit an initial report to IDPH, which was done on July 11, 2024 at 10:00 AM.

On July 11, 2024 at 1:46 PM, on July 12, at 12:27 PM, and on July 16, at 12:33 PM, V3, Social Service Director, stated the facility's assessment tool to determine a Capacity for Sexual Consent is done initially when a resident shows interest in having sexual activity with another resident. V3 stated R1 was liking a resident sometime in April and on April 23, 2024 an assessment for Capacity for Sexual Consent was done that showed R1 had the capacity to say no to uninvited sexual contact. V3 stated R1's BIMS (Brief Interview for Mental Status) on admission was 11/15, which showed she was moderately impaired in cognition and able to give consent, as she knew that resident by name and room number. V3 also added, "Having a high BIMS score does not necessarily mean they have good judgement." V3 stated on June 25, 2024, during R1's cognitive reassessment, R1 was found to have severe cognitive impairment, and therefore R1 would not be able to provide consent to sexual activity. V3 added when a resident is not able to give consent ,then they are identified at risk for sexual abuse.

On July 12, 2024 at 12:00 PM, V1 gave additional information that he notified the police on July 11, 2024 and he and the police interviewed R1 prior to her discharge to another facility. V1 stated an investigation was not done prior to this on the above incident, as he was under the impression R1 had had a consensual relationship with R2

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based on the Social Service Assessment dated April 23, 2024.

On July 12, 2024 at 3:01 PM, V8 (Psychiatric Advanced Practice Nurse-ANP) stated R1 has Dementia, Schizophrenia, and Neurocognitive disorder, and was admitted to the 3rd floor (secure Behavioral unit). V8 stated she saw the facility video of the incident between R1 and R2, and it was evident R1 did not know what she was doing. V8 stated during consultation, R1 showed moderate to severe cognitive capacity as she was not able to recall the incident with R2, and did not seem to be upset or bothered as a reasonable person would. V8 stated R1 being able to give consent is questionable as she is unable to know and understand and can easily be taken advantage of. V8 stated R2 is a younger man who is hypersexual and thinks he is a "Casanova". V8 stated R2 has the capacity to make decisions, but was in a manic psychotic state, with erratic behavior with up and down cycles and was going in and out of resident's rooms.

Facility policy and procedure titled 'Abuse Prevention and Reporting' (effective date November 28, 2016) included as follows:
The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents.
This facility has the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001713	A. BUILDING: ___ B. WING ___	C 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE WEST CHICAGO	**201 WEST NORTH AVENUE WEST CHICAGO, IL 60185**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 residents. Sexual Abuse includes, but not limited to, sexual harassment, sexual coercion, or sexual assault (42 CFR 483.12 Interpretive Guidelines) including non-consensual or non-competent to consent sexual activity... Generally, sexual contact is nonconsensual if the resident either: Appears to want the contact to occur, but lacks the cognitive ability to consent, OR does not want the contact to occur. This will be done by: -Filing accurate and timely investigative reports. -Implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property, and mistreatment and making necessary changes to prevent future occurrences. Internal Investigation: Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation. Investigation Procedures: The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Residents to whom the accused has regularly provided care, the employees with whom the accused has regularly worked, will be interviewed to determine whether any one has witnessed any prior abuse, neglect, exploitation, mistreatment or misappropriation of resident property by the accused individual." External Reporting: When an allegation of abuse, exploitation, neglect, mistreatment or	S9999		

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misappropriation of resident property has occurred, the resident's representative and the Department of Public Health's regional office shall be informed by telephone or fax. Public Health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported and is being investigated.
Informing Local Law Enforcement: The facility shall also contact local law enforcement authorities (i.e., telephoning 911 where available) in the following situations:
-Sexual abuse of a resident by staff member, another resident, or visitor...
If there is reasonable suspicion that a crime has been committed that is not listed above and does not involve serious bodily injury, then a report to local law enforcement and department of Public Health as soon as possible but within 24 hours of when the suspicion was formed."

Facility Policy titled 'Sexuality-Capacity to Consent Determination' (effective date January 7, 2019)
Purpose: To establish criteria for determining the capacity to consent when resident to resident sexual activities occur.
Capacity and Consent: Residents have the right to engage in consensual sexual activity. However, anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility shall ensure the resident is evaluated for capacity to consent. Residents without the capacity to consent to sexual activity may not engage in sexual activity ...
Capacity may be defined as an individual's physical or mental ability relative to a specific task, e.g., executing a will, consenting to medical treatment, or sexual consent ....

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S9999	Continued From page 15 Capacity to consent to sexual activity are not required to be completed on all resident, but rather on an as needed basis when circumstances arise that warrant the assessment. Any resident previously assessed will be re-assessed with a change in level of cognition. Facility policy titled "Baseline Care Plan" (Effective November 28, 2012) included as follows: "Purpose: To develop a baseline care plan within 48 hours of admission to direct the care team while a comprehensive care plan is developed that incorporates the resident's goals, preferences, and services, that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being." (A)	S9999		