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| S 000 | Initial Comments<br><br>Complaint Investigation 2392794/IL158335 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br>300.1210b)<br>300.1210c)<br>300.3240b)<br>300.3240e)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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 | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>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.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>Section 300.3240 Abuse and Neglect<br><br>b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)<br><br>e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)<br><br>These requirements were not met as evidenced by:<br><br>Based on interview and record review, the facility failed to protect a resident from being sexually abused by another resident, failed to assess residents for abuse risk upon admission, failed to have effective interventions in place to keep residents free from abuse and/or abusing other residents, failed to have adequate supervision | S9999 | | |

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| S9999 | Continued From page 2<br>and effective interventions in place to monitor residents with impaired judgement/decision making skills, assessed as requiring staff supervision for all Activities of Daily Living (ADLs) and assessed to have wandering behaviors, who resided on the dementia/locked unit of the facility.<br><br>These failures applied to two (R1 and R2) of two residents reviewed for abuse and supervision and resulted in R1 being sexually assaulted by R2. R1 is not able to give consent for sexual activity due to cognitive impairment and was taken to local hospital and received prophylactic antibiotics.<br><br>Findings include:<br><br>R1 is a 69-year-old female who has resided at the facility since 2020, with past medical history including, but not limited to history of falling, muscle weakness, adult sexual abuse, chronic kidney disease, unspecified dementia unspecified severity, essential primary hypertension, anxiety disorder, major depressive disorder, etc.<br><br>During the complaint investigation on 5/24/2023 at 3:15 PM, R1 was observed in the dining room with peers and was taken to her room for private interview. R1 was alert and oriented to her name only. R1 did not recall the sexual assault incident and could only answer yes or no to questions. R1 was asked if she recalled having sex with a male resident and she said no, she is not in a relationship with anyone and does not recall having sex with anyone. R1 was asked if she would like to have sex if she had a boyfriend and she said, "not exactly."<br><br>Local police incident report dated 3/31/2023 titled "criminal sexual assault incident" at or about 1630 | S9999 | | |

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| S9999 | Continued From page 3<br>hour, reported 1804 hours, described the victim as R1. In the narrative, the report stated in part, on March 31, 2023, at 1804 hours, officers were dispatched to the facility in reference to a criminal sexual assault, upon arrival the officer met with a staff V5 (Nurse Manager) who related that a resident (R1) who is diagnosed with dementia was observed by staff having sex with another resident (R2). V5 added that he believed R2 may have lured R1 to his room due to her dementia. The report stated that the local fire department also arrived at the scene, while they were preparing to transport R1 to the hospital, V12 (Police Officer) asked R1 if she knew what happened today or why the police was in the facility and she stated that she did not know and that while trying to gather information from R1, she appears confused.<br><br>Care plan initiated 9/04/2020 states that R1 has impaired cognitive function related to dementia, goal states that R1 will maintain current level of decision-making ability by the next review date. Interventions include but not limited to communicate with the resident/family/caregiver regarding resident's capabilities and needs, discuss concern about confusion, disease process, nursing home placement with resident/family/care giver, the resident needs supervision/assistance with all decision making.<br><br>Care plan initiated 6/8/2021 stated that R1 is a wanderer as evidenced by history of attempts to leave facility unattended, impaired safety awareness, resident wanders aimlessly. Interventions include distract resident from wandering by offering pleasant diversions, structured activities, food, conversations, televisions, books resident prefers, monitor for fatigue and weight loss etc. | S9999 | | |

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| S9999 | Continued From page 4<br><br>Abuse care plan dated 3/7/2023 stated that R1 is at risk for abuse due to severe cognitive impairment and being long term care at SNF. Interventions include to assess for abuse risk quarterly and as needed. R1 did not have any documented assessment for abuse risk since admission.<br><br>Minimum data set assessment (MDS) dated 3/13/2023, section C (Cognitive) coded R1 with brief interview for mental status (BIMS) score of 3, indicating severe impairment. Section G (functional status) of the same assessment coded R1 as requiring limited to extensive assistance with one-person physical assist for all activities of daily living (ADLs) including walking in room and corridor, as well as locomotion on and off unit. Another BIMS assessment dated 4/6/2023 also coded R1's cognition as severe impairment.<br><br>Hospital record for R1 dated 3/31/2023 documented the chief complaint as, reported sexual assault at a nursing home, patient with severe dementia. The same record documented in part, 69-year-old female from a nursing home due to reported sexual assault, patient has history of frontotemporal dementia, has been unable to recall any events that led her to the hospitalization. Patient was unable to name the place, year or even the date of her birthday, alert to self only and is unable to provide any meaningful information. The hospital record also stated that R1's dementia is severe, unlikely that she was able to consent to the act, resident complained of discomfort to the genital area and was treated with Ceftriaxone 500mg IM, doxycycline 100mg and metronidazole 500mg, resident to continue doxycycline and | S9999 | | |

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| S9999 | Continued From page 5<br>metronidazole pending genital culture result.<br><br>R2 is a 67-year-old male who has resided at the facility since 2020, with past medical history of Unspecified psychosis, essential primary hypertension, hyperlipidemia, alcohol dependence, nicotine dependence, delusional disorder, other sexual dysfunction, unspecified dementia, etc.<br><br>5/24/2023 at 3:05 PM, R2 was observed in his room, alert and oriented with some confusion, did not recall R1 or being friends with any female resident. Stated that he does not recall having any sexual relationship with anyone and would not like to do so.<br><br>Care plan initiated 2/02/2020 states that R2 is an elopement risk/wanderer as evidenced by history of attempts to leave facility unattended and impaired safety awareness. Interventions included 1:1 monitoring, resident moved to a secured unit, monitor location every 60 minutes, monitor wandering behavior and document attempted diversional interventions in behavior log, etc.<br><br>Care plan initiated 12/13/2021 states that R2 has public displays of affection (holding hands, hugging, kissing, etc.) towards another peer, peer unable to reciprocate due to cognition, goal states that R2 will display affection in a safe and respectful manner. Interventions include allow family to be part of care plan meeting, involve R2 in activities, staff on duty to redirect as needed.<br><br>Further review of R2's medical record did not show any abuse risk assessment since admission or abuse care plan for R2 prior to the incident. | S9999 | | |

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| S9999 | Continued From page 6<br><br>MDS assessment dated 1/19/2023 coded R2 in section C (cognition) with a BIMS score of 10, section G (functional) of the same assessment coded R2 as requiring limited assistance with one-person physical assist for all ADLs except for eating.<br><br>MDS assessment dated 4/19/2023 coded R2 in section C (cognition) with a BIMS score of 13, section G (functional) of the same assessment coded R2 as requiring limited assistance with on-person physical assist for all ADLs except for eating.<br><br>5/24/2023 at 12:18 PM, V4 (Social Service) said that none of the residents (R1 and R2) had any abuse risk assessment prior to the incident and added that assessment is supposed to be done on admission and when something happens. They both (R1 and R2) have an abuse care plan now, not sure if there is one prior to the incident.<br><br>Facility reported incident dated 4/7/2023, presented by V1 (Administrator) documented that staff entered the room and observed R1 and R2 engaged in sexual activity, neither resident was in distress. The report continued that the local police was called, R1 was taken to the hospital per police protocol for further evaluation, R2 has been scheduled for a therapeutic home visit and was picked up by a family member. The report concluded that both residents willingly engaged in the sexual activity and abuse cannot be substantiated.<br><br>On 5/24/2023 at 11:32 AM, V1 (Administrator) said that both residents were found engaging in a sexual activity by staff, the nurse was called, and the residents were separated. V1 said that he is | S9999 | | |

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not sure if it was abuse or consensual, staff who observed them said that they seem to have enjoyed it, none of them was in any distress.

On 5/25/2023 at 3:40 PM, V6 (LPN) said that she was informed by the resident assist (V7/RA) that R1 and R2 were in the room getting busy and when she got to the room, she observed them lying down and R1's hands were around R2's neck. V6 said she asked them (R1 and R2) to stop, and they did. V6 said she had no idea how long the residents were gone before they were found. Both R1 and R2 are wanderers. R2 has an arm bracelet to prevent him from eloping and will trigger if R2 tries to enter the elevator.

5/25/2023 at 10:38 AM, V7 (RA) said that she was making rounds after lunch around 1:00 PM and saw that the door to R2's room was closed and that was unusual because all the doors are normally left open. She knocked on the door and opened it, then saw R1 and R2 having sex and she told them to stop, and they both got up. V7 added that she did not know that the residents were not in the dining room, she was not looking for them, just making rounds.

5/25/2024 at 11:35 AM, V8 (Medical Doctor) said that he is the attending physician for R1. V8 stated that he was told that (R1) had sex with another resident. He saw R1 on the 27th of May prior to the incident, she is only alert and oriented x1 and not capable of consenting to sex.

5/25/2023 at 2:09 PM, V12 (Police Officer) said that he is the officer in charge of the sexual assault allegation between R1 and R2 and when they responded to the facility for sexual assault, R1 was confused; did not know why the police were there or why she was going to the hospital,

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| S9999 | Continued From page 8<br>is unlikely that she consented to the act.<br><br>5/26/2023 at 12:54 PM, V3 (VP of Clinicals) said that she was very involved with the sexual assault allegation and that the facility conducted a full investigation and spoke to all nurses and CNAs. At first, they thought that R2 forced himself on R1, after the investigation it was clear that R1 was the one initiating the incident, V3 never spoke to R1 or R2 but said that R1's sister was very upset, and they think that race played a part in her anger.<br><br>On 5/31/2023 at 9:56 AM, V1 (Administrator) said that during the abuse allegation investigation, he tried to speak to R2, but he really didn't want to talk to him, social services followed up with him later that day. V1 said that he did not speak to R1, when asked why not, he said that he speaks to the residents sometimes when investigating, not all the time, it depends on the nature of the investigation. V1 added that he relied on the interview of the social worker with R1 in drawing his conclusions.<br><br>6/1/2023 at 10:32 AM, V18 (Medical Director) said that that the facility notified her immediately of the sexual assault incident between two residents, she is not clinical at the facility and not familiar with the residents but based on the information she was provided and after some research she is not sure if R2 should be labeled as a sexual abuser. The staff stated that R1 appears to be friendly with R2 and has expressed her desire to engage in sexual activity with him. Surveyor informed V18 that based on surveyors interview and record review, it's unlikely that R1 has the cognitive ability to consent to a sexual act. V18 said, well that changes everything, I was just going with the information I was provided. If a | S9999 | | |

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| S9999 | Continued From page 9<br>resident is not capable of consenting, then staff have to watch her closely and intervene when they see her entering another resident's room. This becomes obvious that the facility needs to up its game as far as supervision.<br><br>A document provided by V2 (DON) titled resident supervision (undated) states in its policy statement states that routine resident checks shall be made to assure that resident's safety and wellbeing are maintained. Under policy interpretation and implementation, the policy states in part, to ensure the safety and well-being of our residents, resident checks will be made at least every 2 hours throughout each 24-hour shift by nursing service personnel.<br><br>Facility abuse prevention policy dated 2/2017 stated in part that the facility affirms the right of residents to be free from abuse, neglect ...or mistreatment. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The facility is committed to protecting residents from abuse, neglect ...by anyone including, but not limited to facility staff, other residents, consultants, volunteers ...friends or any other individuals. Under resident assessment, the document stated that as part of the resident's life history on the admission assessment, comprehensive care plan and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect ...Through the care planning process, staff will identify any problems, goals, and approaches which would reduce the chances of abuse, neglect ...for theses residents. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches and placement considering his or her safety as well as the safety | S9999 | | |

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| S9999 | Continued From page 10<br>of other residents and employees of the facility.<br>(A) | S9999 | | |