(X6) DATE

Illinois Department of Public Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			:
		IL6009872	B. WING		1	1/2024
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WEST CI	HICAGO TERRACE	928 JOLIE WEST CH	ET ROAD ICAGO, IL 6	60185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Facility Reported In 1/5/2024/ IL168673	icident Investigation of				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	300.610a) 300.1210a) 300.1210b) 300.1210d)3) 300.3210t)					
	Section 300.610 R	esident Care Policies				
	procedures governifacility. The written be formulated by a Committee consisting administrator, the amedical advisory conformed and othe policies shall complete the facility and shall accomplete the facility and shall facility.	dvisory physician or the ommittee, and representatives or services in the facility. The ly with the Act and this Part. It is shall be followed in operating I be reviewed at least annually documented by written, signed				
	Section 300.1210 Online Nursing and Person	General Requirements for nal Care				
	facility, with the part the resident's guard applicable, must de comprehensive car	nsive Resident Care Plan. A ticipation of the resident and dian or representative, as evelop and implement a e plan for each resident that le objectives and timetables to				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 02/16/24

TITLE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
A. BUILDING.	·	С
IL6009872 B. WING		01/31/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STAT	TE, ZIP CODE	
WEST CHICAGO TERRACE 928 JOLIET ROAD WEST CHICAGO, IL 6018	85	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)  b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.  d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:  3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.  Section 300.3210 General  t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or		

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		IL6009872	B. WING		01/3	) 1/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	01/3	1/2024
	HICAGO TERRACE	928 JOLIE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
\$9999	misappropriation of These requirments Based on interview failed to protect a re from sexual abuse with known history failure resulted in R R2. This applies to for sexual abuse in The findings include R1 has multiple dia schizoaffective disc disease without hea glaucoma, based o R1's quarterly MDS November 17, 2023 was cognitively inta required "partial/mo staff with regards to hygiene, shower/ba body dressing. The was independent w transfer, and ambul R1's risk for abuse 2022, showed an ur for abuse assessme answered for the for resident have a dia illness?" "Does the of social inappropris screaming, repetitiva allegations, wander	are not met as evidenced by: and record review, the facility esident's (R1) right to be free from another resident (R2) of sexual behaviors. This 1 being sexually abused by 1 of 6 residents (R1) reviewed the sample of 6.  groses including order, hypertensive heart art failure, dystonia, and in the face sheet.  (Minimum Data Set) dated 8, showed that the resident ct. The MDS showed that R1 orderate assistance" from the poral, toileting and personal thing, and upper and lower as same MDS showed that R1 ith eating, bed mobility,	S9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE	SURVEY	
			A. BUILDING:			_
		IL6009872	B. WING		1	C <b>31/2024</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WEST C	HICAGO TERRACE	928 JOLII				
112010	IIIOAGO TERRAGE	WEST CH	IICAGO, IL 6	0185		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ige 3	S9999			
	aggression towards abuse assessment answered for any o	s others?" The same risk for indicated that "*If YES is f the above questions, risk for abuse so initiate an "at				
	showed that the resabuse/neglect base assessment as evid mental illness. The R1 to be treated wifrom mistreatment The same active ca	an initiated on May 23, 2023, sident was at risk for ed on the comprehensive denced by R1's diagnosis of e goal of this care plan was for th respect, dignity and be free while residing in the facility. are plan documented, "On commate made unwanted R1]."				
	he occupies the sec (R2) occupies the f R1 stated that on the specific time) of Jan roommate (R2) man this information) in masturbate in bed at leaving the door and time he could see at According to R1, on 5, 2024, while R2 with stayed in his (R1) the was surprised when (R1) was in his long through the was were held down by attempting to push while R2 was on to pulled out and R2's pushing up and down areas. According to	24, at 11:16 AM, R1 stated that cond bed, while his roommate irst bed closest to the door. The early morning (cannot give nuary 5, 2024, he saw his sturbating (R1 was gesturing bed. R1 stated that R2 would almost daily, while naked, d curtain open and most of the and hear R2 doing the act. In that early morning of January was masturbating in bed, he will be doed. R1 stated that he does happening because his arms R2's knees and he was R2 off him. R1 stated that p of him, R2 had his penis a penis was rubbing and with his face, chin, and neck to R1, he believes that R2 was his in his mouth, but he (R1)				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
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		IL6009872	B. WING		01/3	31/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WEST C	HICAGO TERRACE	928 JOLIE				
	I	WEST CH	ICAGO, IL 6	0185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
	stated that after the male staff at the factor same interview, R1 why R2 did what he does not know what that he does not was him again. According	rush R2 away from him. R1 incident he reported to the bility's front desk. During the stated that he does not know a did to him, he was fearful and the was happening. R1 added and the incident to happen to ng to R1, the police came to interviewed him with regards				
	Agency submitted of in-part that on Janureported that his roof inappropriate with his giggling, then he pudid a body assessmit found. [R2] stated thim. Nurses couns and moved [R1] to on 30 (minute) checand MD (Medical Dordered a stat Haldsafe in the facility, a given and [R1] stated distress. [R1] also that time. [R1] has responsible for hims showed in-part, "Up (January 5, 2024) la approximately arour police notification a of him, held his arm humped him. Then put it on his face, no put his penis in his able to push him of	cident report to the State on January 10, 2024, showed ary 5, 2024, at 3:39 AM, "[R1] ommate [R2] was sexually the sexual point by laying on top of him and shed [R2] off of him. Nurses that he was just playing with eled [R2] on social boundaries another hallway. [R2] was put cks for increased supervision octor) was notified and ol order. [R1] stated he feels and emotional support was ed he was in no emotional denied police notifications at no family to notify and is self." The final incident report on staff interviewing [R1] on after that morning and 8:30 am, [R1] wanted and stated that [R2] laid on top as down with his knees and dry [R2] took his penis out and eck and chin in an attempt to mouth at that time he was fonto the floor. Police came terviewed [R1] and [R2] with				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		IL6009872	B. WING			C <b>31/2024</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
WEST C	HICAGO TERRACE	928 JOLII				
			IICAGO, IL 6			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
\$9999	Director) and DON [R1] explained the athe police interview ever happened ther above did happen. arrested [R2] and to processing." The sthat the allegation obehavior towards R R2 was admitted to 2023. R2 had multi schizophrenia, schidisorder, restlessne behavior, psychosis known physiological sheet.  R2's quarterly MDS showed that the rest The MDS showed that the rest The MDS showed that substantial/maximatoileting and person upper and lower booff footwear and person upper and lower booff	(Director of Nursing) present. above to the police and when ed [R2] he denied the event in eventually admitted that the At that time the police pook him to the county jail for ame incident report showed of R2's sexual inappropriate in was substantiated.  The facility on August 21, in in in items in	\$9999			
	inappropriate to a fe	emale resident. R2 was luring				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE :	
			A. BOILDING.			,
		IL6009872	B. WING		1	, 1/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WEST C	HICAGO TERRACE	928 JOLIE				
	THORSE TERRIAGE	WEST CH	ICAGO, IL 6	60185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 6	S9999			
	the female resident back to his room. R2 was re-directed by staff although was not accepting redirection easily.					
	exacerbation of psy inappropriate behave female staff and fer making the females them around and anot redirectable and redirected. The formeducated R2. R2 signification for involuntation of the second seco	23, at 10:21 AM, R2 had vchosis and sexual viors directed towards both male residents. He was a uncomfortable by following sking them for a kiss. He was distaring into space when mer PRSC counseled and tated that he wanted a nine have sexual intercourse ferred to the hospital as per ary/judicial admission.				
	hospital's behavior	unit with multiple admitting gaggressive behavior and				
	sexually inappropriates resident. R2 asked would "make love to counseled by Admir	23, at 11:39 AM, R2 made ate comment to a female I the female resident if she o me/sleep with me." R2 was nistrator with PRSC, Assistant and CNA (Certified Nursing				
	reported that R2 sta while the CNA was to move his belong started lying sidewa penis and started s resident to close cu	23, at 11:00 AM, the CNA arted playing with his penis helping resident's roommate ings out of the room. R2 ays in bed while playing with taring at CNA. CNA asked artain for privacy in which				

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across the hall to assist another resident. While

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
			A. BUILDING:			:
		IL6009872	B. WING		1	1/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WEST C	HICAGO TERRACE	928 JOLIE WEST CH	ET ROAD ICAGO, IL 6	0185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 7	S9999			
	R2 entered the other	resident with the door closed, er resident's room without asked the CNA "mom you ok."				
	sexually inappropria R2 denied the alleg mean it that way. R behavior. R2 was o	23, at 5:05 PM, R2 was ate towards a female resident. ation but stated that he did not 22 was educated on sexual counseled by the former PRSC o himself at all times and not mself.				
	resident accused R sexually inappropria shoulder and he as the female resident "couple weeks ago"					
	allegation that he en uninvited and at odd	23, at 10:16 AM, R2 had nters the female rooms d times. R2 confirmed that he ut he does not know that the				
	R2 was observed h resident on her nec	at 6:32 PM, CNA reported that ugging and kissing a female k. R2 was redirected and s inappropriate behavior.				
	CNA and roommate naked masturbating Also, a puddle of ur resident will not allo stated, "I'll clean it, of	at 5:30 PM showed, "As per e, resident [R2] seen in bed g without curtains in place. ine on floor. As per CNA, w her to clean the urine and don't come inside". d to leave room until the mess				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						,
		IL6009872	B. WING		1	1/2024
					1 0170	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WEST C	HICAGO TERRACE	928 JOLIE				
		WEST CH	ICAGO, IL 6	60185		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
1710		,	17.0	DEFICIENCY)		
20000	Cantinuad Francis	O	S9999			
S9999	Continued From pa	ige 8	29999			
	is cleaned. Roomm	ate also stated, "he's been				
	messing with my st	uff, and he pissed on the floor				
	and he's jerking off	in his bed with no privacy".				
		resident [R2] in his room.				
		ed naked rubbing his private				
		, "you have to do these things				
		sed". Resident stated, "I'm just				
		esident was told to put his				
		taff can clean the floor. lo, I'll clean it". Resident was				
		s clothes on and that he can't				
		losed his curtains as told and				
		CNA was able to clean the				
		As roommate [R3] presents as				
		be shifted to [a different room]				
		tor of Nursing) notified.				
	Resident will be see	en by psych social tomorrow				
	(October 16). On ge	oing care."				
		, at 6:40 PM, a female resident				
		abbed her hand and the				
		d R2 not to touch her. The				
		ent reported that she told R2				
	not to come to her i	room again during the night.				
	- October 26, 2023	, at 5:17 AM, R2 stayed up the				
		to and from his room. R2				
		nes not to go into other				
		resident remained adamant				
		o another male resident's				
		oally aggressive towards staff.				
		3, at 9:18 AM, R2 was				
		nal space of a nurse. R2				
		behind medication cart				
		te comments. R2 was				
		SC and was counseled about				
		aries. R2 was also counseled				
		propriate language, not babe,				
	honey, momma to f	emaies.				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:	A. BUILDING:		
		IL6009872	B. WING		01/3	; 1/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WEST CI	HICAGO TERRACE	928 JOLIE				
	OLUMBA DV OTA		ICAGO, IL 6			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 9	S9999			
	displayed behaviors disruptive socially in inappropriate reject documented that R2 and was referred to notes under comme up on a behavior the 2023). Resident unaboundaries with fem following females at touch female reside comment to staff, "A repeatedly. Delusic putting arms up wan non-redirectable. (A Resident put on 1:1 doctor] ordered peti will monitor."  - November 1, 2023 "10:35am - Resident Resident asked ma penis. Resident has (female) around and space. Resident is in fight people with puphoned [Psychiatris monitoring." R2 was nospital. R2 was resident as R2 was resident.	was redirected with rejection social service. The same ents showed, "Writer followed at occurred on (November 1, able to maintain appropriate nale residents/staff. Resident round the facility. Attempted to ent. Made an inappropriate Are you feeling my penis" onal. Making gestures of by nting to fight. Resident Administrator)/DON notified. monitoring. [Psychiatric tion for hospitalization. Writer 8, at 1:50 PM showed, at is inappropriate with staff. He activity staff to touch his is been following nurse d not respecting her personal making gesture of wanting to tting his fist up to them. Writer				
	petitioned to be sen hospital because th residents and was r	3, at 3:17 PM, R2 was again to to the psychiatric e resident pushed two making aggressive comments.				

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to the facility from psychiatric hospital, based on

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6009872	B. WING		01/3	1/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WEST C	HICAGO TERRACE	928 JOLIE				
	Г		ICAGO, IL 6			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 10	S9999			
	the progress notes.					
	"7:27am - Resident nurses station targe Resident walked up personal space and asked to leave the stated, "you use to out, my girlfriend go threatening comme_you know what I rethe nurse's station. nurses station, nurse started knocki started banging on proceeded to banging Dining area cleared [Director of Nursing	23, at 8:00 AM showed, noted agitated, walked in eting [V6 (female nurse)]. To to the nurse invading her was non redirectable when nurses station. Resident be my girlfriend, can I take you of raped, then started making ints of I will beat someone's a mean." Resident walked out Upon resident leaving the ses locked the door. Resident ing on the glass window, then nurse's station door then ing on psych social door. I for other residents' safety. I and [Psychiatrist] made II 911 and send resident to the violent behavior."				
	displayed behaviors name calling halluc verbally disruptive vinappropriate sexua to internal stimuli." was redirected but notes showed under up on a behavior the 2023). Resident psycerbally aggressive targeting a nurse. Finurse's station. Respersonal space by enurse while agitated yelling. Resident markets.	23, at 3:07 PM showed, "[R2] sof yelling/ screaming hitting, inations delusions pacing verbally threatening socially ally inappropriate responding. It was documented that R2 it was rejected. The same or comments, "Writer followed at occurred on (November 19, sychosis exacerbated. Resident, agitated and threatening, Resident would not leave sident violated nurses' getting extremely close to di, verbally aggressive and ade a delusional statement, and, she got raped." A takes no sense. Nurses had				

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IIIINOIS L	epartment of Public	Health				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6009872	B. WING		01/3	2 1/2024
NAME OF		CTDEET ADI	ODECC CITY O	CTATE ZID CODE		
NAIVIE OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WEST C	HICAGO TERRACE	928 JOLIE WEST CH	ICAGO, IL 6	0185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
\$9999	difficulty getting agg station. When reside called; door locked. through window at a began violently knot escaped to psych-spaced to hallway. We came to psych-socidoor with increasing police to arrive; knot [Administrator]/ DO ordered petition for willing with police. We November 20, 2023 the resident was diapsychosis. R2's Not notes showed that a back to the facility.  - November 28, 202 reported that R2 hat Housekeeper state uncomfortable. R2 keep his distance for the counseled about his to himself. Resident that everyone thinks.	gressive resident out of nurses' ent out of nurse station police. Resident continue to peer targeted nurse. Resident cking on the door. Writer ocial office when resident Writer wrote petition. Resident al office violently banging on gestrength. Writer waited for ocking stopped.  N notified. [Psychiatrist] hospitalization. Resident went Writer will monitor." R2's B, progress notes showed that agnosed at the hospital with ovember 27, 2023, progress the resident was readmitted.  23, at 11:37 AM, housekeeper we been following her around. If that R2 makes her feel was reminded by the nurse to rom staff and other residents.  23, at 3:53 PM, R2 made at a comment to the C counseled R2.  24 to:27 AM showed, "It was that resident was sexually dent rubbed CNA's butt as he his hand. Resident was se behavior; to keep his hands to denied the behavior, stating is he is the "antichrist."	S9999	DEFICIENCY)		
	Resident takes no a Writer will monitor."	accountability for his actions.				

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- January 3, 2024, at 4:30 PM showed, "It was

STATEMENT OF DEFICIENCIES (X1) PROVIDER SUPPLIER (X2) MULTIPLE CONSTRUCTION A BUILDING:  IL 6009872    MANDE OF PROVIDER OR SUPPLIER   STREET ADDRESS. CITY, STATE, ZIP CODE	Illinois D	Department of Public	Health				
IL6009872   STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
WEST CHICAGO TERRACE  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 12  reported by [female nurse] that when she was walking with another staff member this resident grabbed her arm and was told to let her go. This resident multiple times to remove himself from between her and the other resident that she was speaking with. [Psychiatrist] give I omg IM (intra muscularly) Haldol stat. Writer attempted to give Haldol resident refused and started yelling; therefore, approved order for Haldol 10 mg po (by mouth) stat was given. Writer spoke with resident after giving pm (as needed) Haldol 10 mg po. Resident was redirected and said he's ok. Social department/DON made aware of situation."  - January 4, 2024, at 5:42 PM, created by V5 (Psychiatrist) showed that he provided service to R2 on January 4, 2024. V5 documented in-part, "F/U (follow up) psychiatric assessment/medication management. # pt (patient) is more hypersexual. Pt's case was discussed with DON and medication nurse." The same notes showed, "Plan: add Haldol 5 mg bid"			IL6009872	B. WING			
WEST CHICAGO TERRACE  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 12  reported by [female nurse] that when she was walking with another staff member this resident grabbed her arm and was told to let her go. This resident multiple times to remove himself from between her and the other resident that she was speaking with. [Psychiatrist] give 10 mg IM (intra muscularly) Haldol stat. Writer attempted to give Haldol resident refused and started yelling; therefore, approved order for Haldol 10 mg po (by mouth) stat was given. Writer spoke with resident after giving pm (as needed) Haldol 10 mg po. Resident was redirected and said he's ok. Social department/DON made aware of situation."  - January 4, 2024, at 5:42 PM, created by V5 (Psychiatrist) showed that he provided service to R2 on January 4, 2024. V5 documented in-part, "F/U (follow up) psychiatric assessment/medication management. # pt (patient) is more hypersexual. Pt's case was discussed with DON and medication nurse." The same notes showed, "Plan: add Haldol 5 mg bid	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY DISTRICT TAG   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY DISTRICT TAG   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY DISTRICT DATA   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE DO THE APPROPRIATE DATA   CACH DATA   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE DO THE APPROPRIATE DATA   CACH DATA   PREFIX TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE DO THE APPROPRIATE DATA   CACH DATA   PROVIDER CROSS-REFERENCE DO THE APPROPRIATE DATA   COMPLETE DATA   PROVIDER CROSS-REFERENCE DO THE APPROPRIATE DATA   COMPLETE DATA   PROVIDER CROSS-REFERENCE DO THE APPROPRIATE DATA   COMPLETE DATA   CACH DATA   PROVIDER CROSS-REFERENCE DO THE APPROPRIATE DATA   COMPLETE DATA   CACH DATA					,		
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 12  reported by [female nurse] that when she was walking with another staff member this resident grabbed her arm and was told to let her go. This resident then interrupted the other nurse while talking with another resident. Nurse asked resident multiple times to remove himself from between her and the other resident that she was speaking with. [Psychiatrist] called, per [Psychiatrist] give 10 mg IM (intra muscularly) Haldol stat. Writer attempted to give Haldol resident refused and started yelling; therefore, approved order for Haldol 10 mg po (by mouth) stat was given. Writer spoke with resident after giving prn (as needed) Haldol 10 mg po. Resident was redirected and said he's ok. Social department/DON made aware of situation."  - January 4, 2024, at 5:42 PM, created by V5 (Psychiatrist) showed that he provided service to R2 on January 4, 2024. V5 documented in-part, "F/U (follow up) psychiatric assessment/medication management. # pt (patient) is more hypersexual. Pt's case was discussed with DON and medication nurse." The same notes showed, "Plan: add Haldol 5 mg bid	WEST	HICAGO TERRACE	WEST CH	ICAGO, IL 6	0185		
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- January 5, 2024, at 3:45 AM created by V9 (LPN/Licensed Practical Nurse) showed, "Resident's roommate [R1] reported that [R2] laid on top of him while he was sleeping and was giggling. [R2] stated he was just playing with him in a joking manner. Resident counseled on social boundaries, placed on half hour check, paged [V5/Psychiatrist]." R2's progress notes dated January 5, 2024, at 7:49 AM, showed that V5 was notified of R2's behavior with orders to give Haldol 10 mg once by mouth.	S9999	reported by [female walking with another grabbed her arm ar resident then interrutalking with another resident multiple tin between her and the speaking with. [Psy [Psychiatrist] give 1 Haldol stat. Writer aresident refused an approved order for stat was given. Wr giving prn (as need was redirected and department/DON mr. January 4, 2024, at (Psychiatrist) shows R2 on January 4, 20 "F/U (follow up) psy assessment/medica (patient) is more hy discussed with DOI same notes showed (twice a day) po (by January 5, 2024, at (LPN/Licensed Prace "Resident's roommon top of him while giggling. [R2] stated in a joking manner. boundaries, placed [V5/Psychiatrist]." January 5, 2024, at notified of R2's beh	e nurse] that when she was er staff member this resident and was told to let her go. This upted the other nurse while resident. Nurse asked hes to remove himself from he other resident that she was exchanged to give Haldol and started yelling; therefore, Haldol 10 mg po (by mouth) hiter spoke with resident after ed) Haldol 10 mg po. Resident said he's ok. Social hade aware of situation."  at 5:42 PM, created by V5 ed that he provided service to 024. V5 documented in-part, yehiatric ation management. # pt repersexual. Pt's case was N and medication nurse." The d, "Plan: add Haldol 5 mg bid y mouth)."  at 3:45 AM created by V9 ctical Nurse) showed, ate [R1] reported that [R2] laid he was sleeping and was d he was just playing with him Resident counseled on social on half hour check, paged R2's progress notes dated to 7:49 AM, showed that V5 was avior with orders to give	\$9999			

- January 5, 2024, at 1:32 PM created by V4

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IL6009872   B. WING	STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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WEST CHICAGO TERRACE    CALID   CALID			IL6009872	B. WING		1	
CALL   DEFICIENCY	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  S9999 Continued From page 13 S9999  PRSD (Psychiatric Rehabilitation Service Director) showed, "It was reported by the resident's roommate that resident [R2] made unwanted sexual contact to roommate [R1] while [R1] was lying in bed. Administrator and DON were notified. Roommate [R1] was assisted by psych social to call the police. Roommate [R1] made a report to police with DON and PRSD present. Police officers also spoke with resident [R2]. Resident stated to police that he "pot on top of his roommate [R1] while roommate was lying in bed." Resident further stated that [R1] raised his arms and asking, "What are you doing?" Resident went on to state that he pulled out his private part and was pushing up and down on roommate's chest. After resident's statement, resident was told by police to put on his shoes. Resident was handcuffed and escorted from the facility by police."  R2's active care plan until January 5, 2024, initiated on November 1, 2023, showed that the resident had inappropriate social boundaries as evidenced by inappropriate touching of others, invading resident or staff personal space and asking inappropriate questions about staff members personal lives. The care plan's goal documented, "R2] will have no incidents/behaviors of inappropriate social boundaries through next review. The target date for this care plan was February 5, 2024. There	WEST C	HICAGO TERRACE					
EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG		Г		ICAGO, IL 6			
PRSD (Psychiatric Rehabilitation Service Director) showed, "It was reported by the resident's roommate that resident [R2] made unwanted sexual contact to roommate [R1] while [R1] was lying in bed. Administrator and DON were notified. Roommate [R1] was assisted by psych social to call the police. Roommate [R1] made a report to police with DON and PRSD present. Police officers also spoke with resident [R2]. Resident stated to police that he "got on top of his roommate [R1] while roommate was lying in bed." Resident further stated that [R1] raised his arms and asking, "What are you doing?" Resident went on to state that he pulled out his private part and was pushing up and down on roommate's chest. After resident's statement, resident was told by police to put on his shoes. Resident was handcuffed and escorted from the facility by police."  R2's active care plan until January 5, 2024, initiated on November 1, 2023, showed that the resident had inappropriate social boundaries as evidenced by inappropriate touching of others, invading resident or staff personal space and asking inappropriate questions about staff members personal lives. The care plan's goal documented, "[R2] will have no incidents/behaviors of inappropriate social boundaries through next review. The target date for this care plan was February 5, 2024. There	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
initiated on November 1, 2023, showing, "Contact psychiatrist/MD and any other mental health staff regarding behavior and interventions as needed, encourage resident to participate in psychosocial programming to assist him/her in gaining insight into illness/behaviors/inappropriate social boundaries and redirect and counsel resident	S9999	PRSD (Psychiatric Director) showed, "resident's roommat unwanted sexual co [R1] was lying in be were notified. Room psych social to call made a report to popresent. Police offic [R2]. Resident state of his roommate [R bed." Resident furth arms and asking, "Nesident went on to private part and wa roommate's chest. resident was told by Resident was hand facility by police."  R2's active care plainitiated on Novembresident had inapprevidenced by inapprinvading resident or asking inappropriat members personal documented, "[R2] incidents/behaviors boundaries through for this care plan was were three interventinitiated on Novembresychiatrist/MD and regarding behavior encourage resident programming to ast into illness/behavior	Rehabilitation Service It was reported by the e that resident [R2] made ontact to roommate [R1] while d. Administrator and DON nmate [R1] was assisted by the police. Roommate [R1] olice with DON and PRSD cers also spoke with resident ed to police that he "got on top 1] while roommate was lying in ner stated that [R1] raised his What are you doing?" o state that he pulled out his s pushing up and down on After resident's statement, y police to put on his shoes. cuffed and escorted from the on until January 5, 2024, per 1, 2023, showed that the opriate social boundaries as ropriate touching of others, r staff personal space and e questions about staff lives. The care plan's goal will have no of inappropriate social next review. The target date as February 5, 2024. There tions for this care plan all oer 1, 2023, showing, "Contact d any other mental health staff and interventions as needed, to participate in psychosocial sist him/her in gaining insight rs/inappropriate social	\$9999			

Illinois Department of Public Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			,
		IL6009872	B. WING		1	31/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WEST C	HICAGO TERRACE	928 JOLIE WEST CH	ET ROAD ICAGO, IL 6	0185		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
\$9999	boundaries." This include additional in manifested inappropriate touch 2023, through Januon R2's progress not R2's active care plainitiated on Novemlexhibits sexually insymptoms (as evidadvantage of a peeconsent, manipulat sexually orientated remarks. Physical [December 26, 202 inappropriate comm 2024] reported by a sexually inappropriate comm 2024, and to himself), sinteractions. The tawas April 5, 2024. for this care plan al 2023, showing, "Edappropriate male to encourage resident and encourage resident and encourage reswith women. Encourage reswith women. Encourage resident and encourage reswith aspect of This care plan was additional intervent manifested inapprostarting November 2024, as document	care plan was not revised to interventions after the resident opriate social boundaries and sing starting November 19, pary 3, 2024, as documented otes.  an until January 5, 2024, ber 1, 2023, showed, "[R2] appropriate behavioral enced) by attempting to take er who lacks the ability to ing others, crude comments/ profane or suggestive touching, grabbing. On 23, resident made a sexually ment to staff. On [January 3, a CNA that resident was atte to staff. The care plan's '[R2] will act appropriately idents/staff, using no ge, keeping healthy boundaries showing respect in all arget date for this care plan. There were three interventions I initiated on November 1, lucated resident on female interaction, at to attend psych-social groups ident to learn how to be friends urage resident to defocus on of women to see the person." not revised to include ions after the resident opriate sexual behaviors 19, 2023, through January 3, ted on R2's progress notes.	S9999			
		24, at 12:23 PM, V4 Rehabilitation Service				

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Illinois D	epartment of Public	Health				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6009872	B. WING		01/3	5 1/2024
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NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WEST C	HICAGO TERRACE	928 JOLIE WEST CH	ICAGO, IL 6	60185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 15	S9999			
	as manifested by or facility, at times wor respect boundaries staff and residents "momma." V4 state inappropriate to state inappropriate touch she was aware that masturbating but wact without privacy, sexual behavior wareported and docum R2's sexual commerubbing a CNA's bothe arm of a female interventions were escalating sexual b R2 was re-directed the PRSC (Psychial Coordinator), which does not respond word wounseling. V4 statement any in-house program to address manage/control his sexual behaviors. Is stated that she was January 5, 2024, at reported to her (V8) R2's penis was out and chest area. V4 2024, at approximal R1 about his allegated the same consistent top of him, and R2 and chest area. Ac narrating the sexual	t R2 was socially inappropriate onstant pacing around the uld be staring at staff, does not and personal space of the and would constantly call staff, ed that R2 was also sexually ff, with a report of ing of staff. According to V4, R2 had sexual behavior of as not aware that R2 does the V4 was aware that R2's s escalating due to multiple nented incidents including ents to the housekeeper, R2 of tom area and R2 grabbing enurse. V4 was asked what placed with regards to R2's ehaviors. V4 responded that by the staff and counseled by tric Rehabilitation Service according to V4, R2 at times well to redirection and ted that R2 also does not en or outside psychosocial is his mental illness and to socially inappropriate and During the same interview, V4 informed by V8 (PRSC) on around 9:00 AM, that R1 that R2 went on top of him, and was rubbing on R1's face a stated that on January 5, tely 10:00 AM, she talked to tion of sexual abuse. R1 gave at information that R2 went on rubbed his penis on his face is cording to V4, while R1 was I incident, R1 was anxious, nore shaken and stammering.				

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V4 added that R1 appeared shaken and very

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STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
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		IL6009872	B. WING		01/3	1/2024
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WEST C	HICAGO TERRACE	928 JOLIE				
		WEST CH	ICAGO, IL 6	60185		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
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				DEFICIENCY)		
S9999	Continued From pa	ge 16	S9999			
00000	Continued From pa	90 10	00000			
	disturbed about the	sexual incident. V4 stated				
	that she told R1 tha	t the police will be called to				
	report the sexual in	cident and R1 agreed to it. V4				
		ary 5, 2024, at approximately				
		call was placed to the police				
		rt R1's sexual abuse allegation				
		es two police officers came to				
	the facility to interview R1 and R2. V4 stated that V2 (Director of Nursing) and herself were preser					
	when the police interviewed separately, both R1					
	and R2. R1 was inside the psychosocial room					
	and told the police officers that his roommate					
		ed, held his arms down, got on				
		est area, R2's pants were				
		2 rubbed his penis on R1's				
		up and down from his chest				
	to upper abdominal	area and all over his (R1)				
	face and chin. Whe	en the police spoke to R2				
	while the resident w	as inside his room, at first R2				
	denied the allegation	n and stated that they (R1 and				
		ng but eventually R2 told the				
		was in his bed, he got on top				
		s pulled down, R1's arms were				
		sking him, "what are you				
		ted to move his penis (R2) up				
		e and chest, while R1 was				
		ording to V4, after the police				
		ne police officers told R2 to put				
		cuffed R2 and escorted R2 out				
	of the facility.					
	On January 40, 000	04 at 0.45 DM 1/0 /Dint 5				
		24, at 2:45 PM, V2 (Director of				
		t on January 4, 2024, at				
		0 AM, she talked to V5				
		egards to R2's increasing				
		ncluding making sexual				
		estive remarks to the female				
		ards V6 (Nurse). V2 stated				
		e remarks like, "Babe do you				
		?" R2 would go inside the				

Illinois Department of Public Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		IL6009872	B. WING		01/3	31/2024
		120003872			01/3	1/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI <b>928 JOLIE</b>		TATE, ZIP CODE		
WEST C	HICAGO TERRACE		ICAGO, IL 6	0185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
S9999	nursing station and be staring at young female staff uncom against a resident, respecting resident boundaries, manife According to V2 she masturbate in bed, open. Aware that in service department PRSD about R2's eand when the PRSO R2, the resident wahe was "sorry" for his repeat the same se V2, she was presenthe Police on Janua between 9:15 AM a Police that his penis straddling on R1's of the V10 PM shift, and at time 11:00 PM shift. V10 make sexual sugger give me a kiss, then According to V10, Finallways at night, reare for male or fem would show his fist talk to me." V10 stare-directed to stop as he was wandering in the manas seen R2 wander ooms and took out to wander on the variety of the variety hard to rewandering in the manas seen R2 wander ooms and took out to wander on the variety hard to rewandering in the manas seen R2 wander ooms and took out to wander ooms and took out the variety of the variety hard to rewandering in the manas seen R2 wander ooms and took out the variety of the variety hard to rewandering in the manas seen R2 wander ooms and took out the variety of the va	stare at V6 and R2 would also female CNAs which made the fortable. R2 would walk getting too close and not and/or staff personal sting, "on your face behavior." was aware that R2 would naked with door and curtain furses would inform the social including the PRSC and including the PRSC and including sexual behaviors. Or the PRSD would talk to a not directable or would say its behavior but still would axual behavior. According to at when R2 was interviewed by any 5, 2024, at approximately and 9:45 AM. R2 told the awas out, and he was chest.  24, at 2:58 PM, V10 (CNA) full-time staff at the facility are from 11:00 PM through 7:00 es picks up 3:00 PM through 0 stated that R2 would often estive remarks like, "momma in I'll go to bed" and then laugh. R2 regularly goes to all unit egardless of if the unit hallways ale and when re-directed he and say, "You want this? Don't ated that R2 could be easily and go back to his room, when in the female unit, however, it direct R2, when he was ale unit. V10 stated that he er inside the male resident a coffee from the table, a radio	S9999			
	According to V10, F hallways at night, re- are for male or fem would show his fist talk to me." V10 stare-directed to stop a he was wandering i was very hard to re- wandering in the ma- has seen R2 wander rooms and took out	R2 regularly goes to all unit egardless of if the unit hallways ale and when re-directed he and say, "You want this? Don't ated that R2 could be easily and go back to his room, when n the female unit, however, it direct R2, when he was ale unit. V10 stated that he er inside the male resident				

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Illinois Department of Public Health

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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		IL6009872	B. WING			1/2024
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NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WEST C	HICAGO TERRACE	928 JOLIE				
		WEST CH	ICAGO, IL 6	60185		
(X4) ID	=	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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S9999	Continued From pa	ge 18	S9999			
	or re-direct R2 and	stated, "I'm afraid he will hit				
	me, I'm scared of h	im." V10 stated that R2 does				
	not listen to female	staff and would only listen to				
		stated that she remembers				
		jing and telling a former				
		he facility to come to his room				
	at least twice and on both occasions she (V10)					
		2. During the same interview,				
	V10 stated that during her night shift rounds, she would observe R2 naked in bed, masturbating					
		urtain open, and R2 would				
make sexual suggestive comments like, "come join me, momma." V10 stated that this sexual						
		pens almost every time she				
		was at least five times per				
		V10, when R2 would				
		navior, she would attempt to				
		form the nurse on duty. V10				
	stated that R2 occu	pies bed 1 which was closest				
		s roommate (R1) occupies				
		that R1 was a very quiet and				
		d does not cause any problem				
		er residents. V10 stated that				
	_	January 4, 2024, from 11:00				
		y 5, 2024, at 7:00 AM. V10				
		or hearing any sexual abuse				
	January 4th through	1 during her entire shift from				
	January 4th through	i tile Stil.				
	On January 16 202	24, at 3:15 PM, V11 (CNA)				
		is a full-time staff at the				
		work from 3:00 PM through				
		at times picks up 11:00 PM				
		nift. V11 stated that R2				
		llong the hallways and main				
		uld wander inside other				
		king for food, mostly in the				<b> </b>
		ited that R2 had behavior of				
	attempting to hug s	taff and female residents. V11				
	added that R2 had	attempted to touch her lower				

Illinois Department of Public Health

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STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIERCLIA IDENTIFICATION NUMBER:    IL6009872   B. WING	Illinois D	epartment of Public	Health				
ILEGO9872   STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
WEST CHICAGO TERRACE  (A) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MILST BE PRECEDED BY FULL TAG  SUMMARY STATEMENT OF DEFICIENCY MILST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 19  back or attempted to hug her, and when she told R2 to stop, the resident got aggressive and in a loud voice asked her, "want some of this, momma" while showing his fist. V11 stated that R2 does not want to be told, re-directed or be corrected. According to V11, one time (does not know specific date) she was asked by R2 if she wanted to go to bed with him. V11 stated that R2 makes her very uncomfortable and uneasy. During the same interview, V11 stated that most of the time when R2 was in his bed, R2 would be constantly masturbating, at times naked or hands under his pants without cover, curtain and door wide open. According to V11, each time she saw this sexual behavior of R2, she would close the door to provide privacy but R2 would get mad and aggressive, she then would tell the nurse on duty. The nurse would either talk to R2 or tell the psychosocial staff about the sexual behavior. V11 stated that she was the assigned CNA for R2 on January 4, 2024, from 11:00 PM through January 5, 2024, at 7:00 AM. V11 denied seeing and/or hearing any sexual abuse from R2 towards R1 during her entire shift from January 4, through the 5th. However, during the early morning of January 5, 2024, she saw R1 very upset and hyper while walking with a male			IL6009872	B. WING		1	
WEST CHICAGO TERRACE  (A) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MILST BE PRECEDED BY FULL TAG  SUMMARY STATEMENT OF DEFICIENCY MILST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 19  back or attempted to hug her, and when she told R2 to stop, the resident got aggressive and in a loud voice asked her, "want some of this, momma" while showing his fist. V11 stated that R2 does not want to be told, re-directed or be corrected. According to V11, one time (does not know specific date) she was asked by R2 if she wanted to go to bed with him. V11 stated that R2 makes her very uncomfortable and uneasy. During the same interview, V11 stated that most of the time when R2 was in his bed, R2 would be constantly masturbating, at times naked or hands under his pants without cover, curtain and door wide open. According to V11, each time she saw this sexual behavior of R2, she would close the door to provide privacy but R2 would get mad and aggressive, she then would tell the nurse on duty. The nurse would either talk to R2 or tell the psychosocial staff about the sexual behavior. V11 stated that she was the assigned CNA for R2 on January 4, 2024, from 11:00 PM through January 5, 2024, at 7:00 AM. V11 denied seeing and/or hearing any sexual abuse from R2 towards R1 during her entire shift from January 4, through the 5th. However, during the early morning of January 5, 2024, she saw R1 very upset and hyper while walking with a male	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS CITY S	STATE ZIP CODE	•	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999 Continued From page 19  back or attempted to hug her, and when she told R2 to stop, the resident got aggressive and in a loud voice asked her, "want some of this, momma" while showing his fist. V11 stated that R2 does not want to be told, re-directed or be corrected. According to V11, one time (does not know specific date) she was asked by R2 if she wanted to go to bed with him. V11 stated that R2 makes her very uncomfortable and uneasy. During the same interview, V11 stated that most of the time when R2 was in his bed, R2 would be constantly masturbating, at times naked or hands under his pants without cover, curtain and door wide open. According to V11, each time she saw this sexual behavior of R2, she would get mad and aggressive, she then would tell the nurse on duty. The nurse would either talk to R2 or tell the psychosocial staff about the sexual behavior. V11 stated that she was the assigned CNA for R2 on January 4, 2024, from 11:00 PM through January 5, 2024, at 7:00 AM. V11 denied seeing and/or hearing any sexual abuse from R2 towards R1 during her entire shift from January 4th through the 5th. However, during the early morning of January 5, 2024, she saw R1 very upset and hyper while walking with a male					37/112, 211 3332		
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 19  back or attempted to hug her, and when she told R2 to stop, the resident got aggressive and in a loud voice asked her, "want some of this, momma" while showing his fist. V11 stated that R2 does not want to be told, re-directed or be corrected. According to V11, one time (does not know specific date) she was asked by R2 if she wanted to go to bed with him. V11 stated that R2 makes her very uncomfortable and uneasy. During the same interview, V11 stated that most of the time when R2 was in his bed, R2 would be constantly masturbating, at times naked or hands under his pants without cover, curtain and door wide open. According to V11, each time she saw this sexual behavior of R2, she would close the door to provide privacy but R2 would get mad and aggressive, she then would tell the nurse on duty. The nurse would either talk to R2 or tell the psychosocial staff about the sexual behavior. V11 stated that she was the assigned CNA for R2 on January 4, 2024, from 11:00 PM through January 5, 2024, at 7:00 AM. V11 denied seeing and/or hearing any sexual abuse from R2 towards R1 during her entire shift from January 4th through the 5th. However, during the early morning of January 5, 2024, she saw R1 very upset and hyper while walking with a male	WEST C	HICAGO TERRACE			60185		
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R2 to stop, the resident got aggressive and in a loud voice asked her, "want some of this, momma" while showing his fist. V11 stated that R2 does not want to be told, re-directed or be corrected. According to V11, one time (does not know specific date) she was asked by R2 if she wanted to go to bed with him. V11 stated that R2 makes her very uncomfortable and uneasy. During the same interview, V11 stated that most of the time when R2 was in his bed, R2 would be constantly masturbating, at times naked or hands under his pants without cover, curtain and door wide open. According to V11, each time she saw this sexual behavior of R2, she would close the door to provide privacy but R2 would get mad and aggressive, she then would tell the nurse on duty. The nurse would either talk to R2 or tell the psychosocial staff about the sexual behavior.  V11 stated that she was the assigned CNA for R2 on January 4, 2024, from 11:00 PM through January 5, 2024, at 7:00 AM. V11 denied seeing and/or hearing any sexual abuse from R2 towards R1 during her entire shift from January 4th through the 5th. However, during the early morning of January 5, 2024, she saw R1 very upset and hyper while walking with a male	S9999	Continued From pa	ge 19	S9999			
reception staff towards the nursing station to report the incident with R2.  On January 18, 2024, at 3:39 PM, V8 (PRSC) stated that she was the case manager of R2. V8 stated that R2 was a difficult resident and had required constant re-direction to make sure that he is behaving appropriately. Since R2's admission to the facility, the resident does not know proper behavior towards female residents and staff by addressing them in a derogatory and	59999	back or attempted to R2 to stop, the reside loud voice asked he momma" while shore R2 does not want to corrected. According know specific date) wanted to go to be makes her very under the time when R2 constantly masturbate under his pants with wide open. Accord this sexual behavior door to provide privaggressive, she the The nurse would eithe psychosocial staff at V11 stated that she on January 4, 2024 January 5, 2024, at and/or hearing any towards R1 during the through the 5th morning of January upset and hyper which reception staff toware report the incident of the stated that she was stated that R2 was required constant to he is behaving appliadmission to the facknow proper behaviore.	to hug her, and when she told dent got aggressive and in a er, "want some of this, wing his fist. V11 stated that to be told, re-directed or being to V11, one time (does not a she was asked by R2 if she d with him. V11 stated that R2 comfortable and uneasy. terview, V11 stated that most 2 was in his bed, R2 would be ating, at times naked or hands hout cover, curtain and door ing to V11, each time she saw of R2, she would get mad and en would tell the nurse on duty. The talk to R2 or tell the about the sexual behavior. It was the assigned CNA for R2, from 11:00 PM through the talk to R2 or tell the about the sexual behavior. Was the assigned CNA for R2, from 11:00 PM through the early of 5, 2024, she saw R1 very hile walking with a male ards the nursing station to with R2.  24, at 3:39 PM, V8 (PRSC) the case manager of R2. V8 a difficult resident and had de-direction to make sure that ropriately. Since R2's cility, the resident does not ior towards female residents	29999			

Illinois D	epartment of Public	Health				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6009872	B. WING		01/3	) 1/2024
NAME OF I		CTDEET ADI	DDECC OITY C	TATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WEST C	HICAGO TERRACE	928 JOLIE WEST CH	ICAGO, IL 6	0185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 20	S9999			
	personal boundarie and the residents a comfortable, espec Nurse) whom he copass. R2 constantly and had asked fem room, even though have the capacity to According to V8, and female, mostly female, mostly female, mostly female around R2's last readmission 18, 2023, from the nurses and CNAs of him because they for right with him (R2), incident on January behavior was escall progress notes. R2 comments to the hold of a female nurse a area. V8 stated that re-direction from the was not redirectable staff would counsel receptive and some was "acutely aware wrong, but he could behavior." According many times that he female but because cannot have the relicounseled about he advised to talk to an worker and was encoutside psychosocia refused. According	s by getting too close to them				
	worker and was endoutside psychosociarefused. According to the facility there wattended any of his	couraged to attend in-house or al programs and activities but to V8, since R2's admission was no documentation that he				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6009872	B. WING		01/3	1/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WEST C	HICAGO TERRACE	928 JOLIE				
	 -		ICAGO, IL 6			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 21	S9999			
	masturbating because communicated to hintervention/plan the team) put in place to behavior. V8 responsive was aware of written R2 when the sexual On January 23, 202 Practitioner) stated concerns, the facilite V12 stated that for behavior, usually the for the management Psychiatrist may acresident was at the a best practice, a resident was at the abest practice, a resident with another resident with hypersymonitoring until the	R2 had a behavior of use this behavior was not er. V8 was asked what e facility IDT (interdisciplinary o address R2's hypersexual anded that the only plan that was to re-direct and counsel I behavior occurs.  24, at 2:06 PM, V12 (Nurse that for any behavior by usually calls the Psychiatrist. The residents with hypersexual ey are sent out to the hospital and of the behavior, or the ladress the behavior while the facility. According to V12, as esident with hypersexual residing in a room by himself resident that was not at risk for est practice to place the sexual behavior on a 1:1 behavior subsides or until any ion from the Psychiatrist had				
	showed that two po facility on January 5 10:31 AM for a repor report showed that to R1 in the presen- "that two nights ago [R2] tried to rape hi said that he was lying	report dated January 5, 2024, dice officers responded to the 5, 2024, at approximately ort of a sexual assault. The the two police officers spoke ce of several staff members, to he believed his roommate, m." The report showed, "[R1] and in bed trying to fall asleep,				
	holding them down woke up and saw [I arms down. [R1] sa	one pushing down on his arms, by his sides. [R1] said that he R2] on top of him, holding his aid he began trying to lift his off of him, and that [R2]				

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IIIINOIS L	epartment of Public	Health				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						,
		IL6009872	B. WING		1	1/2024
NAME OF		CTREET AD		STATE ZID CODE	· <u> </u>	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WEST C	HICAGO TERRACE	928 JOLIE WEST CH	ICAGO, IL 6	0185		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 22	S9999			
	continued to stradd holding his arms do moved his body fur his penis from his shis penis on [R1's] near [R2's] penis. I whether or not [R1' of the incident." The (redacted) said that statements to them incident and all stat with the statements that they were not sis hypersexual and incidents involving inappropriately/sext staff members and where [R2] touched (Redacted) also sate a distinct mole near only know about if he down." The same of two police officers where members. "[R2] was a sleep in his begin to the meant by 'Messis he was kind of wreapbout his penis bein said that it was, but answer saying that thought [R1] put his	le him on the bed while own. [R1] said that [R2] then ther up [R1's] body, removed eweatpants, and began rubbing face. [R1] saw a black mark [R1] was unable to say [R1] was erect at the time e report showed in-part, "Both a [R1] has given several and their staff about the ements have been consistent is he gave us. They also said surprised by this because [R2] there have been multiple				

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wanted him to stop. I asked how long [R2] thought he was wrestling with [R1] and he

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<u> </u>	COMP	LETED
					0	)
		IL6009872	B. WING		01/3	1/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WEOTO	UOAGO TERRAGE	928 JOLIE	T ROAD			
WEST CI	HICAGO TERRACE	WEST CH	ICAGO, IL 6	60185		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 23	S9999			
\$9999	estimated it to be a if he was on the bet this, and [R2] said to f [R1], near chest [R2] about his penis and again [R2] said changed his answe inside of his pants to police report showed two counts of Dome transported to the Company of the facility's policy abuse effective Marfacility affirms the rifree from verbal, phoneglect, exploitation property, involuntar This facility therefore exploitation, misappendistreatment of contraction of the facility is doing all the purpose of this facility is doing all the prevent occurrence exploitation, misappendistreatment of contraction in the purpose of this facility is doing all the prevent occurrence exploitation, misappendistreatment of contraction in the purpose of this facility is doing all the prevent occurrence exploitation, misappendistreatment of contractions.	bout one minute. I asked [R2] d or next to the bed during that he was on the bed on top level on [R1]. I again asked is being outside of his pants. I that it was, but then quickly be saying that his penis was the whole time." The same ed that R2 was charged with estic battery and was County jail.  and procedure regarding rich 2022 showed in-part, "This ight of our consumers to be enysical, sexual, mental abuse, in, misappropriation of my seclusion or mistreatment. The prohibits abuse, neglect, propriation of property, and insumers. In order to do so, mpted to establish a consumer timer secure environment. It is policy is to assure that the heat is within its control to establish of property and insumers."	S9999			
	have any existing p guidelines in caring	ed that the facility does not olicy and procedure to provide				
		(B)				

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