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S 000	Initial Comments Complaint Investigation 2425430/IL175416	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.690 b) 300.690 c) 300.1210 b) 300.1210 c) 300.3210 t) 300.3240 b) 300.3240 c) 300.3240 e) 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 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.	S9999		

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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 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.

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.

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S9999	Continued From page 2 Section 300.3240 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident 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 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) e) 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 requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to adequately supervise a resident (R1); failed to prevent resident-to-resident sexual and physical abuse; failed to to identify and report resident-to-resident suspected crimes and abuse immediately to the local law enforcement, the Administrator, the residents' representatives, and the State Agency; failed to thoroughly investigate all alleged violation of abuse; failed to prevent further abuse from occurring while the investigation was in progress; failed to implement measures to provide safety and supervision to prevent further abuse; and failed to submit a final report of the investigation report to the State Agency for six of six residents (R1, R2, R5, R6, R10, and R11)	S9999		

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reviewed for abuse in the sample of 50. These failures resulted in R1, a resident with a history of sexual aggression, sexually assaulting (R2, R5, and R11) on multiple occasions, R1 sexually groping a resident (R10), and R1 physically assaulting a resident (R6).

Findings include:

V1's (Administrator's) Employee Business File documents V1's hire date was 6-16-22.

R1's Physician's Order Sheet (POS), dated 6-16-24 through 7-15-24, documents R1 has the diagnoses of Sexual Aggression, Dementia with behavioral disturbances, Anxiety, and Major Depression Disorder. These same POS's document R1 receives Depakote 125 mg (milligrams) three times daily for the diagnosis of Dementia with behavioral disturbance and Finasteride five mg one tablet daily for the diagnoses of Sexual Aggression and Benign Prostatic Hyperplasia.

R1's Minimum Data Set (MDS) Assessment, dated 11-19-21, documents R1 is severely cognitively impaired.

R1's Care Plan, dated 7-8-24, documents, "(R1) has a history of sexual inappropriateness towards female peers. Resident, facility, and next of kin agree that (R1) is unable to consent to sexual relations at this time related to impaired cognition. Start: 3-2-22 (R1) to be one-on-one with staff at all times through duration of long-term care stay. Start: 7-8-24 (R1) placed in private room. (R1) has behaviors that other may find disruptive/socially inappropriate. (R1) likes to

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walk around the skilled nursing facility. (R1) will sometimes go into resident's rooms. Start: 5-6-20 15 minute close and constant supervision to monitor whereabouts and proximity to those easily upset by behaviors as needed. Start: 5-26-20 Move (R1) to secure unit."

R1's Behavior Tracking Records, dated 1-1-24 through 7-10-24, do not include tracking or behavioral interventions to address R1's sexual inappropriateness with peers.

R2's MDS (Minimum Data Set) Assessment, dated 5-1-24, documents R2 is severely cognitively impaired.

R2's Quality Committee Behavior Referral and Quality Care Reporting Form, dated 7-8-24, documents, "Date of occurrence: 7-5-24. Behavior: Another resident (R1) was masturbating (R2) in hallway."

R2's IDT Progress Notes, dated 7-8-24 at 9:00 AM, document, "(R2) touched inappropriately by peer (R1)."

R5's MDS Assessment, dated 4-14-24, documents R5 is severely cognitively impaired.

R6's MDS Assessment, dated 4-21-24, documents R6 is cognitively intact.

R10's MDS Assessment, dated 4-19-24, documents R10 is cognitively intact.

R11's MDS Assessment, dated 3-26-24, documents R11 was cognitively impaired. R11's Progress Notes document R11 passed away on 6-8-24.

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R1 and R2's IDPH (Illinois Department of Public Health) Facility Reported Incident Report, dated 7-9-24 at 12:37 PM, documents, "Incident Category: Resident Abuse. Incident Description, "On July 5th (2024) at approximately 5:30 PM, a nurse aide (V3) was alerted to check on (R2) because she heard grunting sounds coming from his room. Upon entering the room, (V3/Certified Nursing Assistant/CNA) saw (R1's) hand down the front of (R2's) brief. (V3) promptly separated both parties and called for the nurse (V4/Licensed Practical Nurse/LPN)."

R1's Staff Interviews, dated 7-8-24 regarding R1 and R2's Incident on 7-5-24, document V3 heard grunting sounds coming from R2's room, and upon entering saw R1's hands down the front of R2's brief.

R1's Social Service Progress Notes, dated 7-8-24 at 9:00 AM and signed by V13 (Social Service Director), document V13 did a follow-up visit with R1, and explained to R1 that we (residents) have to keep our hands to ourselves.

R1's Inter-Disciplinary Note, dated 7-8-24 at 9:00 AM, documents, "Quality Assurance team review of occurrence 7-5-24 (R1) inappropriately touching peer resident (R2). Increased Prozac and room move to private room with private bathroom. Continue 15-minute checks."

R2's Quality Committee Behavior Referral and Quality Care Reporting Form, dated 7-8-24, (three days after occurrence) documents, "Date of occurrence: 7-5-24. Behavior: Another resident (R1) was masturbating (R2) in hallway. Describe interventions used to manage behavior: Separated residents to their own rooms. 7-8-24 Summary of event and actions taken: Separate

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perpetrator to another hallway."

On 7-10-24 at 8:20 AM, V2 (Director of Nursing/DON) stated, "On Friday (7-5-24), I was at church and (V4/LPN/Licensed Practical Nurse) called and reported to me that (V3/CNA/Certified Nursing Assistant) found (R1) masturbating (R2). I called (V4) back and told him to put (R1) on 15-minute checks. On Monday we (facility staff) met and decided to move (R1) to another hallway in a private room. (R1) used the dining room for that hallway. Since (V1) had quit working here on Wednesday (7-3-24), I called (V7/Corporate Manager) and reported this to her. (V7) had me send an initial abuse report to IDPH on Friday, and then I sent the final report on Monday (7-8-24). I did not call the police or (R1 and R2's) family yet."

On 7-10-24 at 8:30 AM, V8 (CNA) stated, "I have worked here for one month. (R1) likes to masturbate with himself and likes to go into other resident rooms. (R1) ambulates on his own and can go anywhere throughout the facility, except for on the secured unit. (R1) knows what is going on and if he does not want to answer questions, he will just stare. (V1) used to be the Abuse Coordinator, but I was told he no longer works here. I do not know who the Abuse Coordinator is now.""

On 7-10-24 at 8:35 AM, R2 was sitting in a wheelchair watching television. R2 was confused to time and place and was unable to answer questions regarding the allegation of sexual abuse between him and R1 that occurred on 7-5-24.

On 7-10-24 at 9:10 AM, R7 was sitting in his room in a wheelchair. R7 stated, "(R6) told me

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(R1) tried to rape him."

On 7-10-24 at 9:15 AM, R6 stated, "About one to two weeks ago, (R1) came knocking on my bedroom door and came into my room. (R1) told me it was one of his relatives' birthdays and he wanted to celebrate with me. (R1) said to me 'You have really nice feet.' (R1) tried to grab my feet. I could tell by the look in (R1's) eyes that he wanted to do something sexual with me. (R1) tried to force himself on top of me and I felt like (R1) was trying to rape me. I started kicking (R1) and yelling for help. I yelled at (R1) to 'Get out!' (R1) closed the curtain and I do not know where he went. I jumped out of bed and took off running to the nurses' desk. I told (V14/Agency CNA) what happened, and he just laughed. I have been raped before when I was younger and do not want to be around (R1). (R1) was living on my hallway until this week. I still have to see him in the dining room. I try to ignore him. My right knee has hurt ever since I kicked (R1). I also told (V1) about this."

On 7-10-24 at 9:20 AM, R1 stated, "I have given sexual pleasure to three guys (R2, R5 and R11). I got caught j***ing (R2) off and they sent me to this room. (R2) enjoys it, and I do it whenever I get the urge. I have given (R2) sexual pleasure twice. I j****d (R11) off at least four to five times. (R11) has died now. I have j****d (R5) off twice. I do it in (R5's) room. I tried to give (R6) pleasure, but he wouldn't let me. They (R2, R5, and R11) could not do anything with my penis. They have tried, but my penis is too small. I was told I broke a rule and I cannot do it again. I have to try to keep myself busy with the radio and writing letters to keep my mind off of it."

On 7-10-24 at 9:20 AM through 9:40 AM, R1 was

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sitting in his room without staff supervision. During this time, R1 stated, "I have given sexual pleasure to three guys (R2, R5 and R11). I got caught j***ing (R2) off and they sent me to this room. (R2) enjoys it and I do it whenever I get the urge. I have given (R2) sexual pleasure twice. I j****d (R11) off at least four to five times. (R11) has died now. I have j****d (R5) off twice. I do it in (R5's) room. I tried to give (R6) pleasure, but he wouldn't let me. They (R2, R5, and R11) could not do anything with my penis. They have tried but my penis is too small. I was told I broke a rule, and I cannot do it again. I have to try to keep myself busy with the radio and writing letters to keep my mind off of it."

On 7-10-24 at 10:15 AM, R5 was sitting in a padded wheelchair in the dining room. R5 was confused to time and place and was unable to answer questions regarding any alleged sexual abuse that occurred between him and R1.

On 7-10-24 at 10:20 AM, V4 (Licensed Practical Nurse/LPN) stated, "I was working on 7-5-24. Around 5:45 PM that night, (V3) was yelling for me. (V3) was standing in front of (R2) in the hallway right outside of (R1's) room. (R2) was sitting in his wheelchair. (R1) was standing to the right side of (R2). (V3) told me she caught (R1) masturbating (R2). (R1) has never had one-on-one supervision of staff since I have been here. (R2) is confused and yells out. I was not sure who to call and report this to since (V1/Administrator) was not available. I called (V2/Director of Nursing) to report the incident. (V2) told me to put (R1) on 15-minute staff checks, but (R1) was already on 15-minute checks before. We just took (R1) and (R2) to their rooms for the night. (R1) walks independently throughout the facility. I was not

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told to do any further supervision of (R1). I did not work the weekend after that, so I do not know when (R1) got moved to another hallway. I do not know who the Administrator is. I did not contact the police or (R1 and R2's) family."

On 7-10-24 at 10:20 AM, V4 (LPN) stated, "I was working on 7-5-24. Around 5:45 PM that night, (V3) was yelling for me. (V3) was standing in front of (R2) in the hallway right outside of (R1's) room. (R2) was sitting in his wheelchair. (R1) was standing to the right side of (R2). (V3) told me she caught (R1) masturbating (R2). I called (V2/Director of Nursing) to report the incident. (R2) is confused and yells out."

On 7-10-24 at 10:25 AM, V3 (CNA) stated, "I have worked second shift at the facility for six years. On 7-5-24 after supper around 5:45 PM, I was coming up the hallway facing (R2). (R2) was in his wheelchair in the hallway outside of (R1's) room, and (R1) was bending over top of (R2). (R1) had his hand down the front of (R2's) pants and was stroking (R2's) penis up and down. I could see exactly what (R1) was doing to (R2). (R2) was sexually groaning. I screamed at (R1) 'No! Stop!" (R1) is alert enough to know what he is doing, and acts like he does not hear you when he is doing wrong. (R2) is confused. Around eight months or so ago, I walked into (R1's) room and caught (R1) sitting on his roommate's (R11's) bed with his hand on (R11's) penis. I saw (R1's) hand on (R11's) penis and (R11's) brief was off. (R11) did not say anything and cannot move out of bed without the staffs help. (R11) was very confused. I reported this incident to (V1/Administrator). One night about a week ago, (R6) came up to a few of us at the nurse's station and said (R1) tried to attack him. (R6) told me he had been sexually assaulted

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before and did not know whether to cry or scream. I told the nurse (R6) felt like he was going to be sexually assaulted by (R1). I do not remember what nurse I told. I do not know who the Abuse Coordinator is. Another day around a couple months ago, I found (R1) sitting beside (R5) in (R5's) bed. I reported this to the Social Service Director (V13). I feel sorry for (R5) if (R1) was masturbating (R5), as (R5) would not like it and was molested as a child. A week or two ago, (R10) was crying and I asked her why. (R10) said (R1) was rubbing her shoulders and kept rubbing lower and lower until (R1) started to rub her boobs. (R10) said she reported this to (V1). I know (V15) was aware of this incident also. (R1) has not had one-on-one staff supervision for over a year. I did not report any of these occurrences to the police. I thought that was management's job."

On 7-10-24 at 1:35 PM, R10 stated, "Last week, I was in the dining room downstairs sometime between lunch and supper. I was waiting on activities to start and was reading a book. (R1) came up behind me and started to rub my shoulders. I told (R1) to get off of me. (R1) started to rub harder and then started to rub my boobs on the outside of my shirt. I did not want him to do that. I feel like that is sexual abuse. I started yelling and staff came. The staff came and told me to report this to (V1). I reported this to (V1) immediately and (V1) said he would keep a close eye on (R1). After that I have seen (R1) in the dining room and I do not want him around me."

On 7-10-24 at 2:00 PM, V13 (Social Service Director) stated, "I have worked here for a year and four months. I know around a year and a half

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ago, the hallways were split up with men on one due to (R1) having a sexual encounter with a female resident. On Monday (7-8-24), (V2) told me about what had happened between (R1) and (R2) on Friday (7-5-24). I went down on Monday and spoke to (R1). (R1) would not say much and ignored me. I told him it was inappropriate to touch another resident inappropriately and he needs to keep his hands to himself. (R1) replied, 'Ok. God bless.' I then went to talk to (R2) about the incident, and he just asked me if he was in trouble. (R2) did not talk about the incident. I know (R1) was not moved from his room to a room on a different hallway until Monday (7-8-24). I make (R1's) behavior tracking logs and put them out on the halls for the CNAs to track (R1's) behavior and to document what interventions were used and if they are effective. I have not implemented a behavior tracking with interventions to address (R1's) sexual inappropriateness with other residents. I do not know of any interventions implemented after to increase supervision of (R1) after the incident between him and (R2) on Friday (7-5-24). I am responsible for (R1's) behavioral care plan. According to (R1's) care plan, (R1) should have had one-on-one staff supervision at all times. I was not aware of that."

On 7-10-24 at 5:50 PM, V19 (CNA) stated, "I work third shift. (R1) was moved sometime this week to another hallway after masturbating (R2). (R1) never had one-on-one supervision and walks independently. (R8 and R38) always wander around and go into other residents' rooms. (R8 and R38) live on the same hallway as (R1)."

On 7-11-24 at 10:00 AM, V2 (Director of Nursing/DON) provided a list of all residents who

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reside on the same two hallways as R1 or use the same dining room as R1 (R2-R10 and R12-R50).

On 7-11-24 at 10:15 AM, V1 (Administrator) stated, "I did not know (R1) had a history of sexual aggression or was care planned to have one-on-one supervision. I worked there for the past two years (hire date 6-16-22) and (R1) never had one-on-one supervision during that time. I do not recall any sexual allegations made regarding (R1) with any residents, therefore, there are no abuse investigations regarding (R5, R6, R10 and R11), and the families and police have not been notified."

On 7-11-24 at 10:20 AM, V17 (R2's Family Member) stated, "(R2) is very confused now. When (R2) was alert and in his right mind, (R2) would have been disgusted by another man touching him sexually. (R2) would not have wanted anyone to know about it. (R2) would have been so embarrassed and had never showed any interest in men. I have not talked to the facility in two weeks. No one from the facility has contacted me about another resident masturbating my husband."

On 7-11-24 at 10:36 AM, V18 (R1's Family Member) stated, "(R1) would always be sexually interested in women. I never knew of (R1) having sexual interests in men. (R1) would not have told me if he does. The facility called my a few days ago and said they were moving (R1) to another room due to (R1) inappropriately touching another resident. (R1) should be supervised so he is not able to do sexual things with other residents. The facility called my a few days ago and said they were moving (R1) to another room due to (R1) inappropriately touching another resident."

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On 7-11-24 at 11:45 AM, V15 (CNA) stated, "Last week I heard (R10) crying outside of (V1's) office and reporting something to (V1) about something (R1) had done to her. I did not hear the entire conversation."

On 7-11-24 at 11:50 AM, V7 (Corporate Manager) stated, "I have managed this home since February 8, 2024, and have not been aware of any abuse allegations regarding (R1), except for the allegation made on 7-5-24 regarding R1 and R2. I have searched (V1's) office and there are no abuse investigations regarding (R1, R5, R6, R10 or R11)."

On 7-11-24 at 1:00 PM, V14 (Agency CNA) stated, "Around a week ago or so, I do recall (R6) coming out of his room and telling me that (R1) said (R6) had pretty feet and tried to touch him sexually. I went down to (R6's) room and removed (R1) from the room. I told the nurse. I do not recall who the nurse was. I did not report this to the Administrator. I do not know who the Abuse Coordinator is."

On 7-11-24 at 2:15 PM, V19 (CNA) stated she does not know who the Abuse Coordinator is to report abuse to.

On 7-11-24 at 2:30 PM, V2 (DON) provided the a list of residents (R2-R10 and R12-R50) residing on the two hallways and the dining rooms to where R1 has resided after R1 had sexually and physically assaulted R2, R5, R6, R10 and R11 on multiple occasions.

On 7-12-24 at 10:20 AM, V16 (R5's Representative) stated, "(R5) never had interest in men and would have been embarrassed if a

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man did anything sexual with him. No one from the facility has tried to call me or has left me a message regarding anything for over a month. I was not aware of any abuse allegations regarding (R5)."

R1, R2, R5, R6, R10 and R11's Medical Records do not include any documentation of investigations, police notification, resident representative notification, or IDPH notification of R1 sexually or physically assaulting R2, R5, R6, R10 or R11.

The facility's Abuse Prevention Program policy, dated 11-28-16, documents, "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of property, and exploitation as defined below. This will be done by establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment, identifying occurrences and patterns of potential mistreatment, exploitation, neglect, and abuse of resident, and dementia management and resident abuse prevention. This facility is committed to protecting our residents from abuse by anyone including, but no limited to, facility staff, other residents, consultants, volunteers, and other agencies providing services to the individuals. Sexual Abuse is non-consensual sexual contact of any type with a resident. Staff supervision: On a regular basis, supervisors will monitor the ability of the staff to meet the needs of the residents, staff understanding of individual resident care needs. Possible sexual abuse: Determine if the allegation involves either physical sexual contact involving penetration, verbal harassment, or physical contact that did not involve penetration."
"Sexual Abuse is the non-consensual sexual

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contact of any type with a resident. Sexual Abuse the non-consensual sexual contact of any type with a resident. Employees are required to immediately report any occurrences of potential/alleged mistreatment, exploitation, neglect, and abuse of residents to a supervisor and the Administrator (V1). If an allegation of physical sexual contact is involved: Contact the police. Staff obligations are to immediately report abuse, neglect, exploitation, and theft to supervisory personnel and administrator. Employees are required to immediately report an occurrence of potential/alleged mistreatment, exploitation, neglect, and abuse of residents they observe, hear about, or suspect to a supervisor and the administrator. The administrator or designee is also responsible for informing the resident or their representative of the results of the investigation and of any corrective action taken. If the events that cause the reasonable suspicion result in serious bodily injury or suspected criminal sexual abuse, the report shall be made to at least one law enforcement agency of jurisdiction and IDPH (Illinois Department of Public Health) immediately after forming the suspicion. The administrator or designee will also inform the resident or resident's representative of the report of an occurrence of potential abuse of resident and that an investigation is being conducted. The administrator, or designee will inform the resident or resident's representative of the conclusions of the investigation."
"Upon learning of the report, the administrator, or designee, shall initiate an investigation. Possible sexual abuse: Determine if the allegation involves either physical sexual contact involving penetration, verbal harassment, or physical contact that did not involve penetration. As part of the resident social history assessment, staff will identify residents with increased vulnerability for

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abuse or who have needs and behaviors that might lead to conflict. Dementia management and resident abuse preventions include how to assess, prevent, and manage aggression. Through the care planning process, staff will identify problems, goals, and approaches which would reduce the changes of mistreatment, neglect, and abuse of these residents. Staff will continue to monitor goals and approaches on a regular basis. Staff supervision: On a regular basis, supervisors will monitor the ability of the staff to meet the needs of residents, staff understanding of individual resident care needs, and situations such as inappropriate language, insensitive handling, or impersonal care will be corrected as they occur. Upon learning of the report, the administrator or designee shall initiate an investigation. Residents who allegedly mistreat or abuse another resident will be removed from contact with that resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement considering his or her safety, as well as the safety of other residents and employees of the facility. The administrator or designee is responsible for forwarding the final written report of the results of the investigation and corrective action to the Department of Public Health within five working days of the reported incident. Within five working days after the report of the occurrence a complete written report of the conclusion of the investigation, including the steps the facility had taken in response to the allegation, will be sent to the (Illinois) Department of Public Health/IDPH."

(A)