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S 000	Initial Comments Complaint Investigations: 2524470/IL192688 2524391/IL192706 Investigation of Facility Reported Incident of 04-22-2025/IL191748	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1210b) 300.3240c) 300.3240e) 300.3240g) 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 b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	S9999		

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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 300.3240 Abuse and Neglect

c) A facility administrator who becomes aware of abuse or neglect of a resident 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)

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 Regulations are not met as evidenced by:

Based on observation, interview, and record review the facility failed to protect a resident (R2) from resident-to-resident sexual abuse for one of four residents (R2) reviewed for abuse in the sample of ten. This failure resulted in R1 a cognitively intact resident sexually assaulting R2 a cognitively impaired resident on more than one

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S9999	Continued From page 2 occasion. Findings include: On 5/21/25 at 9:25 AM, V6 (Certified Nursing Assistant/CNA), stated on Saturday 5/3/25 during breakfast V6 saw R1 sitting in the dining room at a table with R2. R1 had R2's toy in R1's right hand and R1's left hand was between R2's legs touching R2's vagina. V6 told R1 "don't touch her like that" and V6 moved R2 to the middle of the dining room away from R1.V6 stated she left the dining room and came back 20 minutes later and R1 was sitting next to R2 again, with R1's hand further up between R2's legs. V7 couldn't see R1's hand because it was all the way up R2's shorts. V7 stated she told R1 "this is the second time I have told you not to do that". V7 stated V15 (Licensed Practical Nurse)/LPN called V1 (Administrator in Training) to report the abuse allegation. V6 stated V1 did not come to the facility and did not give the staff guidance on safety interventions to put in place to keep R2 from further sexual abuse from R1. On 5/21/25 at 10:16 am, (V7 CNA) stated Saturday morning on 5/3/25, V7 walked in the dining room and saw R1 and R2 sitting at the table, and R1 was sitting next to R2. R1 had R2's baby doll in R1's right hand and R1's left hand was in between R2's legs up R2's shorts and touching R2's private area. V7 stated V7 stopped R1 and told R1 it's not right to touch R2. V7 stated V7 immediately told V15 (LPN) of what V7 witnessed in the dining room. V7 stated we immediately removed R2, and R1 starting crying and said, "I'm sorry". V7 further stated R2 has been having increased behaviors where R2 is crying out and pointing to her vagina since this incident happened.	S9999		

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S9999	Continued From page 3 On 5/22/25 at 12:36 PM, V15 (LPN) stated V7 and V6 came up to V15 and stated they had witnessed R1 touching R2 between R2's legs and on R2's vagina. V15 stated V15 first contacted V5 (Assistant Director of Nursing) who told V15 to call V1 (Administrator in Training). V15 called V1 to report the sexual abuse between R1 and R2 to V1. V1 told V15 to leave it alone and not do anything until V1 came in to do the investigation. V15 stated V1 did not come to the facility that weekend to do the investigation. V15 stated V1 did not give any further interventions or instructions to keep R1 away from R2. On 5/20/25 at 4:00 PM, V4 CNA, stated one day after the occurrence between R1 and R2, R1 told V4 that R1 shouldn't have, but R1 touched R2. V4 stated R2 has the mindset of a four-year-old and is nonverbal. V4 stated R1 can self-propel in manual wheelchair around the facility. On 5/21/25 at 11:53 AM, V9 (Guardian), stated V9 was not made aware of an allegation of sexual abuse towards R2. V9 stated R2 would be so upset and scared that this happened to R2. R2 has been mentally and physically handicapped R2's entire life. On 5/20/25 at 4:01 PM, R2 was lying in bed in low position with a fall mat on the floor. R2 was alert but nonverbal. On 5/20/25 at 3:30 PM, R1 was laying in R1's bed watching television. R1 was alert and answered questions appropriately. R1 stated R1 didn't want to talk about what happened with R2. On 5/21/25 at 12:19 PM, R1 was observed in the dining room sitting two tables away from R2.	S9999		

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R2's Minimum Data set (MDS) dated 3/10/25 documents R2 is severely cognitively impaired.

R2's current Medical Diagnosis list documents R2 has diagnoses of cerebral palsy, intellectual disabilities, anxiety, and depression.

R2's current care plan does not contain documentation of interventions to keep R2 free from sexual abuse.

R2's current medical record does not include any documentation or assessment of R2 after being sexually abused by R1.

R2's medical record does not include a completed trauma care assessment after the alleged sexual abuse on 5/3/25.

R1's current care plan does not include interventions to address R1's sexual behaviors.

R1's current medical record does not include documentation of R1's sexual abuse allegation that occurred on 5/3/25.

The facility's Abuse, Prevention, &Prohibition Policy dated 12/2024 documents each resident has the right to be free from abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, agency staff, family members or legal guardians, friends, or other individual. While the facility investigation is under way, steps will be taken to prevent further abuse. The person identified in the allegation of abuse will have no contact with residents or other employees during the investigation process. A licensed Nurse will assess the resident for injuries and notify the residents physician and responsible

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party. Social Services will complete a Trauma Informed care assessment and provide follow up care regardless of if allegation is substituted. This policy documents sexual abuse is defined as non-consensual sexual contact of any type with a resident.

(A)
Statement of Licensure Violations 2 of 2:
300.610a)
300.1210b)
300.1210d)6)
300.1220b)3)

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

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

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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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review the facility failed to initiate a resident head

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count once an exit door was alarming without known cause, failed to ensure a gait to the outside smoking patio was kept secure, failed to develop a care plan and implement interventions for residents at risk for elopement, and failed to provide adequate supervision for two of three residents (R6 and R7) reviewed for elopement risk in the sample of 10. These failures resulted in cognitively impaired resident (R6) who required assistance with ADL's (Activities of Daily Living) exiting the facility without staff knowledge or supervision on 4-22-25, and being found 2.2 miles away from the facility, on a concrete median, by a stop light, in the dark, with complaints of being cold. The road R6 traveled along was a busy main road that had numerous steep hills and curves.

Findings include:

1. R6's MDS (Minimum Data Set) dated 4-4-25 documents R6 is cognitively impaired.

R6's Admission Record documents R6 was admitted to the facility on 6-24-24 with the diagnoses of Chronic Obstructive Pulmonary Disease, Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side, Type II Diabetes Mellitus, Obstructive Sleep Apnea, Chronic Pain, and Depression.

R6's Elopement Risk Assessment dated 3-26-25 documents R6 was a moderate risk for elopement and exit-seeks at times.

R6's admission Care Plan dated 6-24-25 through Discharge dated 4-24-25 documents R6 has impaired cognitive function or thought processes and requires staff assistance with transfers and toilet use.

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R6's Care Plan does not include any interventions to address R6's exit-seeking or risk for elopement as identified on R6's Elopement Risk Assessment dated 3-26-25, until after R6 eloped on 4-22-25.

R6's Fall Risk Assessment dated 4-4-25 documents R6 was at high risk for falling and has intermittent confusion.

R6's Final Report dated 4-22-25 and signed by V1 (Administrator-in-Training) documents, "Summary: (R6) noted off facility grounds by oncoming staff. Noted (R6) to have left facility without notification or staff knowledge. Staff Interviews: (V11/Licensed Practical Nurse/LPN) reported noting "smoking patio" alarm sounding. Did not note anyone around, assumed wind to have blown open. Stated did not enact facility procedure as this was "not an exit" and residents typically would not be able to exit facility grounds through this door or patio."

R6's Social Service Progress Note dated 4-4-25 at 10:12 AM and signed by V14 (Social Service Director) documents, "(V14) has reviewed (R6's) assess (assessment). (R6) initially kept saying he needed to get to the bank, transportation took (R6) to the bank, (and) it was not the correct bank. As I had noted before (R6) has poor cognition but doesn't feel he does. This has all recently started with (R6) wanting to go to the bank."

R6's Social Services Progress Note dated 4-22-25 at 2:58 PM and signed by V14 documents, "(R6) left the facility without alerting staff. (R6) was located and brought back to the facility."

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On 5-22-25 at 10:20 AM this surveyor observed the smoking patio where R6 exited the facility. The exit to this patio leads to a rocky embankment and then to a sidewalk that leads to the front parking lot. This surveyor drove from the front parking lot to the college campus where R6 was found. During the drive there was a steep hill that leads to the main road. From this main road to the local college where R6 was found per odometer reading was 2.2 miles from the facility and the road had many curves and hills.

On 5-22-25 at 9:00 AM V12 (LPN) stated, "I came into work early on 4-22-25 and came by the (community college) at 5:00 AM. I was at a stop light, and I saw (R6) standing with a wheeled walker in the middle of a concrete divider that separates two streets. I asked (R6) what he was doing, and he said he was going home. (R6) said he wasn't going back there (the facility). I tried several times to get (R6) to get in the car with me. I called the nursing home and (V1/Administrator-in-Training) and I had to turn around because I was at stop light. By the time I turned around (R6) was gone. It was dark and (R6) had dark colored clothes on. (V13/CNA/Certified Nursing Assistant) came and met with me to look for (R6). (R6) had gotten inside a college building and (V13) brought (R6) to my car and we were able to get (R6) in and bring him back to the facility. The weather was chilly and (R6) had a black jacket and stocking cap on. It was 47 degrees out. (R6) stated he was cold. (R6) stated he had left the facility around midnight. I called (V11/LPN) and (V11) was not aware that (R6) had left the facility unattended. I brought (R6) back to the facility. The road (R6) was found on is very busy with stop lights and lots of traffic from college students

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and other traffic."

On 5-22-25 at 9:10 AM V13 (CNA) stated, "(R6) was very quiet and had confusion. (R6) went out to the front parking lot around two months ago and threatened to leave and I was able to get (R6) back inside. (R6) was walking with a walker within the facility. On 4-22-25 I was told (R6) went out the door where the residents smoke. The alarm went off and the nurse (V11) thought the alarm was going off due to a resident going outside to smoke. (V11) shut the alarm off. V12 (LPN) called me and had me come and help find (R6). (R6) was over two miles away. (V12) lost sight of (R6). I found (R6) inside the college. It was 5:50 AM, dark, and cold. (R6) wanted to go home. (R6) was wanting to get on a bus to go home. (R6) would not be safe to by outside by himself."

On 5-22-25 at 10:25 AM V14 (Social Service Director) stated, "(R4) had poor cognition at times. (R4) was not safe to walk outside on the road by himself. (R4) needed a walker."

On 5-22-25 at 11:15 AM V2 (Director of Nursing) stated, "(R4) had confusion and needed a walker. (R4) was not safe to leave the facility unattended and away from the facility 2.2 miles. A lot of the road (R4) used did not have sidewalks."

On 5-22-25 at 1:00 PM V11 (LPN) stated, "I was working the night of 4-22-25 and heard the smoking patio door alarming around 2:00 AM. I went to the alarm and thought the wind blew the door open and sounded the alarm. I did not see any residents outside, so I shut the alarm off. I should have done a resident head count and did not. Sometime after 5:00 AM that morning, (V12/LPN) called the facility and said she had

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found (R6) wandering around by the college. I had no idea (R6) was even missing from the facility."

On 5-22-26 at 1:30 PM V10 (LPN) stated, "(R6) has a lot of confusion and would try to exit-seek. Prior to (R6's) elopement, (R6) would set off alarms and try to leave the facility. (R6) would not be safe leaving the building unattended by staff, especially after dark."

2. R7's current Care Plan documents "Potential risk for elopement related to cognitive deficits, history of wandering, walks, or wheels about aimlessly without a purpose. (R7) is at high risk. Interventions: Place electronic sensor device to alert staff of exit attempt (or if unavailable, place on 1:1 (one on one) observations). Routinely check device placement, check battery function, check door device functioning, and evaluate effectiveness."

R7's Elopement Risk Assessment dated 4-22-25 documents R7 is a high risk for elopement.

On 5-22-25 from 12:45 PM to 1:05 PM R7 was wandering aimlessly up and down the hallways and the dining room. R7 did not have one on one staff supervision or and electronic sensor device in place during this time.

On 5-23-25 at 9:45 AM R7 was lying in bed and V12 (LPN) and V13 were providing incontinence cares. R7 did not have an electronic sensor device in place.

On 5-23-25 at 9:50 AM V12 (LPN) stated, "(R7) has never had an electronic monitoring device on or one-on-one staff supervision that I am aware of."

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FONDULAC REHABILITATION & HCC	901 ILLINI DRIVE EAST PEORIA, IL 61611

(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
S9999	Continued From page 12 The facility's Elopement Policy dated 04/2025 documents, "Policy: It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for elopement. All residents so identified will have these issues addressed in their individual care plans. Responsibility: All staff is responsible. Definitions: For the purpose of this policy, "missing resident" or "eloped" if he/she is seen leaving the buildings or is seen walking away as a result of responding to a door alarm. 4. When a door alarm sounds, staff shall immediately respond to and determine the cause of the alarm. The staff person responding to the alarm will check the outside of the building to determine if a resident has exited the building. If, upon investigation, no reason can be found for the sounding off that alarm the charge nurse will initiate an accounting of all residents at risk for elopement. If, after all at-risk residents are accounted for, the cause of the alarm is still undetermined, a complete head count of all residents will be conducted." (B)	S9999		