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S 000	Initial Comments Complaint investigation 2458293/IL179225 Investigation to Facility Reported Incident of 9/23/24/IL179197	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999		

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applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to 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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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

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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 misappropriation of property.

These requirements were not met as evidenced by:

Based on interview, observation, and record review, the facility failed to ensure residents were free from peer to peer sexual abuse by (R1) for 3 of 11 residents (R2, R3, R7) reviewed for peer to peer sexual abuse in a sample of 11. This failure resulted in R2, R3, and R7, all of whom are cognitively impaired and incapable of giving informed consent to sexual activity, witnessing masturbation, being touched on the breasts and genitals, and having unsolicited sexual comments directed toward them. These actions would cause a reasonable person to experience feelings of fear, embarrassment, anger, and shame.

Findings include:

R1's Admission Record documented an Admission Date of 9/13/24 and listed diagnoses including Atrial Fibrillation, Adjustment Disorder, Alzheimer's Disease, and Chronic Viral Hepatitis C. R1's Minimum Data Set (MDS) dated 9/20/24 documented that R1 has moderate deficits in cognition and ambulates independently.

1. An Illinois Department of Public Health (IDPH) Final Report dated 10/4/24 stated, "On 9/23/24 at approximately 12:55pm this afternoon, (V1,

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Administrator) notified that resident (R1) made unwanted contact toward resident (R2) It was witnessed by (V13, Licensed Practical Nurse/LPN), that R1 lifted the shirt of R2 and touched her breast. Residents were immediately separated, and (V1) was notified. Nurse assessment completed, noting no issues. (R2) was interviewed, and she could not give any details of such incident and states she doesn't know what we were talking about. (V1) and (V4, Social Services Designee), interviewed (R1) with his sister present and (R1) reports not remembering this and that he doesn't touch women that way. His roommate, (R5) was interviewed, and he stated he could hold a conversation with (R1) on certain days and on other days he does not make any sense. Conference with (V14, R1's Physician) and a thorough chart review, assessment, and medication review was completed. (V14) decided to make changes to (R1's) medications. (V14) feels that (R1's) medication changes need time to become therapeutic. (V4) will meet with (R1) three times a week to facilitate and guide socially appropriate conversations and behaviors between residents and keeping him engaged in a meaningful activity. (R1)'s behaviors will continue to be monitored, and (V14) will review on an ongoing basis to determine if any changes need to be made. One to one activity with (R1) will be increased. (V4) will meet with (R2) 2 times weekly for 2 weeks to ensure she does not experience any adverse effects and continues to feel safe at the facility. Both residents are doing well at this time and have had no adverse effects from this incident. (V14), Police, and Ombudsman all notified of this conclusion."

R2's Admission Record documented an Admission Date of 2/10/23 and listed diagnoses

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including Alzheimer's Disease and Diabetes Type 2. R2's MDS dated 7/26/24 documented that R2 is severely cognitively impaired and requires a wheelchair for mobility. R2's Care Plan dated 9/23/24 documented a problem area, "I received unwanted contact by a male resident. Due to my cognition, I have no recollection and remain at baseline cognition and mood," with a corresponding intervention, "Keep me and other resident involved in incident in safe distance from each other."

On 10/16/24 8:55am, R2, who was alert only to herself, was observed self-propelling in her wheelchair in the hallway outside her room.

On 10/16/24 at 9:45am, V5, family member of R2, stated, "A nurse called him 2 ½ weeks ago and said a male resident had touched (R2)'s breast." V5 stated before she developed Dementia, R2, "Would never have put up with being treated that way. She would have been extremely upset."

2. An IDPH Final Report dated 10/4/24 stated, "On 9/27/24 at approximately 2:55pm, (V1) notified that (R1) made unwanted contact toward resident (R3) It was witnessed by (V13), (R1) was hugging (R3) in the hall and then (R1) grabbed (R3)'s breast. Residents were immediately separated and (V1) was notified. Nurse assessment completed noting no issues. (R3) was interviewed, and she could not give any details of such incident and states she doesn't know what we are talking about. (R1) was sent to (a local hospital) for a psychological evaluation. (R1) received evaluation form (local counseling center) and he did not meet the requirements (for inpatient psychiatric referral). (Counseling center) wants to do outpatient therapy. Labs for (R1)

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were positive for Covid and Marijuana. (V4) will continue to meet with (R1) three times a week to facilitate and guide socially appropriate conversations and behaviors between residents and keeping (R1) engaged in a meaningful activity. (R1's) behaviors will continue to be monitored, and (V14) will review on an ongoing basis to determine if any changes need to be made. (V4) will meet with (R3) two times weekly for two weeks to ensure she does not experience any adverse effects and continues to feel safe at the facility."

R3's Admission Record documented an Admission Date of 9/11/24 and listed diagnoses including Unspecified Dementia and Diabetes Type 2. R3's MDS dated 9/18/24 documented that R3 is moderately cognitively impaired, is ambulatory, and wanders daily. R3's Care Plan dated 9/27/24 documented a problem area, "I received unwanted contact from another resident. I remain at baseline for cognition and mood. No distress noted," with a corresponding intervention, "Keep me and other resident at a safe distance from each other."

On 10/15/24 at 9:10am, R3 was observed ambulating in the hallway. R3 was alert only to herself.

On 10/18/24 at 10:20am, V12, family member of R3, stated he was called on 9/27/24 and told that a male resident had grabbed R3's breast. V12 stated he was told they were going to send R1 out for psychiatric treatment, and that's the last he heard of it. V12 stated he was never informed about a male resident trying to lift R3's shirt on 9/26/24. V12 stated had R3 not been confused, "She would have been very upset and probably would have socked him in the jaw, she never

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S9999	Continued From page 6 would have tolerated behavior like that." 3. On 10/11/24 at 3:05pm, V10, CNA, stated that sometime during the week of 9/29/24, R1 started displaying a behavior of lying on his bed, unclothed, masturbating, with the door open. V10 stated one day that week, date unknown, she had to redirect him every few minutes to close the door, but when she walked away, he would open it again. V10 stated R7 was ambulating by R1's room, and R1 had the door open again. V10 stated R7 looked into the room as she walked by and R1 made sexual comments directed at R7 and encouraged R7 to enter the room and engage in sexual activity. V10 stated she redirected both residents, and that R7 was upset. V10 stated she reported this to her charge nurse, she cannot remember whom, and that person went to V1's office to report the incident. V10 stated that to her knowledge, R1 was not at any time placed on 15-minute checks or one to one monitoring. V10 stated that R1 was ambulatory and fast moving, "Especially when we only have 2 CNAs for the whole building, let alone did we not have extra staff to do one on one (monitoring) with him. I felt (R1) was dangerous to be around our female residents, many of them are confused and can't consent (to sexual activity) and they are too weak to fight him off." R7's Admission Record documented an Admission Date of 2/24/23 and listed diagnoses including Unspecified Dementia. R7's MDS dated 9/6/24 documented that R7 is severely cognitively impaired and ambulates independently. R7's Care Plan dated 8/30/24 documented a problem area, "The resident is an elopement risk/wanderer," with a corresponding intervention, "Redirect resident to another area." There were no problem areas related to unwanted sexual	S9999		

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S9999	Continued From page 7 contact from other residents. On 10/16/24 at 2pm, R7 was observed ambulating in the hall. R7 was alert only to herself. On 10/16/24 at 3:55pm, V7, family member of R7, stated he was unaware of the incident on the week of 9/29/24 between R7 and R1. V7 stated R7 is very confused and has Dementia. V7 stated if R7 was not confused, she would have been upset and embarrassed when the incident occurred. R1's Physicians Orders for September 2024 documented the following: Increased supervision every 15 minutes, order date 9/24/24. Citalopram 20mg. (milligrams) give one tablet at bedtime, start date 9/24/24. Citalopram (increase to) 30 mg give one tablet at bedtime, order date 9/27/24. Quetiapine 25mg. one tablet at bedtime, order date 9/13/24. Quetiapine 25mg. (increase to) two tablets at bedtime, order date 9/24/24. Quetiapine 25mg. (add) one tablet every morning, order date 9/27/24. A Physicians Progress Note dated 9/24/24, authored by V14, stated, "New resident to nursing home. He has a history of Dementia, Depression, recent Renal Insufficiency, Hypertension, GERD (Gastro-Esophageal Reflux) Hyperlipidemia, Gout, Atrial Fibrillation. Has been having issues in the nursing home since arriving inappropriately touched a female patient. Plan: Citalopram 20 mg. daily with Seroquel 50mg. daily for depression. and to control inappropriate sexual activity."	S9999		

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R1's Current Care Plan last revised 10/11/24 documented, I am demonstrating inappropriate behaviors, exposing privates to female workers, making inappropriate comments to female workers, masturbating in doorway of room, walking around refusing to wear pants, exposing self, etc., with a date initiated as 9/24/24. Interventions/Tasks include: 10/10/2024 Resident was transferred to (regional psychiatric inpatient facility, ER). 10/9/24 Denied admittance by (Gero psych regional hospital). 9/23/24 Medication changes by MD. Family approved. 9/27/24 Resident was sent to (local hospital ER) for evaluation. Returned 9/28/24 positive for Covid. Psych Eval done from (local mental health center) and recommended outpatient therapy with (health agency). Care plan meeting held with POA 10/7/2024 related to inappropriate behaviors. POA wants to do Medication changes first. Denied admittance to (behavioral health inpatient facility): Date initiated 10/9/24. Increased supervision: Date initiated 9/24/24. Referral was sent to (regional psychiatric inpatient facility): Date initiated 10/9/24."

R1's Nursing Progress Notes documented the following:
9/23/24: "Resident was observed inappropriately lifting a residents shirt and touching her breast. Resident is being kept away from female resident at this time."
9/24/24: "Sexually inappropriate toward staff."
9/24/24: "This AM staff was in residents room changing bed linens. Staff glanced over and resident was masturbating. Staff redirected resident to close his curtain and the door for privacy."
9/26/24: Resident sitting at nurses station. (R3) was standing next to resident. Resident

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attempted to lift (R3's) shirt while this writer was walking back up to the desk. Behavior was stopped.
9/27/24: "Resident was seen hugging (R3). Staff was telling resident to stop touching her. Resident proceeded to grab (R3's) breast. He was also telling her that he is her husband. Resident was redirected to his room; he is now in his bed resting."
9/27/24: Per (V2, Director of Nurses), send to ER for psychiatric evaluation.
9/28/24: Resident arrived back at the facility at 11:10 from (ER). Resident tested positive for Covid and is on isolation. Resident also tested positive for marijuana. POA (Power of Attorney) believes he used substances before coming to facility. Resident arrived at facility on 9/13/24 so it still could be in his system. Resident received a psychiatric eval from (local mental health center), he did not meet requirements (for inpatient treatment) but they would like to do outpatient therapy with him. Must call Monday to schedule a follow up appointment to be scheduled after patient is off isolation Resident stated that he is depressed from being in the nursing home and not having his dog. Resident stated that he understands that his behaviors have not been right, and he will not treat other residents inappropriately. Order to increase Citalopram, spoke with (V14) and POA, order placed. (V14) would also like a second dose of Seroquel 25 milligrams given in the morning. Order placed.
10/6/24: "This nurse took resident his evening meds when resident was noted to be masturbating. Resident stated, 'Give me some pu**y' This nurse explained to resident that behavior was inappropriate."
10/7/24: "Activity Director was helping pass breakfast trays and went into this resident's room, resident told Activity Director to lay down in bed

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so he could feel her breast, admin went into residents room and told resident that behavior was inappropriate. This nurse contacted POA, POA will be coming to facility to have meeting with administrative staff."
10/7/24: (V1 and V4) had a care plan meeting with this residents POA. We discussed the inappropriate sexual behaviors this resident had been exhibiting. POA decided she wanted to try and change a couple of medications first. We informed the nurses on shift of what POA had decided to do. We discussed with POA about how this behavior is highly inappropriate and the next steps if it continues. POA said whatever we had to do; they were ok with. Resident will be monitored on this medication to see if behaviors decline.
10/7/24: ST (Speech Therapist) attempted to see patient for therapy in room with Occupational Therapy present during therapy attempt. Patient refused treatment and said he 'wanted to have fun' and exposed groin area to therapists and began masturbation. Therapists attempted to redirect patient with no success and patient educated on appropriate behavior during therapy interventions. Administrator and nursing staff notified of this interaction.
10/7/24: "Resident has been inappropriate with staff all day. Every time a staff walks past his room or into his room he begins to masturbate in front of them. Stands in his doorway doing the same in front of female residents. We have attempted to keep door closed but resident keeps opening door and masturbating. He has tried to touch staff in sexual ways, and we are keeping certain residents away from him R/T (related to) other incidents. MD was notified and awaiting reply."
10/7/24: "Resident was walking in hallway in gown flashing female staff members with his

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penis and buttocks. This nurse and another CNA went to redirect resident and informed him he needed to be covering himself up with pants when walking through the hallways. Resident went back into room, laid down on his bed and starting masturbating while this nurse and other CNA were in room."
10/8/24: "Resident continues to come out into doorway of room masturbating, asking all female CNAs to come closer to him. Redirection has continued to fail."
10/9/24: "Resident has been awake almost the entire shift. Resident has been in and out of his room with no pants on holding his penis numerous times. Resident has stated to female CNA, 'come here, you want to f**k' and touched another female CNA on the butt. Resident has been redirected back to room to put pants on but will not comply. Continues to go into female rooms."
10/9/24: "This nurse was in residents room trying to get him to put pants on, resident then said, 'You should be scared of me. Show me your t**s, a**, and pu**y.' Nurse finished assisting resident with putting his pants on and left the room."
10/9/24: "CNA reported to DON that this resident was in the hallway asking for a specific female resident. CNA redirected resident to his room."
10/9/24: "CNA informed DON that resident came out of his room completely naked and was quickly redirected and instructed to put his clothes back on."
10/10/24: "Called and gave report about resident to (regional psychiatric inpatient facility)."
10/10/24: "(V1 and V4) transported this resident to (regional psychiatric inpatient facility)."

Review of R1's 15 Minute Checks Log Documents showed the following:
9/23/24: No documentation.

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9/24/24: No documentation.
9/25/24: Checked every 15 minutes.
9/26/24: Checked every 15 minutes.
9/27/24: Checked every 15 minutes.
9/28/24: No documentation from 3:45pm to 6:00pm.
9/29/24: No documentation from 2:15pm to 6:00pm.
9/30/24: No documentation.
10/1/24: No documentation from 6:15am to 6:00pm.
10/2/24: No documentation from 6:15am to 5:45pm.
10/3/24: No documentation from 6:15am to 6:00pm.
10/4/24: No documentation.
10/5/24: No documentation.
10/6/24: No documentation.
10/7/24: No documentation.
10/8/24: No documentation from 6:15am to 5:45pm.
10/9/24: No documentation.
10/10/24: No documentation.

There was no documentation in R1's record to indicate he had received one to one monitoring.

On 10/11/24 at 2:30pm V8, Certified Nursing Assistant (CNA), stated she was aware from reports of other staff that R1 had sexual acting out behavior toward female peers, but she had never personally witnessed it. V8 stated R1 was ambulatory, wanders, and was confused at times. V8 stated R1 frequently had to be redirected from getting into peers rooms. V8 stated she was not aware of R1 ever being put on 15-minute checks or one to one monitoring. V8 stated, "We just tried to watch him as best as we could."

On 10/11/24 at 2:55pm, V9, CNA, stated on

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numerous occasions, R1 would come out of his room naked with an erection and require redirection. V9 stated R1 was, "Very ambulatory, and very fast, and sometimes we didn't have enough staff to keep up with him." V9 stated to her knowledge, R1 was never on one to one monitoring. V9 stated she thinks after one of R1's episodes of acting out he was placed on 15-minute checks for 24 hours. V9 stated interventions for R1's behavior were to, "Redirect him as best they could with snacks or activities."

On 10/15/24 at 9:50am, R5 was alert and oriented. R5 stated he was previously roommates with R1. R5 stated maybe a month ago, R3 wandered into their room, and R1 was asking her to come over to his bed, but R3 wandered back out. R5 stated he doesn't recall telling staff about it, and he could not say for sure why R1 beckoned R3 to the bed. R5 stated R1 was moved to a different room, shortly after, but at no time had R5 ever seen staff with R1 one to one or doing frequent checks with him. R5 then stated, "I think they tried to keep an eye on him as best they could, and I heard them frequently holler at him to stop." R5 stated there are only a few men on A hall where R5's room is, most are confused or bedridden females. R5 stated R1 was, "At times totally with it, but other times really confused." R5 stated one night about midnight, a couple of weeks ago maybe, he saw R1 standing in the A hall at the end closest to the dining room, no staff were present. R5 stated it looked like he was stalking somebody or hiding, he was up against the wall, with his palms flat to the wall, like he was trying to go unnoticed. R5 stated, "I said (R1) what are you doing, and he said, I'm lost and need to go to the bathroom, so I showed him where it was, but he already knew where the bathroom was. At that time they had already

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moved him from my room to one across the hall." R5 stated he did not inform staff of this incident. R5 stated R1 had also been frequently walking out of his room naked despite staff redirecting him.

On 10/15/24 at 2:10 pm, V4 (Social Services Designee) stated when R1 was initially admitted to the facility, he did not display any behaviors. V4 stated the first episode staff had witnessed was on 9/23/24 when R1 touched R2's breast. V4 stated she attempted meeting with R1 after this incident, but he was sexually suggestive and could not be redirected. After the 9/27/24 incident when R1 grabbed R3's breast, V4 stated she started seeking inpatient psychiatric placement for R1 but received several denials as, since he was not suicidal or homicidal, he was not appropriate for that level of care. When asked about behavior interventions for R1, V4 stated, "We tried to redirect him, offer food or drinks, and tried to check on him every 15 minutes. But we didn't have enough staff to watch him honestly. He would sneak out of his room when the CNAs weren't watching him. V4 stated at one point we did have a male receptionist sit outside his door, over a weekend, but couldn't remember which weekend. V4 stated when R1 was admitted to a psychiatric unit on 10/10/24, V4 and V1 transported him in the facility van, while R1 masturbated and made sexual comments the entire trip and could not be redirected. V4 stated she has met with R2 and R3 and completed trauma assessments on each one, and they have shown no signs of after affects from the abuse.

On 10/16/24 at 10:05am, V1 confirmed she is the facility's Abuse Coordinator. V1 stated nobody reported the incident the week of 9/29/24 with R7 walking by R1's room and him masturbating and

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beckoning her in. When asked if anything had been done to try to assess the scope of R1's potential victims, V1 stated she was only aware of R2 and R3. V1 stated when staff witness or hear about abuse, they are to report it to her immediately.

On 10/16/24 at 1:25pm, V1 stated that after V13 reported the incident between R1 and R2 on 9/23/24 she notified all staff that R1 and R2 were to be kept apart and if seen together, to take them to their respective rooms. V1 stated V14 changed some of R1's psychotropic medications in response to the incident, and "Staff tried to check on (R1) every 15 minutes." V1 stated when the second incident took place on 9/27/24, R1 was sent to the Emergency Room and was deflected for inpatient admission. V1 stated while there R1, tested positive for marijuana and Covid, and upon his return, was put in a room by himself on isolation. V1 stated, "We tried to have staff sit outside his door if we had enough staff, sometimes we had extra staff who could do this, and sometimes not. Otherwise, staff tried to keep an eye on him every 15 minutes." V1 stated R1 was sent to a psychiatric inpatient unit on 10/10/24 and will not be allowed to return to the facility as he is not appropriate for the facility due to his behavior.

On 10/24/24 at 9:25am, V14 stated he began taking care of R1 when R1 was admitted to the facility. V14 stated when staff made him aware of R1's sexual acting out behaviors, he had tried adjusting some of R1's psychotropic medications, but the behavior continued and R1 was placed inpatient for psychiatric treatment, where he remains. V14 stated R1 has proved to be inappropriate to be a resident at the facility due to his behaviors. V14 stated R1 was confused at

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times, but his behavior seemed manipulative in that he seemed aware enough to target confused residents.

On 10/22/24 at 10:25am, V13 (LPN) stated that on 9/23/24, she saw R2, who is alert only to self, self-propelling in her wheelchair toward R1. After a few seconds she realized they were too close to each other, so she walked over to intervene and saw R1 taking his hand out from under R2's shirt. V13 stated R2 did not display any reaction. V13 stated she went to V1, Administrator, and reported what she saw. V13 stated she and V1 reviewed security camera footage which clearly showed R1 first placing his hand on R2's breast on top of R2's clothing, and then reaching under R2's shirt and touching R2's breast. V13 stated she had never witnessed any previous peer to peer behavior from R1, although he was verbally sexually inappropriate with staff. V13 stated she thinks after that, R1 was then placed on every 15-minute checks, for how long, she was not sure. V13 stated on 9/26/24, she witnessed R1 attempt to lift R3's shirt. V13 stated the residents were redirected, but she did not report this to V1 as potential abuse. V13 stated on 9/27/24, she witnessed R1 hug R3, and V15, LPN, who was close by, could see from where V15 was standing that R1 had touched R3's breast. V13 stated R3 is alert only to herself. V13 stated V13 and V15 reported the incident to V1, and the intervention to prevent further contact between the two was to move R3 to a different hall, and staff were told by V1 to, "Keep an eye on the two of them to make sure they weren't together." V13 stated R1 was masturbating in his room frequently with the door open and would leave his room unclothed and had to be redirected. V13 stated she thought at some point a support staff member had been assigned to sit outside R1's doorway for one shift.

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S9999	Continued From page 17 V13 stated, "We didn't have enough staff to keep (R1) away from female residents." V13 stated she told V1, Administrator, that R1 needed one to one monitoring, and V1 said they didn't have enough staff for that, "And we should just try our best to watch him." V13 stated there are frequently two nurses and two CNAs on day shift (6am to 6pm) for the whole building of 40 plus residents. V13 stated CNA's are quitting because they are tired of working short staffed, and V13 stated she put in her two week notice today. V13 stated, "(R1) posed a threat to our female residents, it made me feel awful to know we couldn't do enough to protect them, and it's part of the reason I'm leaving." The facility's Abuse Prevention Policy dated 8/16/19 documented, "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. The facility therefore prohibits mistreatment, 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, neglect, or abuse of our residents." (B)	S9999		