STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E306	A. BUILDING _____ B. WING _____	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH AURORA CARE CENTER	310 BANBURY ROAD NORTH AURORA, IL 60542

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F 000	INITIAL COMMENTS Investigation of Complaint #2378920/IL165922 A Partial-Extended Survey was completed	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a female resident was protected from a male resident with a known history of hyper-sexual behaviors resulting in the sexual abuse of 1 female resident (R1). This applies to 1 of 5 residents (R1) reviewed for sexual abuse in the sample of 6. The Immediate Jeopardy began on October 12, 2023 when R4 was admitted to the facility and direct care staff were not made aware of R4's history of hyper-sexual behaviors, and no interventions were put in place to protect other	F 600	**Attachment A** **Statement of Licensure Violations**	11/16/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 600	Continued From page 1 residents, resulting in a resident being sexually abused. V1 (Administrator) and V2 (DON-Director of Nursing) were notified of the Immediate Jeopardy on October 31, 2023 at 11:45 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on November 1, 2023, but non- compliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. The findings include: The EMR (Electronic Medical Record) shows R1 was admitted to the facility on May 2, 2023. R1 has multiple diagnoses including, cerebral palsy and mild cognitive impairment of uncertain or unknown etiology. R1's MDS (Minimum Data Set) dated August 8, 2023 shows R1 is cognitively intact, requires supervision with dressing, locomotion off the unit, and eating, limited assistance with bathing and personal hygiene, and is independent with all other ADLs (Activities of Daily Living). R1 is always continent of bowel and bladder. On October 26, 2023 at 9:34 AM, R1 was sitting in her room. R1 said, "We got a new resident (R4) and he tried to kiss me the other night (October 13, 2023). He tried to kiss me, and I said I don't know you! I cannot kiss someone I don't know! I was so scared. I am so afraid he is going to come back in my room. He tried to touch me all over. He put his hand up my shirt and touched my breasts. I hollered for help, and he ran out of the room. It was on Friday (October 13, 2023) around 2:00 AM. I couldn't sleep for a	F 600		

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F 600	Continued From page 2	F 600		

while because I was scared. No one came in my room to help me. The next morning, I told [V5] (Activity Director) around 10:00 AM. She asked me what was wrong with me because I wasn't smiling. I told her I almost got raped last night." During the interview with R1, R1 kept interrupting the conversation, standing up, and walking down the hallway, saying she needed to walk to the front of the building and ask the V1 (Administrator) if there was any chance R4 would return to the facility.

The local police department's Case Summary Report printed October 26, 2023 at 2:41 PM shows the following documentation by V16 (Police Officer): "On Friday, October 13, 2023, at approximately 1158 (11:58 AM) hours, I, [V16] (Police Officer) responded to [the facility] for a reported criminal sexual abuse incident that occurred earlier in the day - approximately 0200 hours (2:00 AM). ...I began interviewing [R1] who was observed to be in distress and crying. [R1] stated that a male entered her room around 0200 hrs (hours) and woke her up by sitting on her bed. She was sleeping while laying on her right side. The male said, hey, and showed her something on his phone. [R1] said she was like, "what the F are you doing in my room," and the male proceeded to start touch her. [R1] indicated physically that her breasts were being touched and later described the act as rubbing. Per [R1], the male then asks for a kiss, and would she be his girlfriend, and she tells him to leave. [R1] stated that her roommate [R5] was awake as she began to call for help and instructed her to get help. As [R5] began to respond, the male ran out of the room .... [R1] reported being very shaken up after the incident and could not stop crying. She reported she had not eaten because she was

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F 600	Continued From page 3	F 600		

afraid to see the male. I asked if any force was used or if she was threatened when this happened. [R1] stated that she forced his face away when the male attempted to kiss her. When asked if the two have interacted previously, [R1] stated the male followed her around 10:00 PM to the shower-room and said she looked sexy in her robe ...." The local police department's Case Summary report continues to show V16 (Police Officer) interviewed R4. The report shows: "I asked [R4] if he was doing anything this morning, early this morning, and he replied he was felt on a girl's nipples ... I asked [R4] what happened after he entered [R1's] room. [R4] stated he was trying to have sex with her and was in the mood to have sex. He followed that statement by saying he does not think that is normal and that he knows better. ...When asked what he showed [R1] on his phone, [R4] replied that he showed her the time. [R4] stated [R1] asked for the time and he told her it was 1:53 (AM). I asked what interrupted him in the room, and he said that her roommate [R5] kept saying that [R1] was asleep, and he was trying to get to it and have sex. [R4] said he could see that she was not asleep and did not want to argue about it. ...I asked again if he was in any other rooms, and he stated he was. [R4] said he was, and he saw a teenage black girl, but did not want to have sex anymore and was going to be good. [V1] (Administrator) asked [R4] if he made it a habit to have sex with people he does not know. [R4] replied, that was his M.O. (Modus Operandi)."

On October 26, 2023 at 9:29 AM, R5 was lying in her bed, in the room she shares with R1. R5 said, "[R4] came into our room two times during that night (October 13, 2023). Around 2:00 AM, he got near to [R1's] bed and was asking her for

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F 600	Continued From page 4	F 600		

a kiss. I heard everything. The second time he came in I told him she's asleep get out of our room, and he left the room."

The EMR shows R5 was admitted to the facility on September 25, 2021 with multiple diagnoses including major depressive disorder, anxiety disorder, mild cognitive impairment, autistic disorder, and diabetes.

R5's MDS dated October 2, 2023 shows R5 is cognitively intact.

On October 26, 2023 at 10:35 AM, R3 was sitting in her bed in the room she shares with R6. R3 said, "[R4] came in our room twice that night. I asked what he was doing. He left and someone came and said he shouldn't be in our room. He tried to go over and see my roommate (R6), but she was sleeping."

On October 26, 2023 at 10:43 AM, R2 said, "There was a tall black man in my room. He was new to our building and just came that day. I was sound asleep and woke up to [R4] fondling my shoulder. I swatted at him, and I told him to leave, and he left. I did not tell anyone until the next day."

The facility's final report to the state agency dated October 19, 2023 shows: "Summary: On October 13, 2023 approximately around 2:30 AM, [R4] went into [R2's] room and got into her bed and startled her. [R4] later went into [R1's] room and sat on her bed waking her up as well. The nurse on duty was informed about [R4] going into their rooms and he told him to go back to his room when he was observed by the doorway. [R1] reported to staff on the next shift that when

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F 600	Continued From page 5 [R4] was in her room he woke her up and touched her. [R1] was assessed for injuries none were noted. Investigation: When interview by the police and Administrator; [R2] stated she was more startled when she realized someone was in her bed. She stated that [R4] did not say anything to her and he just left her room. She told her nurse that [R4] was in her room and she was fine. The nurse on duty (V9) (RN-Registered Nurse) stated that when [R2] told him what occurred he went to look for the resident that [R2] described to him. Later on, [V9] (RN) saw [R4] in the doorway of another resident he told [R4] to return to his room. [R1] stated that when [R4] came into her room and woke her up he asked her if he could kiss her, and she said no. [R4] then asked her to look at his phone and then reached over and touched her. [R1] asked him to stop and leave the room. [R1's] roommate, [R5] was also interviewed and said she heard what [R4] said to [R1] and when [R1] asked [R4] to leave the room, [R5] also asked [R4] to leave the room. [R5] said she went back to sleep after this occurred and forgot to tell anyone about what she witnessed. [R4] did admit that he got into [R2's] bed because he thought she was someone else. [R4] also stated that he did go to [R1's] room after leaving [R2's] room. [R4] admitted waking [R1] up asking her for a kiss and touching her. [R4] stated that [R1] said it was okay for him to touch her. [V9] (RN) was also interviewed and stated that [R1] did not inform him of the event with [R4]. Conclusion: It was determined that [R4] did go into [R2's] bedroom and got into bed with her. And it was also determined that [R4] also went to [R1's] room and got into bed with her and touched her. [R1] was assessed and there were no injuries she also confirmed that she was not in any pain or hurt. [R4] was monitored one on one	F 600		

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F 600	Continued From page 6 after the investigation was initiated until he left the facility. The police returned to the facility after the event was filed and removed [R4] from the facility and took him to the local police department. [R2] and [R1's] care plans have been reviewed. Staff will continue to monitor both [R1] and [R2] for any concerns they may have. [R1] and [R2] both reported that they feel comfortable in the facility." On October 26, 2023 at 11:04 AM, V1 (Administrator) said, "I found out about the incidents with [R4] around 10:30 AM on October 13, 2023. Around 10:30 AM, we put [R4] on one-to-one monitoring, and the police were notified around 11:15 AM, and took the resident into custody around 4:00 PM. [R1] said he sat on her bed and touched her. [R2] said he got into bed with her. [R3] said she talked to [R4] the night before, that he went in her room, but nothing sexual happened. We were told he could walk around, and he would ask girls if he could kiss them. Not all of the staff were made aware of his kissing tendencies." The EMR shows R4 was admitted to the facility on October 12, 2023. The EMR continues to show R4 was discharged on October 13, 2023 with local police department. V8's (NP-Nurse Practitioner) documentation created October 14, 2023 shows R4 had multiple diagnoses including schizophrenia and asthma. R4's MDS was not completed at the time of this investigation. [Psychiatric Hospital) documentation dated September 23, 2023 at 2:24 PM shows: [R4] is a 28-year-old male admitted to [Psychiatric Hospital] voluntarily. Chief complaint from intake:	F 600		

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F 600	Continued From page 7 "I was high on weed oil and I was trying to talk to a girl in the room. I was trying to kiss her and touch her butt. I tried to kiss her. Patient is a 28-year-old male admitted to [Psychiatric Hospital] voluntarily for acute psychosis. Patient reportedly had walked into another resident's room in his nursing home with intent to physically assault them. Patient has been hypersexual, inappropriately touching nursing home staff, and sexually aggressive towards emergency medical services staff. UDS (Urine Drug Screen) positive for cannabis. Patient began masturbating in front of the sitters at the emergency department and was unable to be redirected. Patient has been seen responding to internal stimuli. He has disorganized and tangential thought process. He has a history of schizophrenia and has been non-compliant with his medications. Nursing home reports that patient has been decompensating due to refusing to comply with treatment. Patient presents with auditory and visual hallucinations, paranoia, disorganization, and flight of ideas. Patient states that he has been very paranoid lately. Patient has cognitive delay. Patient's mother is POA (Power of Attorney) and guardian. Patient demonstrates poor insight into illness, poor judgment, and poor impulse control. Patient is on SAO (Sexually Acting Out) precautions. Patient requires inpatient hospitalization for safety and stabilization." On October 26 2023 at 9:47 AM, V5 (Activity Director) and V6 (Social Worker) were sitting in their office. V5 said, "I came into work on Friday, October 13, 2023, and [R1] wanted to talk to me and she came back here to my office. She said the new guy (R4) came in and touched on her, feeling on her breasts, and I reported it to [V1]	F 600		

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(Administrator). He was a new admission, 24 to 48 hours or so. Corporate screens the individuals before they come to us. We used to be part of a team where we reviewed the paperwork and decided if the person was a good fit for our facility, but now Corporate makes those decisions and we are not given any information about the residents. We were not told about him before he came. We were not asked to put a plan in place to monitor [R4] or anything to protect the other residents. We got the information after he arrived. When we were able to look at his history and saw about his history of trying to kiss other residents and sexually grabbing staff members from other facilities, we were like woah! We never had a meeting to discuss him before he came or any precautions we should have taken. It was all a big surprise after the sexual abuse happened." V6 (Social Worker) said, "We were not told about [R4's] psychiatric diagnosis or his history of trying to kiss residents, or sexually acting out at previous facilities before he came to the facility. One minute he was not at the facility, and the next minute he was. There was nothing put in place to protect the residents from [R4]. We didn't even know about it until it was too late. The decision was made by Corporate to take this resident. We would have said he was not appropriate for our facility. Once he had sexually abused a resident the night of October 13, 2023, then I heard about it from [V1] (Administrator) that morning. He ended up in our office as a one-to-one observation resident late in the morning on October 13, 2023. When we left at 3:00 or 3:30 PM, we took him up to [V1's] (Administrator) office and he had to sit with her. He was very agitated sitting with us and did not want to be watched so closely. We never had a team meeting before [R4] came to the facility to

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decide if he was appropriate. After he was admitted, he was in the hallway, wandering all over the place. We ourselves did not go around to interview other people to see if it happened to anyone else. If we would have known he was sexually active, we could have protected our residents."

On October 26, 2023 at 3:12 PM, V7 (Nurse) said, "I admitted [R4] on October 12, 2023 towards the end of my shift around 2:00 PM. He had just gotten here, and I was getting ready to go home. I did not receive a report from the previous facility. I briefly looked at the paperwork from his previous facility and saw he had some sexual behaviors, so I gave the information to the next nurse and told her what I read. [V1] (Administrator) or [V2] (DON) never told me anything about the resident I was going to be taking care of. There was no plan in place to keep an eye on him."

On October 26, 2023 at 9:15 AM, V8 (CNA-Certified Nursing Assistant) said, "I worked from 3:30 PM to 11:30 PM on October 12, 2023. [R4] came to the facility around 2:30 PM. No one told us we had to keep an eye on him. He was walking all around the facility, during my shift, pacing and pacing. I was never told to keep an extra eye on him. I did not know anything about his background."

On October 26, 2023 at 2:15 PM, V9 (RN) said, "After midnight, I came out from the nurse's station, and I see this guy (R4) outside the door of [R1]. His room was across the hall from hers, and I said what are you doing there, because the door was cracked open, and it is usually always closed. He moved away from the door, and I said

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F 600	Continued From page 10 go back to your room. I closed [R1's] door. I did not check on [R1] or [R5]. [R4] was a new admit, and I did not know him or anything about him. I told the other nurse working with me that night that the new resident was wandering around. After a while, [R1] and [R5] tried to use the toilet and they asked me to watch them because there is a guy that is looking at them. I did not know that night that he touched the resident's breasts. I told [V1] (Administrator) the next morning that maybe she could move the guy because he kept looking into the female resident's rooms. He kept wandering around. About an hour after that, another lady, [R2] woke up and said a man came in her room and scared her. She said I just woke up and he was there. I said okay, I'll tell [V1] (Administrator) in the morning about this. I saw him go in [R3's] room too. I said you should stay in your own room, and he said she's my friend. I said you should not go around, and he said if you keep on following me, I need privacy too. I am not sure about his mental capacity. He was admitted on the other side of the building, and I did not get report on him. Nobody told me about him having a history of sexual abuse. Administration did not give me any warning." On October 26, 2023 at 12:35 PM, V10 (Director of Psychosocial Rehab) said, "We did not want to take this guy (R4), we could not meet his needs. [V11] (Regional Marketing Director) and [V12] (Corporate Hospital Liaison) said they were at [psychiatric hospital]. He put in an email and said we needed to do this as a favor. I tried to explain to him we could not take this guy. I emailed the owner of the company. [R4's] referral was awful, and he was not stable. [V11] (Regional Marketing Director) overrode us and said we had to take him. I am very upset with them. They keep	F 600		

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sending us people and we are next to a grade school. We asked for a denial and [V11] said it was a favor. They told [V1] (Administrator) that she cannot deny his referral."

An email thread provided by V1 (Administrator) on October 26, 2023 shows: On October 5, 2023 at 8:16 AM, V12 (Hospital Liaison) sent an email to V1 (Administrator), V2 (DON), and V11 (Regional Marketing Director), as well as others. The email shows: [R4] is slow to respond and has a cognitive deficit. He was aware why he was at the [Psychiatric Hospital]. I did not have the referral yet and the C/M (Case Manager) did share some info with b/4 (before) I did the bedside. He stated he went into a girl's room and tried to kiss her. I asked him if she wanted to be kissed. He said that she didn't like it too much. I talked to him about consent and that going forward if he feels he wants to kiss someone he needs to ask that person before he does it. I also told him that if he came to the facility and liked a girl there and wanted to kiss her that before he acted on it that he needed to talk to the nurse or S/W (Social Worker) at the facility and tell them that was what he wanted to do so they could help him in knowing what to do next. I asked him if that was something he could do and he said yes. Then he said that he no longer has interest in girls. He is aware that he will have a shared room. He is a smoker, so I informed him of our smoking rules - which he states is understood. He told me he did have a THC vape pen - which his mother bought for him while he was OOP (Out on Pass). He stated he tried to buy it, but since he did not have his ID he could not buy it, so he asked his mom, and she bought it for him. He receives SSI/SSD (Social Security/Disability) but is unsure how much he receives. He is aware

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that he will need to turn it over to the facility and would be interested in starting a resident trust fund. He is African American, and he states to me that he wants to go in facility where there is a majority of white people. He stated that male staff do not respect him and would prefer white female CNAs and white female nurses. Diagnoses, 160 pounds, bipolar disorder severe w/psychosis, schizophrenia."

On October 5, 2023 at 10:39 AM, V1 (Administrator) responded to V11 (Regional Marketing Director), V12 (Hospital Liaison), and V2 (DON), "I'm concerned about this referral and his request for a staff of a different gender and race. Most of my CNAs are African American, Latino, African, and Filipino, same thing with my nurses. I don't want him trying to kiss some of our residents that cannot tell him no."

On October 5, 2023 at 2:43 PM, V11 (Regional Marketing Director) responded to V1, V2, and V12, "Is patient ambulatory?" To which V12 (Hospital Liaison) responded at 2:48 PM, "Yes."

On October 5, 2023 at 3:00 PM, V11 (Regional Marketing Director) replied to V12 (Hospital Liaison), V1 (Administrator), and V2 (DON), "Proceed with admission. Spoke with [V1] via phone at 1459 (2:59 PM)."

On October 26, 2023 at 3:11 PM, V1 (Administrator) said, "I told corporate I did not think he was appropriate for our facility. They told me I had to take him and that was that."

On October 30, 2023 at 11:11 AM, V17 (Psychiatrist) said, "The way you protect other residents from a resident with [R4's] history is

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don't admit a guy like that! I would not have admitted him in the first place because of his history. I saw him on October 13, 2023 via telehealth, and I was aware he already crawled into bed with some female residents. I could not even talk to him about it. He would not engage in an interview. This facility is not set up to take care of psychiatric patients like [R4]. I have been told by [V10] (Director of Psycho-Social Rehab) that the facility does not have programming in place. Each time a patient like [R4] has a psychotic exacerbation, it changes their brain chemistry, and they are less likely to respond to their medications. He is a very sick man. The decision to accept him at the facility was made higher up in the corporate ladder. I know the staff at the facility did not want him. I was never asked for suggestions or involved in any advance planning on how to handle him once he got there so other residents were protected from his behaviors."

The local county Judicial Circuit Court records show R4 was charged on or about "10/13/2023" with committing the following offenses: "Aggravated Criminal Sexual Abuse to Handicapped Victim, Aggravated Battery to Pregnant or Handicapped Person, Criminal Sexual Abuse Unable to Give Consent, and Battery Makes Physical Contact."

The facility's policy entitled "Abuse Prevention Program" revised "11/28/2016" shows: "Policy: This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint

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F 600	Continued From page 14 not required to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents ... The following definitions are based on federal and state laws, regulations, and interpretive guidelines. ...Sexual Abuse is non-consensual sexual contact of any type with a resident." The Immediate Jeopardy began on October 12, 2023. The facility presented a removal plan to remove the immediacy on October 31, 2023 at 4:01 PM. The survey team reviewed the removal plan and was unable to accept the plan to remove the immediacy. The removal plan was returned to the facility for revisions. The facility presented a revised removal plan to remove the immediacy on November 1, 2023 at 9:49 AM. The survey team reviewed the removal plan and was unable to accept the plan to remove the immediacy. The removal plan was returned to the facility for revisions. The facility presented a revised removal plan to remove the immediacy on November 1, 2023 at 11:57 AM, and the survey team accepted the removal plan on November 1, 2023 at 12:34 PM. The Immediate Jeopardy was removed on November 1, 2023 when the facility took the following actions to remove the immediacy. On October 31, 2023, the following was initiated: 1. The Administrator, Director of Nursing, Social Services, Regional Clinical Director, and Hospital	F 600		

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F 600	Continued From page 15 Liaison will establish a plan for evaluating a resident's acceptability to the facility clinically. Admission Criteria checklist to be used going forward for new referrals to determine if individualized plans are needed. {Attachment} 2. R4 no longer resides at the facility. R1 placed a restraining order against R4. R1 still resides at the facility. R2, R3, and R5 still reside at the facility with no negative outcomes; facility will provide additional counseling if needed. 3. The Administrator, Director of Nursing, Social Services, and Hospital Liaison will have an individualized plan for any new resident requiring individual centered interventions to be put into place upon admission. 4. Clinical staff will be in-serviced prior and upon admission of any history information needed in order to provide care to a new admission that requires interventions. Administrator/Director of Nursing/Designee will complete education regarding the new process for clinical staff in person or via phone. Information will be provided in the Agency staffing binder. Completion date: November 2, 2023. The following systemic measures have been implemented to ensure all alleged deficient practices do not recur: A) Residents who are high risk for behaviors will have resident centered interventions put in place to prohibit and prevent residents from being abused. B) Facility will inform direct care staff of incoming residents' history upon admission. For Quality Assurance (QA) Measures: Administrator/Director of Nursing/Designee will	F 600		

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F 600	Continued From page 16 monitor compliance through the QA process on all new residents admitted to the facility one time a week for 3 months. Administrator/ Director of Nursing/Designee will contact additional assistance from the physician, and [Corporate] management as needed. The Quality Assurance team including the Regional Clinical Manager will monitor compliance through the quarterly Quality Assurance meetings by reviewing the audit tool {Attachment}.	F 600		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to supervise a newly admitted male resident (R4) with known hyper-sexual behaviors resulting in R4 entering 5 female residents' rooms (R1, R2, R3, R5, R6), sexually abusing (R1), and getting into bed with R2 and touching her shoulder. This applies to 5 of 5 residents (R1, R2, R3, R5, R6) reviewed for sexual abuse in the sample of 6. The Immediate Jeopardy began on October 12,	F 689		11/16/23

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2023 when R4 was admitted to the facility and direct care staff were not made aware of R4's history of hyper-sexual behaviors, and no interventions were put in place to protect other residents, resulting in a resident being sexually abused. V1 (Administrator) and V2 (DON-Director of Nursing) were notified of the Immediate Jeopardy on October 31, 2023 at 11:45 AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on November 1, 2023, but non- compliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.

The findings include:

The EMR (Electronic Medical Record) shows R1 was admitted to the facility on May 2, 2023. R1 has multiple diagnoses including, cerebral palsy and mild cognitive impairment of uncertain or unknown etiology.

R1's MDS (Minimum Data Set) dated August 8, 2023 shows R1 is cognitively intact, requires supervision with dressing, locomotion off the unit, and eating, limited assistance with bathing and personal hygiene, and is independent with all other ADLs (Activities of Daily Living). R1 is always continent of bowel and bladder.

On October 26, 2023 at 9:34 AM, R1 was sitting in her room. R1 said, "We got a new resident (R4) and he tried to kiss me the other night (October 13, 2023). He tried to kiss me, and I said I don't know you! I cannot kiss someone I don't know! I was so scared. I am so afraid he is going to come back in my room. He tried to

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touch me all over. He put his hand up my shirt and touched my breasts. I hollered for help, and he ran out of the room. It was on Friday (October 13, 2023) around 2:00 AM. I couldn't sleep for a while because I was scared. No one came in my room to help me. The next morning, I told [V5] (Activity Director) around 10:00 AM. She asked me what was wrong with me because I wasn't smiling. I told her I almost got raped last night."

On October 26, 2023 at 9:29 AM, R5 was lying in her bed, in the room she shares with R1. R5 said, "[R4] came into our room two times during that night (October 13, 2023). Around 2:00 AM, he got near to [R1's] bed and was asking her for a kiss. I heard everything. The second time he came in I told him she's asleep get out of our room, and he left the room."

The EMR shows R5 was admitted to the facility on September 25, 2021 with multiple diagnoses including major depressive disorder, anxiety disorder, mild cognitive impairment, autistic disorder, and diabetes.

R5's MDS dated October 2, 2023 shows R5 is cognitively intact.

On October 26, 2023 at 10:35 AM, R3 was sitting in her bed in the room she shares with R6. R3 said, "[R4] came in our room twice that night. I asked what he was doing. He left and someone came and said he shouldn't be in our room. He tried to go over and see my roommate (R6), but she was sleeping."

On October 26, 2023 at 10:43 AM, R2 said, "There was a tall black man in my room. He was new to our building and just came that day. I was

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sound asleep and woke up to [R4] fondling my shoulder. I swatted at him, and I told him to leave, and he left. I did not tell anyone until the next day."

The facility's final report to the state agency dated October 19, 2023 shows: "Summary: On October 13, 2023 approximately around 2:30 AM, [R4] went into [R2's] room and got into her bed and startled her. [R4] later went into [R1's] room and sat on her bed waking her up as well. The nurse on duty was informed about [R4] going into their rooms and he told him to go back to his room when he was observed by the doorway. [R1] reported to staff on the next shift that when [R4] was in her room he woke her up and touched her. [R1] was assessed for injuries none were noted. Investigation: When interview by the police and Administrator; [R2] stated she was more startled when she realized someone was in her bed. She stated that [R4] did not say anything to her and he just left her room. She told her nurse that [R4] was in her room and she was fine. The nurse on duty (V9) (RN-Registered Nurse) stated that when [R2] told him what occurred he went to look for the resident that [R2] described to him. Later on, [V9] (RN) saw [R4] in the doorway of another resident he told [R4] to return to his room. [R1] stated that when [R4] came into her room and woke her up he asked her if he could kiss her, and she said no. [R4] then asked her to look at his phone and then reached over and touched her. [R1] asked him to stop and leave the room. [R1's] roommate, [R5] was also interviewed and said she heard what [R4] said to [R1] and when [R1] asked [R4] to leave the room; [R5] also asked [R4] to leave the room. [R5] said she went back to sleep after this occurred and forgot to tell anyone about what she

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witnessed. [R4] did admit that he got into [R2's] bed because he thought she was someone else. [R4] also stated that he did go to [R1's] room after leaving [R2's] room. [R4] admitted waking [R1] up asking her for a kiss and touching her. [R4] stated that [R1] said it was okay for him to touch her. [V9] (RN) was also interviewed and stated that [R1] did not inform him of the event with [R4]. Conclusion: It was determined that [R4] did go into [R2's] bedroom and got into bed with her. And it was also determined that [R4] also went to [R1's] room and got into bed with her and touched her. [R1] was assessed and there were no injuries she also confirmed that she was not in any pain or hurt. [R4] was monitored one on one after the investigation was initiated until he left the facility. The police returned to the facility after the event was filed and removed [R4] from the facility and took him to the local police department. [R2] and [R1's] care plans have been reviewed. Staff will continue to monitor both [R1] and [R2] for any concerns they may have. [R1] and [R2] both reported that they feel comfortable in the facility."

On October 26, 2023 at 11:04 AM, V1 (Administrator) said, "I found out about the incidents with [R4] around 10:30 AM on October 13, 2023. Around 10:30 AM, we put [R4] on one-to-one monitoring, and the police were notified around 11:15 AM, and took the resident into custody around 4:00 PM. [R1] said he sat on her bed and touched her. [R2] said he got into bed with her. [R3] said she talked to [R4] the night before, that he went in her room, but nothing sexual happened. We were told he could walk around, and he would ask girls if he could kiss them. Not all of the staff were made aware of his kissing tendencies."

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The EMR shows R4 was admitted to the facility on October 12, 2023. The EMR continues to show R4 was discharged on October 13, 2023 with local police department. V8's (NP-Nurse Practitioner) documentation created October 14, 2023 shows R4 had multiple diagnoses including schizophrenia and asthma.

R4's MDS was not completed at the time of this investigation.

The facility does not have documentation to show they had an interim care plan or any other type of care plan in place addressing R4's hyper-sexual behaviors, this was confirmed by V1 (Administrator) on October 31, 2023 at 9:14 AM.

[Psychiatric Hospital) documentation dated September 23, 2023 at 2:24 PM shows: [R4] is a 28-year-old male admitted to [Psychiatric Hospital] voluntarily. Chief complaint from intake: "I was high on weed oil and I was trying to talk to a girl in the room. I was trying to kiss her and touch her butt. I tried to kiss her. Patient is a 28-year-old male admitted to [Psychiatric Hospital] voluntarily for acute psychosis. Patient reportedly had walked into another resident's room in his nursing home with intent to physically assault them. Patient has been hypersexual, inappropriately touching nursing home staff, and sexually aggressive towards emergency medical services staff. UDS (Urine Drug Screen) positive for cannabis. Patient began masturbating in front of the sitters at the emergency department and was unable to be redirected. Patient has been seen responding to internal stimuli. He has disorganized and tangential thought process. He has a history of schizophrenia and has been non-compliant with his medications. Nursing

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home reports that patient has been decompensating due to refusing to comply with treatment. Patient presents with auditory and visual hallucinations, paranoia, disorganization, and flight of ideas. Patient states that he has been very paranoid lately. Patient has cognitive delay. Patient's mother is POA (Power of Attorney) and guardian. Patient demonstrates poor insight into illness, poor judgment, and poor impulse control. Patient is on SAO (Sexually Acting Out) precautions. Patient requires inpatient hospitalization for safety and stabilization."

On October 26 2023 at 9:47 AM, V5 (Activity Director) and V6 (Social Worker) were sitting in their office. V5 said, "I came into work on Friday, October 13, 2023, and [R1] wanted to talk to me and she came back here to my office. She said the new guy (R4) came in and touched on her, feeling on her breasts, and I reported it to [V1] (Administrator). He was a new admission, 24 to 48 hours or so. Corporate screens the individuals before they come to us. We used to be part of a team where we reviewed the paperwork and decided if the person was a good fit for our facility, but now Corporate makes those decisions and we are not given any information about the residents. We were not told about him before he came. We were not asked to put a plan in place to monitor [R4] or anything to protect the other residents. We got the information after he arrived. When we were able to look at his history and saw about his history of trying to kiss other residents and sexually grabbing staff members from other facilities, we were like woah! We never had a meeting to discuss him before he came or any precautions we should have taken. It was all a big surprise after the sexual abuse

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happened." V6 (Social Worker) said, "We were not told about [R4's] psychiatric diagnosis or his history of trying to kiss residents, or sexually acting out at previous facilities before he came to the facility. One minute he was not at the facility, and the next minute he was. There was nothing put in place to protect the residents from [R4]. We didn't even know about it until it was too late. The decision was made by Corporate to take this resident. We would have said he was not appropriate for our facility. Once he had sexually abused a resident the night of October 13, 2023, then I heard about it from [V1] (Administrator) that morning. He ended up in our office as a one-to-one observation resident late in the morning on October 13, 2023. When we left at 3:00 or 3:30 PM, we took him up to [V1's] (Administrator) office and he had to sit with her. He was very agitated sitting with us and did not want to be watched so closely. We never had a team meeting before [R4] came to the facility to decide if he was appropriate. After he was admitted, he was in the hallway, wandering all over the place. We ourselves did not go around to interview other people to see if it happened to anyone else. If we would have known he was sexually active, we could have protected our residents."

The facility's "3 Day Assignment" Sheet, provided by the facility on October 26, 2023 shows. V18 (RN), V19 (LPN-Licensed Practical Nurse), V7 (Nurse), V9 (RN), and V8 (CNA-Certified Nursing Assistant) worked at the facility on October 12 and 13, 2023.

On October 26, 2023 at 1:34 PM, V18 (RN) said, "[V10] (Director of Psychosocial Services) told me [R4] was a wanderer. I did not know he had

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sexual behaviors that needed to be monitored."

On October 26, 2023 at 1:37 PM, V19 (LPN) said, "No one told me to keep an eye on [R4] or monitor his behaviors. He was a touchy, feely guy."

On October 26, 2023 at 3:12 PM, V7 (Nurse) said, "I admitted [R4] on October 12, 2023 towards the end of my shift around 2:00 PM. He had just gotten here, and I was getting ready to go home. I did not receive a report from the previous facility. I briefly looked at the paperwork from his previous facility and saw he had some sexual behaviors, so I gave the information to the next nurse and told her what I read. [V1] (Administrator) or [V2] (DON) never told me anything about the resident I was going to be taking care of. There was no plan in place to keep an eye on him."

On October 26, 2023 at 9:15 AM, V8 (CNA) said, "I worked from 3:30 PM to 11:30 PM on October 12, 2023. [R4] came to the facility around 2:30 PM. No one told us we had to keep an eye on him. He was walking all around the facility, during my shift, pacing and pacing. I was never told to keep an extra eye on him. I did not know anything about his background."

On October 30, 2023 at 3:41 PM, V20 (CNA) said, "I was not told anything about [R4's] behaviors or to keep an eye on him when he came to the facility. I worked from 2:00 PM to 10:00 PM on October 12, 2023, the day he was admitted, and the following morning as well."

On October 30, 2023 at 3:45 PM, V21 (CNA) said, "I was working on the morning shift the day

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[R4] was admitted (October 12, 2023). He came towards the end of my shift. I was not told anything about his behaviors or to follow him around."

On October 30, 2023 at 3:49 PM, V22 (CNA) said, "I worked on the 2:00 PM to 10:00 PM shift on October 12, 2023. [R4] came to the facility around 2:00 PM. I was not assigned to watch him or anything. No one told me he had sexual behaviors."

On October 30, 2023 at 4:05 PM, V24 (CNA) said, "I was working at the facility on Thursday, October 12, 2023. [R4] was admitted that day. We had a COVID outbreak that day and I was helping to move residents around to different rooms. I was never told about [R4] having sexual behaviors or that I had to observe him and report any concerns."

On October 26, 2023 at 2:15 PM, V9 (RN) said, "After midnight, I came out from the nurse's station, and I see this guy (R4) outside the door of [R1]. His room was across the hall from hers, and I said what are you doing there, because the door was cracked open, and it is usually always closed. He moved away from the door, and I said go back to your room. I closed [R1's] door. I did not check on [R1] or [R5]. [R4] was a new admit, and I did not know him or anything about him. I told the other nurse working with me that night that the new resident was wandering around. After a while, [R1] and [R5] tried to use the toilet and they asked me to watch them because there is a guy that is looking at them. I did not know that night that he touched the resident's breasts. I told [V1] (Administrator) the next morning that maybe she could move the guy because he kept

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looking into the female resident's rooms. He kept wandering around. About an hour after that, another lady, [R2] woke up and said a man came in her room and scared her. She said I just woke up and he was there. I said okay, I'll tell [V1] (Administrator) in the morning about this. I saw him go in [R3's] room too. I said you should stay in your own room, and he said she's my friend. I said you should not go around, and he said if you keep on following me, I need privacy too. I am not sure about his mental capacity. He was admitted on the other side of the building, and I did not get report on him. Nobody told me about him having a history of sexual abuse. Administration did not give me any warning."

On October 26, 2023 at 12:35 PM, V10 (Director of Psychosocial Rehab) said, "We did not want to take this guy (R4), we could not meet his needs. [V11] (Regional Marketing Director) and [V12] (Corporate Hospital Liaison) said they were at [psychiatric hospital]. He [V11] put in an email and said we needed to do this as a favor. I tried to explain to him we could not take this guy. I emailed the owner of the company. [R4's] referral was awful, and he was not stable. [V11] (Regional Marketing Director) overrode us and said we had to take him. I am very upset with them. They keep sending us people and we are next to a grade school. We asked for a denial and [V11] said it was a favor. They told [V1] (Administrator) that she cannot deny his referral."

An email thread provided by V1 (Administrator) on October 26, 2023 shows: On October 5, 2023 at 8:16 AM, V12 (Hospital Liaison) sent an email to V1 (Administrator), V2 (DON), and V11 (Regional Marketing Director), as well as others. The email shows: [R4] is slow to respond and has

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a cognitive deficit. He was aware why he was at the [Psychiatric Hospital]. I did not have the referral yet and the C/M (Case Manager) did share some info with b/4 (before) I did the bedside. He stated he went into a girl's room and tried to kiss her. I asked him if she wanted to be kissed. He said that she didn't like it too much ..... He is African American, and he states to me that he wants to go in facility where there is a majority of white people. He stated that male staff do not respect him and would prefer white female CNAs and white female nurses. Diagnoses, 160 pounds, bipolar disorder severe w/psychosis, schizophrenia."

On October 5, 2023 at 10:39 AM, V1 (Administrator) responded to V11 (Regional Marketing Director), V12 (Hospital Liaison), and V2 (DON), "I'm concerned about this referral and his request for a staff of a different gender and race. Most of my CNAs are African American, Latino, African, and Filipino, same thing with my nurses. I don't want him trying to kiss some of our residents that cannot tell him no."

On October 5, 2023 at 2:43 PM, V11 (Regional Marketing Director) responded to V1, V2, and V12, "Is patient ambulatory?" To which V12 (Hospital Liaison) responded at 2:48 PM, "Yes."

On October 5,2 023 at 3:00 PM, V11 (Regional Marketing Director) replied to V12 (Hospital Liaison), V1 (Administrator), and V2 (DON), "Proceed with admission. Spoke with [V1] via phone at 1459 (2:59 PM)."

On October 26, 2023 at 3:11 PM, V1 (Administrator) said, "I told corporate I did not think he was appropriate for our facility. They told

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F 689	Continued From page 28 me I had to take him and that was that." On October 30, 2023 at 10:53 AM, V1 (Administrator) said they did not do any advance planning for R4's admission to the facility to ensure residents would be kept safe. "In this instance, Corporate told me we had to take the resident, but did not give us any tools or ideas on how we should take care of him." On October 30, 2023 at 11:11 AM, V17 (Psychiatrist) said, "The way you protect other residents from a resident with [R4's] history is don't admit a guy like that! I would not have admitted him in the first place because of his history. I saw him on October 13, 2023 via telehealth, and I was aware he already crawled into bed with some female residents. I could not even talk to him about it. He would not engage in an interview. This facility is not set up to take care of psychiatric patients like [R4]. I have been told by [V10] (Director of Social Services) that the facility does not have programming in place. Each time a patient like [R4] has a psychotic exacerbation, it changes their brain chemistry, and they are less likely to respond to their medications. He is a very sick man. The decision to accept him at the facility was made higher up in the corporate ladder. I know the staff at the facility did not want him. I was never asked for suggestions or involved in any advance planning on how to handle him once he got there so other residents were protected from his behaviors." The Immediate Jeopardy began on October 12, 2023. The facility presented a removal plan to remove the immediacy on October 31, 2023 at 4:01 PM. The survey team reviewed the removal	F 689		

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F 689	Continued From page 29 plan and was unable to accept the plan to remove the immediacy. The removal plan was returned to the facility for revisions. The facility presented a revised removal plan to remove the immediacy on November 1, 2023 at 9:49 AM. The survey team reviewed the removal plan and was unable to accept the plan to remove the immediacy. The removal plan was returned to the facility for revisions. The facility presented a revised removal plan to remove the immediacy on November 1, 2023 at 12:27 PM, and the survey team accepted the removal plan on November 1, 2023 at 12:34 PM. The Immediate Jeopardy was removed on November 1, 2023 when the facility took the following actions to remove the immediacy. On October 31, 2023, the following was initiated: 1. The Administrator, Director of Nursing, Social Services, Regional Clinical Director, and Hospital Liaison will establish a plan for notifying staff of new resident's behaviors which will impact other residents right to privacy, safety, and freedom from abuse. Resident Bio form to be used for new resident admissions. 2. The Administrator, Director of Nursing, Social Services, Regional Clinical Director and Hospital Liaison will have an individualized plan for any new resident requiring individual centered interventions to ensure the residents are appropriately supervised upon admission. 3. Direct care staff will be in-serviced prior to and upon admission of a new resident and given a plan to ensure that staff are aware of resident's behaviors which would impact other residents' right to privacy, safety, and freedom from abuse.	F 689		

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F 689	Continued From page 30 Information will be provided in the Agency staffing binder. Completion date: November 2, 2023. The following systemic measures have been implemented to ensure all alleged deficient practices do not recur: A) The facility will notify staff of any needed plans in place for residents who are high risk for interventions. Facility will have resident centered interventions put in place to supervise and prevent residents from being abused. Residents will be monitored for behaviors and reported immediately to Administrator/Director of Nursing. B) Facility will inform direct care staff of new residents' history before and upon admission with Resident Bio For Quality Assurance (QA) Measures: Administrator/Director of Nursing/Designee will monitor compliance through the QA process as new residents are admitted one time a week for 3 months. Administrator/Director of Nursing/Designee will contact additional assistance from the physician, and [Corporate] Management as needed. The Quality Assurance team including the Regional Clinical Manager will monitor compliance through the quarterly Quality Assurance meetings by reviewing the audit tool.	F 689		