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S 000	Initial Comments Facility Reported Incident Investigation of 2/8/24/IL169979	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.3240a) 300.3240e) 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. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such	S9999		

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S9999	Continued From page 1 accident, injury or change in condition at the time of notification. 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. 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) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These requirements were not met as evidenced by: Based on interviews and record review, the facility failed to protect the resident's right to be free from sexual abuse by staff and failed to have a system in place to prevent residents from	S9999		

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S9999	Continued From page 2 potential abuse by staff after an allegation of staff to resident sexual abuse was made and while allegation was still pending investigation by law enforcement. This failure applied to one of one (R1) resident reviewed for sexual abuse and resulted in R1 being sexually abused by a facility CNA (Certified Nurse Aide). Findings include: R1 is a 43 year old female, initially admitted to the facility on 8/24/21 with medical history that includes: anoxic brain damage, acute and chronic respiratory failure with hypoxia, acute and chronic respiratory failure with hypercapnia, history of sudden cardiac arrest, fusion of the cervical spine region, need for assistance with personal care, post-traumatic stress disorder, muscle weakness, Schizoaffective disorder, depression, anxiety, and aphonia (loss of ability to speak related to disease). Review of R1's medical record included review of the following documentation: MDS (Minimum Data Set) assessment dated 1/19/24, documents R1's BIMS (Brief Interview for Mental Status) score as a "15" - indicating that cognition is intact. Physician Order Summary (active orders as of 2/19/24) documents the following physician orders: - Monitor for side effects of anti-depressive and antianxiety medication (Order Date 1/17/24) - Only female staff to work with resident, work in pairs every shift (Order Date 2/14/24) - Alprazolam tablet 0.5mg Give 1 tablet by mouth three times a day for Anxiety (Order Date 5/25/23)	S9999		

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S9999	Continued From page 3 - Mirtazapine Oral Tablet 7.5 MG (Mirtazapine) Give 1 tablet by mouth at bedtime for Depression related to MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED (F32.9) (Order Date 10/11/23) - Sertraline HCl Oral Tablet 25 MG (Sertraline HCl) Give 1 tablet by mouth in the morning for depression total of 25mg (Order Date 10/06/23) It is to be noted that other than above medications for anxiety and depression, R1 has no current orders for any other psychotropic or psychiatric medications. Review of behavior tracking for the past month for R1, does not document any events of inappropriate behavior (i.e., hallucinations, inappropriate behavior, yelling/screaming, etc.). Reviewed R1's nursing progress nurse - nothing noted in progress notes that indicates R1 has been exhibiting any signs and symptoms of psychosis or inappropriate behaviors. Resident electronic medical record has flag that reads: "Special Instructions: FEMALE STAFF ONLY, CARE IN PAIRS. Enhanced Barrier Precaution: History of MDRO, KPC; Site; GB Bile; Duration: Indefinite. //HIGH FALL RISK//." Care plan for abuse trauma mistreatment PSWB mood was initiated on 2/8/24 and includes intervention of having two caregivers address her needs and observe the entire situation. Have supervisory personnel observe care delivery, as possible and in accordance with privacy and dignity considerations. Social Service Trauma Screening dated 1/19/24 documents, (Question #5) R1 has no psychiatric	S9999		

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S9999	Continued From page 4 history and/or present mental health diagnosis, including psychotic symptoms (e.g., delusional thinking, hallucinations) and possible misinterpretation of events and the intentions of others; (Question #8) R1 has no history or presence of dysfunctional behavior (e.g., provoking, aggressive, manipulative, derogatory, disrespectful, abhorrent, insensitive, attention-seeking, criminal history and/or otherwise abrasive/inappropriate behavior), including roaming/wandering into peer's rooms/personal space. Total score on Trauma Screening was a "2"; per scale, a "2" is less than minimal symptomology. Hospital record for visit on 2/8/24 does not indicate that there are any physical injuries but hospital documents R1 agreed to SANE (Sexual Assault Nurse Examiner) assessment and was prescribed antibiotics prophylactically. Facility provided documentation of incident and investigation regarding allegation R1 made of sexual abuse against a facility staff member, which reads: "On February 8, 2024, at about 11:45am, received report that resident alleged that a few nights ago, between Friday and Monday night (2/2/2024 to 2/5/2024), a male CNA, African-American, with mohawk hairstyle, came into her room, standing at the bedside leaning on the bed, then started kissing her face, touching her chest area, and attempted to open her legs. CNA whispered to her that they should have a "relationship." Per resident, she pushed him away and he left the room. No other physical contact occurred after this. The resident is unable to remember exactly when the incident happened and unable to identify the name of the alleged perpetrator. The resident stated that the CNA was not assigned to care for her. Investigation started,	S9999		

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S9999	Continued From page 5 nursing assessment nursing assessment conducted with no significant findings noted, police came and interviewed resident, family notified, physician called with order to transfer resident to ER. Resident initially declined to go to the hospital. After explanation and encouragement, she agreed and was picked up by paramedics and transported to the hospital. A few hours later, resident returned to facility in stable condition with new order for Doxycycline and Metronidazole PO until 2/16/2024 for prophylaxis. Family notified by resident herself. Physician informed and updated. ER visit note dated 2/8/2024 revealed "no visible signs of abuse or neglect ...Resident is alert and oriented x 2-3, has the demonstrated ability to use the call light, she has clear speech, she owns a cellular phone in addition to facility phone at her bedside, and she talks to her husband every day. While at the facility, resident has history of calling 911 herself when she was in distress. She did not place any call to 911 during or immediately after this alleged incident. At the time of reporting, resident denied any sexual penetration, she denied pain and no new skin alteration noted during physical assessment. Resident's vital signs remain within baseline, no changes in mental state, range of motion, or appetite, and she did not appear to be in any form of distress. Resident verbalized feeling safe at the facility. Resident chose to go back to the facility despite having the opportunity to be transferred from the hospital to another care facility. Resident expressed a desire to stay in her current room and she also verbalized to not having a preference for the gender of a caregiver. Resident seen and examined by multiple providers and continued to be assessed by clinical staff after the brief ER visit. Psychotherapist, Psychiatric NP, County	S9999		

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S9999	Continued From page 6 Detective, and IDT team followed up with resident's allegations. Resident was re-interviewed. Resident reported significant inconsistencies in her statements. Hospital and other medical records reviewed, and husband/family interviews made. Records revealed that resident had panic attacks since she was about 8 years old. She recalled having been asked a lot of questions by the police when she was in first grade. She was sexually abused by her own father when she was young. Resident can be anxious, restless, and frustrated at times secondary to adjustment due to loss of independence, and adjustment to health decline. She has long history of anxiety which goes back to childhood due to past traumatic events and reported seeing outpatient psychiatrists in the past. Currently taking psychotropic medications. Based on the description by the resident of the perpetrator, there is no African American male CNA with mohawk hairstyle who work at the facility during night shift. Investigation completed. Allegation of sexual abuse made by the resident is not substantiated. Facility is working closely with law enforcement regarding this case. County detectives and police are conducting a separate investigation. Resident continues to reside at the facility. Wellness checks ongoing. Care plan meeting held with resident/family and IDT in attendance. Care plans updated. Resident and family informed of the outcome of the investigation. No concerns presented." Interview with R1 on 2/16/24 at 5:07PM, R1 was noted to be alert and oriented to person, place, and time and seemingly of sound mind - statements were coherent and appropriate. R1 stated that she was told by the facility that someone from the State was coming to talk to her and that she did not have a problem talking with	S9999		

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S9999	Continued From page 7 State surveyor. R1 stated that she alleged that a CNA sexually abused her but did not feel like she was taken seriously. R1 stated that "they (facility) were just trying to cover their a**es". R1 added that the two male police officers that interviewed her initially, while still at the facility did not appear to take her seriously because they were whispering and making faces at each other. R1's eyes were visibly watering up throughout interview. R1 said she had been thru a similar incident in her 20's, where she was raped after a party. R1 said she thought she was over with this part of her life. R1 stated the CNA was not her regularly assigned CNA but that he had provided care for her before. R1 said he had tried to kiss her previously, but she shoved him away and he left her alone. R1 stated she did not report this because she thought he was just being playful since he stopped when she told him "get out of here." R1 added, but on this day (of the sexual assault), he was in a "mood," like a bad mood and nothing was going to stop him. R1 then changed the subject and proceeded to talk about her daughters and wanting to just go home and get out of the facility. R1 was seemingly disturbed and did not want to talk about the sexual assault allegation any longer. Surveyor advised R1 that we did not have to talk about it anymore if she was uncomfortable and the interview could be continued later. R1 was interviewed on 2/17/24 at 2:36PM, R1 was again noted to be alert and oriented to person, place, and time and seemingly of sound mind. Surveyor asked R1 to please recount the events that occurred on the night of the sexual assault that she reported. R1 stated the CNA involved, came into her room after she pressed her call light because she needed to be cleaned up after a bowel movement. After the CNA	S9999		

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provided care, R1 stated, he just came up and was pushing on me. R1 was asked if she knew the name of the individual and she said he has an African name that she cannot pronounce but that she could identify him if she saw him. R1 added he has taken care of her in the past. He has a strong accent, and he has a mohawk. Surveyor asked R1 to elaborate on the "mohawk" hairstyle and R1 said, it's not like an 80's punk, it's the shape of the lining but it's only about an inch or two thick. R1 stated the CNA inserted his penis into her vagina. R1 said that her brain wouldn't let her talk. (It is to be noted that R1 has a medical condition - aphonia - that limits her ability to speak). R1 stated she used to have a black belt in karate and that if her legs weren't weak, she would be able to fight and defend herself. R1 said, "I hate to say that he is stronger than me. I couldn't understand well what he was saying. I kept moving like a fish. I didn't have a roommate at the time". Surveyor asked R1 if there is any particular reason why she didn't report right after the incident happened. R1 stated she didn't report it because she wasn't planning to tell anyone because she felt ashamed. R1 stated, "There was this white guy (CNA) working with me the next day or whenever it was. He was nice and we were talking and then the next thing I know he got the nurse and then I told her about it. It all happened so fast at that point". R1 said, I feel like the first two cops who came didn't believe me. R1 was visibly upset and started using profanity to express how angry she was at the assailant and how she would physically hurt him if she could. R1 said about the police officers that, "something like this should happen to them to see how they feel about it and F*** them
". R1 added she felt ashamed and didn't know what would happen if she told. What if the facility threw her out for reporting? Surveyor asked R1 if

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she ever told the nurse at the facility that the male CNA put his penis in her vagina. R1 said, "I don't think so, I don't think I got that far because she ran out pretty quickly. They came in and were asking me questions and next I remember; I was here talking to the two cops". R1 was asked if there were any other details about the CNA involved that she could remember. R1 said that on previous occasions when he works, she has seen him wearing a black jacket, like a Jordan light jacket or something; "he doesn't wear glasses or anything like that".

On 2/17/24 at 1:29PM V8 (Registered Nurse) was interviewed and confirmed that she was the nurse who took the report of sexual abuse from R1. V8 said, "I've worked here since October 2022. R1 is pretty much alert and oriented times three, she is a little forgetful. She needs full care, and she makes her needs known. She has no Alzheimer's or Dementia, sometimes she has a hard time finding the words to say. I can't recall the exact date, but the CNA called me into the room because she had a bruise on her belly, but it was from the shot that she had gotten and I started asking her if anyone had been rough with her, etc. Then she asked to talk to me privately. She said that somebody tried to put it in. I said what do you mean, and she said you know what I mean. I asked her if I could tell the DON because I told her it was inappropriate and if it was okay to tell the DON because the DON is male. She never said that he put it in. I did not tell the detective anything different than what I am telling you. I have been working with her since June and she is comfortable talking to me. She said she meant to tell me and that she had seen him before. I think if you showed her a picture, she could point him out; per R1's description, he wasn't that tall, thick African accent, he's black

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S9999	Continued From page 10 and dark skin (not caramel)". On 2/17/24 at 12:18PM V2 (Director of Nursing) was interviewed regarding R1's sexual abuse. V2 stated, "V8 (Registered Nurse), came to my office and told me that R1 reported sexual abuse. So, we went together to talk to R1. R1 said that a few days ago - it happened on a day that V8 was not working - R1 said that a CNA came into her room and was standing next to her watching TV. He said they should be in a relationship. He started kissing her face and touching her chest. He was touching her left leg but her left leg was weak. She said she was able to push him off. Then he left and never came back. She said he was African American, stocky, about my height. Then I went to V1 (Administrator), and we followed the protocols. I spoke to her family. The brother was concerned. The social worker reached out to her spouse. At the time of the incident, R1 couldn't yell out because she has issues with her voice. She has no history of reporting being abused while being here in the facility". V2 was asked about R1's cognitive status and V2 said that R1 has "normal" cognition and coherent thought processes. Surveyor asked if V2 had any special training or experience in how to approach victims of sexual abuse. V2 said, "I haven't had any special abuse training while I have been here". V2 added V6 (CNA) was the assigned CNA for R1 on the night that they had narrowed down the incident to but that R1 was adamant that it wasn't him who assaulted her. V1 (Administrator) was interviewed on 2/16/24 at 11:02AM. V1 stated the nurse (V8) had made an allegation of sexual abuse to V2 (Director of Nursing) and then V2 reported it to V1. V1 stated, "911 was called, along with the physician, and the police. The police came to the facility and a report	S9999		

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was filed. They physician ordered for R1 to be transferred to the local hospital". V1 said, "When I reviewed the hospital record, there was no evidence of sexual abuse. Police, detectives, and CSI came to the facility. R1 had said that it was a CNA on the night shift, who was not assigned to her, a black male. Per R1, the CNA had a similar build to V2 (Director of Nursing). She said it happened when V8 (Registered Nurse) was not here. Those dates were narrowed down to February 2nd - 5th but at some point, she told the police it was on Sunday. I got the punches and schedule from HR to identify who worked that Sunday and identified four black, male staff who worked that night. Based on their description, I immediately suspended V5 (CNA) and V6 (CNA)". V1 added that she immediately interviewed, educated, and suspended V5 and V6. V6 had been assigned to care for R1 on that night and V5 was assigned on the second floor. V1 stated, "I suspended them both on the 8th (February). I could not substantiate the allegation, so I closed the investigation. We updated R1's care plan to only have female staff and care in pairs was implemented during the investigation. I offered her a room change and she refused".

On 2/16/24 from 3:57PM - 4:10PM V7 (Cook County Police Detective) was interviewed via phone. V7 stated, "I reviewed the video footage and during the time frame that the victim provided. There was a subject, a CNA in her room for approximately 15 minutes and that would be during the time frame that she made the allegation. Being that there was a delay in reporting, bed linens had been changed and she had bathed. I can't say that I have a suspect in custody, or any arrests made at this time. I can say that there's two suspects but until I do a photo lineup with the victim, I won't be able to

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properly identify the subjects. I shared the same information with the administration of the nursing home. I met with V1 (Administrator) on the date of the incident (reporting) and wanted to try to get video footage because like I said it was delayed by four days. The recordings were put on my flash drive. The monitors for it are on the 3rd floor but the base for it is the basement - the DVR storage device was in the basement. So, we had viewed it up there and then I was able to transfer it but (V1) had to go tend to other issues, but the Maintenance Supervisor watched the video with me. He was the one helping me load it onto the flash drive. The first thing I did was collect video footage, the incident allegedly Sunday between 11am - midnight; and we identified the days V8 (Registered Nurse) off, Fri - Mon from 11-midnight. While viewing the footage I can see the subject in the hallway - one goes in the room for approx. 15 minutes and the other one was outside. I have to get a proper identity by photo lineup with the victim. Ideally, she will be able to identify someone. We need to have the proper evidence to present to the State's Attorney's office. It's just paused at this point, and it was delayed because of lack of evidence (i.e., clothing, linens - it was reported about four days later). I would say that they (V5 and V6 / CNA's) should be off pending criminal investigation. The victim (R1) is still residing there; she wanted to stay at the facility. My concern (with V5 and V6 allowed to be back at work) would be how are they interacting with her or threatening her while they are on duty. Unless she is protected. I would say my opinion is they shouldn't be working. I told V1 (Administrator) the same thing I'm telling you".

On 2/16/24 at 4:52PM, V9 (Regional Plant Operations), confirmed that he was the individual helping the police detective (V7) download the

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S9999	Continued From page 13 video from the facility footage. V9 said, (about the video), "I watched a little of it, I was more trying to get the thumb drive. I think the time frame was from about 11:30PM - 1AM but it was hard to tell the time because we were forwarding it at like 32x speed. I can't tell you how long it was in actuality, but I saw one CNA go in for some time and then two CNA's. They're nighttime staff so I didn't recognize them, or could I tell you who they are. The video stays on the hard drive for like 24 hours or three days, something like that. We pay an outside company. There are no copies. I think after a certain amount of time, they can't access it. They have to have enough memory". On 2/17/24 from 9:17AM - 9:50AM, V7 (Cook County Police Detective) was interviewed in person. V7 stated regarding R1's sexual assault, "It was reported four days after it happened. So, the investigation is considered delayed because at that point there may have been more evidence. It's an ongoing investigation. First (R1) said she didn't know what day it happened but then she said it was on a day that (V8 Registered Nurse) was off, so we determined it happened sometime between Friday - Monday". V7 expressed concern over how the facility is keeping R1 safe from the CNA's (V5 and V6) and how is the facility ensuring that R1 is not being intimidated by staff. V7 was asked about facility's statement that there were inconsistencies regarding R1's "story," V7 shrugged his shoulders and said, "We have to treat it as if it happened until we have evidence of the contrary". On 2/19/24 at 11:28AM, V10 (Hospital Site SANE Clinical Lead) was interviewed via phone and said, "I did not do the exam myself, but I am the supervisor. (At the hospital), R1's sexual assault exam finished up at like 8PM or so". V10 was	S9999		

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S9999	Continued From page 14 asked if it is uncommon for there to be no visible or physical injuries in cases of rape, since R1's hospital record does not document any bruises or scratches, etc. V10 replied that in the setting of sexual assault, it is not uncommon for there to be no documented physical injuries. V10 said, "The female genitalia, in particular, by design is able to accommodate items being inserted into it so there may not always be any physical signs. That would not be an indicator of whether something was inserted or not. We don't release the medical forensic documentation because it is evidentiary, it would need to be subpoenaed". V10 was asked if there was any reason to believe R1 was not being truthful about the events that happened and responded, "I believe all of my survivors. These exams are very intrusive and traumatic for the patient. I would think that someone who is willing to subject themselves to something of this nature would do so for a reason. There are photos and samples, etc. taken. These exams are very intrusive (emphasized) - they are not easy to go thru. There's nothing in the charting that names the particular person (aggressor)". V10 was asked about facility concern that R1's "story" was inconsistent. V10 responded, "They are not at liberty to make that judgment. Everyone has a different level of comfort with law enforcement - it is possible that depending on the person's comfort level they would provide more or less information. Everyone's experience is different, and it is possible that they may say more or less with different people, it's not unusual. There is no one way that survivors will "act" as everyone is different and responds differently. It was very strange and inappropriate for the facility to repeatedly ask for the full forensic record when we have told them repeatedly that we cannot divulge that information. That is information that we can only provide to the patient herself".	S9999		

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S9999	Continued From page 15 On 2/17/24 at 12:42PM, V11 (Social Services Director) was interviewed. V11 stated she first spoke to R1 about the sexual abuse and then spoke to the husband. V11 stated R1 told her there was a guy, she had turned on her call light and he answered her call light. V11 said, "He tried to kiss her, and she pushed him away and told him to get out, go away and he left. I asked her to describe him, she said he was medium build, not too tall, mohawk haircut, and of African descent. She said she had seen him before, but he was not her caregiver that night and that she hoped she wasn't making a mistake in reporting this". V11 was asked if R1 has a history of making false allegations while in the facility. V11 said, "(R1) has no history of making false allegations that I am aware of. She did tell me that in her younger years someone touched her inappropriately and now the person is in jail because of it". V11 was asked about her training with sexual assault victims and stated, "about five years I had training on how to interview a person, body language, tone of voice, sincerity in their voice. We look at family history, background, diagnoses. The only thing that really stood out was that her story was inconsistent". Surveyor asked V11 to go into more detail about the so-called inconsistency in R1's recollection but V11 did not provide any specific examples of what was inconsistent in R1's recollection of events. V11 added, she did speak with R1's husband and that R1's brother is currently the POA but R1 wanted to change it to be her husband. V11 was asked why R1 needs a POA and V11 clarified R1 needed a POA because when she came in, she was not alert and decisional because of her medical history. V11 said, "She does have history of anoxic brain injury and history of schizoaffective disorder, but if she didn't want a POA right now, she wouldn't need	S9999		

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one. It's her choice, she wants to have one". Surveyor asked if R1 was currently receiving any care from psychiatry or psychologist and facility provided current notes from psychology visits for January and February 2024, there is nothing in the psychology notes indicating that R1 is delusional or shows poor insight, judgement. Notes document that R1's strengths include that R1 is friendly, open minded, honest, engaged, and demonstrates awareness.

Psychiatric Note, written by V12 (Mental Health Nurse Practitioner) dated 11/3/2023 documents R1 has a history of depression, panic attacks, and anxiety; has not had any psychiatric hospitalizations in the past and has seen outpatient psychiatrist in the past. R1 has reported no psychosis or hallucinations and it is documented that it appears unlikely that R1 has diagnosis of schizoaffective disorder. Attempted to contact V12 during this survey but was unable to reach V12.

Interview with V6 (CNA) on 2/21/24 at 3:59PM, V6 said, "I started working there in July 2023. I have worked on the first, second, or third floor. Right now, I am a floater, but I work on the third floor the most. I used to have a regular schedule, but the management of the office was not stable for like four months now. They were changing DON's and Administrators and schedulers. I used to work all weekends, Thursday thru Sunday but due to the unstable management issue, I only work night shift, 7pm to 7am. I am familiar with(R1). I don't normally work with her like that because I get rotated. I don't work on that (East) side that much. I work more on the West side of the third floor. In a two week pay period, I might work only one or two times on the third floor, east side. She (R1) is one person assist because she

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can turn and scoot up on her own. She is a good woman, she is nice. She is confused and our duty is to correct her. Sometimes I don't understand what she is saying. Sometimes her sheets are all wet and I have to tell her to press her call light. She does press her call light but once in a while she doesn't use it. She is able to make her needs known and will ask for the nurse if she needs her meds. She usually calls when her phone is not charging and will ask for a charger or her phone is dead. Sometimes when I go to her, she will tell me about her husband being pulled over while driving. I haven't seen any changes in her behavior. She has never reported any inappropriate behavior to me. I was shocked when they told me that she made those allegations. I don't think anyone would do such a thing to her. She is alert enough to shout out or report to the nurse. She is not slow or dull to the extent that she would not be able to report to the next person that comes into room. I have never tried to touch or kiss her inappropriately. I would never do that to any one of my residents. I would never do such a thing to a woman, let alone a bed bound woman. I would rather kill myself first. My administrator said that the person who abused her has worked here for a long time, more than two years. I don't think that I have even worked more than three days in February".

Review of facility provided Timecard for V6 (CNA) shows that V6 worked the 7pm - 7am shift on February 1, 2, 3, 4, 5, and 6; on February 6, 2024, worked until 7am and then was not back on duty again until February 15, 2024, at 7pm.

Interview with V5 (CNA) on 2/21/24 at 3:17PM. V5 said, "I normally work 7pm - 7am. I don't remember exactly what days I worked but I usually Mon, Tue, Wed. I can't really recollect but

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S9999	Continued From page 18 I don't work a particular floor. I float. I don't have a permanent floor. I might be assigned to first floor one day and then third floor another day. I have experience working on all floors. I am familiar with (R1). She is alert and a bit disoriented, she is not stable mentally. She will talk about things in the past and bringing them to the present - like being confused. She is incontinent and I help her by changing her brief when she has a bowel movement. She is bed bound, to my knowledge she never gets out of bed. She is a total care. Recently she has been agitated, like she wants to go home. I think she is bored being there. She is a little bit scared. I don't know what is responsible for that. In my opinion, she is just bored of being there and wants to go home. She has been shaking like when I ask her to turn, when I am giving her care. She is like nervous. I have not been working with her, so I work with her only once in a while. I have not worked with her since about the 23rd. The last time I worked with her was on Monday night into Tuesday - the 5th (February). Before that, it had been a long time. I have not been on that side in a long time. On that night, she had called like four times. When I went into the room, she said she didn't need anything and didn't realize she had pulled the call light. The third time, she had me plug the socket back into the wall for the call light. Then the fourth time, she asked me to change her. She had a very large bowel movement; I cleaned her very well and gave her a new brief and she asked for water. I got her water and she said thank you. It was around 11-12 midnight. That was how I left her that night. She didn't call during the night. I did the normal routine of checking through the night, and she was asleep. In the morning, I asked her if she needed to be changed and she said she was dry. That was on Tuesday morning before I left. I never attempted to kiss her or touch her	S9999		

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S9999	Continued From page 19 inappropriately. Never, never, I would never do that. I have worked as a CNA for about seven years. I have dealt with dementia patients, and I have been accused of being sexually inappropriate. I have never been found guilty or convicted of any type of abuse towards a resident". Review of facility provided Timecard for V5 (CNA) shows that V5 worked the 7pm - 7am shift on February 1, 2, 3, 4, 5, 6, 7, and 8; on February 8, 2024, worked until 7am and then was not back on duty again until February 14, 2024, at 7pm. Documentation of facility investigation, staff interviews, documents the following: 2. (V6 - CNA) interviewed 2/8/2024 3:44pm. "He worked over the weekend and remembered being assigned to 3rd floor, (R1's room#). He is a floater, and he works 2nd floor and 3rd floor. Resident is incontinent and can be wet during the night. He recalled in one of the nights he worked with her that she was very wet. She allowed him to clean and change her diaper, gown/clothes, and sheets. She always says "Thank you" after incontinence care. One night, (R1) told him that he forgot to put powder in between her thighs, so he did put powder as preferred by the patient and then he closed the diapers. He does not have any issue with patient." - SUSPENDED PENDING INVESTIGATION" 3. (V5 - CNA) called twice at 3:57 pm 2/8/2024. "Returned call at 4:22pm, recalled having worked in 3rd floor, said that he did not do anything wrong. SUSPENDED PENDING INVESTIGATION " 4. V13 (LPN) - called at 4:15 pm on 2/8/2024	S9999		

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S9999	Continued From page 20 "Regular nurse scheduled in 3rd floor. (R1) Rm (#) was assigned to her. She worked in the same unit for about 1 year. Patient never reported any abuse. When informed of the description of the perpetrator, Nurse stated that only 2 male CNAs would likely fit the description, (V6 and V5)". On 2/16/24 at 11:02AM, V1 (Administrator) was interviewed regarding what actions were taken in response to this sexual abuse investigation. V1 stated V5 (CNA) and V6 (CNA) were suspended immediately on February 8th. V1 added the allegation could not be substantiated so she closed the investigation. Surveyor asked V1, if there were any stipulations with which V5 and V6 were allowed to come back to work or if there were any limitations or monitoring put on their returning to duty. V1 said, "No, only intervention added was for only female staff and care in pairs for R1". On 2/17/24 at 12:54PM V4 (Regional Director of Operations) said, "The hospital is saying there is no evidence there, so there is no injury there". Surveyor then asked V4 if the hospital record says the abuse did not happen or that there are no physical injuries? V4 said, "We are proceeding as if the resident is telling the truth. The hospital social worker will call us and say this is what's going on and they have actually reported things to IDPH, so I don't understand why they didn't do that in this case". Surveyor stated to V4 we cannot confirm if/who calls in complaints to the Department. On 2/17/24 at 5:09PM V1 (Administrator) said, "I did not say that it didn't happen, I just could not substantiate it, so I allowed them (V5 and V6) to come back to work. I thought about what you said yesterday that you had a concern, and I decided	S9999		

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this morning to call them and suspend them again". Surveyor asked if there is a plan for allowing V5 and V6 to return to work. V1 stated they will discuss amongst Administration and provide the surveyor with updates tomorrow.

2/21/24 at 2:13PM V1 (Administrator) and V4 (Regional Director of Operations) stated they did start doing some QA tools - having the managers go around and checking with random residents on all floors and asking if they have any concerns with abuse and ask if they feel safe in the facility and to see if they know who the abuse coordinator is in the facility. They started this on Saturday, 2/17/24 as part of our intervention, and we are updating our policy for when staff are allowed to return to work.

Facility provided suspension documentation V5 (CNA) and V6 (CNA) were suspended related to abuse investigation on 2/16/24, document signed by V1 (Administrator). It is to be noted that both, V5 and V6 were on duty thru the morning of 2/16/24, therefore suspension did not take effect until 2/17/24.

R1 was the only witness to the sexual abuse and based on evidence obtained during this survey, surveyor determined that the burden of proof was met based on credibility of the witness, review of R1's medical records, and interviews conducted.

Interview with V14 (Medical Director) on 2/23/24 at 3:16PM. V14 stated he has been the medical director for about a month now he was not made aware of this incident when it happened but that the primary care physician was contacted. V14 stated, in the future, he should also be made aware of any serious issues, such as this event. V14 added he has worked with facility

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S9999	Continued From page 22 administration to formulate a plan to try and prevent this in the future, such as instituting training and updating their protocols. All staff will have to sign off to confirm that they understand the training. V14 said this is not something he takes lightly and since this is a criminal investigation, he feels that staff involved should be cleared from the criminal investigation before they are allowed to return to work; even if it takes five years. Facility Abuse Prevention Program - Policy (Effective Date November 22, 2017) reads: 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. PURPOSE: The purpose of this policy and the Abuse Prevention Program is to describe the process for identification, assessment, and protection of residents from abuse, neglect, misappropriation of property, and exploitation. This will be accomplished by: o conducting pre-employment screening of employees and pre-admission screening of residents; o orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse neglect, exploitation, and misappropriation of property; o establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment; o identifying occurrences and patterns of potential mistreatment;	S9999		

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S9999	Continued From page 23 o immediately protecting residents involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property; o implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences; o assuring that physical restraints are used sparingly and properly, and that chemical restraints are not used; and o filing accurate and timely investigative reports. The facility prohibits abuse, neglect, misappropriation of property, and exploitation of its residents, including verbal, involuntary seclusion. The facility has a "no tolerance" philosophy; persons found to have engaged in such conduct will be terminated... The resident's physician and representative, if necessary, shall be notified of any incident or allegation of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property... III. PROTECTION The facility will remove any alleged perpetrators) of abuse or neglect from any further contact with residents pending an investigation ... A. Employee. If the alleged perpetrator is an employee, the employee will be sent home and/or advised not to return to work until further notice. If that employee shall be immediately suspended without pay from employment at the facility, not having any further resident contact, pending the outcome of an investigation. If the allegation is found unsubstantiated, the employee will be reinstated with back pay. If the allegation is substantiated, the facility will take all appropriate steps under the circumstances, which may	S9999		

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S9999	Continued From page 24 include re-education, discipline, termination and/or reporting to local authorities and/or licensing agencies ... (A)	S9999		