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| S 000 | Initial Comments<br><br>Complaint Investigtions:<br>2488180/IL00179039<br>2489585/IL00181392<br>2489947/IL00182053<br><br>Investigation of:<br>Facility Incident Report of 10/04/2024 (IL00179816)<br>Facility Incident Report of 11/13/2024 (IL00181680)<br>Facility Incident Report of 11/25/2024 (IL00182474)<br>Facility Incident Report of 11/26/2024 (IL00182104) | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations 1 of 2<br><br>300.610a)<br>300.686a)1)2)10)<br>300.686b)<br>300.686c)<br>300.686d)1)3)4)5)6)<br>300.690a)<br>300.690b)<br>300.690c)<br>300.695a)1)2)3)<br>300.695b)3)<br>300.695c)1)<br>300.695e)<br>300.1040a)2)<br>300.1040b)1)2)3)4)<br>300.1040c)<br>300.1210a)<br>300.1210b)<br>300.1210d)6)<br>300.3210o) | S9999 | | |

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| S9999 | Continued From page 1<br>300.3210t)<br>300.3240b)<br>300.3240e)<br>300.3240g)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.<br><br>Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Medications<br><br>a) For the purposes of this Section, the following definitions shall apply:<br><br>1) "Adverse consequence" - unwanted, uncomfortable, or dangerous effects that a medication may have, such as impairment or decline in an individual's mental or physical condition or functional or psychosocial status. It may include, but is not limited to, various types of adverse medication reactions and interactions (e.g., medication-medication, medication-food, and medication-disease). | S9999 | | |

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2) "Antipsychotic medication" - a medication that is used to treat symptoms of psychosis such as delusions, hearing voices, hallucinations, paranoia, or confused thoughts. Antipsychotic medications are used in the treatment of schizophrenia, severe depression, and severe anxiety. Older antipsychotic medications tend to be called typical antipsychotics. Those developed more recently are called atypical antipsychotics.

10) "Psychotropic medication" - medication that is used for or listed as used for psychotropic, antidepressant, antimanic or antianxiety behavior modification or behavior management purposes in the Prescribers Digital Reference database, the Lexicomp-online database, or the American Society of Health-System Pharmacists database. Psychotropic medication also includes any medication listed in 42 CFR 483.45(c)(3). (Section 2-106.1(b-3) of the Act)

b) State laws, regulations, and policies related to psychotropic medication are intended to ensure psychotropic medications are used only when the medication is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. (Section 2-106.1(b) of the Act)

c) Psychotropic medication shall only be given in both emergency and nonemergency situations if the diagnosis of the resident supports the benefit of the medication and clinical documentation in the resident's medical record supports the benefit of the medication over the contraindications related to other prescribed medications. (Section 2-106.1(b-3) of the Act)

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d) A resident shall not be given unnecessary drugs. An unnecessary drug is any drug used:

1) In an excessive dose, including in duplicative therapy;

3) Without adequate monitoring;

4) Without adequate indications for its use;

5) In the presence of adverse consequences that indicate the medications should be reduced or discontinued (Section 2-106.1(a) of the Act); or

6) Any combination of the circumstances stated in subsections (d)(1) through (5).

Section 300.690 Incidents and Accidents

a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.

b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local

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law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.
(Source: Amended at 37 Ill. Reg. 2298, effective February 4, 2013)

Section 300.695 Contacting Local Law Enforcement

a) For the purpose of this Section, the following definitions shall apply:

1) "911" - an emergency answer and response system in which the caller need only dial 9-1-1 on a telephone to obtain emergency services, including police, fire, medical ambulance and rescue.

2) Physical abuse - see Section 300.30.

3) Sexual abuse - sexual penetration, intentional sexual touching or fondling, or sexual exploitation (i.e., use of an individual for another person's sexual gratification, arousal, advantage, or profit).

b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning

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911 where available) in the following situations:

3) Sexual abuse of a resident by a staff member, another resident, or a visitor;

c) The facility shall develop and implement a policy concerning local law enforcement notification, including:

1) Ensuring the safety of residents in situations requiring local law enforcement notification;

e) The facility shall also comply with other reporting requirements of this Part.

(Source: Added at 26 Ill. Reg. 4846, effective April 1, 2002)

Section 300.1040 Care and Treatment of Sexual Assault Survivors

a) For the purposes of this Section, the following definitions shall apply:

2) Sexual Assault - an act of nonconsensual sexual conduct or sexual penetration, as defined in Section 12-12 of the Criminal Code of 1961, including, without limitation, acts prohibited under Sections 12-13 through 12-16 of the Criminal Code of 1961.

b) The facility shall adhere to the following protocol for the care and treatment of residents who are suspected of having been sexually assaulted in a long term care facility or elsewhere (Section 3-808 of the Act):

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1) Notify local law enforcement pursuant to the requirements of Section 300.695;

2) Call an ambulance provider if medical care is needed;

3) Move the survivor, as quickly as reasonably possible, to a closed environment to ensure privacy while waiting for emergency or law enforcement personnel to arrive. The facility shall ensure the welfare and privacy of the survivor, including the use of incident code to avoid embarrassment; and

4) Offer to call a friend or family member and a sexual assault crisis advocate, when available, to accompany the survivor.

c) The facility shall take all reasonable steps to preserve evidence of the alleged sexual assault, and not to launder or dispose of the resident's clothing or bed linens until local law enforcement can determine whether they have evidentiary value, including encouraging the survivor not to change clothes or bathe, if he or she has not done so since the sexual assault.

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 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

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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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3210 General

o) The facility shall also immediately notify the resident's family, guardian, representative, conservator, and any private or public agency financially responsible for the resident's care

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whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise.

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

Section 300.3240 Abuse and Neglect

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act)

e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act.

These Requirements were NOT MET as evidenced by:

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| S9999 | Continued From page 9<br><br>Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse; failed to protect the resident's right to be free from sexual abuse; failed to ensure residents that were perpetrators of substantiated sexual assault did not have continued access to their victim/other residents. The facility also failed to document appropriate indications and clinical needs for psychotropic medications for 1 resident (R5). This failure affected 4 residents (R1, R4, R5, R7) resulting in R3 hitting R4 in the face, R5 from being sexually assaulted by R1, R6 from hitting R5 in the face, R6 pushing R7 to the ground, and R7 being hit in the face by R8. As a result, R4 suffered; R1 to have bleeding from the nose; R7 to have swelling to the face and severe back pain. In addition, the facility failing to develop further interventions to prevent R1 from further abusing other residents, failing to prevent R6 from further abusing other residents, and allowing R1/R6 continued access to any floor within the facility places all 142 residents at risk for abuse. The facility's governing body (regional team) also failed to develop/implement the abuse policy to ensure regulatory standards are met and the regional team failed to be competent regarding abuse regulatory requirements. This failure contributed repeated physical abuse (R3 being hit by R4, R1 being hit by R6, R6 pushing R7 and R7 being hit by R8), R5 being sexually assaulted by R1, and has to potential to affect all 142 residents that reside within the facility.<br><br>Findings include:<br><br>Facility Report | S9999 | | |

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Incident, dated of alleged event 10/04/2024, documents, in part, "Standard notes: (R3, R4); Allegations: Verbal and physical resident to resident altercation. Resident was noted with a right eye swelling."

R3's Face Sheet documents medical diagnoses that include but are not limited to paranoid schizophrenia; generalized anxiety disorder; other recurrent depressive disorders. R3's Minimum Data Set (MDS), dated 9/20/24, documents, in part, that R3's Brief Interview for Mental Status (BIMS) score is 15 which indicates R3 is cognitively intact.

On 11/25/24, at 12:03 PM, R3 said, "(R4) came to my side of the room and grabbed the collar on my shirt. He (R4) was mumbling something that I (R3) couldn't understand. I (R3) told him (R4) to stop touching me and let go of my collar. He (R4) tried to hit me (R3) and then we tussled. I (R3) punched him (R4) in the face. I (R3) didn't hurt him (R4) that bad. It could have been worse. Just a little "shiner" on his (R4) eye. I'm (R3) not gonna let no motherf***** hurt me! I'm (R3) 62 years old! No mother f***** gonna come on my side of the room and f*** with me! Stupidity! I'm (R3) gonna stand my ground. I'm (R3) a man. I (R3) ain't gonna take no s*** from no one."

R3's progress note, dated 10/2/24, at 1:43 PM, by V5 (Psychiatric Rehabilitation Services Coordinator/PRSC), documents, in part, "(R3) has had a Behavior incident. Behaviors exhibited were verbally disruptive. Interventions implemented since the behavior were 1:1. (will be empty if not medication was provided.) If medication was provided, it was provided for.. Effectiveness of medication provided is Discussed negative behavior Discussed better

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behavior options Discussed other means to express anger. (R3) Verbally Understands."

R3's progress note, dated 10/10/24, at 9:54 AM, by V5 (Psychiatric Rehabilitation Services Coordinator/PRSC), documents, in part, "NOTIFICATION: It was brought to writers' attention that resident had a disagreement with his roommate. Writer approached resident to find out what the issue was, and to counsel and educate him on avoiding conflict. Writer also asked if resident wanted the option of moving to a different room. Resident indicated that it was just a minor disagreement and he verbalized 'We are ok right now and I (R3) do not want to move to another room'. Writer encouraged resident to seek out staff whenever he has any concerns. Resident was receptive to counseling and education. Writer will continue to monitor and document all progress."

R3's progress note, dated 10/10/24, at 3:18 PM, by V7 (Social Service), documents, in part, "ROOM CHANGE NOTIFICATION: Resident was moved from room... for peaceful co-existence. Notification provided to all parties involved. Staff will continue to work with resident and document as needed."

R4's Face Sheet documents medical diagnoses that include but are not limited to schizoaffective disorder, unspecified; other and signs involving appearance and behavior; unspecified dementia, unspecified severity, with other behavioral disturbance; major depressive disorder, recurrent, unspecified; anxiety disorder, unspecified; hemiplegia, unspecified affecting left nondominant side; dependence on wheelchair. R4's Minimum Data Set (MDS), dated 11/08/24, documents, in part, that R4's Brief Interview for

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Mental Status (BIMS) score is 4 which indicates R4's cognition is severely impaired.

On 11/25/24, at 12:16 PM, R4 stated, "It's okay here. I (R4) don't remember when it happened. Roommate (R3) came up to me. He's (R3) the only one that messes with me (R4). He (R3) just sucker punched me (R4). I (R4) don't feel safe here. They (staff) didn't move (R3) out of my (R4) room right away. I (R4) was scared he (R3) was gonna punch me again. I (R4) have nowhere else to go so I (R4) just gotta deal with it. Telling you about this ain't gonna help. Just go. I (R4) said just go."

R4's progress note, dated 10/1/24, at 4:53 PM, by V5 (Psychiatric Rehabilitation Services Coordinator/PRSC), documents, in part, "(R4) has had a Behavior incident. Behaviors exhibited were Other. Interventions implemented since the behavior were Social Service Referral 1:1 Other. Co- peer was moved to a different room. (will be empty if not medication was provided.) If medication was provided, it was provided for. . Effectiveness of medication provided is. Discussed negative behavior Discussed other means to express anger Other. (R4) Verbally Understands."

R4's progress note, dated 10/2/24, at 7:47 AM, by V6 (Registered Nurse/RN), documents, in part, "Writer was informed about healed swelling noted on the right eye. Resident narrated what happen between him and his roommate that resulted to fight. His roommate confirmed the fight incident which happened a copy of day ago. Writer suggested a room change needed."

R4's progress note, dated 10/10/24, at 6:45 PM, by V7 (Social Service), documents, in part,

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"BEHAVIOR NOTE F/U: Roommate already transferred from (room change) for peaceful co-existence. CPD (Chicago Police Department) was notified. Officer... and officer... dispatched to the facility. Police report... generated. Staff will continue to monitor and document as needed."

On 11/25/24, at 12:40 PM, V4 (Social Service Director) said, "I (V4) met with, but I cannot recall ..."

On 11/26/24, at 10:11 AM, V5 (PRSC) said, "I (V5) know (R3) and (R4). I (V5) am aware of an incident that happened with them, but I (V5) was not here. Not sure what or when it happened. When I (V5) came back I (V5) was told that there was a verbal altercation between the 2 but I (V5) don't know what happened. I (V5) don't know anything about it."

On 11/26/24, at 10:17 AM, V7 (PRSD/Psychiatric Rehabilitation Service Director) said, "I (V7) was not there but I (V7) was told they had an altercation, so I (V7) changed their rooms. It wasn't the same day the altercation occurred. It was later because no one reported right away. Someone on the floor told me. I (V7) can't remember. I (V7) changed their rooms to avoid further altercations.

On 11/26/24, at 10:24 AM, When asked about R3 and R4 FRI (facility reported incident), reported date 10/4/24, V2 (Director of Nursing/DON) replied, "We (V1 and V2) weren't told until later and told different stories. The nurse should have reported it, but it wasn't done. I (V2) can't say for sure when they (R3 and R4) were separated. By the nurse not reporting the swollen eye and R4 telling the nurse that his roommate (R3) did that to (R4) put the resident at risk for another abuse

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incident."

On 11/26/24, at 10:31 AM, V6 (RN), "When I (V6) came in for my shift on October 2nd, 2024, I (V6) noticed (R4's) eye was swollen. (R4) said (R3) hit him (R4). (R3) wasn't sure what happened. They (residents) will tell you otherwise. Neither resident could tell me the date it happened. They (facility) move me from one floor to another all the time so I'm (V6) not sure when it happened either. I (V6) don't know when it happened. Residents are confused at times. I (V6) didn't report the eye injury to the doctor or nurse practitioner because it (eye injury) wasn't that bad. No, I (V6) didn't call his (R4) family. I (V6) didn't tell anyone about it because I (V6) didn't feel what they (R3 and R4) told me was true. I (V6) did not report it, I (V6) just put it in the progress note. Yes, you should report all alleged abuse." When asked who the abuse coordinator is V6 replied, "Umm.. the DON (Director of Nursing). I (V6) report it to my supervisor."

On 11/26/24, at 10:40 AM, V1 (Administrator) stated the alleged abuse for R3 and R4 was substantiated.

On 11/27/24, at 1:33 PM, V1 (Administrator) said, " ... Staff should report alleged abuse even if they think they (residents) are lying. Even if they (residents) are lying we (facility) still have to investigate it. Nurses are NOT mandated reporters. (R3 and R4) date on the FRI (Facility Reported Incident) was the date it was reported to me. It's (R3 and R4 10/04/24 reported FRI) definitely not the date it happened on. There's different dates for everything. I'm (V1) not sure when it occurred ..."

On 12/03/24, at 2:06 PM, V17 (Medical Director)

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said, "I (V17) am the Medical Director of the facility ... I (V17) am the primary for all patients ... They (residents) end up in wards a lot because they (residents) are fighting... Alleged abuse and unknown injury should be called to me (V17). I'm (V17) not sure if they (staff) called me (V17) about (R4') eye. Some will call. Facility's policy is to call the physician. I'm (V17) not gonna knock the nurse's down." When asked if a resident hit another resident's face causing swelling to the resident's eye caused harm to that resident, V17 replied, " ... it can be serious because they could go blind. Globe busted of the eye is a serious injury..."

On 11/25/2024, at 11:59 AM, R6 recalled that R6 heard a "loud noise" coming from R6's neighbor's (R5's) room after 9:00 PM a few days prior. R6 stated that R6 went into R5's room and observed R5 laying in bed with R5's pants down. R6 explained that R1 was on the side of R5's bed with his hands penetrating R5's vagina. R6 then punched R1 in the face to stop R1 from "raping" R5. R6 stated that R5 was R6's friend and R6 knew that R5 couldn't defend herself against R1 because R5 gets "groggy" after taking her psychotropic medications. R6 stated that R1 stopped "raping" R5 after R6 punched R1 in the face and continued to try and hit R1 and he ran out of the room. R6 recalled staff entered the room after R1 ran out. R6 affirmed that R6 intended to punch R1 in the face.

On 11/25/2024, at 12:04 PM, R5 stated that R5 was sexually assaulted by R1 at nighttime around 9:00 PM the week before or so. R5 explained that R5 had recently taken R5's antipsychotics and that the medication makes R5 "really out of it". When R5 woke up, R5 recalled that R5's pants were down, R1 was standing over R5 and his

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fingers were penetrating R5's vagina. R5 stated that R5 wanted to fight R1 off of R5, but couldn't and recalled that R6 "saved (R5's) life" by punching R1 in the face. R5 affirmed that the sexual act performed on R5 by R1 was "not consensual". R5 stated that the nurse assessed R5 but the police didn't come until the next day until the afternoon and a rape kit was not done until the next evening. R5 stated that R5 would have wanted to go to the hospital for treatment but the nurse that assessed R5 never offered. R5 stated that R5 gave a statement to the staff and then no staff ever followed up. R5 stated that R5 needs aftercare to process the assault and the facility has not provided any. R5 explained that since the incident, R5 has been extremely depressed, feels dehumanized, has trouble sleeping, and is in fear that living in the facility will cause her to get sexually assaulted again. Additionally, R5 stated that R5 has had flashbacks "all the time" from both the incident and past incidents of sexual assault from R5's ex-husband.

Record review of R5's medication administration record documents in part that R5 was administered a Quetiapine 300 mg tablet at 9:00 PM by V21 (Registered Nurse).

On 11/25/2024, at 1:02 PM, V7 (Psychosocial Rehabilitation Services Director) stated that V9 was notified of the incident that occurred on 11/13/2024 at around 9:00 PM by V13 (Registered Nurse) and I called V22 (Psychosocial Services Rehabilitation Coordinator) and V1 (Administrator) because V7 was not in the facility. V9 stated that V13 stated R5 was inappropriately touched by R1 and that R6 witnessed it and punched R1 in the face. V7 instructed V22 to gather witness statements and

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assess the situation. V7 stated R1 and R5 were sent to the hospital on that night when the incident happened (INCONGRUENT STATEMENT) and that R1 was not on 1:1 supervision after the incident. V7 recalled that the facility initiated hourly checks to monitor R1 after the incident until R1 was sent to the hospital. V7 stated that these checks were documented in the electronic health record. Surveyor requested documentation of these checks and documentation was not received before the end of the survey. V7 stated that no trauma assessment was completed after the incident for any of the residents and that "trauma assessments should be completed after the resident is exposed to trauma".

Record review of R1's electronic health record does not indicate that hourly supervision/checks were completed for R1 after the incident occurred.

On 11/25/2024, at 1:32 PM, V1 (Administrator) stated that V1 is the abuse prevention coordinator and completed the investigation regarding R1 sexually assaulting R5 and R6 hitting R1 on 11/13/2024. V1 stated that facility substantiated sexual abuse occurred to R5 and physical abuse occurred to R1. V1 was unsure if substantiated abuse cases were supposed to be reported to the QAPI committee. V1 stated that QAPI committee has not been made aware or reviewed the substantiated abuse that occurred on 11/13/2024. V1 explained "(R1) is not in the facility so we can't do any kind of root cause analysis or evaluation of the plans of care. We cannot take further action until R1 returns from the hospital". V1 stated that V1 was unaware of R5's plan of care was updated or any after care was provided after R5 was assaulted. V1 was unaware if R6's plan

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of care was updated after the incident.

On 11/25/2024, at 2:07 PM, V25 (Licensed Practical Nurse) stated that V25 was assigned to take care of R5 on 11/14/2024. V25 stated that V25 did not receive anything in report about R5 getting sexually assaulted the night prior and nothing was documented in the medical record. V25 stated that V25 was told about the incident by R5 and that V25 immediately called the administrator and V7 (Psychosocial Rehabilitation Services Director) who was aware of the situation. V25 recalled that no one had gotten R5 care after the incident, so V25 notified the physician, local law enforcement, and sent R5 to the hospital for a rape kit. V25 stated that residents that have been sexually assaulted must be sent out immediately so that a rape kit can be accurate and collect the needed evidence.

On 11/26/2024, at 3:30 PM, V13 (Registered Nurse) stated that V13 was assigned to care for R1 on 11/13/2024. V13 recalled that R1 came on back on to the 5th floor where he resides and R1 had blooding coming from R1's nose. R1 was mumbling and couldn't say what happened. I was notified before I left that R1 was supposedly touching R5's buttocks. V13 notified R1's primary care physician of the incident but did not report the incident to V1 because all the staff already knew at V1 was aware. V13 confirmed that V13 did not sent R1 out for evaluation or notify law enforcement of the incident. V13 stated V17 (Medical Director) told V13 to "continue to monitor". V13 recalled that V22 (Psychosocial Rehabilitation Services Coordinator) came to the unit and told R1 not to go on other units and asked R1 to stay in his room. It did not work. V13 denied that 1:1 monitoring occurred and stated that a certified nursing assistant was in the day

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room where R1 was in. V13 needs close monitoring due to V13 "always being in other people's rooms".

On 11/26/2024, at 3:30 PM, V9 (Psychosocial Rehabilitation Services Aide) stated that V9 was not assigned to care for R1 that night, but that the facility "couldn't find the psych rehab aide that was assigned to the (R5's) floor" so V9 got involved. V9 said V22 came to V9 and assisted V9 with the incident. V9 said that R6 reported to V9 that R1 was on top of R1 with R1's hands in R5's vagina. V9 stated that no one was assigned to care for R1 1:1 after the incident. V9 stated that V9 believed a staff member should be with R1 because R1 is always going into other resident's rooms, is overbearing and is a flirt with other female residents. V9 stated that V9 was unaware who the abuse prevention coordinator was and would report any allegations of abuse to V22.

On 11/26/2024, at 4:02 PM, V22 (Psychosocial Rehabilitation Services Coordinator) stated that V22 was in the building when the incident occurred on 11/13/2024. V22 recalled that by the time the V22 arrived to R5's floor, the incident was over with and R1 was back on R1's floor. V22 explained that V7 (Psychosocial Rehabilitation Services Director) tasked V22 with obtaining witness statements for the incident. V22 affirmed V22 reviewed the witness statements. V22 stated that R5 stated that R1 touched R5's vagina while R5 was asleep. V22 expressed that V22 doubted the veracity of R5's statement. V22 stated, "When (R5) told me that, I (V22) asked (R5), "How could you (R5) know if he (R1) was touching you in your sleep? You are asleep. People can't know if they are being touched when they are asleep".

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On 11/27/2024, at 12:09 PM, V29 (Registered Nurse) stated that V29 was assigned to R1 on 11/14/2024. V29 was told by V25 that R1 had touched R5 inappropriately. V29 recalled notifying V17 and sent R1 to the hospital. V29 stated that V29 told V1 about the incident, but that V1 was already aware. V29 stated that V29 did not complete an assessment of R1. V29 stated that V25 had called the police and a police report was completed.

On 11/27/2024, at 1:01 PM, V21 (Registered Nurse) affirmed that V21 was assigned to care for R5 and R6 on 11/13/2024. V21 recalled that V21 was pulling meds from the medication cart at the nurse's station and V21 heard yelling from down the hallway. V21 stated that R6 was screaming at R1 and R1 left the room. V21 stated that R6 was yelling saying "(R1) touched my friend!". V21 stated that R5 said R5 was sleeping and woke up to R6 hitting R1 in the face. V21 recalled giving R5 psychotropic medications earlier and the night and R5 appeared "really confused and tired". V21 recalled that R5 was wearing sweatpants but could not recall if the sweatpants were pulled down prior to V21's assessment. V21 stated that V21 called V2 (Director of Nursing) and medical director to report the incident. V21 recalled that V2 instructed V21 to complete risk management paperwork and tell V22 (Psychosocial Rehabilitation Services Coordinator). V21 stated that V21 did not call law enforcement to report reasonable suspicion of a crime "because (V2) didn't tell me (V21) to". V21 could not recall who was the abuse prevention coordinator for the facility.

On 11/27/2024, at 3:11 PM, V20 (Certified Nursing Assistant) stated that V20 was assigned

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to care for R5 on 11/13/2024. V20 recalled that V20 was passing linen to the residents when V20 heard "hollering". V20 came out of the room V20 was in and followed V21 to R5's room. When V20 got to the room, R1 was leaving and was bleeding a lot from R1's nose. V20 recalled that the stairwell R1 entered after the incident was "covered in blood". V20 stated that R6 had punched R1 in the face. V20 recalled observing R5 laying on R5's side on R5's bed with R5's pants down and R5's "rear end exposed". V20 stated R5 was upset, told V20 that R1's hands were in R5's vagina and that R5 was going to call her lawyer. V20 stated V21 called V22 to the floor to handle the situation. V20 stated that V20 witnessed abuse, V20 would report it to the nurse on duty. V20 was unaware of any additional interventions provided for R1, R5, or R6 to prevent further harm from occurring. V20 denied knowledge of an abuse prevention coordinator for the facility.

Review of R5's care plan does not indicate any intervention was added to protect R5 from further abuse after the incident that occurred on 11/13/2024.

Review of R1'scare plan does not indicate any intervention was added to protect R5 or other residents from further abuse after the incident that occurred on 11/13/2024. Additionally, R1's care plan identifies that R1 had sexually inappropriate and aggressive behaviors towards other residents prior to the incident.

Review of R6's care plan does not indicate any intervention was added to protect R1 or other residents from further abuse after the incident that occurred on 11/13/2024.

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R5's progress notes document in part on 11/14/2024, the police were notified at 1:28 PM, of the incident and that a police report was completed due to an inappropriate physical contact with a male peer. R5 was sent to the hospital on 11/14/2024 at 2:48 PM for sexual assault follow up and returned at 8:28 PM. A rape kit was completed during R5's emergency room visit.

R1's progress notes documents in part on 11/14/2024, the police were notified at 2:49 PM, and R1 left for evaluation at 3:55 PM. R1 was admitted for a psychiatric hospitalization on 11/14/2024 and returned on 11/26/2024.

On 12/02/2024, at 11:20 AM, R5 stated that R5 still feels fearful in the facility because R1 is back in the facility. R5 explained that R1 has been on R5's floor "at least 5 or 6 times since (R1) came back last week". R5 stated that R1 having continued access to R5 makes R5 feel "terrified", and "depressed". R5 expressed that "the facility just doesn't care that I was sexually assaulted. They just don't care ... I need to leave this facility so bad!"

On 12/02/2024, at 11:25 AM, V13 (Registered Nurse) affirmed that V13 was assigned to care for R1. V13 stated, "I (V13) don't know where (R1) is, maybe downstairs?".

On 12/02/2024, at 11:30 AM, V1 and V2 (Director of Nursing) were observed sitting in V2's office. Surveyor asked V1 and V2 where R1 was. Surveyor turned from the entrance of the office and observed R1 enter the elevator with other residents (no staff present within the elevator or supervising R1). V1 left the office and walked down the hall before the elevator door closed and

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saw R1 on the elevator. V1 redirected R1 off the elevator. By R1 entering the elevator unsupervised, surveyor observed R1 having potential access to R5 and other vulnerable residents.

On 12/02/2024, at 12:57 PM, V1 stated that since readmission, R1 has had "increased monitoring" that would prevent access to R5. V1 could not give specifics on what the definition of "increased monitoring". Surveyor reviewed observing R1 entering the elevator unsupervised with V1 and asked V1 if that would allow R1 to have continued access to R5 or other vulnerable residents. V1 responded, "I see what you mean". V1 was not aware of any other interventions that were added to protect R5 from R1 after R1 was readmitted.

Review of R1's care plan on 12/02/2024, documents in part that no new interventions were added to R1's behavioral care plan to prevent further abuse to R5 or other residents. On 11/29/2024, "-no description provided-" was added to R1's behavioral care plan.

On 12/03/24, at 2:06 PM, V17 (Medical Director) said, "I (V17) am the Medical Director of the facility. V17 stated that V17 gets over 50 calls a day from nursing homes so the facility "probably notified me" of the incident between R1, R5, and R6. V17 could not give a reason as to why the facility did not send out R1 and R5 until later in the day on 11/14/2024. V17 stated that V17 always orders residents that are victims of sexual assault to go to the hospital as quick as possible to get a rape kit completed. V17 stated that physical abuse and sexual abuse is serious but depends on the resident on how much they are affected by it. V17 explained that for some people, "sexual abuse does not really phase

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them, while other people kill themselves over it". V17 affirmed that trauma from abuse can cause mental harm, in addition to physical harm, and can be manifested by flashbacks, difficulty sleeping, personality changes, depression, etc.

On 12/03/2024, at 2:46 PM, V16, (Pharmacist) reviewed R5's medication orders and stated that Quetiapine has sedative properties, but it depends on the individual to how sedated they may become. V16 stated "At a 300 mg dose, especially (R5) taking it two times per day could cause sedation."

On 12/04/2024, at 9:42 AM, surveyor observed R1 sitting in the day room with other residents. 2 staff members were in the dining room with the backs turned to R1 (indicating R1 was not being supervised)

On 12/04/2024, at 9:45 AM, V18 (Psychosocial Rehabilitation Services Aide) approached surveyor and asked, "You are from the state right? Is (R1) supposed to have one to one (1:1) monitoring? I was assigned to (R1) yesterday but no staff is assigned to monitor (R1) today. I (V18) figured you (surveyor) would know and could help. V18 affirmed that R1 has not had supervision all morning and came downstairs to the day room by himself". V18 stated, "I don't want (R1) to hurt anyone else or get in trouble". This action would allow R1 continued access to R5 and other vulnerable residents.

R1's face sheet documents in part the following diagnosis: shizoaffective disorder, insomnia, bilateral cataracts, dorsalgia, anemia.

R1's minimum data set (dated 8/26/2024) documents in part a brief interview of mental

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status score of 10, indicating moderate cognitive impairment.

R1's "Aggression and Violence History and Screening Assessment" indicates that R1 has physical and verbal aggression towards others.

R5's face sheet documents in part the following diagnosis: Bipolar disorder, current episode, severe with psychotic features, schizophrenia, unspecified asthma, and restlessness and agitation.

R5's minimum data set (dated 10/18/2024) documents in part a brief interview of mental status score of 15, indicating that R5 is cognitively intact.

R5's "At Risk for Abuse Assessment" identifies that R5 is at risk for abuse and that a care plan is needed to be initiated.

R5's care plan identifies that R5 is at risk for abuse based on the comprehensive assessment and mental health diagnoses.

R6's face sheet documents in part the following diagnosis: schizoaffective disorder, muscle weakness and difficulty walking.

R6's minimum data set (dated 10/28/2024) documents in part a brief interview of mental status score of 15, indicating that R6 is cognitively intact.

R6' "Aggression and Violence History and Screening Assessment" (10/28/2024) identifies that R6 has a history of aggressive behavior (including throwing food on other residents), severe mental illness.

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R6's care plan identifies that R6 has aggressive behaviors towards both staff and other residents.

2. On 12/4/2024, at 1:28 PM, R6 stated that R1 was "just on the elevator with me and some of the other residents". When asked about the incident between R6 and R7, R6 recalled that R6 was called downstairs to get food. R7 was downstairs and had made fun of R6's weight, saying R6 "looked like a bag of bees". R7 continued to heckle R6, so R6 recalled pushing R7 to the ground. R6 described the push as "way too hard" and felt regret that hurt R7. R6 stated that "(R7) is always talking s***, but (R7) didn't deserve to hit the ground that hard". R6 stated that the staff made R6 go to the hospital afterwards for evaluation. R6 denied that R6's plan of care had changed after the incident.

On 12/16/2024, at 12:11 PM, R7 was observed limping on the unit, and utilizing the siderail to hold self up. R7 had facial grimacing. R7 stated that a week or so prior, R6 had pushed R7 to the ground. R7 recalled that the incident took place downstairs right by the elevators. R7 stated that no one told R6 to do it, that R6 "just has a problem with me and hurts me (R7)". R7 stated that this wasn't the only incident between R7 and R6, and that R7 had gotten a black eye from R6 before. R7 couldn't give any further details about the black eye incident. R7 explained that R7 was still in pain from the incident and described the pain as "10/10" and "some of the worst pain I've (R7) ever felt". R7 stated the pain has impacted her ability to ambulate and sleep at night. R7 stated that the facility switched her floor so that R7 and R6 wouldn't live on the same floor, but R7 "still sees (R6) around the facility, off of the floor, and when (R7) is smoking". R7 described R6 as

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"really, really, really big. Like (R6) is a big, fat person." which is intimidating to R7. R7 stated, "I am so scared living here after being hit by R8 and pushed by R6. I am always afraid I am going to get jumped every day. I wish I could go home and live with my family."

On 12/5/2024, at 10:56 AM, V1 stated that the facility had completed an investigation related to an abuse allegation that occurred between R6 and R7 on 11/25/2024. V1 stated that R6 had pushed R7 to the ground and that no staff observed the altercation. V1 affirmed that the facility substantiated physical abuse occurred to R6 from R7. V1 stated that R7 was sent to the hospital after the incident for evaluation and R7's care plan would be updated upon R7's readmission. V1 stated that root cause analysis was not completed for this incident and was not reviewed by the QAA (Quality Assurance Agency)/QAPI committee. V1 stated no interventions were added to R6's care plan after R6 physically abused R1 on 11/13/2024.

On 12/5/2024, at 12:31 PM, V1 stated that the facility had completed an investigation related to an abuse allegation that occurred between R7 and R8 on 11/26/2024. V1 stated that R7 was hit in the face by R8. V1 affirmed that the facility substantiated physical abuse occurred to R6 from R7. V1 stated that R7 and R8 were sent to the hospital after the incident for evaluation and R7 and R8's care plan would be updated upon their readmission. V1 stated that root cause analysis was not completed for this incident and was not reviewed by the QAA/QAPI committee. V1 stated no interventions were added to R7's care plan after R7 was physically abused by R6 on 11/25/2024, to further protect R7 from abuse.

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Record review of final investigation report related to the incident between R6 and R7 on 11/25/2024, documents that the physical abuse was substantiated. The report summarizes that around 8:32 PM, R6 was going downstairs to get food and had an altercation with R7, which caused R6 to push R7 to the floor.

On 12/18/2024, at 3:31 PM, V15 (Regional Director of Operations) stated that the facility's census was 142.

On 12/19/2024, at 11:25 AM, V17 (Medical Director) stated that V17 was made aware of the incident that occurred between R6 and R7 and affirmed that V17 is the primary care physician for both residents. V17 stated that V17 was not aware that R7 had severe back pain but that the back pain "had to be from the incident, as (R7) doesn't have a history of chronic back pain or anything like that." V17 affirmed that when R7 was at the hospital on 11/26/2024, medical imaging was completed and no fracture was identified of R7's back. V17 stated that being pushed to the ground can cause severe back pain.

R7's Face Sheet documents medical diagnoses that include but are not limited to schizophrenia, bipolar disorder, and delusional disorders. R7's (9/20/24) BIMS Brief Interview for Mental Status) determined a score of 13 (cognition intact).

R7's progress notes on 11/25/2024 document in part, " ...Writer was informed that resident was involved in a physical altercation near the lobby. The incident occurred around evening time. There was a verbal disagreement between resident and female copeer that escalated into physical contact. Staff intervened to separate the

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two residents and ensure safety of fellow residents, staff and themselves. No injuries were reported. Resident was provided with counseling and redirection. Resident's family member could not be reached for notifying at this time. MD notified, room transfer was promptly initiated to separate resident from the copeer. Staff will continue to monitor and document as needed ..."

R7's (11/26/24) Aggression and Violence History Screening states "Resident was involved in physical altercation with a male co-peer."

R7's (12/18/24) risk for abuse assessment determined a score of 4 (at risk).

R7's (11/25/24) care plan states resident is at risk for abuse/neglect based on comprehensive assessment as evidenced by: Behavior that might be characterized as provoking, antagonizing, history/current behavior of physical abuse or threatening physical aggression towards others. 5/25/24: Resident was verbally aggressive towards staff and co peers whilst being redirected.

On 12/04/2024, at 11:53 PM, V19 (Regional Director of Behavioral Health Services) affirmed that V19 is a part of the regional team (governing body) that helps to oversee operations within the facility. V19 affirmed that V19 reviews abuse allegations that occur in the facility. V19 stated that V19 primarily completed the abuse investigation between R6 and R7 along with the behavioral specialist. V19 stated that the investigation concluded that physical abuse did occur to R7 from R6. V19 stated that the facility "did not know what caused R6 to hit R7" (no root cause analysis). V19 stated that the investigation could not be completed within the 5 day working

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days because statements were conflicting. V19 stated that investigations can be extended and that you send a request to the state survey agency to request more time. V19 recalled that the facility has to do this on rare occasions since V19 has started, under 5 times (these statements are incorrect, indicating V19 is not competent with regulatory requirements regarding abuse).

On 11/25/2024, at 1:40 PM, V1 (Administrator, unlicensed) stated that V1 is the administrator of the facility and is the abuse prevention coordinator. V1 stated V1 does not have an active Licensed Nursing Home Administrator (LNHA) License from the Illinois Department of Financial and Professional Regulation (IDFPR). V1 affirmed that V1 submitted the examination packet in June when V1 took over as the administrator for a temporary license. V1 explained that V1 has called "many times" and they (IDFPR) haven't stated that anything was wrong but was just taking a long time to process. V1 confirmed that V1 began as the assistant administrator in January 2024 and has 6 months of assistant administrator experience. V1 stated that V1 has over 60 hours of college credit and is utilizing the qualifying experience pathway of 60 hours plus 2 years of management experience in a nursing facility. V1 stated that prior to employment at the facility, V1 worked as a director of a Specialized Mental Health Rehabilitation Facility (SMHRF) and prior to that was the director of a Supportive Living Facility. V1 stated that V1's direct supervisor is V15 (Regional Director of Operations) as well as the regional team. V1 stated that all reportable incidents go to the regional team for review, which includes the Regional Director of Operations, Regional Director of Behavioral Health Services and the chief clinical officer. V1 stated that policies are

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made by the regional team at the corporate level and that the regional team develops/implements policies within the facility.

On 12/17/2024, at 2:34 PM, V15 stated that V1's experience at a SMHRF does count as qualifying experience because SMRFS are subject to the nursing home care act starting in 2013.

Review of (210 ILCS 45/) Nursing Home Care Act. Documents in part, " ...(210 ILCS 45/1-101) (from Ch. 111 1/2, par. 4151-101) Sec. 1-101. This Act shall be known and may be cited as the Nursing Home Care Act. (Source: P.A. 85-1378.) ...(210 ILCS 45/1-113) (from Ch. 111 1/2, par. 4151-113) Sec. 1-113. "Facility" or "long-term care facility" means a private home, institution, building, residence, or any other place, whether operated for profit or not, or a county home for the infirm and chronically ill operated pursuant to Division 5-21 or 5-22 of the Counties Code, or any similar institution operated by a political subdivision of the State of Illinois, which provides, through its ownership or management, personal care, sheltered care or nursing for 3 or more persons, not related to the applicant or owner by blood or marriage. It includes skilled nursing facilities and intermediate care facilities as those terms are defined in Title XVIII and Title XIX of the federal Social Security Act. It also includes homes, institutions, or other places operated by or under the authority of the Illinois Department of Veterans' Affairs. "Facility" does not include the following: ... (8) Any "Supportive Residence" licensed under the Supportive Residences Licensing Act; with the program established under Section 5-5.01a of the Illinois Public Aid Code, except only for purposes of the employment of persons in accordance with Section 3-206.01; (9) Any "supportive living facility" in good standing ...

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| S9999 | Continued From page 32<br><br>(13) A facility licensed under the Specialized Mental Health Rehabilitation Act of 2013; ..."<br><br>Review of licensee application form for "Nursing Home Administrator Temporary Non-examination Packet" documents in part, " ... EDUCATIONAL QUALIFICATIONS In order for your application to be processed, ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED with the application and required feed unless otherwise directed in the instructions. ONE OF THE FOLLOWING EDUCATIONAL QUALIFICATIONS MUST BE MET IN ORDER TO BE ELIGIBLE TO SIT FOR EXAMINATION AND/OR RECEIVE A TEMPORARY LICENSE; 1. Graduation from an accredited college or university with minimum of Baccalaureate degree (degree may be in any field. There is no experience requirement.); or 2. Satisfactory completion of an approved course of instruction in nursing home administration ...; 4. An associate degree or a minimum of 60 semester hours or 90 quarter hours of credit earned from an accredited college or university and qualifying experience (verification of qualifying experience supporting document VE must accompany application.) ... QUALIFYING EXPERIENCE is defined as 2 years of full-time employment as an assistant nursing home administrator or director of nursing in a facility licensed by the Illinois Department of Public Health pursuant to the Nursing Home Care Act; or 2 years management in a corporation which owns and operates licensed nursing home facility ..."<br><br>Review of V1's application for a temporary nursing home administrator's license documents in part the following: A) V1 began employment at the facility on 01/02/2024, as the "administrator" B) V1's employment with the facility includes V1 | S9999 | | |

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acting as the abuse prevention coordinator C) V15 verified V1's employment for the facility D) V1 has 76 college credit hours. E) V1 was still in process of getting a long-term care administration certificate from the college V1 attended when V1 applied for the temporary license F) V1 submitted the application to IDFPR on 6/12/2024. G) V1 is not a registered nurse. No further employment verification was submitted to IDFPR that demonstrates that V1 possesses the needed qualified experience to obtain a temporary LNHA license.

Record review of V1's employee file documents in part that V1's employment at a Specialized Mental Health Rehabilitation Facility (SMHRF) from 7/2021 to 12/2023, was verified by V24 (HR/Payroll).
Record review of administrator job description documents in part that the administrator "serves as the facility's Abuse Coordinator and Compliance Officer" and requires "an unencumbered, active LNHA License in the state of Illinois and 1-year experience in a supervisory capacity in long-term and post-acute care".

On 12/03/2024, at 11:25 AM, V15 stated that V15 is the regional director of operations, is a licensed nursing home administrator, and is V1's direct supervisor. V15 stated that V15 sometimes participates in the facility's QAA meetings. V15 affirmed that V15 was a part of V1's hiring process but did not verify V1's employment, that HR did. V15 explained that V15 assisted V1 was completing the application for V1's temporary license and that V15 was meeting the educational requirements by having 60 credit hours and 2 years of administration experience. V15 stated that V1 had 6 months of assistant administrator experience at the facility before V1 became the

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administrator but was the director of a SMHRF. V15 was unsure if a SMHRF was licensed by the Nursing Home Care Act and "would need to find out". V15 reaffirmed that V15 believed V1 was qualified.

On 12/03/2024, at 11:28 AM, V15 affirmed that all reportable incidents are sent to V15, the regional director of behavioral services or the vice president of clinical. V15 stated that V15 was "unsure" and was "not very familiar" with the substantiated sexual assault that occurred to R5 from R1, and substantiated physical abuse cases (R6 hitting R1 and R3 getting hit by R4). V15 was not aware if a QAPI meeting was held for the substantiated abuse cases. V15 stated that all substantiated cases of abuse get reported to V15. V15 could not recall if the cases were substantiated and was unaware if the facility completed QAPI meetings after the abuse was substantiated. V15 stated that the facility should be reviewing abuse in it's QAPI meetings. V15 affirmed that the regional team is responsible for ensuring V1 carries out policies. V15 stated that the facility staff do not make/review it's policies, that the chief clinical officer makes all policies. V15 reviewed the facility's abuse policy and affirmed that the policy the facility provided states that it meets the regulations for abuse in 2016. V15 was not aware that the regulations were updated in 2022 and that the policy stated the regulations were for abuse regulations in 2016. V15 reviewed the final reportable (dated 12/2/2024) regarding substantiated physical abuse between R6 and R7 and affirmed that the investigation was not completed within 5 working days. V15 affirmed that the incident between R6 and R7 was not completed timely because the evidence was conflicted. V15 was unsure if you could extend an investigation, not thoroughly

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completing it within 5 working days, and would "have to check the regulations". V15 stated that initial reportable of abuse must be submitted to the state survey agency immediately but no later than 4 hours (these statements are not correct, indicating V15 is not competent with regulatory requirements regarding abuse).

On 12/19/2024, at 11:25 AM, V17 (Medical Director) stated, "I don't know what would happen if an administrator isn't licensed. I can't answer that question-I don't work with them (licensed nursing home administrators) unless something critical happens, so I don't know all of what they do. I work with V2 (Director of Nursing)."

Review of facility assessment (3/1/2024) documents in part as a part of the administrator's job duties, "...Notification to Operations team of any reportable incidents and/or unusual occurrences including allegations of abuse, resident-to-resident altercations, falls with injury, elopements, injuries of unknown origin, unexpected resident death...".

Facility policy, titled, "Abuse," effective date 3/2022, documents, in part, "The following is an Abuse Prevention Program that meets CMS requirements in the updated Appendix PP, effective November 28, 2016, and the October 4, 2016, CMS Final Rule, 81 Fed. Reg. 68688 - 68872. This facility affirms the right of our consumers to be free from verbal, physical, sexual, mental abuse, neglect, exploitation, misappropriation of property, involuntary seclusion, or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of consumers. In order to do so, the facility has attempted to establish a consumer sensitive and

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consumer 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 abuse, neglect, exploitation, misappropriation of property and mistreatment of consumers. This will be done by: conducting pre-employment screening of employees and pre-admission screening of consumers ... identifying occurrences and patterns of potential mistreatment ... immediately protecting consumers involved in identified reports of possible abuse, neglect, exploitation, mistreatment, and misappropriation of property; implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences ... filing accurate and timely investigative reports. This facility is committed to protecting our consumers from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other consumers, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals.
Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a consumer other than by accidental means (210 ILCS 45/1-103). Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a consumer (42 CFR 483.5). This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and/or maintain physical, mental, and psychosocial well-being. This assumes that all instances of abuse of consumers, even those in a coma,

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cause physical harm or pain or mental anguish (42 CFR 483.12 Interpretive Guidelines). The term "willful" in the definition of "abuse" means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. (42 CFR 483.5). Physical Abuse is the infliction of injury on a consumer that occurs other than by accidental means and that requires medical attention (77 Ill. Adm. Code 300.330). Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment (42 CFR 483.12 Interpretive Guidelines). Sexual Abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault (42 CFR 483.12 Interpretive Guidelines). Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to consumers or families, or within their hearing distance, regardless of an individuals' age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, saying things to frighten a consumer, such as telling a consumer that he/she will never to be able to see his/her family again (42 CFR 483.12 Interpretive Guidelines). Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation (42 CFR 483.12 Interpretive Guidelines). II. Pre-Admission Screening of Potential Consumers
This facility shall check the criminal history background on any consumer seeking admission to the facility in order to identify previous criminal convictions. This facility will: Request a Criminal History Background Check within 24 hours after admission of a new consumer; Check for the consumer's name on the Illinois Sex Offender Registration Web site. www.isp.state.il.us; Check for the consumer's name on the Illinois Department of Corrections sex registrant search

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page. www.idoc.state.il.us; While the background or fingerprint checks, and/or Identified Offender Report and Recommendations are pending, the facility shall take all steps necessary to ensure the safety of consumers. Internal Reporting Requirements and Identification of Allegations: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment, or misappropriation of consumer property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence. Employees, without fear of retaliation, may also independently report to the state survey agency any allegation of abuse, neglect, exploitation, mistreatment, or misappropriation of consumer property, and to local law enforcement or the state survey agency if they have a suspicion that a crime was committed. All consumers, visitors, volunteers, family members or others are encouraged to report their concerns or suspected incidents of potential abuse, neglect, exploitation, mistreatment, or misappropriation of consumer property to the administrator or an immediate supervisor who must then immediately report it to the administrator or the designated individual in the administrator's absence. Such reports may be made without fear of retaliation. Anonymous reports will also be thoroughly investigated. Reports will be documented, and a record kept of the documentation. Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations or suspicion of potential

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abuse, neglect, exploitation, mistreatment, or misappropriation of consumer property. Upon learning of the report, the administrator or a designee shall initiate an incident investigation. Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two hours of the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. The nursing staff is responsible for reporting the appearance of suspicious bruises, lacerations, or other abnormalities of an unknown origin as soon as it is discovered. The report is to be documented on a facility incident report and provided to the nursing supervisor, administrator, or designated individual. Following the discovery of any suspicious bruises, lacerations or other abnormalities of an unknown origin, the nurse shall complete a full assessment of the consumer for other bruises, laceration, or pain ... Any incident or allegation involving abuse, neglect, exploitation, mistreatment, or misappropriation of consumer property will result in an investigation. For consumer injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an "injury of unknown source." An injury should be classified as an "injury of unknown source" when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the consumer; and The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the

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incidence of injuries over time. If classified as an "injury of unknown source," the person gathering facts will document the injury, the location and time it was observed, any treatment given and notification of the consumer's physician, responsible party. The Department of Public Health will be notified. Time frames for reporting and investigating abuse will be followed. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the consumer, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Investigation Procedures. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the consumer, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. Consumers to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed. Final Investigation Report. The investigator will report the conclusions of the investigation in writing to the administrator or designee within five working days of the reported incident. The final investigation report shall contain the following: Name, age, diagnosis and mental status of the consumer allegedly abused, neglected, exploited, mistreated, or from whom property was misappropriated; The original allegation (note day, time, location, the specific allegation, the alleged perpetrator, witnesses to the occurrence, circumstances surrounding the occurrence and any noted injuries); Facts determined during the process of the investigation, review of medical record and

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interview of witnesses; Conclusion of the investigation based on known facts; The police report, if applicable; If the allegation is determined to be valid and the perpetrator is an employee, a separate sheet listing the employee's name, address, phone number, title, date of hire, copies of previous disciplinary actions, and current employment status (still working, suspended or terminated). Quality Management Review. Any investigation that concluded that abuse, neglect, exploitation, mistreatment, or misappropriation of consumer property occurred shall be reviewed by the facility Quality Management committee for possible changes in facility practices to ensure that similar events do not occur again. The investigation shall be reviewed at the next quarterly Quality Management committee meeting, or sooner if possible. This report shall be made immediately. Informing Local Law Enforcement. The facility shall also contact local law enforcement authorities (i.e., telephoning 911 where available) in the following situations: Physical abuse involving physical injury inflicted on a consumer by a staff member or a visitor; Physical abuse involving physical injury inflicted on a consumer by another consumer except in situations where the behavior is associated with dementia or developmental disability; Sexual abuse of a consumer by a staff member, another consumer, or visitor; When there is a reasonable suspicion that a crime has been committed in the facility by a person other than a consumer; When a consumer death has occurred other than by disease processes. If there is a reasonable suspicion that a crime has been committed that results in serious bodily harm, a report shall be made to local law enforcement and IDPH immediately. If there is a reasonable suspicion that a crime has been committed that is not listed above and does not involve serious bodily injury,

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then a report to local law enforcement as soon as possible but within 24 hours of when the suspicion was formed. Five-day Final Investigation Report. Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health. The final investigation report shall contain the following: Name, age, diagnosis and mental status of the consumer allegedly abused, neglected, exploited, mistreated, or from whom property was misappropriated; The original allegation (note day, time, location, the specific allegation, the alleged perpetrator, witnesses to the occurrence, circumstances surrounding the occurrence and any noted injuries); A summary of facts determined during the process of the investigation, review of medical record and interview of witnesses; Conclusion of the investigation based on known facts; The police report, if applicable; If the allegation is determined to be valid and the perpetrator is an employee, a separate sheet listing the employee's name, address, phone number, title, date of hire, copies of previous disciplinary actions, and current employment status (still working, suspended or terminated)."

(A)

Statement of Licensure Violations 2 of 2

300.615e)
300.615i)
300.615j)

Section 300.615 Determination of Need

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| S9999 | Continued From page 43<br>Screening and Request for Resident Criminal History Record Information<br><br>e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)<br><br>i) The facility shall provide for or arrange for any required fingerprint-based checks to be taken on the premises of the facility. If a fingerprint-based check is required, the facility shall arrange for it to be conducted in a manner that is respectful of the resident's dignity and that minimizes any emotional or physical hardship to the resident. (Section 2-201.5(b) of the Act) If a facility is unable to conduct a fingerprint-based background check in compliance with this Section, then it shall provide conclusive evidence of the resident's immobility or risk nullification of the waiver issued pursuant to Section 2-201.5(b) of the Act.<br><br>j) The facility shall be responsible for taking all steps necessary to ensure the safety of residents while the results of a name-based background check or a fingerprint-based background check are pending; while the results of a request for waiver of a fingerprint-based check are pending; and/or while the Identified Offender Report and Recommendation is pending. | S9999 | | |

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These Requirements were NOT MET as evidenced by:

Based on interview and record review, the facility failed to ensure that background checks for 3 (R1, R3 and R4) residents were initiated within 24 hours of admission, failed to order fingerprints for 2 residents (R1 and R3) that had hits on their background checks and failed to verify that they immediately notified Illinois Department of Public Health's Identified Offender Program Office via Identified Offender Program Management Information System (IOPMIS) for 2 residents (R1 and R3). This failure has the potential to affect all 142 residents residing in the facility.

Findings include:

Email dated 12/18/24, at 3:31 PM, per V15 (Reginal Director of Operations), documents, in part, "The census on 11/25/24 was 142."

On 11/25/24, surveyor requested background checks from V1 (Administrator) for R1, R3 and R4 due to abuse allegations. V1 said that V7 (PRSD/Psychiatric Rehabilitation Service Director) and V8 (Admissions Director) are in charge of the background checks. V1 stated that he (V1) will notify V7 to obtain the documents surveyor requested.

Review of documents provided showed R1 who had an admission date of 1/07/2010, had a Illinois Sex Offender Registry, dated 1/05/2011; Illinois Department of Corrections, dated 4/14/2017; CHIRP (Criminal History Information response Process), dated 11/11/2024, documents, in part, "RESULT: MULTIPLE HITS - FEE FINGERPRINTS REQUESTED."; and a "State

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Level Criminal Background Check ILLINOIS STATE POLICE," dated May 8, 2017, documents, in part, "Finding: MULTI HIT - SUBMIT FINGERPRINT." R1's background checks were not completed within 24 hours of admission. R1's fingerprints or request for fingerprints was not present.

R1's face sheet documents in part the following diagnosis: schizoaffective disorder, insomnia, bilateral cataracts, dorsalgia, anemia. R1's minimum data set (dated 8/26/2024) documents in part a brief interview of mental status score of 10, indicating moderate cognitive impairment.

Review of documents provided showed R3 who had an admission date of 2/21/2017, had a CHIRP (Criminal History Information response Process), dated 2/22/2017, documents, in part, "Result: HIT. Date of Arrest 05/16/1990 IVC (Illinois Vehicle Code) Felonies; Date of Arrest, Possession of Controlled Substance." R3's Illinois Sex Offender Registry, Illinois Department of Corrections, and fingerprints were not present.

R3's Face Sheet documents medical diagnoses that include but are not limited to paranoid schizophrenia; generalized anxiety disorder; other recurrent depressive disorders. R3's Minimum Data Set (MDS), dated 9/20/24, documents, in part, that R3's Brief Interview for Mental Status (BIMS) score is 15 which indicates R3 is cognitively intact.

Review of documents provided showed R4 who had an admission date of 10/29/2014, and a re-entry admission date of 12/2/2018 had CHIRP (Criminal History Information response Process), dated 11/10/23. R1's Illinois Sex Offender Registry, and Illinois Department of Corrections

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were not present.

R4's Face Sheet documents medical diagnoses that include but are not limited to schizoaffective disorder, unspecified; other and signs involving appearance and behavior; unspecified dementia, unspecified severity, with other behavioral disturbance; major depressive disorder, recurrent, unspecified; anxiety disorder, unspecified; hemiplegia, unspecified affecting left nondominant side; dependence on wheelchair. R4's Minimum Data Set (MDS), dated 11/08/24, documents, in part, that R4's Brief Interview for Mental Status (BIMS) score is 4 which indicates R4's cognition is severely impaired.

On 11/25/24, at 1:02 PM, V7 (PRSD/Psychiatric Rehabilitation Service Director) said, "Admissions does the background checks on residents."

On 11/26/24, at 12:04 PM, V8 (Admissions Director) said, "Yes, I'm (V8) responsible for doing the resident background check. When a new resident comes, we (facility) have 24 hours to perform the background checks. I (V8) do it once they are in the facility, day one, cause I (V8) know the importance of the background checks. Name, date of birth, male, female, color. Before we (staff) accept a resident, we (staff) run Illinois Department of Corrections, Sex Offender, and National Sex Offender. Once in the facility, we (staff) run the background check through Illinois State Police Department. When there are hits prior we (staff) don't accept the individual. Nine out of ten times you'll find out the offenses prior to coming into facility. If there are hits when the resident is here, I (V8) upload it into system and let PSRD Psychiatric Rehabilitation Service Director) know it's in the system and the PRSD takes over from there. (V7) is the PSRD. I (V8)

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don't do anything with the hits. I (V8) wasn't responsible for (R1's, R3's and R4's background checks. It was someone else. Looks like they missed doing the checks."

On 11/26/24, at 12:16 PM, V7 (PRSD) said, "I (V7) cannot find (R3's and R4's) background checks. I (V7) wasn't here then. I (V7) cannot find (R1's and R3's fingerprints. I'm (V7) not sure if they were done. If there are hits on resident background checks, I (V7) am responsible to do fingerprints and report to IDPH (Illinois Department of Public Health). Fingerprints should be done within 5days. Within 5 days I (V7) have to schedule the fingerprint. When I (V7) do the fingerprint I (V7) notify IDPH. Immediately after I (V7) receive it, I (V7) schedule the fingerprint. The purpose for getting the fingerprints is to report to IOP (Identified Offenders Program). The fingerprints are gonna tell me, at the end of the day, the risk assessment for the offense. Risk assessments tell you high, medium, low at risk for the behavior, level of offense. Risk assessments determine resident's needs for their behaviors like maybe in a single room, medium risk roommate, high risk no roommate. Let me tell you this. I (V7) came in May. I'm (V7) working on audit still. I'm (V7) working on spreadsheet that shows each resident, offenses, fingerprints so they have access to the information when I'm not here."

Facility presented document titled, "Identified Offender Facility Policy and Procedure," dated 2011, documents, in part, " ... In accordance with the provisions of the Nursing Home Care Act, this facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions. Identified Offender: Any person who has been convicted of, found guilty of,

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|---|---|---|---|
| | IL6001895 | A. BUILDING: _____ B. WING _____ | C 12/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTHVIEW MANOR | 3311 S. MICHIGAN AVE. CHICAGO, IL 60616 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
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adjudicated delinquent for, found not guilty by reason of insanity for, or found unfit to stand trial for, any of the statute citation numbers listed in the Identified Offender Conviction List or any of the statute citation numbers listed in the Sex Offenses List of the IDPH Identified Offenders Program attached to this procedure. Identifying Offenders: 1. Check for the resident's name on the Illinois Sex Offender Registration Web site. www.isp.state.il.us 2. Check for the resident's name on the Illinois Department of Corrections sex registrant search page. www.idoc.state.il.us 3. Conduct a Criminal History Background Check: Within 24 of admission, request a name-based Uniform Conviction Information Act (UCIA) criminal history background check based on name, date of birth and other identifiers required by the Department of State Police for any resident seeking admission to the facility. If the resident was admitted from the hospital AND the hospital notified the facility that the UCIA name check was ordered it does not have to be ordered. However, if the name check response initiated by the hospital is not received within 3 days of admission, the facility will order another UCIA name check. 4. Check the UCIA response against the statute citation numbers from the IDPH Identified Offender Conviction List and the IDPH Sex Offenses List . a. If the UCIA response lists no convictions or the convictions do not match the Identified Offender or Sex Offender statute citation numbers, the resident IS NOT an Identified Offender, and there is nothing more the facility has to do. b. If the UCIA response contains convictions that match the Identified Offender or Sex Offender statute citation numbers, the resident IS an Identified Offender and must be reported to Identified Offenders Program. Identified Offender Facility Policy and Procedure Page 2 of 10 C 2011 5. Request a live scan UCIA

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|---|---|---|---|---|
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fingerprint check: If the UCIA name check states a fingerprint inquiry must be submitted; or b. If the identifying information on the UCIA name response is inconclusive; or c. It does not match the individual submitted. d. The fingerprint-based background must be requested within 72 hours after receiving the name-based background check and must be conducted within five business days after receiving the name based results. e. The facility may also request a waiver of the fingerprint check within 72 hours from the Division of Healthcare Regulations 217/785-2629 if the resident is completely immobile or meets the criteria related to the resident's health or lack of potential risk, such as the existence of severe, debilitating physical, medical, or mental condition that nullifies any potential risk presented by the resident. A waiver will only be valid while the resident is immobile or while the criteria supporting the waiver exist. While the background or fingerprint checks, waiver request, and/or Identified Offender Report and Recommendations are pending, the facility shall take all steps necessary to ensure the safety of residents. Reporting Results if the Resident is an Identified Offender 1. Once the facility determines the resident is an Identified Offender, the facility must request in 72 hours for the resident to undergo a live scan State and Federal Bureau of Investigation (FBI) fingerprint check on the premises within five business days. The fingerprint check must be requested on the Nursing Home Resident Fingerprint Inquiry Consent Form attached. One copy of the form will be sent to the live scan vendor, one will be kept by the facility, and one will be given to the resident. 2. Immediately complete and submit the Illinois Department Public Health (IDPH) Identified Offender Information (IOI) Form attached and fax it to the IDPH Identified

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| | IL6001895 | A. BUILDING: _____ B. WING _____ | C 12/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTHVIEW MANOR | 3311 S. MICHIGAN AVE. CHICAGO, IL 60616 |

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|---|---|---|---|---|
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Offender Program (IOP) at 312-814-2757, along with a copy of the UCIA response. The facility will not wait for the fingerprint results to send the Identified Offender Information Form to IDPH. 3. Check for confirmation from the Identified Offender Program within one business day, confirming that all the information was submitted correctly or what additional information is needed. Call 312-793-3913 if you have not heard from them. 4. After the confirmation from the Identified Offender Program, the facility will receive a phone call from the Illinois State Police Division of Internal Investigation within three business days scheduling an on-site facility interview with the resident and the administrator. Identified Offender Facility Policy and Procedure Page 3 of 10 C 2011 5. Once the investigator has completed the investigation portion, a forensic psychologist will review all the documentation to complete the risk assessment. As part of his or her analysis, the forensic psychologist may need to personally interview the resident. If so, he or she will contact the facility to arrange for an interview. 6. The facility will receive an Identified Offender Report and Recommendations within four to six weeks. The Identified Offender Report and Recommendations shall detail whether and to what extent the Identified Offender's criminal history necessitates the implementation of security measures within the long term care facility. The Identified Offender Report and Recommendations shall be sent to the long term care facility, the chief of police, IDPH, and the ombudsman. The Identified Offender Report and Recommendations shall be incorporated into the facility's plan of care. Maintain written documentation of compliance with the above requirement."

Facility Policy titled, "Resident Rights," dated

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| S9999 | Continued From page 51<br>3/2021, documents, in part, " ... PROCEDURE: 1. The residents will be assured of the following rights: Safe and good care ... Right to Privacy ..."<br>(C) | S9999 | | |