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	IL6012330	A. BUILDING: _____ B. WING _____	03/24/2025

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Z 000	COMMENTS Licensure Survey	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 350.3240b) 350.3240c) 350.3240f) 350.3240 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident prohibited by Section 2-107 of the Act shall immediately report the matter to the Department and to the facility administrator. (Section 3-610(a) of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident prohibited by Section 2-107 of the Act shall immediately report the matter by telephone and in writing to the resident's representative, and to the Department. (Section 3-610(a) of the Act) f) Resident as perpetrator of abuse. 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) This regulation was not met as evidenced by:	Z9999		

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Based on interview and record review, the facility failed to identify and prevent sexual abuse for 2 of 2 residents, R1 and R2, when they were allowed to take naked photographs of one another while in the shower. The facility policies on abuse do not contain information regarding resident to resident sexual abuse

Findings include:

On 11/01/24, facility notified the Illinois Department of Public Health (IDPH) of resident abuse. The report documented "(R1) reported that someone took his picture in the shower and he did not like it. Upon investigation, it was determined (that) his peer (R2) to (took) the pictures. Date of incident occurred: 10/29/24. Perpetrator: (R2)."

Facility's investigation report dated 11/09/24 describes the following:

- On 11/06/24 at 4:00 PM, E7 (Direct Service Professional, DSP) stated that on 10/29/24 approximately at 4:30 PM (second shift), R2 brought (facility tablet) to E7 and stated "hey look what (R1) did." E7 saw various pictures of R1 nude in the bathroom with time stamp they were just taken only minutes before. E7 told R2 "that's not appropriate, looks like you took these pictures because it shows R1 in the shower." R2 responded "it was (R1)." E7 secured the (tablet) and notified E13 (Qualified Intellectual Disability Professional, QIDP). E7 added that R2 finds reasons to go into the bathroom while R1 is showering. For example, R2 will say he gave R1 a towel. On one occasion while R1 was in the shower, R2 squeezed past E7 to go upstairs saying he needed to use the toilet, even when

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reminded he can use the first floor bathrooms. At times, E7 establishes his presence on the second floor when R1 is showering. R2 will visually check if E7 is still present and display signs of frustration such as grunting, yelling or showing annoyance.

- On 10/30/24 written reports by E16 (DSP) at 2:30 PM and E17 (DSP) at 2:45 PM documented that while in the gym with E16 and E17, R1 stated out of the blue "I don't like them taking pictures of me in the shower; they take pictures of me in the shower, I got no clothes on and I don't like that."

- On 11/01/24, R1 was shown pictures of clients in the facility and identified R2 as "he took pictures of me in the shower" with an (tablet).

- On 11/04/24 at 7:35 PM, E12 (DSP) stated that on 10/29/24 (second shift), E7 told E12 that R2 took pictures of R1 in the shower. E12 saw the unclothed pictures of R1 on the (tablet). E12 asked R2 about the picture and R2 stated "it wasn't me." E12 stated "it had happened a few times last week and a couple months ago; in both cases E12 deleted the pictures and told E13 (QIDP). E13 stated she would call the parents. For the incident a couple months ago, E12 informed co-worker E18 (DSP).

- On 11/08/24 at 3:30 PM, E18 (DSP) stated that E12 and E13 generally delete pictures from the (tablet). E8 attempts to keep R1 and R2 from invading one another's private space, both resist redirection to allow each other privacy. E18 once found R2 using the toilet in the staff bathroom while R1 was standing in the bathroom talking with R2. R2 exerts some control over R1, as an example, R2 may tell R1 to go (to) someone and R1 will do it.

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Z9999	Continued From page 3 - On 11/04/24 at 6:45 PM, E13 (QIDP) stated that she is aware of a resident's picture taken while in the shower. E7 texted E13 asking to take away tablet with nude pictures of R1 taken by R2 while R1 was in the shower. E13 stated there were other instances of pictures taken (of client/s unnamed) that were fully or partially naked. E13 added that R1 will pull other (unnamed) client's pants down and R2 takes a picture of that. E13 stated that she met R2 on 10/30/24 and R2 stated "R1, he did it." - Summary: R1 revealed that it was R2 who took pictures of him while R1 was naked in the shower. R2 showed the pictures to E7. E7 texted E13. Neither E7 nor E13 notified the supervisor. R2 was at home with his family when R1 disclosed that R2 had taken the pictures, as a result, there has not been an interview with R2. Since person taking picture is another resident and not staff, this case is not one of sexual abuse. It is one that demonstrates inappropriate Social and/or sexual behavior. - Finding: Staff failed to follow the policy for reporting incidents. This resulted in a delay addressing the issue, and this caused some distress for R1. - Outcome: R2 had a planned home visit Friday 11/01/24 to Monday 11/04/24. Since he was already home, no additional action such as a suspension was necessary to separate him and R1. Upon returning from home visit, R2 was relocated to the first floor to allow separation in their private spaces, and enable greater staff supervision. Facility's Nightly Absences Calendar for October	Z9999		

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and November 2024 documented that R1 and R2 were present in the facility on 10/29/24, 10/30/24 and 10/31/24. R2 started home visit on 11/01/24 through 11/05/24. R2 was back in the facility on 11/06/24.

On 3/05/25 at 3:19 PM, E12 (DSP) stated the following:
- E12 did not see the pictures E7 told him about (on 10/29/24)
- E12 previously saw other solo photos of R1 and R2 on the facility tablet when they were not wearing anything while in the shower; E12 did not check the date of those photos. Photos were taken on different days, maybe a Friday and a Monday.
- E12 started checking the tablet when R1 showed some photos of random items mixed with naked pictures of R1 and R2. There were more than one picture seen. Photos were always in the shower on the second floor.
- E13 (QIDP) was immediately notified but no report was written
- R2 never showed E12 any naked picture
- When E12 first started E12 was told to make sure R2 doesn't go into other bathrooms because he likes to help residents, for example by scrubbing the back of R1
- Staff don't have any direction about monitoring R1 and R2 in the shower since the 10/2024 incident
- R2 has his own smart phone

On 3/06/25 at 3:24 PM, E7 (DSP) stated:
- R2 showed inappropriate pictures of R1 in the upstairs bathroom on 10/29/24
- There were more than one picture of R1 standing in the shower without clothing as if he was aware that his picture was being taken
- What's happened before, maybe last year or so,

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is E7 walked into one of the 2nd floor walk-in showers with R2 in the bathroom while R1 was taking a shower, date unknown, E7 reported it to a E22 (Supervisor) This is how we know this is repeated behavior, R2 will have R1's shampoo or soap for R1 like R2's handing R1 his soap or shampoo. E13 (QIDP) is aware.
- Staff are to keep an eye on them during showers. The moving of R2 to the first floor helped a lot.

On 3/06/24 at 4:11 PM, E11 (Investigator) stated:
- E19 (Vice President) is trying to get the police report, E19 thinks it states how many pictures were taken; it looks like 35 pictures were taken in rapid succession
- E19's notes documented a five minute window of pictures taken on the same date
- 11/01/24 is the initial report sent to IDPH, E1 (Director) is the one to send the final report and notify guardians
- E11 thinks it was just an error of omission (for not including the number of photos taken of R1 on the tablet)
- It is not abuse because it was not staff to client, it was client to client
- R1 and R2 should have behavior support plans
- E1 should respond to how the facility ensured clients are not at risk of having their naked photos taken, E11 did minimal recommendations.
- The shift supervisor on campus is the DSP's immediate supervisor during their shift
- E11 would have noted it if there was a body check done
- R2 was not interviewed because he was at home; a phone interview could have been done; R2 was not interviewed upon his return to the facility; E19 spoke with the guardian of R2
- E11 got the impression that it was R1 who would pull people's pants down and R2 would take a

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picture. Pictures taken when pants were pulled down and what image/s were taken is unknown (victim with or without underwear). E13 should have an IDT (Interdisciplinary Team Meeting) for this incident of pulling pants down
- No other clients in the facility were interviewed. It did not sound like many of the guys were interested in using the facility tablet at that time. We do not know if any other clients saw the naked pictures of R1 or R2 on the facility tablet nor if any client would say something if they saw naked pictures of R1 or R2
- R1 was not asked if he gave permission for his pictures to be taken by R2 while in the shower on 10/29/24 but R1 did say on 10/30/24 that he did not like it

On 3/04/25 at 1:55 PM, Director E1 stated that the facility's ongoing monitoring and intervention on preventing clients from taking naked photographs of other clients is having R2 moved to the first floor and R1 is with staff supervision at showertime. R2 is to use the shower in the first floor or the basement.

On 3/05/25 at 4:09 PM, E1:
- was asked how the facility ensured clients do not take naked photos of each other. E1 stated that's part of their Empower Training where QIDPs went over each client's cognitive abilities and risk assessment. Empower covers relationship boundaries and other topics. We had to start with getting all the families of the clients in the facility on board, training is provided based on trainer availability
- was asked what is the facility doing to ensure ongoing monitoring of the client's activities. E1 stated that staff should report inappropriate behavior of clients regardless of whether an allegation was made or not, regardless of history.

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Inappropriate behaviors include hugging and kissing. Empower training will start in the future to focus on inappropriate boundaries, relationships and touch on sex. Some parents don't want to expose the clients to sex.
- E1 also stated that the facility does not monitor R2's personal cell phone, his family does. Clients should have and use their personal devices in their bedroom. R2's family checked his personal device and they said they did not see anything inappropriate.
- There was an IDT after the investigation, E11, E19, E20 (Assistant Vice President) and E1 met on teams meeting
- R2's parents said they were not surprised to hear of this because they see how R1 and R2 interact with each when they come to pick up R2.

On 3/06/25 at 9:15 AM, E1 also stated:
- Our facility policy on abuse does not cover peer to peer abuse
- E1 didn't ask the police to return to the facility upon R2's return to the facility to check his devices: cell phone. R2's family did that after the family was informed of what pictures to look for and to what extent. R2's family said they did not see anything.
- Empowerk training started after the 10/29/24 incident. The training is a collection of different sexual education programs. There are two groups for the home. The topics discussed are as safe touch, introduction to consent, and hand shaking up to sexual contact.
- E21 (Head of Security) said that the local police department's language do not have a distinction between videotape versus pictures. There were 13 pictures of R1 all unclothed and all in the bathroom. The dates were on the same day.
- R1 is now on staff supervision during showers. Yes it is not in R1's Individual Service Plan (ISP)

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but it is in the daily checklist sheet.
- Empower training started on 11/10/24 with getting families on board the program. The training will be provided based on trainer availability.
- R2 moved to first floor upon return to facility because more staff are available on the first floor.

As of 3/07/25 (after requests on 3/05/25 and 3/06/25 about the documentation of resident trainings and the facility policy on incident reports) the facility failed to submit documentation regarding topics discussed with R1 and R2 as part of Empower training and failed to submit the incident report policy.

On 3/06/25 at 12:45 PM, E1 stated that R1 and R2 do not have Behavior Support Plans (BSPs), Qualified Intellectual Disability Professionals (QIDPs) determines the need for BSPs.

On 3/06/25 approximately at 11:05 AM, E3 (QIDP) stated that R1 and R2 currently do not have behavior programs.

On 3/07/25 at 10:58 AM, E2 (Director) stated that E19 and E1 had meetings about the 10/29/24 incident between R1 and R2. There is no documentation of those meetings. E1 met with R2's parents on 11/06/24 about moving him downstairs (for bedroom and shower). The procedures listed in the policy on Resident to Resident Abuse were not implemented for R1. R1 and R2 do not have behavior programs. R1 does not have documentation of the special team meeting after the incident of 10/29/24. The floater guides for R1 and R2 do not specify the monitoring required during showers for both. There is no documentation of these monitoring during showers.

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E13 was unavailable for a telephone interview on 3/06/25 at 10:47 AM, on 3/07/25 at 9:06 AM and on 3/07/25 at 11:14 AM because E13 did not answer the telephone.

On 3/04/25 at 11:57 AM while in the kitchen, R2 held his cell phone that has two camera lenses on the back of the device in his hands.

On 3/04/25 at 11:33 AM, R1 stated "yeah" when asked if he is respected when he is showering. At 3:11 PM, R1 stated "no" when asked if he is asked before his picture is taken. R1 stated "yeah, no" when asked if he tells other clients that it's okay for them to take his picture.

On 3/04/25 at 12:25 PM in the living room, R1 and R2 touched each other's hands. Then R1 put his hands/stroked over R2's legs which were propped up on the coffee table. R2 had pants on.

On 3/05/25 at 7:38 AM, R2 came out of the first floor hallway bathroom and made hand gestures to R1.

On 3/05/25 at 3:33 PM, R2 stated "I don't know" when asked if he gave permission for his picture to be taken in the shower. R2 stated "no" when asked if he took pictures of other clients in the shower and if others took his picture in the shower. R2 stated "yes" when asked if he has a phone. R2 stated "no" when asked if his phone can take pictures.

On 3/06/25 at 8:45 AM, R1 stated "no" when asked if 1) he took pictures of other clients in the shower, 2) someone took his picture in the shower and 3) if R1 gave permission for his picture to be taken in the shower.

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On 3/07/25 at 9:36 AM, R1 put his arm over R2's shoulder, placed the hood of R2's jacket over R2's head and then moved in front of R2 and positioned his face two inches away from R2's face.

Undated police report documents victim information notice/city police department of an incident of deceptive practices, unlawful videotaping of victim, R1, on 10/29/24 at 3:30 PM.

R1's Individual Service Plan (ISP) dated 8/13/2024 lists a relationship service goal of respecting personal space when interacting with others. Listed methodology include R1 to not stroke/tickle peers or staff, R1 should not slouch on peers when sitting on couch, R1 should not enter bathroom when a peer is in the shower/getting dressed, R1 should not invite a peer to enter the bathroom when he is in the shower/getting dressed. R1's ISP does not contain information regarding behaviors of taking naked photos of peers while in the shower or being photographed naked while in the shower. R1's overall age equivalent is 4 years and 8 months, Severe Intellectual Disability (ID).

The facility failed to provide R1's Floater Guide Sheet before 10/29/24 (date of reported incident) after requested on 3/06/25 at approximately 1:00 PM.

On 3/06/25 at 1:52 PM, E3 (QIDP) email answer to the request for the copy of the previous Floater Guide of R1 was "those guides were outdated and were not being used by staff/were in my office."

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R1's Floater Guide sheet dated 01/03/2025 documents R1 is on 24 hour supervision level; R1 is independent with shower but should be monitored; Behavior: "can be too touchy-feely with peers especially R2." Remind R1 to keep appropriate space when together.

R2's ISP dated 10/25/24 listed that R2 does not have a formal behavior program but has informal behaviors to look out for including food and object relocation and non-compliance while at DT (Day Training). R2's ISP does not contain information regarding behaviors of taking naked photos of peers while in the shower or being photographed naked while in the shower. R2's overall age equivalent is 6 years and 2 months, Moderate ID.

The facility failed to provide R2's Floater Guide Sheet before 10/29/24 (date of reported incident) after requested on 3/06/25 at approximately 1:00 PM.

On 3/06/25 at 1:52 PM, E3 (QIDP) email answer to the request for the copy of the previous Floater Guide of R2 was "those guides were outdated and were not being used by staff/were in my office."

R2's Floater Guide sheet dated 01/03/2025 documents R2 is on 24 hour supervision level; R1 is independent with shower but should be monitored; Behavior: "occasionally may need reminders to be appropriate and respectful with staff; R2 has a cell phone which he may use at inappropriate times."

Facility's 12/24 Policy on Reporting Abuse/Neglect Allegations documents:
I. Purpose. To establish a uniform policy and procedures for reporting and responding to all

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abuse/neglect allegations and deaths.
III. Policy. It is the policy and the responsibility of (facility) to report all allegations of abuse/neglect and deaths to the Office of the Inspector General in the Illinois Department of Human Services within the required time frames in an appropriate and thorough manner. All employees (which includes owners/operators, contractors, subcontractors and volunteers) of (facility) shall adhere to the standards set forth in this policy directive. Nothing in this policy directive precludes the agency's responsibilities as outlined in Illinois Administrative Code, Chapter 1, Title 59, Part 50, herein referred to as "Rule 50."
VI. Definitions. Sexual abuse: Any sexual contact or intimate physical contact between an employee and an individual, including an employee's coercion or encouragement of an individual to engage in sexual activity that results in sexual contact, intimate physical contact, sexual behavior or intimate physical behavior. Sexual abuse also includes:
" An employee's actions that result in the sending or showing of sexually explicit images to an individual(s) via computer, cellular telephone, electronic mail, portable electronic device, or other media with or without contact with the individual; OR
" An employee's posting of sexually explicit images of an individual online or elsewhere whether or not there is contact with the individual. Sexual abuse does not include allowing individuals to, of their own volition, view movies or images of a sexual nature, or read text containing sexual content unless the individual's guardian prohibits the viewing of such movies or images or reading of such material.
Sexual contact: Inappropriate sexual contact between an employee and an individual involving either an employee's genital area, anus, buttocks

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	IL6012330	A. BUILDING: _____ B. WING _____	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLK HOUSE	6300 NORTH RIDGE AVENUE CHICAGO, IL 60660

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or breast(s) or an individual's genital area, anus, buttocks or breast(s). Sexual contact also includes sexual contact between individuals that is coerced or encouraged by an employee.
Sexually Explicit Images: Includes, but is not limited to, any material which depicts nudity, sexual conduct, or sadomasochistic abuse, or which contains explicit and detailed verbal description or narrative accounts of sexual excitement, sexual conduct, or sadomasochistic abuse.
Sexually Explicit Images do not include those images contained in sex education materials used by employees to educate individuals.
VII. Procedures.
A. Reporting.
1. If an employee witnesses, is told of, or suspects an incident of physical abuse, sexual abuse, mental abuse, financial exploitation, neglect or a death has occurred, the employee or agency shall report the allegation to the OIG Hotline (1-800-368-1463). The employee or agency shall report the allegation immediately, but no later than the time frames specified herein.

2. Nothing precludes the employee from reporting the allegation to the agency according to its procedures. [Internal reporting procedure: Staff will immediately report any concerning interaction/behavior between another staff person/resident, resident/resident, or family member/resident to the Supervisor. The Supervisor will immediately notify the Director/Assistant Vice President (AVP) (generally, the Supervisor notifies the Director, who then notifies the AVP; if the AVP is unavailable, the Director notifies Vice President). The AVP/VP will notify the Agency Abuse/Neglect Coordinator and Executive Director. The Director/AVP will notify applicable state agencies

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Z9999	Continued From page 14 (DCFS, IDPH, OIG).] 3. The agency shall then ensure that allegations of abuse, neglect and deaths are reported to OIG no later than the time frames specified herein. D. Incident Management/Investigation 2. If there is an allegation or indication of a physical injury, sexual assault or any situation where a victim's health is in question, the agency shall immediately seek appropriate medical attention. Facility's Undated Policy on Photographing, Recording and Videoing Residents documents: Definitions: For the purposes of this policy, "photography or recording" refers to recording an individual's likeness (e.g., image or picture) or voice using photography (e.g. cameras or cellular telephones), audio recording (e.g., a tape or digital recorder), video recording (e.g., video cameras or cellular telephones), digital imaging (e.g., digital cameras or web cameras), or other technologies capable of capturing an image or audio data (e.g., Skype). Purpose: As a responsible provider of care, (facility) must take reasonable steps to protect our residents, visitors, employees and other staff members from unauthorized photography or recording. Due to the sensitive nature of resident information and to protect privacy, the policies and guidelines below apply to all photography, imaging, audio, video, or other electronic recording of residents, visitors, employees, or other persons present within a (Facility). I. Policy Regarding Photography or Recording The following guidelines apply to all photography or recording by employees and other third parties. 1. Residents, family members, and/or the resident's visitors are generally permitted to take photographs or recordings of one another, related to the resident who is being visited, unless	Z9999		

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otherwise instructed by (facility) staff, provided that such activity complies with the guidelines below.
2. The resident, family members, and the resident's visitors are prohibited from photographing or recording other (facility) residents without obtaining (facility's) consent.
II. Procedure for Inappropriate Photography or Recording
1. If a resident, family member, employee, visitor, or other third party is engaging in photography or recording in violation of the above guidelines, the resident, family member, visitor, or other third party should be given a copy of the above policy and politely asked to cease the inappropriate photography or recording and delete all content.

Facility's Resident Electronic Device Policy Revised 5/2020 documents "Residents with cameras on their electronic device will only take pictures that are appropriate and will obtain consent for the picture from the persons involved."

Facility's Abuse Prevention Policy - Resident/Resident Behaviors, effective 6/15/2014, documents:
The purpose of this policy is to ensure that the facility is proactively maintaining an environment where individuals are free from serious and immediate threat to their physical and psychological health and safety.
POLICY: The facility will ensure that individuals are not subjected to physical, verbal, sexual or psychological abuse or punishment
PROCEDURE:
1) The Administrator or their designee (see policy) is immediately notified of any resident/resident behaviors.
2) The Administrator monitors on a daily basis for

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trends that may develop between residents including trends related to time of day, circumstances, etc. The Administrator assesses to ensure potential abuse will not go undetected.
3) A trend of resident/resident behaviors may be defined as, but is not limited to, 3 or more occurrences toward a targeted peer or group within a very short time period. A trend may also be identified as repeatedly impacting an environment or repeatedly limiting client's access to their home within a specified time period.
4) If a trend has been identified, the IDT (InterDisciplinaryTeam) will convene as soon as possible and may:
a. Determine if this behavior is a natural part of the peer relationship, and if so, add appropriate documentation to the IPP(IndividualProgramPlan).
b. Rule out medical, environmental or psycho-social situations that may be impacting the individual's behavior.
c. Implement a formal Behavior Support Plan (BSP) or review current BSP for effectiveness.
d. Evaluate for addition supports.
e. Refer to psychiatrist for evaluation of medication or medication change.
f. Evaluate for change in activity schedule including day program placement.
g. Evaluate for change in residential placement.
h. Recommend hospitalization
i. Other IDT recommendations
5) If resident abuse is identified, alleged perpetrator will be provided 1:1 support or removed from the environment immediately and for the duration of the immediate threat.
6) If the threat is pervasive or on-going, the facility will remove the individual from contact with all peers until the individual aggressor has received appropriate and effective treatment as determined by the facility. If the guardian is

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Z9999	Continued From page 17 unwilling to facilitate treatment or the treatment is ineffective in removing the threat the facility may require emergency hospitalization or initiate discharge. 7) Impacted individuals may be referred for counseling if appropriate. (B)	Z9999		