Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | IL6015135 | A. BUILDING: ______<br>B. WING ______ | C<br>09/02/2021 |

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| GOLFVIEW DEVELOPMENTAL CENTER | 9555 WEST GOLF ROAD<br>DES PLAINES, IL 60016 |

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| Z 000 | COMMENTS<br><br>Complaint Investigation:<br>2195630/IL136793<br><br>Facility Reported Incident Investigation of 08-09-2021/IL136909 | Z 000 | | |
| Z9999 | FINDINGS<br><br>Statement of Licensure Violations:<br><br>350.620a)<br>350.3240a)<br>350.3240f)<br><br>Section 350.620 Resident Care Policies<br>a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.<br><br>Section 350.3240 Abuse and Neglect<br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.<br>f) Resident as perpetrator of abuse. 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. | Z9999 | Attachment A<br>Statement of Licensure Violations | |

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Based on record review, observation, and interview, the facility failed to ensure they followed their policy to prevent abuse and neglect for 1 of 1 client who was physically aggressed in his bedroom (R1) from another client who has a known history of physical aggression (R2); failed to ensure staff were immediately placed on administrative leave after 1 of 1 allegation of potential physical abuse affecting R1 who was physicially aggressed and found on the floor of his bedroom with mulitple bruises, abrasions, contusions, bite marks and punctures; failed to appropriately monitor one of one client with a history of sexual misconduct (R4); and failed to ensure an allegation of inappropriate sexual misconduct was throughly investigated, in the sample with a history of sexual misconduct (R4), who was involved in a sexual misconduct incident with R5 on 8/9/21.

Findings include:

1) The un-dated policy and procedure entitled, "Prevention of Mistreatment and Abuse of Clients", was reviewed. The purpose of the policy is stated to assure a positive environment free of abuse and neglect for individuals receiving services is maintained, incidents are thoroughly investigated, and that clients are not subject to physical, sexual, psychological,verbal abuse or neglect. Physical abuse is defined as hitting, kicking burning or cutting of a client. Sexual abuse is defined as but not limited too genital or anal intercourse, or oral sex with a client, or fondling of the breasts, genitals or anal area without consent.

The facility IDPH notification, dated and timed 7/28/21 at 3:45pm, was reviewed. The report

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states R1 was sent to the hospital due to a fall from his wheelchair.

The Incident Report Investigation for the incident of 7/28/21 involving R1 was reviewed. The report states on 7/28/21 at approximately 3:40 pm, R1, who is non-ambulatory, was found on the floor by E3 (Training Counselor). E3 reported the incident to staff nurse (E4). Per the initial report, a large contusion was noted to his left jaw area with abrasions to both arms. R1 was conscious, and breathing was within normal limits. Based on the appearance of those injuries, a call to 911 was made for evaluation and treatment.

The report continues, stating among the first responders were the Cook County Sheriff's Department, who secured the scene where the incident occurred (R1's room) and gathered names of the facility staff that were present in the building at the time. Cook County Deputes also began reviewing video footage from the facilities' camera system.

The report indicates the author of the investigation, E2c(Administrator), reviewed the video footage in the hallway where R1's room is located on the second floor. The video was reviewed on four different occasions, and a timeline was established to determine any staff or residents entering R1's room. The time line is as follows:

1:54pm - R3 enters R1's room. Leaves room at 1:56pm.
1:56pm - R2 enters R1's room.
2:01pm - E3 enters R1's room.
2:02pm - E3 leaves R1's room.
2:05pm - E5 (Training Counselor) enters R1's room. Appears to be collecting clothes hangers.

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2:07pm - E5 leaves R1's room.
2:12pm - E3 enters R1's room.
2:15pm - E3 leaves R1's room.
2:18pm - R2 leaves R1's room.
2:23pm - R2 exhibiting agitated/acting out behavior in the hallway of the wing near the elevators/nursing station. The behavior continued until approximately 2:27pm with her being escorted to her room (across the hallway from R1's room)
2:28pm - R2 enters R1's room.E6 (Qualified Intellectual Disability Professional), and E5 enter room 226 as well).
2:29pm - E6 and E5 leave R1's room.
2:43pm - R2 appears briefly in the doorway of R1's room, then re-enters R1's room.
3:24pm - E3 enters R1's room. Discovers R1 on the floor.
3:25pm - R2 leaves R1's room. E3 also leaves R1's room.
3:26pm - E3 enters (another room).
3:27pm - E3 leaves (another room). Walks toward dining room/nurses station.
3:31pm - E5 enters R1's room. Leaves room.
3:31pm. E5 enters R1's room with E6.
3:33pm - E4 enters R1's room.

The report indicates R1's room was secured by the Cook County Sheriff's Department from 3:40pm through 9:00pm on 7/28/21, to preserve and collect evidence from the area where the incident was reported to have occurred. Photos were provided to E2 from Z2 (Guardian/sister of R1) at approximately 7:20pm. The photos showed what appeared to be a large contusion on his left lower jaw, linear abrasions and discolorations to his right forearm, discolorations to his right hand, abrasions and possible puncture wounds to his right hand. Other photos showed linear abrasions to his left forearm, discolorations

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to his left hand. There is also the appearance of bite marks to both hands and his back area.

E2 interviewed E6 on 7/29/21 and 8/3/21. E6 is the QIDP assigned to R2. E6 stated R2 was running and grabbed E6's arm at about 2:23pm. E6 stated another staff member verbally re-directed R2 to her room, and she was compliant with that directive. E6 stated she followed R2, and saw her return to her room. Shortly thereafter, E6 observed R2 leave her room and enter R1's room. E6 and E5 went into R1's room, just before the shift meeting, and then left the room with R2 remaining in R1's room with R1. E6 admitted she did not return to R1's room until she was notified R1 was discovered lying on the floor.

E2 interviewed E5 on 7/29/21 and 8/3/21. E5 stated E5 was in R1's room shortly after 2pm on the day of the incident. He observed R1 up in his wheelchair, near his nightstand and dresser, which are positioned against the wall at the corner of the room near the window. R1 was listening to his music at the time. Just before the shift meeting at 2:30pm, E5 stated R2 had been acting out in the hallway of the wing, and was being physically aggressive toward staff. E5 stated E5 assisted in escorting R2 into her room, and then observed R2 enter R1's room across the hall. E5 said he went into R1's room, and saw R2 seated in a chair sitting peacefully. R1 was in his wheelchair at that time. E5 then left for the 2:30pm shift meeting.

E2 interviewed E3 on both 7/29/21 and 8/3/21. E3 stated when he discovered R1 on the floor (at approximately 3:24pm from the video review), R1's head was near the wall, just below the window. E3 stated he left the room to alert the

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nurse on duty, E4, and the case manager, E6. E3 stated he also reported what appeared to be a fall to E5. E3 stated E3 observed injuries to R1's face and arms. E3 stated E3 did not return to R1's room after he reported the alleged fall, but instead E3 relieved E5 in assisting with the visiting Podiatrist.

E2 interviewed E4 (Nurse) on both 7/28/21 and 7/29/21. E4 stated E3 notified E4 R1 was discovered on the floor. This occurred at approximately 3:30pm. E4 stated he went into R1's room and observed R1 was on the floor, noting R1 had discoloration to his left lower jaw and was bleeding from both his arms. E4 stated E4 assisted in getting R1 into R1's bed for further assessment. E4 notified the Nurse Practitioner(E7) by phone, who directed E4 to transport R1 to the Emergency room. E4 called 911.

E2 interviewed agency staff member, Z3 on 7/30/21. Z3 visited with R1 just after 1:15pm, and did not observe any apparent injuries to R1 at that time. R1 had just received a new wheelchair. Z3 also stated R2 has a pattern of going into R1's room and shuts off his radio.

The Resident information/Synopsis of the investigation indicates R1 is blind, non-ambulatory, and non-verbal. He has the diagnoses of Profound Intellectual Disability and Cerebral Palsy. R1 is 4 feet 7 inches tall and is contracted on the knees, which he often draws up when seated in his wheelchair. R1 enjoys listening to music and will interact with staff through facial expressions and reaching out to hold hands. Per interview with staff, R1 has the ability to slide out of his wheelchair, which until the date of this incident was a standard

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wheelchair.

R2, per the incident investigation report was admitted to the facility in December of 2020. R2's diagnoses include Profound Intellectual Disability and Autism. R2 is ambulatory and currently has a behavioral intervention plan to address self-injurious behavior (SIB), physical aggression, tantrums, and non-compliance. R2 is known to engage in SIB when she is hungry, and may become physically aggressive at times. Per reports of staff, R2 will enter rooms which tend to be quiet, and requires re-direction from staff to leave other residents' rooms. R2 is currently prescribed psychotropic medication to help control her behaviors.

The summary and conclusion of the facility investigation state based on the evidence collected through interview, assessed injuries to R1, and the physical environment in R1's room, the facility concluded R1 was the victim of physical aggression from R2, and the injuries sustained by R1 resulted from R2's physically aggressive behavior between 2:28pm and 3:24pm. The facility could not determine the exact actions from R2, but it is evident R2 bit R1 on his hands, and R1 either came out of his chair on his own, or was pushed out of the chair by R2. The injury to R1's lower jaw may have resulted from striking the side of his face against the dresser where he had been positioned near his wheelchair. The facility could not determine what prompted the physical aggression from R2, but it was known R2 was exhibiting physically aggressive/acting out behavior in the hallway at approximately 2:23pm, just prior to entering R1's room. R2 remained in R1's room until 3:25pm, just after R1 was discovered lying on the floor with the injuries that were noted.

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| Z9999 | Continued From page 7<br><br>The facility investigation also concluded the allegations of neglect involving staff members E5, E6, and E3 are substantiated due to their inaction in effectively monitoring R1, and re-directing R2. As a result, these staff members have been terminated from their employment at this said facility. This report was authored by E2 (Administrator).<br><br>The Emergency Room report involving R1, dated 7/28/21, was reviewed. The report states R1 presented into the ER as a trauma activation after being found on the ground next to R1's wheelchair at his group home. R1 is non-verbal. Per EMS, group home staff found R1 on the ground next to his wheel chair, no further details about what happened. Per EMS, R1 is usually strapped into his wheelchair, but the strap was apparently not on R1 when they arrived.<br><br>The physical exam shows R1's contracted. His skin showed evidence of multiple traumas. There were excoriations to the bilateral arms, contusions to the bilateral arms, multiple bite wounds to the bilateral arms, and a bilateral jaw contusion. There was noted swelling to the bilateral forearms and hands. R1 was moving his arms bilaterally, but was moaning with movement at times. X-rays were performed of the chest, pelvis, bilateral hands, and bilateral forearms. CT scans were performed on the facial bones, chest, abdomen and pelvis with contrast, thoracic and lumbar spine without contrast. Final diagnoses were multiple bite wounds, blunt facial trauma, arm contusions and arm abrasions. R1 received Fentanyl for pain, was started on IV fluids, and given ampicillan for post bite prophylaxis. R1's tetanus was also updated. No bony injuries were noted on imaging, but presented with extensive | Z9999 | | |

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| Z9999 | Continued From page 8<br>soft tissue injuries which required hospitalization. Trauma service recommended medical admission. Lab work was completed, and R1 was noted to be in metabolic acidosis, where he was on room air, maintaining O2 sats greater than 95%. R1's respiratory status was being monitored. As of 8/12/21, R1 was still an inpatient in the hospital.<br><br>During an interview with E1 (Residential Services Director) on 8/6/21 at 11:30am, E1 told this writer R1 was in the hospital because of neglect. E1 stated R2 will bite if not supervised, and has a history of SIB and aggressive behavior. E1 stated R2 likes to go in R1's room, because it is quiet. R2 wears sound proof head phones. E1 stated R2 should not have been in R1's room. E1 stated clients can visit with other clients in their rooms, if they are able to give consent to that visit. E1 stated R1 does not have the ability to give R2 permission to come into his room. E1 stated R1 is non-verbal and blind. E1 stated when R2 becomes agitated, R2 should be re-directed by staff into R2's room. E1 stated they reviewed the tape, and saw R2 had been aggressive in the hallway, just prior to entering R1's room. E5 and E6 were both aware that R2 went into R1's room. E1 confirmed both staff should have re-directed R2 out of R1's room. Neither of them did that, but rather, left R2 un-monitored in R1's room, and went to the all staff meeting. E1 stated E3, who found R1 on the floor, should never have left him there and attended to another resident across the hall. E3 should have immediately called for assistance, and called for a nurse. E1 stated R1's face was bruised, and he was bleeding from his mouth and his nose, as well as had bite marks and puncture marks on R1's arms. E1 stated E1 does not know how R1 got out of his wheelchair, and R1 | Z9999 | | |

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| Z9999 | Continued From page 9<br>had just received a new wheel chair just hours before this incident occurred. E1 stated R1 either un-fastened R1's seat belt, or R1 was pulled out of R1's wheelchair by R2. E1 was asked what they are doing to prevent R2 from aggressing any other residents going forward. E1 stated they are in the process of protective action, and have made R2 a 1:1, which means one staff needs to be with R2 at all times, and must stand next to R2 within arms length of her body. E1 was asked if R2 could be observed, and E1, with this writer, went to the second floor on this date at 12:25pm.<br><br>R2 was observed eating R2's lunch in the second floor dining room. R2's 1:1 staff was observed walking away from R2, to assist another client, and was not within arms length from R2's body. The staff member observed was E8(Training counselor). R2 was observed standing up and running down the hall, and into R2's bedroom, with E8 chasing after her, not within arms length. Upon entry into R2's room, R2 was sitting on her bed, and E8 was sitting on a chair next to the door. R3, who is R2's roommate, was also in her room, sitting on R3's bed. E8 was sitting closer to R3's bed than R2's bed. E1 was present with this writer, and when E1 asked E8 why she is sitting so far away from R2, E8 stated E8 is also the 1:1 for R3. E8 confirmed when E8 left the room to monitor R2 at lunch, R3 no longer had 1:1 monitoring. E1 had to appoint another direct care staff to be a 1:1 for R3, so E8 could just be the 1:1 for R2. E1 was asked if staff understand what 1:1 means, as E8 clearly did not demonstrate knowledge of how a 1:1 within arms length should be performed. E1 stated they did do training during one of the 2:30pm all staff meetings, but clarified they do not have any documentation to show staff were trained. | Z9999 | | |

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R2's Individual Behavioral Intervention Plan, with an end date of 2/18/22, was reviewed. R2's program plan indicates R2 has the following behaviors of SIB, physical aggression, tantrums and non-compliance. The program indicates staff should be aware of the escalation chain of R2 being given some sort of directive. R2 should be directed to her personal space where she is visible by staff, but is not able to reach them until she is calm. Other residents should be removed, and only one or two staff needs to stand there to help R2 deescalate. There is nothing in R2's plan indicating R2 has a 1:1 since R2's incident of physical aggression against R1.

During an interview with E1 on 8/12/21 at 12:50pm, E1 was asked if they have had any meeting to discuss the incident with R2 and R1, and if they added an addendum to address the use of the 1:1. E1 stated they have not, as the QIDP who has R2 in her case load, is the same QIDP who was terminated. E1 was asked if they have guardian consent or HRC consent for the usage of the 1:1. E1 stated they do not, and realizes it has been well over a week since this incident occurred.

During an interview with E2(Administrator) on 8/12/21 at 10:15am, E2 was asked when E3, E5, and E6 were placed on administrative leave. E2 stated it took some time for him to review all of the video footage, and they all were placed on administrative leave on the following Wednesday, a week after the incident occurred (8/4/21). E2 confirmed all three staff continued to work as per their usual assigned days from 7/28/21 through 8/4/21. E2 was also asked if it is their practice to have residents visit in each other's rooms. E2 stated some clients do like to visit with each other, and can give verbal permission to do so.

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| Z9999 | Continued From page 11<br>E2 clarified in the case of R1 and R2, R1 is non-verbal and blind, and is not able to grant that permission to R2. E2 offered further staff should not have been allowing R2 to enter R1's bedroom, especially after R2 just had an aggressive behavior with E6. E2 stated all staff were terminated, because they did not protect R1 from R2, and when E3 found R1 on the floor, he did not immediately obtain medical assistance for him, but rather, addressed the need of another client in (another residents room). E2 stated E3 confirmed to E2 that he saw the blood coming from R1, but still did not immediately call for medical assistance from nursing. E2 stated he cannot get his head around that one; E2 stated it is a major issue in regards to E3's non action. E2 stated E5 and E6 left R2 alone with R1 for close to 56 minutes, without going back to check on R2 after her behavior. E2 offered E6 is R2's QIDP, and she should have known better. E2 was asked why they have not had a special meeting to discuss the next steps to address and discuss the incident involving R2 and R1, and placing R2 on a 1:1 status. E2 stated this kind of thing does not happen all of the time, and if someone is showing physical aggression, maybe you should do a 1:1 for 1-3 days, as an emergency measure for the safety of the clients. E2 stated looking back, he admits they should have followed up and did a special staffing. E2 was made aware of the 1:1 not being correctly implemented during the observation on 8/6/21 by this writer. E2 stated E1 had made him aware of that situation, and confirmed there should never be one staff for 2 clients who are on a 1:1 status. E2 stated E2 is also aware there was no formal training done in regards to the 1:1 for R2 up until 8/6/21. E2 also stated staff had been aware R2 would enter R1's room and turn his radio off and/or his lights off, but still allowed R2 to do so. E2 stated staff | Z9999 | | |

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should have re-directed R2 out of R1's room, every time R2 attempted to do so.

2) The undated Sexual Policy was reviewed. Masturbation is defined as fondling/stimulating one's own body for the purpose of sexual arousal. The policy states if a client chooses to masturbate or engage in sexual self-stimulation, this should be done in a private place so the rights of others are not violated. Consensual sexual activity is defined as by between facility clients, each of whom has been identified by the interdisciplinary team as being able to consent to such activity. Sexual abuse refers to any sexual act committed on an individual through coercion, manipulation or physical force or without consent. The policy indicates when staff become aware of any sexual abuse, the incident should be reported to the nurse in charge. The nurse should assess the client for physical evidence, and findings should be documented on the general incident report, along with the victim's emotional state, physical condition and appearance, as well as any pertinent statements made by the victim or witnesses. The nurse shall notify the Cook County Sheriff's Police, the Doctor, Administrator, Guardian, and the Illinois Department of Public Health. The Supervisor shall secure the area in which the act took place or was alleged to have taken place. These measures shall include removing all residents from the area, utilize gloves to place bedding(if the incident occurred in a bedroom) in a red bag, which is labeled and set aside for criminal investigators. The client's clothing should not be changed, nor should the client's genital, rectal or oral areas be cleansed in any manner.

The IDPH notification form involving R4, dated and timed 8/9/21 at 8:05pm, was reviewed. The

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report indicates R4 was in the bathroom with R5, with an investigation report to follow. The IDPH notification report involving R5, dated and timed 8/9/21 at 8:05pm, indicates R5 and another resident (R4) were in the bathroom together, and she came out topless with her brief and pants pulled down. R5 was sent to the hospital for evaluation. The report does not indicate if R5 was acting like her normal self, or if she was upset or acting different in any way.

The hospital report involving R5, also dated 8/9/21, was reviewed. The report indicates R5 arrived at the Emergency Room on 8/9/21 at 9:26pm. While at the ER, R5 had an external vaginal exam performed, where swabs were obtained, as well as pubic hair combings. The officer who was called in at the scene, Z4 endorsed Z4 saw video footage outside of the bathroom, presumably where the event occurred. Per the officer, the event occurred as follows:

2002(8:02pm)- R5 seeing wandering in hallway outside of male restroom. R4 comes out of the restroom, sees R5, and takes her by the hand. R4 leaves the restroom, and wanders in the hallway momentarily at 8:04pm, and returns to the bathroom. R5 is not seen in the footage at this time. At 8:06pm, R4 leaves the restroom, and does not return. At 8:17pm, R5 walks out of the bathroom alone. R5's shirt is removed and is later found in the restroom. R5's pants are pulled down to R5's ankles. Staff on scene endorse R5 was not acting herself after the event. The report indicates the emergency staff who brought R5 into the ER stated R4 admitted to removing R5's clothing, but only masturbated in front of the patient, and denied touching R5. However, Z4 disclosed to the hospital staff RN a nurse at the facility(unnamed) was told by R4 he did have

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sexual intercourse with R5, and R5 wanted to have sex.

The hospital report indicates permission was obtained for a sexual assault evidence kit, as well as prophylaxis for gonorrhea and chlamydia, as well as pregnancy prophylaxis. (To date, no results are available as to the results of the swabbing performed on 8/9/21).

The Incident Report Investigation for the incident of 8/9/21, involving both R4 and R5 was reviewed. The investigation is authored by E9 (Qualified Intellectual Disability Professional). The report indicates R5 came out of the first floor male bathroom topless. Upon checking the camera (facility video surveillance) noted R4 grabbing R5 on the arm and pulling R5 in the first floor male's bathroom. R4 came out of the bathroom first, and then R5, topless with R5's brief and pants pulled down, came out next. R4 was placed on 1 on 1 supervision. Per the investigation, E9 interviewed R4 on 8/9/21, and asked what happened when he went into the bathroom with R5. R4 stated R5 went into the bathroom and pulled R4's pants down, and stated R5 wanted to have sex with him. E9 told R4 he needed to tell the truth. R4 then stated he took R5 into the bathroom, and R5 pulled R5's pants down, and R4 pulled R4's pants down. R4 stated R4 took off R5's shirt, and then started to touch R5's breast. E9 asked if R4 pulled out R4's penis, and R4 stated R4 must have. E9 asked R4 if R4's penis touched any part of R5's body, and R4 stated it must have. R4 did not want to answer any more questions. R5 was also interviewed by E9 on 8/9/21, however R5 was not able to participate in the investigation, due to her being non-verbal.

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On 8/12/21, E9 interviewed E10 (Training Counselor) and asked E10 if she knew what happened between R4 and R5. E10 stated E10 came in from an outing, and saw R5 walking down the hallway with no top or bra on. E10 took R5 upstairs to put a t-shirt on her. E10 was asked if E10 remembers if R5's pants and brief were down, but E10 stated E10 did not remember.

E9 continues in her report, and states E9 interviewed training counselor, E11, on 8/12/21. E11 stated E11 saw R5 walking by the multipurpose room topless. E11 asked E10 to take R5 up to her room, and then E11 reported the incident to the supervisor. E11 was able to locate R5's t-shirt in the men's bathroom, which E11 also let the supervisor know.

On 8/31/21 at 2:40pm,during an interview with E11 and this writer via the telephone, E11 confirmed E11 was the staff member assigned to the multipurpose room the night of 8/9/21. E11 stated E11 never knew R4 was down on the first floor, because R4 never came into his room. E11 stated the room was very busy, but R4 never came in by E11, nor did he ask E11 to use the bathroom. E11 stated the supervisor told E11 later, he could see R4 was watching for E11, and kind of hiding, not wanting E11 to see R4. That is when R4 pulled R5 into the bathoom on the first floor outside of the multipurpose room. E11 said E11 really did not know R4 that well, but that E11 is sure R4 could be down by the first floor. E11 confirmed E11 really did not know R4 should not be by R5. E11 stated E11 just knew that E11 had to watch the clients in the multipurpose room, and those that went outside.

E9 continued with E9's investigation, and E9's

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report indicates E9 then interviewed E12 (Supervisor) on 8/12/21. E12 stated when E12 came downstairs, E11 and E10 showed R5's clothes they found in the bathroom, so they let the nurse know (E13), so they could watch the video camera, where they saw R4 pulled R5 into the bathroom. R4 was placed on 1 on 1. R4 was interviewed by E12, and asked what happened in the bathroom with R4 and R5. R4 told E12 he only masturbated, but when E13 asked R4 what happened, R4 told her that they had sex.

Under resident synopsis, R4 is a 71 year old male, with the diagnosis of severe intellectual disability. R4's word about what has happened is not known to be generally trustworthy if the action involves something R4 did. R4 also has a behavior plan that addresses inappropriate sexual conduct and physical aggression.

The resident synopsis for R5 states R5 is a 40 year old female with a primary diagnosis of Profound intellectual Disability, and Autistic Disorder. R5 requires assistance with all R5's daily living skills. R5 can follow one step simple commands that apply to R5's daily routine. R5 does not respond to questions and does not identify objects. R5 can clearly verbalize hi and eat only, otherwise is non-verbal.

The conclusion of the investigation, after watching the video surveillance footage, and with R4's extensive history and documentation of inappropriate sexual conduct, concludes R4 did in fact exhibit inappropriate sexual conduct toward R5 in the first floor men's bathroom on 8/9/21 at 8:00pm. The QIDP (E9) will prime staff to monitor R4's and R5's interactions with one another, counsel R4 on the appropriate relationships with his peers, and like for the

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| Z9999 | Continued From page 17<br>Psychiatric Nurse Practitioner to evaluate R4 on a monthly basis if needed. R4 is to remain on 1 on 1 supervision for his inappropriate sexual conduct, and will move R4 to a different room.<br><br>R4's Behavioral Intervention Plan, which is dated 2021/2022, was reviewed. The program states R4 has a history of inappropriate sexual behavior that includes public masturbation, and both homosexual and heterosexual activity. R4 has the history of luring a passive female into the bathroom for purposes of having sex with her. R4's Behavior program notes the following restrictions:<br>* R4 has the restriction from entering the 2nd floor. At anytime R4 is found attempting to go to the second floor, he will be re-directed to either the first or the third floor.<br>* R4 is restricted from using the first floor bathrooms next to the multipurpose room. R4 can use this bathroom only with staff supervision.<br>* R4 has a movement restriction from R5 and a client who is no longer living at the facility, who has since deceased.<br><br>E2(Administrator) was interviewed on 8/12/21 at 10:45am, by this writer. E2 was asked if the detective has spoken with any of their staff in regards to the sexual misconduct allegation between R4 and R5. E2 stated E2 was not aware. E2 was asked if R4 or R5 have any special supervision restrictions. E2 stated not that E2 is aware of, and that both clients are ambulatory. E2 stated R4 is verbal, and R5 is very limited. E2 confirmed neither client could give consent to a sexual relationship. E2 stated the night in question(8/9/21), an activity aid was in the multipurpose room until 8pm. E2 stated he checked the backyard, and another staff was returning from an outing. E2 stated is when R5 | Z9999 | | |

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| Z9999 | Continued From page 18<br><br>came out of the first floor bathroom, without R5's shirt, and R5's pants and brief down at her ankles. E2 offered R4 was dressed. E2 stated both R4 and R5 have freedom to go into that part of the facility. E2 stated there is staff assigned to the multipurpose room, but not to the hallway or restrooms specifically. E2 offered R5 will come down to the first floor, looking for drinks, and R4 likes to hang around that area. E2 stated E2 has E9 currently looking into this incident, and E9 has interviewed R4, who does understand, but R5 could not understand what is being asked of R5. E2 offered R5 does not seem to be able to show the ability to toilet herself or change her incontience brief, so E2 doesn't think that was what R5 was doing in the bathroom. E2 stated R4 has said some conflicting things, based on the evidence that they have so far. E2 offered R4 did say that he touched her breast and masturbated.<br><br>During an interview with E9 on 8/27/21 at approximately 11:30am, E9 was asked if she can clarify what the restrictions mean for R4. E9 stated E9 just received R4 on her case load in June, but when she started at the facility in May, she asked E6 (Qualified Intellectual Disability Professional) who was R4's QIDP at that time, if E6 could explain R4's restrictions to E9, as they were not clear in her mind. E6 explained to E9 if R4 wanted to use the bathroom on the first floor, outside of the multipurpose room, R4 needed to ask the staff who was in charge of the multipurpose at the time, if he could go to the bathroom. Staff were then to supervise R4 while using the bathroom. During a phone interview with E9 on 8/26/21 at 10:50am, E9 clarified E9 did not write the behavior report for R4, but rather, E6 did. E9 was asked if she could explain what the movement restriction means in regards to R5. E9 stated R5 is not really sure if the | Z9999 | | |

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| Z9999 | Continued From page 19<br><br>movement restriction is defined anywhere, but E9 understands it R5 and R4 should be monitored so they are not together. E9 stated after looking at the video footage, it shows E11 did not monitor the bathroom outside the multipurpose room. E9 stated R4 went to activities the night of August 9th, which were held in the multipurpose room on the first floor. E9 explained R5 was walking in the hallway, and that is when R4 grabbed R5's arm, and pulled R5 into the bathroom. E9 was asked if E11 was aware E11 needed to be watching R4, to ensure R4 did not use the downstairs bathroom, unsupervised.E9 stated E9 is not sure, but knows E11 did monitor the outside area. E9 was asked if she asked either E10 or E11 if R5 seemed upset after the alleged incident occurred. E9 stated E9 did not ask that question., because they never said r5 was upset, so it never occurred to E9 to ask that question. E9 stated E9 cannot confirm if sexual intercourse occurred while R4 and R5 were in the bathroom together, because R4 would say yes one minute, and no the next. E9 said E9 does believe something did occur and believes R4 did masturbate in front of R5. E9 stated when E9 watched the video camera footage, R5's back is to the camera, so E9could not really see R5's face to see if R5 was upset. E9 was asked if the clothing R5 had on while the alleged sexual misconduct occurred went to the ER with her to be assessed for criminal evidence. E9 stated E9 is not sure, and did not ask that question. E9 was asked why R4's room has been changed. E9 stated they needed to move R4's room because R4 was on the same wing as another individual who R4 has a past sexual history with, so they needed to move E4 from that wing to ensure that clients safety. E9 stated that client is R6. E9 was asked if any of the staff were aware of the movement restriction from R4 towards R5. E9 stated they have a meeting every | Z9999 | | |

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| Z9999 | Continued From page 20<br><br>day at 2:30pm, and on the back of the meeting form, there is a lot of necessary information typed, which includes the mentioning of R4 having inappropriate sexual conduct, and staff should monitor R4 at all times, and re-direct R4 away from R5, R6, and a third client, R7. E9 also offered there is also a statement located on this same form, indicating when staff is assigned to the multipurpose room, this includes the backyard, first floor bathroom, corridor and bus exit door. This form was received by this writer on 8/27/21, which confirms the above statements. E9 stated after talking with staff, E9 is in the process of changing R4's behavior program, because staff offered prior to having a potential sexual misconduct incident, and seeking out someone, R4 will look out of the room R4 is in, and see if any staff is around. E9 stated this is information staff can watch out for to know the warning signs. E9 was asked if she ever asked E11 directly if he was aware of the movement restriction between R4 and R5, if he was aware E11 needed to monitor the first floor bathroom outside of the multipurpose room, or if R4 asked E11 if R4 needed to use the bathroom, so E11 could supervise R4 as he did so. E9 confirmed E9 did not ask E11 any of those questions. E9 stated E9 is new doing investigations this serious, and going forward, E9 knows to ask more of these types of questions. E9 offered E9 was aware of a history of sexual misconduct between both R4 and R5, but E9 did not include that incident in her investigation either.<br><br>The Incident Report Investigation, dated 2/24/2020, involving both R4 and R5 was reviewed. The incident states R4 was seen coming out of the first floor men's toilet followed by R5 without any clothes on. The report indicates R4 was seen coming out of the men's | Z9999 | | |

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| Z9999 | Continued From page 21<br>toilet with his clothes on, fully dressed. R5 came out, following R4, but R5 was without clothes, with R5's pants down, and R5's diaper down on R5's feet. R5's clothes were found in the bathroom. R5 was assessed by nursing, and no usual findings were noted on R5's body. R4 was interviewed, and gave contradictory statements like, "(R5) asked (R4) to remove the clothes", and did not give clear statements. R5 was unable to be interviewed, as R5 in non-verbal. The conclusion indicates they do not believe inappropriate sexual conduct occurred between R4 and R5, because the body check performed on both clients did not show any abnormalities. Going forward, staff are to monitor that R4 is re-directed away from R5, and to monitor R5 when she is walking around. Staff are to re-direct R5 back to the second floor (where R5's bedroom is located) whenever R5 is seen on the first or third floor (where R4's bedroom is located).<br><br>During a follow up interview with E2 on 8/27/21 at 10:00am, E2 stated E2 personally doesn't think 5 days is enough time to complete a thorough investigation. As far as the investigation not stating if R5 seemed upset, E2 offered there was nothing stating R5 was upset on the initial report. When asked about the police statement from the hospital, stating staff offered to him R5 was upset, E2 stated the hospital report does not indicate which of our staff might have said that, and it is all hearsay. E2 stated the last encounter between R4 and R5 was 17 months ago, so he thinks what they had in place was effective, up until now. E2 stated as far as E11 knowing how to interpret the restrictions that R4 has in place, E2 is not going to say what those restrictions mean. E2 stated you train staff, and expect them to know the program plan. E2 was asked if the restrictions R4 has in place are clearly defined. | Z9999 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOLFVIEW DEVELOPMENTAL CENTER | 9555 WEST GOLF ROAD DES PLAINES, IL 60016 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Z9999 | Continued From page 22<br>E2 stated they may be confusing to some, but to others it may not be. E2 stated E2 does not want to say how others might interpret something, but obviously it worked for 17 months.<br>(A) | Z9999 | | |