STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009278	A. BUILDING: _____ B. WING _____	C 06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNNYMERE	925 SIXTH AVENUE AURORA, IL 60505

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S 000	Initial Comments Facility Reported Incident of 6/5/2025/IL194813	S 000		
S9999	Final Observations Statement Of Licensure Violations: 330.710a) 330.4210a)2)A)B) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. Section 330.4210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by State or federal law based on their status as a resident of a facility. 2) Residents shall have their basic human needs, including but not limited to water, food, medication, toileting, and personal hygiene, accommodated in a timely manner, as defined by the person and agreed upon by the interdisciplinary team. A) A facility shall treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life, recognizing each resident's	S9999		

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individuality.

B) A facility shall protect and promote the rights of the resident.

These REQUIREMENTS are not met as evidenced by:

Based on interview and record review the facility failed to follow its policy for Abuse and Neglect to protect a resident from sexual abuse and report an allegation of sexual abuse.

This failure resulted in R1 experiencing sexual abuse at the facility when V3 (man from the neighborhood, male perpetrator) had his genitals in R1's mouth. R1's medical diagnosis makes assessing the effects of sexual abuse difficult. A reasonable person would not want to have someone's genital in their mouth without consent.

This applies to 2 of 3 residents (R1, R2) reviewed for abuse.

The findings include:

1). The facility submitted a report to the department on June 5, 2025, that showed R1 was sexually abused by V3 (man from the neighborhood, male perpetrator).

On June 20, 2025, at 11:18 AM, V7 (caregiver) stated that on June 5, 2025, after breakfast, R1 went outside to sit in front of the facility on the porch. V7 stated the neighbor V3 (male perpetrator) was seen sitting next to R1 on the porch. V7 saw V2 (Life Enrichment Supervisor) arrive to work at 9:05 AM and told V2 that V3 was on the porch with R1.

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On June 20, 2025, at 10:32 AM, V2 (Life Enrichment Supervisor) stated when V7 told her that V3 was visiting R1, V2 went to the porch. V2 stated she saw R1 was seated, V3 was standing in front of R1 and V3 genitals were in R1's mouth. V2 stated when she called out to R1, V3 stepped back, pushed R1's head away and attempted to zip his pants. R1 then went inside the facility with V2 and 911 was called. V3 left the premises. V2 stated she immediately became concerned that V3 was visiting R1. V2 stated last summer, date unknown, V3 had been seen kissing and hugging R1 but R1 was very confused and did not know who V3 was. V2 stated R1 was very friendly and while sitting on the front porch would wave and call people just walking by the facility to the porch without regard for safety.

On June 20, 2025, at 10:44 AM, V1 (RN-Executive Director) stated last spring or summer, the date was unknown and the occurrence undocumented, V3 visited R1 on the front porch of the facility and had been seen kissing and hugging her. V1 stated she talked to V3 and told him R1 was confused and had dementia and did not know who he was and is not capable of making an informed decision regarding sexual contact. V1 stated she told V3 not to come back to the facility. V1 stated it was a verbal statement, there was no documentation of the incident or report to the police or the department.

R1's medical record showed R1 was admitted to the facility on October 15, 2015, with a diagnosis of dementia and had a court appointed legal guardian.

R1's Resident Care Plan dated May 10. 2025, showed R1 needed full assistance with bathing,

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full assistance with reminding to change clothes and pulling clothes out of the closet, full assistance with oral care and medication, and required no assistance with grooming, incontinent care or bedtime care and was at high risk for falls.

On June 20, 2025, at 1:18 PM, R1 was seated in the living area. R1 stated V1 had talked to her and told R1 she had done something bad. R1 shook her head and had a shamed look on her face but stated she did not want to talk about it. R1 stated she liked to sit outside and "watch the babies in the Army, Navy and Marine uniforms walk by." R1 stated "there are many babies in this place upstairs." R1 stated she was "looking after all the babies."

On June 23, 2025, at 3:18 PM, R1 was able to spell her name. R1 was unable to name the day of the week, the place she was in, what time it was or who the President of the United States was. At 4:30 PM, V2 stated R1 had been mentally declining as evidenced by R1 was no longer able to play bingo without someone assisting her to recognize the letters and numbers on the game card.

On June 24, 2025, at 10:44 AM, V6 (Police Department Detective) stated V3 had admitted to having sexual contact including oral sex, with R1 both last year and the recent incident. V6 stated V3 told the detective V1 had spoken to V3 last year and was told R1 had dementia and was told last year not to come back to the facility. V6 stated when interviewing R1 she could not answer any questions and it was clear R1 was confused. V6 stated there was no report from last spring or summer to document the previous incident, only the recent incident was reported.

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2). R2's admission record showed R2 was admitted to the facility on October 11, 2020, with a diagnoses of Dementia and Parkinson's disease.

R2's care plans were reviewed. R2's care plan showed R2 needed full assistance with bathing, dressing, oral care, grooming, foot care, incontinent care, bedtime care and medication management, R2 was identified as a high fall risk.

The facility provided an incident report dated September 3, 2024, that showed R2 made a statement that R2 was a victim of sexual abuse by an unknown person, on an unknown date and time. The incident report showed R2 stated it was "a male maintenance worker who works at night." There was no documentation provided to validate the report was sent to the department. On June 23, 2025, at 3:30 PM, V2 stated she spoke to V1 who stated there was no fax confirmation evidence that the report dated September 3, 2024, was sent to the department. The investigation concluded that R2's allegation was made due to R2 confusing events in her life due to dementia. The investigation did not indicate whether other residents, the accused employee, other staff were interviewed, and the accused staff was suspended pending the investigation.

The facility's policy titled "Abuse and Neglect Policy" dated January 20, 2025, showed "Purpose: Establishing guidelines for reporting suspected cases of abuse or neglect, ensuring the safety and well being of all residents by creating a comprehensive care plan ...Definitions ...Sexual abuse ...any non-consensual sexual act or behavior ...I. Internal Reporting: Any facility employee or agent who becomes aware of abuse

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S9999	Continued From page 5 or neglect allegations concerning a resident must immediately report the incident to the facility administrator ...2. External Reporting: The facility administrator, employee, or agent who becomes aware of abuse or neglect allegations shall report the incident to the Illinois Department of Public Health (IDPH) ...Documentation: The supervisor or designated authority must document the complaint in detail ...7. Follow up actions: The company will review all reports of abuse and take appropriate actions as required by law." (A)	S9999		