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S 000	Initial Comments Complaint Survey: 2477477/IL178121	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6 300.3210(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 300.1210 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	S9999		

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care needs of the resident.

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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

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 were NOT MET as evidenced by:

Based on interview and record review, the facility failed to protect a resident's right to be free from sexual abuse by a resident with known sexual behaviors and public displays of affection, the facility failed to follow their policy to conduct a thorough investigation of a sexual abuse allegation.

This failure resulted in R2, a 62-year old male resident exposing his genitals to R1, a 68-year old female resident and attempting to insert his penis into R1's mouth. R1 has severe cognitive impairment and is unable to consent to sexual relations.

This applies to 1 of 5 residents (R1) reviewed for

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resident-to-resident sexual assault in the sample of 5.

The findings include:

On September 18, 2024 at 1:39 PM, and on September 23, 2024 at 2:09 PM, V3 (CNA-Certified Nursing Assistant) said on September 10, 2024 she was walking up and down the corridor, picking up dinner trays. V3 noticed R2 was out of his room. V3 said she approached R1's room and the privacy curtain was closed. V3 said she was surprised by this because the staff never leave R1's privacy curtain closed when they are not in the room because R1 is a high fall risk and requires frequent observation. V3 said she went to pull the privacy curtain back and found R2 standing at R1's bedside with one knee on R1's bed. R2's khaki shorts and belt were down around R2's ankles. V3 could see R2's bare buttocks. V3 continued to say R2 had one hand behind R1's head, and his other hand on his penis, and was trying to put his penis in R1's mouth. V3 said she screamed "What are you doing?" very loudly and R2 let go of R1 and started to walk back to his room, which was located next to R1's room, with his pants around his ankles. V3 said as R2 shuffled back to his room, his pants remained around his ankles and his belt buckle was clattering on the floor and could be heard as he walked. V3 continued to say she reported the same information to V1 (Administrator) on September 10, 2024.

The local police department's report dated September 10, 2024 shows V3 (CNA) provided the same statement to the responding police officer.

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The EMR (Electronic Medical Record) shows R1 is a 68-year old female resident admitted to the facility on July 24, 2024. R1 has multiple diagnoses including, pelvis fracture, falls, gastrostomy tube, dysphagia, reduced mobility, spinal stenosis, dementia, schizophrenia, generalized anxiety disorder, and fracture of the fifth lumbar vertebra and sacrum.

R1's MDS (Minimum Data Set) dated July 30, 2024 shows R1 has severe cognitive impairment, requires setup assistance with eating, is dependent on facility staff for bed mobility and transfers between surfaces, and requires substantial/maximal assistance with all other ADLs (Activities of Daily Living). R1 is always incontinent of bowel and bladder.

On September 19, 2024 at 8:41 AM, R1 was sitting at the nurse's station playing a card game with staff and was not able to be interviewed at that time due to the lack of privacy.

On September 19, 2024 at 11:30 AM, R1 was sitting at the nurse's station in a wheelchair, sleeping.

On September 19, 2024 at 1:38 PM, R1 was lying in bed in her room. R1 was not able to answer questions regarding the incident due to her cognitive status.

On September 23, 2024 at 10:21 AM, V8 (Physician) said, "[R1] has very advanced dementia. She cannot consent to sex. You cannot even hold a meaningful conversation with her."

The EMR shows R2 is a 62-year old male resident, admitted to the facility on April 19, 2024.

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R2 has multiple diagnoses including, Parkinson's Disease, dementia with behaviors, anxiety, falls, psychotic disorder with delusions, insomnia, and depression.

R2's MDS dated July 24, 2024 shows R2 is cognitively intact, requires setup assistance with eating, supervision with oral hygiene, partial/moderate assistance with personal hygiene, bed mobility, and transfers between surfaces, substantial/maximal assistance with toilet hygiene, showers, and lower body dressing, and is occasionally incontinent of bowel and bladder.

R2's care plan initiated May 9, 2024 shows, "[R2] exhibits inappropriate or overly friendly behavioral symptoms including touching staff members and himself while receiving care and making unwanted contact (hugging) and gestures (blowing kisses towards others. He has also entered the rooms of other residents. He lacks insight, reasoning and judgement related to his medical needs. He responds to staff redirection." Multiple interventions initiated May 9, 2024 include, "Communicate assertively that resident exercise control over impulses and behavior, intervene and re-direct when any inappropriate behavior is observed, refer for psychiatric evaluation and utilize psychoactive medications as warranted, remind resident to refrain from hostile remarks and inappropriate touching." The facility does not have documentation to show new interventions were initiated until September 17, 2024.

On September 19, 2024 at 8:45 AM, R2 was sitting in his room. V4 (RN-Registered Nurse) was present in the room and a one-to-one sitter was sitting at a table outside of R2's room. V4

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said R2 is able to walk without assistance or an assistive device. V4 continued to say a one-to-one sitter was present because R2 kept going in and out of other resident's rooms, and because R2 had inappropriate sexual behaviors. V4 left the room and the interview with R2 continued. R2 said he has had Parkinson's disease since 2011. R2 did not have a noticeable tremor when doing purposeful movements during the interview, including reaching for cups of water and juice on his bedside table, drinking, or when walking in his room. R2 did have a quiet vocal tone, and occasionally stuttered. R2 said he was hospitalized in June 2023 at a psychiatric hospital for mental problems. R2 continued to say one of the medications he takes causes excessive behaviors such as gambling, sexual feelings, and the need to masturbate. R2 spelled out the name of the medication as pramipexole. R2 said he frequently has hallucinations. R2 continued to say on September 10, 2024, he was in his room and his room was feeling, "Too tiny, too closed in. That bothers me and makes me anxious. I know I am supposed to just suck it up, but sometimes I cannot. I went in [R1's] room and she was lying in bed. I sat on the end of her bed, right next to the board on the end of the bed (resident motions to footboard on his own bed). [R1] was intensely screaming and I wanted to help her. I thought maybe we could chit chat. She asked me if I was the cook, so I knew she didn't have it all upstairs, if you know what I mean." R2 continued to say his pants were falling down due to being uneven because his sister had not sewn his pants correctly. R2 said his pants were falling off and his penis was exposed.

The EMR shows multiple documentations regarding R2 including:

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May 9, 2024 at 4:14 PM, [R2] received a scheduled shower after lunch. CNA reported inappropriate behavior that happened during assisting resident. CNA reported resident touched her lower back. CNA turned and asked him to remove his hand. Resident removed his hand. Resident turned and touched his front perineal area along with masturbation.

May 17, 2024 at 1:30 PM, [R2] was observed taking pictures of residents in shared areas and was told to refrain from doing so in the future.

The facility's final report to IDPH (Illinois Department of Public Health), received on August 10, 2024 shows on August 5, 2024, "[R3] reported that a male resident (R2) made her feel uncomfortable by giving her a hug and a kiss on the cheek because she is married."

On August 6, 2024 at 8:42 AM, V13 (NP) documented, "62-year old male at [facility] being seen today for hypersexual behaviors. Patient attempting to kiss other residents. He stated he has his reasons why he was doing so. He would not disclose to me."

On August 6, 2024 at 5:20 PM, V7 (SSC-Social Service Coordinator) documented, "Writer met with [R2] on nursing unit to discuss room change. Writer explained to patient that he is more appropriately placed on a different nursing unit as he does not directly benefit from the style of dementia-focused activities ... He strongly feels that his (self-described) inappropriate behavior on Monday evening is the result of a change to his [pramipexole] dosage. Discussed with guardian and per her request, patient's sister (V33). [V33] recounted patient's history of hypersexual behaviors and expressed understanding as to

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why relocation may be beneficial for resident. Guardian is also agreeable to room change. Patient ultimately consent to the room change and nursing staff began assisting with relocation to [room close to R1]."

On September 16, 2024, V2 (DON) documented a late entry effective September 10, 2024 at 5:15 PM. V2 documented, "Received report that resident was observed in another resident's room and appeared partially exposed."

On September 11, 2024 at 6:40 AM, V8 (Physician) documented, "I was paged by the DON that yesterday [R2] had an episode of hypersexual behaviors. It was reported that yesterday he was found by the CNA in a female resident's room and partially undressed exposing his genitalia to her. The other resident did not come in contact with him, she was sitting on the edge of her bed, according to social services report. In regard to witness's report that patient was partially unclothed, patient notes that he was wearing a pair of shorts which are uneven and have a tendency to sag down but denies any other activities taking place. ...Patient was seen and examined today. When asked about the incident patient states he was probably behaving inappropriately due to his Parkinson's medications. Patient denies any hypersexual behavior in the past. He ambulates around the facility without an assistive device. A&P (Assessment and Plan): Hypersexual behaviors - discussed in detail with the DON, social services, CNA, and the patient. Refer to psychiatry for psychosis. Refer to neurology for possible change in Parkinson's medications due to possible side effect of hypersexual behaviors, 1-to-1 babysitter advised until further notice. Patient's room changed - advised no shared

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rooms with other residents."

The facility's final report to IDPH (Illinois Department of Public Health) dated September 17, 2024 shows, "reported R1 and R2 were in a room. R2 appeared partially undressed. Separated immediately. .... Abuse cannot be substantiated based on information and facts gathered ..."

Facility documentation shows V2 (DON-Director of Nursing) obtained statements from V3 (CNA) and V10 (LPN) on September 10, 2024. The statements are typed statements. V3 and V10 did not sign their typed statements. The facility does not have documentation to show any other staff provided statements on September 10, 2024.

On September 19, 2024 at 10:39 AM, V2 (DON-Director of Nursing) said, "[V10] (LPN-Licensed Practical Nurse) reported that [R2] was in [R1's] room, which were next to each other. [V3] (CNA) had cared for [R2] all day. They observed [R2] at the bedside of [R1] and [R2's] pants were sagging down. [V3] reported [R2] had his hand on his penis, and his other hand was behind [R1's] head. [R2's] room was moved on August 6, 2024. He was in the Dementia Unit, so he was moved to separate him from [R3]. It was reported he attempted to hug and kiss [R3]. We had psych see him and we made some changes to his pramipexole medication. We were hoping the medication adjustment would help." V2 could not say what other interventions were put in place to protect female residents from R2 after he was moved from the Dementia Unit on August 6, 2024.

On September 19, 2024 at 12:40 PM, V1

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(Administrator) said interviews of staff members were done on September 16, 2024, six days after the alleged sexual abuse. V1 said the facility's abuse policy shows interviews with possible witnesses should be conducted as soon as possible. V1 continued to say as soon as possible means the staff should be interviewed "right away". V1 also said it did not appear the staff that were present in the facility on September 10, 2024 were interviewed as part of the investigation. V1 said, "Interviews with residents and staff were done on September 16, 2024. Maybe we were so overwhelmed about what happened that we didn't interview the people that worked that day." V1 continued to say the allegation of sexual abuse was unsubstantiated based on the facility's investigation.

On September 23, 2024 at 2:09 PM, V32 (CNA) said she had worked the day shift on September 10, 2024 from 6:30 AM to 2:30 PM. V32 said she was assigned to the unit where R2 resided, and he had walked down the hall towards her to ask for a cup of ice. V32 said R2 was wearing khaki pants and a belt. V32 said she did not see R2's pants falling down at any time during her shift, and R2's pants were not falling down while he was walking down the hall to ask for a cup of ice.

On September 19, 2024 at 3:42 PM, V9 (Psych NP-Nurse Practitioner) said, "I see [R2] at least once a month. The nurses called me at home, and it seemed like his sexual behaviors escalated so I put him on Paxil to lower his libido. We are giving him the medication to make him not want to have sex as much and for his anxiety and his mood. I am not sure he is a good candidate to be in that facility. I don't think he was a good candidate to be in a room near a cognitively impaired female resident who cannot give

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consent."

On September 23, 2024 at 11:30 AM, V7 (SSC) said, "During a meeting with [V33] (Sister of R2) on August 6, 2024, [V33] said [R2] has a history of misinterpreting signs from women as being flirtatious or inviting. He made inappropriate gestures to women, and this extended to family members. [R2] made sexual comments to his sister-in-law. It was known that hypersexuality was part of his situation. He was referred to psych after the sister said that, and the staff were made aware of the potential behaviors and to be aware."

The facility does not have documentation to show interventions were put in place regarding R2's sexual behaviors after the kissing/hugging allegation on August 6, 2024 or with R2's room change to a new unit to protect female residents.

The staffing schedules for September 10, 2024 were reviewed with V1 (Administrator) and compared to the staff statements obtained on September 16, 2024, for the sexual abuse investigation. None of the staff statements obtained on September 16, 2024 were signed by the staff member being interviewed. The staffing schedules show the following staff were present in the facility on September 10, 2024 between 2:30 PM and 10:30 PM, during the alleged sexual abuse. the facility does not have documentation to show the following staff were asked to provide statements during the abuse investigation, including:

CNAs:
V15, V16, V17, V18, V19, V20, V21, V22, V23, V23, V25, V26

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LPNs (Licensed Practical Nurses):
V28, V29

RNs (Registered Nurses):
V27, V30, V31

On September 23, 2024 at 2:09 PM, V32 (CNA) said she had worked the day shift on September 10, 2024 from 6:30 AM to 2:30 PM. V32 said she was assigned to the unit where R2 resided, and he had walked down the hall towards her to ask for a cup of ice. V32 said R2 was wearing khaki shorts and a belt. V32 said she did not see R2's shorts falling down at any time during her shift, and R2's shorts were not falling down while he was walking down the hall to ask for a cup of ice. V32 said, as of September 23, 2024, she had not been interviewed regarding R2, including asking what clothes he was wearing that day or if she had seen any type of wardrobe malfunction on September 10, 2024.

The facility's Abuse Prevention Program - Policy, effective November 22, 2017 shows, "Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. ...Definitions: Sexual abuse is non-consensual sexual contact of any type with a resident."

The facility's Abuse Prevention Program - Toolkit, reviewed "09/05/2024" shows: "Investigation Procedures: Regardless of the specific nature of the allegation (physical, sexual, verbal/mental abuse, theft, neglect, unreasonable confinement/involuntary seclusion or exploitation), the investigation shall consist of:

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S9999	Continued From page 12 Interview of the person(s) reporting the incident, interview of the alleged victim, if interviewable, interview of the alleged perpetrator, interview of the witnesses to the incident, if any, which includes visitors to the facility, interview of staff members having contact with the alleged victim and alleged perpetrator during the period of the alleged incident. Interview Process: Determine if written statements will be taken of the interviewee. If statements are taken, ensure that the statement is factual and not conclusory (i.e., no assumptions, only facts observed or known to the interviewee). Whether handwritten or typed, the statement must be signed and dated. If the interviewee refuses to sign, the interviewer should document that fact on the statement and sign and date the statement themselves. To the extent possible, all interviews should be conducted with another person present for the interview." (A)	S9999		