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S 000	Initial Comments Facility Reported Incident of 1/10/25-IL184411	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 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 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	S9999		

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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.

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.

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 and record review the facility failed to ensure 1 of 4 residents (R2) was protected from another resident with known sexually inappropriate behaviors resulting in the sexual abuse of R2. This failure has the potential to affect all 123 residents residing at the facility.

Findings include:

On 01/15/25 at 2:00 PM, The Illinois Department

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of Public Health (IDPH) Detailed Incident Summary of the 1/10/25 incident was reviewed and documented the following:

"January 13, 2025(1/10/25 incident), Final Investigation While staff were helping residents into dining room, they noticed R3 standing over another resident R2 and she was yelling at him to stop. They noted that he had his penis out and was making her rub it with her hand. Assessment completed on R2 by nurse. No injuries noted. R2 stated that she is upset about the incident but feels safe knowing he is not coming back. R2 is a bed bound alert and oriented x4 (times 4) resident. She is total assist with all ADLs (Activities of Daily Living). R3 is alert and oriented x4 resident with a diagnosis of schizophrenia and MDD (Major Depressive Disorder) with psychosis. He has been refusing his medication here at facility. He was sent out to a local hospital in January, and he was admitted. They returned him to this facility on January 4, 2025, still with refusal of medication. We then initiated a behavior contract in which he signed and agreed to. He has broken his contract numerous times. R2 is pressing charges against R3, in which we have issued an IVD (Involuntary Discharge) for 1/10/25. The ombudsman made aware of IVD, V1 LNHA (Licensed Nursing Home Administrator), RN (Registered Nurse)"

On 01/22/25 at 9:30 AM, The Police Investigation was reviewed and documented Field interview with V17, Nursing/Staffing Coordinator said she was approached by staff members who reported an incident that occurred in the dining area earlier. They reported R3 was sitting next to R2 and R2 told staff R3 was feeling on her. V17 spoke with R2 who told her R3 put R2's hand on his penis. R3 knows right from wrong and has

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been sexually harassing other female patients/employees. R3 has been seen coming in and out of female patient rooms and grabs his genitals while speaking to female employees. V18, Police Officer then spoke with R2 who told V18 R3 grabbed her hand and put it on his penis (on outside of his pants). R2 then told V18 a nurse came over to them and stopped R3.

R2's Face Sheet, original admission date of 12/09/19, documented R2 has diagnoses of but not limited to schizoaffective disorder, bipolar type, chronic obstructive pulmonary disease (COPD), Myelodysplastic syndrome, muscle weakness, and abnormal posture.

R2's Minimum Data Set (MDS), dated 12/13/24, documented R2 is moderately cognitively impaired with a Brief Interview for Mental Status (BIMS) of 12 out of 15 and R2 is dependent on staff for dressing, showers/bathe, bed mobility, and transfers. R2 also is dependent on staff for all of her other ADLs.

R2's Care Plan, last care plan review date of 12/26/24, documented Problem: R2 is at risk for abuse and/or neglect related to bipolar disorder, psychotropic medications, poor judgement skills, history of verbal aggression, isolation/withdrawn behavior (may not report abuse), and history of resisting care interventions. On 1/10/25 resident was the recipient of sexual inappropriate behaviors from peer. Goal: Resident will not be abused and/or neglected thru next review date. Interventions include but not limited to 1/10/25 staff intervene residents separated. staff stayed present until Emergency Medical Services (EMS) arrived. Local Police department called to report, Abuse coordinator made aware, psychosocial follow up will continue and keep resident safe

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from harm at all times.

R2's Progress Notes, dated 1/10/2025 at 06:30 AM, documented This nurse received notification from staff that resident was sitting in dining room and another resident (male) came up to her and began sexually assaulting her; the resident was immediately removed from scene to safety; 911 notified; administrator notified; nursing supervisor notified of situation; resident assessed and has no skin issues at this time; resident stated that she does not need to go to the hospital for further evaluation; resident in room at this time with belongings in reach; plan of care continues.

R3's Face Sheet, original admission date of 03/29/24, documented R3 has diagnoses of but not limited to schizophrenia, major depressive disorder, recurrent, sever with psychotic symptoms, and generalized anxiety disorder.

R3's MDS dated, 10/07/24, documented R3 is cognitively intact with a BIMS of 15 out of 15, he requires supervision/touching assistance with his ADLs, he is occasionally incontinent of bladder, he has a colostomy and is always continent of bowel.

R3's Care Plan, last care plan review date of 10/24/24, was reviewed and documented Date Initiated: 01/14/25, R3 has diagnosis of Schizophrenia and may display symptoms that include but not limited to being out of touch with reality (delusional or hallucinations, may have disorganized speech or erratic behavior, decrease in activities. Diagnosis of mental illness 01/10/25 resident sexually inappropriate with peer. 11/26/24- verbally aggressive, 12/25/24- Physical and verbal aggression. Interventions are but not limited to 1/10/25 staff intervene residents

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separated. Resident was sent to Local hospital for evaluation and treatment. Staff stayed present until EMS arrived. Local Police Department called to report, Abuse coordinator made aware, notify psychiatrist of any change in behavior, and staff to intervene if experiencing any aggressive/delusional behaviors, staff will continue to monitor R3 closely at all times to intervene when he becomes psychotic and physically aggressive. R3's care plan did not document R3 was displaying sexually inappropriate behavior and had no interventions in place to prevent sexual abuse of other residents.

R3's Physician's Orders, dated 05/03/24, documented R3 was to get Invega Sustenna Suspension prefilled syringe 234 milligrams (mg)/1.5 milliliters (ml) inject intramuscularly (IM) once a month for schizophrenia. The Invega was discontinued in November 2024.

R3's Physician's Orders, documented R3 started on Abilify 5mg one tablet by mouth one time a day for schizophrenia on 03/31/24. Then on 11/14/24 his Abilify was decreased to 2.5mg. On 11/26/24 there was a new order to increase R3's Abilify to 10mg daily and then on 12/03/24 it was again increased this time to 15mg once a day. R3 was then sent out to the hospital in late December 2024 and when he returned to the facility on 01/07/25 there was a new order to increase his Abilify to 20mg once daily.

R3's Physician's Orders, dated 12/02/24, documented R3 was getting Depakote 250mg delayed release one tab twice a day related to (r/t) schizophrenia and when he returned from the hospital on 01/07/25 it had been changed to Depakote Sodium 500mg Extended Release

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(ER) one tablet at bedtime for schizophrenia.

R3's Physician's Orders, dated 01/07/25, also documented when R3 returned from the hospital he was to get Zyprexa (Olanzapine) oral tablet 10mg every six hours as needed for psychosis and Zyprexa (Olanzapine) Intramuscular (IM) Solution Reconstituted 10mg IM every six hours as needed for psychosis.

R3's Medication Administration Records (MARs) for the Months of August 2024, September 2024, October 2024, November 2024, December 2024, and January 2025 were reviewed and have no documentation of R3 taking his once-a-month antipsychotic injection in August, September, October, and November of 2024. R3's MAR for the month of December 2024 documented he refused his oral Abilify 15mg on 12/03/24, 12/05, 12/06, 12/10, 12/11, 12/12, 12/13, 12/14, 12/16, 12/19, 12/20, 12/23, 12/24, 12/25, and 12/26/24. He refused his oral Depakote 250mg twice a day on 12/03, 12/03, 12/16, 12/17, 12/24, and 12/25. He refused his morning dose on 12/05, 12/06, 12/10-12/14, 12/19, 12/20/24, and his evening dose on 12/18/24.

R3's Electronic Medical Record (EMR) was reviewed, and his progress notes documented the following entries:

On 12/25/24 at 3:30 PM, Social Service staff member reported to this nurse that the resident had asked to speak with her. She had gone into her office and the resident had locked the door behind him and refused to open it, but after a moment, the resident moved out of her way, and she was able to exit the office. The staff member also reported that the resident had once again entered her office, locked the door behind him

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and this time would not allow her to exit the room. Resident then approached her, getting in her face and made some threatening remarks towards her. The staff member was able to remove herself from the office and immediately reported this to this nurse. Social services staff member had requested that the resident be sent out for evaluation due to increased aggressive and threatening behaviors.

On 12/25/24 at 6:15 PM, This nurse entered the resident's room to offer his roommate his medication, which his roommate was not in the room at the time. Upon attempting to exit the room, the resident stated, "hold up, wait." When this nurse turned to face the resident, at which time, the resident jumped up out of his bed and got up in this nurse's personal space and face and said, "what?" Then the resident grabbed this nurse's left arm tightly and got closer to this nurse's face and said, "what you going to do?" This nurse jerked the arm away from the resident and began to quickly exit the resident's room when the resident stated, "why'd you grab my d**k?" This nurse attempted to redirect the resident and instruct him to stay in his room and that his comments and threats were inappropriate. Resident then started saying, "man, you bogus." This nurse then instructed the resident to shut the door to his room to which he did comply once two other male residents got close to his doorway.

On 12/25/24 at 8:49 PM, A nurse assigned to the 500 hall reported R3 grabbed her arm and made threatening and inappropriate sexual remarks to her.

On 12/25/24 at 8:58 PM, Two residents reported R3 made threatening and aggressive remarks to

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them.

On 12/26/24 at 1:34 AM, Resident physically and verbally aggressive towards residents and staff. Police were called and involuntary discharge was issued after as resident was a threat to staff and other residents.

On 12/26/24 at 3:48 AM, Resident walking up and down the hallway with his cell phone in his hand with music blaring. R3 refused to turn down the music and he was unable to be redirected. Behaviors noted on shift report for possible medication changes or other interventions.

On 01/07/2025 2:12 PM, Resident arrived at facility via company transportation. Resident ambulates without assistance. Resident has no complaint of pain or discomfort. Resident is own responsible party. DON and Administrator notified of return. Plan of care will continue.

On 01/08/25 at 9:12 PM, R3 was standing behind the 400 nurse's station and another resident was yelling at R3 to stop following the nurse around and leave the 400 hall.

On 1/10/2025 at 06:58 AM, This nurse entered dining room to witness a verbal altercation between this resident and a female resident that stated he used her hands to touch his genitals without her consent. The residents were separated immediately; incident was reported to abuse coordinator, DON, and local Police Department. Statements were taken and reported to appropriate parties.

Survey Team Interviews:

On 01/15/25 at 1:25 PM, On the day of the

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incident R2 said she was going down for breakfast when R3 came up and sat down beside her. She said she thought he was just trying to be friendly and come to find out he was a pervert. R2 said R3 pulled his penis out of his underwear and tried to make her touch it. She said he didn't try anything else, and it made her feel afraid when he did that. R2 said when R3 did that she started yelling help and the staff came and stopped R3. She said it's affected her because now she doesn't go out to the dining room early, she waits until everyone is seated then she will pick where she wants to sit so she can see if anyone is trying to sit down by her. R2 said she is a little bit worried it will happen again, but she doesn't think it will. She said she is a little leery about going out to the dining room, but she's been going. R2 said there is no reason he or anyone else should be touching his penis. The police came and took a report. R2 said she sits in a geriatric chair, she must have help with everything, and she has never felt afraid until now.

On 01/16/25 at 10:05 AM, R7 who is cognitively intact with a BIMS of 15 out of 15 said she witnessed the incident between R2 and R3. She said R3 kept turning the lights off and then someone would turn them back on. She said R2 was sitting out in the dining room at the table and one of the nurses told R3 to get away from R2. R7 said R3 then started feeling on R2's breast and groin areas and R2 was yelling "no". R7 said she ran and helped R2 by grabbing R2's chair and was trying to move it away from R3. She said R3 grabbed it also and they were fighting over the chair. She said if you ask me what he did was rape. R7 said she hollered for the nurse, and they came.

On 01/16/25 at 10:12 AM, R8 who is cognitively

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intact with a BIMS of 15 out of 15 stated she was in the dining room on the day of the incident between R2 and R3. R8 said R3 kept turning the light off in the dining room and then others would turn it back on. R8 stated R3 was grabbing R2 by the arms and touching her around the chest area. R8 said R2 kept telling R3 to go away, and R8 feels like he (R3) kept turning the light off to keep it dark to stop people from seeing what was going on and so he could attack her again. R8 stated R2 can't defend herself and R3 trying to hurt R2 is not okay. R8 said since this happened the staff have been close by R2 and when R2 is out in the dining room she will look around all the time because she is scared.

On 01/16/25 at 10:30 AM, V5, Licensed Practical Nurse (LPN) stated R3 had been having inappropriate behaviors for a few months prior to the incident involving R2. She said they had tried to get R3 sent out to the hospital, but they wouldn't take him due to the right paperwork not being sent with him. She said R3 had been inappropriate with other staff members, but he hadn't been inappropriate with her. V5 said yes R2 is scared to go back out to the dining room, and she will let you know. She said as far as she knows there have been no new interventions put into place after R3 came back from the hospital the last time.

On 01/16/25 at 11:25 AM, V1, Administrator said R3 has been having behaviors on and off since about October. She said it truly started about mid-November about the 15th or 16th. She said she had staff who have known him for a while tell her his behavior just wasn't right. He was real paranoid and would follow people around. He also became aggressive with staff. V1 said his sexually inappropriate behavior started in

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December a couple of weeks before his last hospital stay. She said he was being sexually inappropriate with staff 100% and female staff specifically. V1 said a lot of the staff were fearful R3 would do something. V1 said R3 was sent to a local hospital and was there for about a week and when he came back to the facility, he was the same. There was no change in his behavior. She said he was still refusing his medication. V1 said while R3 was at the hospital they increased his medications, but he wasn't taking them and then he came back, and this incident happened.

On 01/16/25 at 11:58 AM, V6, Social Service said she had an incident with R3. V6 said R3 never took his medications. She said she was talking with another resident in her office and when that resident left the office R3 started to come in her office then turned around and acted like he was leaving but then he came in and locked the door. She said she was able to get the door unlocked and then he locked it again on her. She said R3 was making threats towards her, trying to touch her a few days earlier, and wouldn't let her get to the door. She said she was screaming and yelling trying to get someone's attention. V6 said she was able to make it to the door was holding it open and was able to get someone to help her. V6 said R3 had been following her around the building and he was hearing voices. She said a lot of the staff are scared of R3. She said when he tried to touch her a few days earlier she told him that it wasn't appropriate for him to do that.

On 01/16/25 at 2:00 PM, V10, Nurse Practitioner (NP) said they have had issues with R3 for months. She said R3 doesn't follow the rules and hasn't been taking his meds. she said he has been talking to people who aren't there. V10 said they have sent R3 out to the hospital several

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times due to his behaviors. She said she even talked with the emergency room (ER) doctor and told them about his behaviors, he is scaring people, and the hospital will send him right back stating R3 isn't a threat to anyone. V10 said R3 can stare at you and it's like he can see right into your soul. V10 said she was scared of R3 and wouldn't assess him with even two other people in the room because he had no control over what he was doing. V10 said when the hospital sent him back, she told the facility not to take him back. She said he would approach people, just wander around, stare at you, and then just walk away. She said she doesn't know what interventions the facility would put into place for him. R3 is very unpredictable, and she feels he is a danger to staff and other residents. She said she told them before Christmas not to take him back because he scared a lot of residents.

On 01/17/25 at 9:09 AM, V2, DON stated that she didn't know R3 had touched and groped R2. She said she knew he had taken his penis out and put it in her (R2) hand. She said that he picked someone out who couldn't tell anyone, and she couldn't stop him. V2 continued to state that the facility had attempted to send R3 out multiple times to the hospital but when he got to ER, the ER would return him.

On 01/17/25 at 9:42 AM, V7, MDS coordinator, in conference room, state she went through his (R3) medical record, and she could not find any documentation that R3 was sexually inappropriate prior to this incident.

On 01/21/25 at 10:10 AM, R2 was sitting up in her reclining chair watching television (TV). 1:1 sitter sitting in the room with her. Follow up interview conducted at this time. R2 said she was sitting

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	IL6001341	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLEVILLE HEALTHCARE CENTER	727 NORTH 17TH STREET BELLEVILLE, IL 62226

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out in the dining room and R3 pulled out his penis and tried to make her touch it. R2 said she doesn't remember somethings about that day because she was kind of blacking out when it was all happening. She said he could have touched her breast and groin area, and he could have told her to put his penis in her mouth she just doesn't remember. She said she was scared when it happened and it's hard to think about. She said most of the time she has a 1:1 with her but that didn't start until after the incident happened with R3.

The facility's daily census sheet, dated 01/16/25, documented the facility had 123 residents currently residing at the facility.

The facility's Abuse Prevention Program, reviewed date of 09/2017, documented "POLICY This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility 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 abuse, neglect, exploitation, misappropriation of property and mistreatment of residents." It further documented "Sexual Abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault by a licensee, employee, or agent (77 Ill. Adm. Code 300.330). Sexual abuse is non-consensual sexual contact of any type with a resident." It also documented "Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care

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S9999	Continued From page 14 approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of the residents." It also documented "Resident Protection Investigation Paths Option 2: Possible Sexual Abuse Determine if the allegation involves either physical sexual contact involving penetration, or verbal harassment or physical contact that did not involve penetration. If an allegation of physical sexual contact with penetration is involved: The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) as required in Section 300.695 in the following situations: For 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); or For sexual abuse of a resident by a staff member, another resident, or a visitor." (B)	S9999		