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	IL6002828	A. BUILDING: _____ B. WING _____	C 06/05/2024

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S 000	Initial Comments Complaint Investigation: 2474087/IL173563 2474080/IL173551	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 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 care needs of the resident.	S9999		

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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.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to protect R1, a resident with dementia from sexual activity from R2, another resident with dementia with known sexual behaviors and a history of wandering into other resident's rooms. This failure resulted in R1 experiencing sexual abuse at the facility when R2 went into R1's room at night and went into R1's bed and sexually assaulted her in her bed. R1 is unable to give consent to the sexual activity and a reasonable person would not want to be touched without consent. This applies to 1 of 3 residents (R1) reviewed for sexual assault in the sample of 3.

The findings include:

Facility census roster dated May 21, 2024, showed that R1, R2 and R3 resided in the Dementia Unit.

Facility Incident Report dated May 22, 2024, included as follows: "Writer received notification from V16 (R1's family) that "an inappropriate event" allegedly occurred in R1's room on an overnight shift between 0100-0300. V16 states that there is a video recording of another resident

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going into R1's room and touching her inappropriately...."

Facility investigation dated May 22, 2024, included interviews and written statements from V7 (Certified Nursing Assistant) that V7 found R2 fully naked in bed on the morning of May 22, 2024, and that on May 20, 2024 at 6:40 AM, when V7 was giving R2 a shower he asked her to touch his private area.

On May 28, 2024, at 10:09 AM, V14 (Police Detective) stated that he reviewed the video recordings taken on May 22, 2024 and confirmed that the allegation of R1's family was seen recorded on camera. V14 stated that the report is in the preliminary stages and the Final Report will quantify details.

Police Incident Report dated May 23, 2024, showed there was evidence of sexual assault by R2 to R1 on May 22, 2024 time stamped between 12:45 AM to 2:00 AM.

The Police Report included the following information summary:
On May 23, 2024, at 11:27 AM, the police dispatched to the facility based for a Sexual Assault report. V16 (R1's family) reported to Police that R1 was sexually assaulted while R1 was a patient at the facility. V16 stated that she is R1's Power of Attorney because R1 has been diagnosed with Dementia leaving V16 to care for her. V16 stated that while R1 lived with her, she had camera's all over the house to keep an eye on R1 at all times. V16 stated that R1's dementia had worsened, so she admitted R1 to the facility on May 17, 2024, so that she could receive the care that she needs. V16 stated that she had placed a camera in plain view in R1's room on

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May 21, 2024, to observe R1's bed area and her room, so that she could check on her from time to time throughout the day. V16 stated that during the early morning hours on May 22, 2024, she checked the camera footage which shows a periodic still image and observed a male sitting on R1's bed. V16 called the facility and spoke with a representative and asked who was in her mother's room to which she was advised that nobody was in her mother's room. V16 later reviewed video footage in which she stated she observed the following in summary: -
- At approximately 12:45 AM, R1 appears to be attempting to dress herself but is struggling to get her bra on.
- A male enters her room and initially appears to attempt to help R1with her bra.
- The male appears to hear someone walking by in her opinion and moves away from R1 before coming back to her.
- V16 stated the male then begins to touch R1 in her private areas.
- The male eventually exposes his penis while touching R1.
- V16 advised that at one point the male's back is facing the camera with his pants down but it cannot be seen what he's doing.
- Eventually the male gets into bed with R1 and under the covers while naked.
- V16 stated she could not tell what the male is doing under the covers or whether or not any penetration occurred with R1.

During police interview with V16, she advised that she wanted to have a sexual assault kit completed on R1 and that she wanted an ambulance to take R1 to the hospital to have this done. An ambulance was requested at the scene and R1 subsequently transported to the hospital.

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Police Incident Supplement Report dated May 27, 2024, included the following information summary:
On May 23, 2024, V11 (Police Officer) and V13 (Police Officer) responded to the facility to process the scene for to assist with documentation and collection for evidence. Apart from taking digital photos of R1's room, including bed, bedding, security camera and two articles of worn clothing, the room was scanned using a forensic light-source, with varying wavelengths to see evidence of biological fluid. Multiple items were collected from R1's bed including piece of clothing and bedding and taken to the station and checked for possible biological/DNA evidence using the forensic light-source (495 nm (nanometer) wavelength with a yellow/orange filter). Digital photos of all the possible biological stains, under lowlight conditions were taken. The stains were checked using a Sirchie Seminal ID AP (Identification Acid Phosphatase) presumptive test for semen and seminal fluid. The white fitted sheet contained a larger stain about halfway down from the top, proximal to the center of the sheet. This stain was also tested and returned with some positive purple specks (indicating a positive test), on the filter paper.

Hospital records dated May 23, 2024, included that R1 was admitted to the hospital for sexual assault of adult and that R1's forensic examination at the hospital was released to law enforcement for further testing.

R1's EMR (Electronic Medical Records) showed that R1 was admitted to the facility on May 17, 2024 with diagnoses of senile degeneration of brain, not elsewhere classified, unspecified dementia, unspecified severity, with other behavioral disturbance, schizoaffective disorder,

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adult failure to thrive, epilepsy, unspecified, not intractable, without status epilepticus.

R1's initial baseline care plan on admission showed that R1 was cognitively impaired.

R1's nursing progress notes showed that R1 was sent to the local hospital Emergency Room on May 23, 2024, as part of an ongoing investigation and did not return to the facility.

Nursing progress notes since admission recorded that R1 is alert with confusion, non-compliant with using her walker, walks independently with rollator & needs supervision due to unsteady gait and that R1 goes into other resident's rooms.

R2's EMR showed that R2 was admitted to the facility on October 25, 2023, with diagnoses including unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, essential (primary) hypertension, adjustment disorder, unspecified, weakness. R2's EMR continues to show R2 was discharged to home on May 22, 2024, at around 11:00 AM.

R2's quarterly MDS (Minimum Data Set) on February 5, 2024, showed that R2 was severely impaired in cognition and required supervision or touching assistance for sit to stand and walk 10 feet and chair/bed-to-chair transfer.

R2's care plan, initiated on November 16, 2023, shows that R2 has a history of wandering. Facility had multiple interventions (initiated on November 16, 2023) including to identify if there are triggers for wandering and to engage the resident in purposeful activity. Facility did not have documentation that staff implemented these

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interventions. As of May 22, 2024, the facility did not have a care plan in place for R2 regarding inappropriate sexual behaviors.

Nursing progress notes in last one month (dated April 18, May 9 and May 20, 2024) recorded that R2 goes from room to room and 'checks on other residents' and also included that he was "redirected to bed after 1:00 AM" during one of these episodes.

Nursing progress notes dated April 25, 2024, included that R2 was assisted by CNA in the shower and inappropriate behavior noted during shower and reported.

On May 29, 2024, at 9:18 AM, V7 (CNA) stated that when she went into R2's room on May 22, 2024, at around 8:30 AM to get him up for breakfast she found him fully naked stretched out in bed. V2 verified that R2 was 'very inappropriate' with her when she was giving him a shower on May 20, 2024, at 6:40 AM. V7 stated "He is does that every time when I give him personal care or give him a shower. I have told the facility about it. He does that to everybody. He has tried to pull me on top of him in the shower. He sits in the shower chair. I have reported his (R2) inappropriateness in the stand-up meetings that is conducted by V1 (Administrator) about a couple of months ago. The facility does nothing about it. He (R2) knows what he is doing and is just taking advantage.

On May 28, 2024, at 9:38 AM, V15 (Registered Nurse/RN) stated that R2 has made comments to her "I am looking at you. I am liking you." V15 stated that when R2's daughter came to discharge him home, she said that he has even "hit on her".

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On May 25, 2024, at 9:29 AM, V1 (Administrator) stated that an allegation was brought to his attention on May 22, 2024 at around 11:00 AM by the family of R1. The family stated that R2 touched R1 and there is no rape. V1 stated that the family said that they had a camera in R1's room, and somebody walked into the room and touched R1. V1 stated that facility was not aware of the camera in the room. V1 stated that R1's family came in and identified R2 who resided a couple doors (room's) down from R1's room. V1 stated that the facility does not have cameras. V1 stated that he requested the camera footage from the family and has not received it yet. V1 stated that it happened at the overnight shift and the staff (1 nurse and 1 CNA) were making rounds and they could have been in another room. V1 stated that there was no screaming to alert to know that the person needed attention. V1 stated that the facility did a body check and there were no marks or bruises on R1. V1 stated that R1's family called the Police (on May 23, 2024) and wanted to have R1 sent to the hospital. V1 stated that he has not got any reports from the hospital. V1 stated that both R1 and R2 have Dementia and are not able to communicate adequately and R2 denied everything. V1 stated that both R1 and R2 are in the Dementia unit and residents with Dementia tend to wander and are hard to control.

On May 25, 2024, at 9:04 AM and 11:59 AM, V4 (Registered Nurse) stated that she worked on the previous night (May 21, 2024) of the alleged incident during the 3:00 PM -11:00 PM shift on the 2nd floor where R1 and R2 resided. V4 stated that R1 is very confused and was wandering all over the unit and not listening. V4 stated that R1 even went into R3's room who was on isolation sat there for 10 minutes and was hard to redirect.

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V4 stated that R1 then went into R2's room and sat there for about 10 minutes and was watching television and eating candy despite attempts to take her out of the room. V4 stated that R2 was waiting patiently outside the room and said to let R1 finish the candy. V4 stated that R1 eventually came out of R2's room after 10-15 minutes of giving R1 Ativan (anti-anxiety medication) as R1 was calmer and sat in the hallway. V4 stated that R2 has been at the facility 2-3 years and wheels himself around and sometimes walks with an unsteady gait. V4 stated that R2 is very curious when someone is yelling or moaning and will come to the nurse's station and report it to staff. V4 stated that 2-3 weeks ago V6 (Licensed Practical Nurse/LPN) said that R2 was sexually inappropriate with her. V4 stated that R2 told V6 to come sit with him and let him hug her and that she corrected him. V4 added that R2 has Dementia and is impulsive but not on purpose or intention. V4 stated that about a month ago, V8 (CNA) reported to her that she saw him masturbating in his room.

On May 25, 2024 at 11:31 AM, V3 (LPN) stated that she was working on May 21, 2024-May 22, 2024 on the 11:00 PM-7:00 AM shift. V3 stated that she received a report from V4 (RN) that R1 did not want to go to bed and that she went into R3's room. V3 stated that R1 was still sitting in front of R3's room between 11:00 PM -12:00 AM and V5 (CNA) was also working on the floor. V3 stated that when she went to talk to R1 to go to her room, she noticed that she had "poop" on herself and V10 (Agency CNA) from the 1st floor helped V5 clean R1 and put her to bed around 12:00-1:00 AM at nighttime. V3 stated that she went back to the nurse's station and that R2 was sitting around the nurse's station in the hallway at that time. V3 added that R2 usually sits there

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during the day and sometimes at night when he doesn't want to sleep. V3 stated that she saw him wheeling himself in the hallway towards his room but did not see him go into his room.

On May 25, 2024, at 4:32 PM, V5 (CNA) stated "I worked Tuesday night on the 11:00 PM to 7:00 AM shift. When I came in, (R1) was seated in the hallway and I asked staff why she was up and not sleeping. She was smelling of feces. The CNA from the agency (V10) that took care of her the previous shift on 2nd floor was still there on the first floor as she was doing a double shift. She said that she tried earlier to change (R1), and she refused. She came up to help me change (R1). I tried to be nice to (R1) and she agreed to be changed and we took her to her room, changed her and put her to bed. It was around 11:35 PM. I was at the computer doing charting. (R2) was up all night in his wheelchair going back and forth to the dining room to watch TV (television) and come back to the nurse's station and went to his room (not sure). I saw him back at the nurse's station at around 2:30 AM. Between 2:00-2:30 AM, V10 (CNA) came from downstairs to assist me change and check the residents. The nurse at some point went to the bathroom. I saw him (R2) sleeping in his bed at 4:00 AM when I did my rounds."

Facility floor plan showed that R1's room was on the same side of the hallway as R2's room with another resident's room in between their rooms and that R3's room was directly in front of R1's room. The floor plan also showed that the nurse's station was not in direct view of R1's and R2's rooms.

Facility Policy and Procedure titled "Ethics Preventing Resident Abuse" (effective January

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11, 2023) showed as follows:
Policy: Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse.
1. Preventing resident abuse is a primary concern for this facility. It is our goal to achieve and maintain an abuse free environment.
2.n. Identifying areas within the facility that may make abuse and/or neglect more likely to occur (e.g. secluded areas) and monitor these areas on regularly scheduled basis.

Facility Policy and Procedure titled "Abuse Prevention" (effective January 5, 2024) included as follows:
Prevention: The facility shall work to prevent abuse by:
A. Training all staff to recognize and report abuse.
B. Care planning appropriate interventions.
K. Monitoring residents with needs and behaviors which might lead to sexually aggressive behavior such as unwelcome advances or inappropriate touching/grabbing.

Facility Policy and Procedure titled "Reporting Abuse to Facility Management" (effective January 5, 2024) included as follows: Policy interpretation and Implementation-
7. To assist one in recognizing incidents of abuse, the following definitions of abuse are provided:
c. Sexual Abuse is defined as, but not limited to, sexual harassment, sexual coercion, or sexual assault.

"B"