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	ASL5105710	A. BUILDING: _____ B. WING _____	C 09/14/2025

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A 000	Initial Comment Complaint Investigation 2515539/ IL196617 295.6000a)13)	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Tyrpe 1 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 1) The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect; 2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment; 3) The right to retain and use personal property, unless such use infringes on the health, safety, or welfare of other individuals, and a place to store personal items that is locked and secure; 4) The right to designate any individual to participate with the resident or in the resident's name in the development of the written service plan; 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes;	A6000		

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A6000	Continued From page 1 6) The right to direct his or her own care and negotiate the terms of his or her own care; 7) The right to refuse services unless such services are court ordered or the health, safety, or welfare of other individuals is endangered by the refusal, and to be advised of the consequences of that refusal; 8) The right to exercise free choice in selected activities, schedules, and daily routine; 9) The right to exercise free choice in selecting a primary care provider, pharmacy, home health provider, or other service provider and to assume responsibility for any additional costs incurred as a result of such choices. However, an establishment may specify how medications are packaged by a pharmacy if the resident receives administration of medication; 10) The right to request to relocate or refuse to relocate within the facility based upon the resident's needs, desires, and availability of such options; 11) The right to the free exercise of religion and to participate or refuse to participate in religious, social, recreational, rehabilitative, political or community activities; 12) The right to be free of chemical and physical restraints; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; 14) The right to confidentiality of the resident's medical, financial, or other records. The release of a record shall be by written consent of the resident or the resident's representative and shall specify the circumstances under which each individual record may be released, except as specified by law; 15) The right to privacy in financial and personal affairs; 16) The right of access and the right to review and copy the resident's personal files maintained	A6000		

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A6000	Continued From page 2 by the establishment, during normal business hours or at a time agreed upon by the resident and the establishment; 17) The right to privacy with regard to mail, phone calls, and visitors; 18) The right to uncensored access to the State Ombudsman or his or her designee, and the right to refuse access to a State Ombudsman or Department reviewer; 19) The right to be free of retaliation for or constraint from criticizing the establishment or making complaints to appropriate agencies or any agency or individual; 20) The right to 24 hour access to the establishment and all common areas of the establishment; 21) The right to a minimum of 30-day notice of any change in a fee or charge or the availability of a service; 22) The right to a minimum of 90-day notice of a planned establishment closure; 23) The right to a minimum of 30-day notice of an involuntary residency termination, except where the resident poses a threat to himself or others, or in other emergency situations, and the right to appeal such termination; 24) The right to a 30-day notice of delinquency and at least 15 days right to cure delinquency. (Section 95 of the Act) b) Nothing in this Part is meant to limit a resident's right to choose his or her health care provider. (Section 75(h) of the Act) This Requirement Was Not Met as Evidenced by: Based on interview and record review the facility failed to ensure a resident (R1) was safe from sexual abuse. This failure resulted in R2 entering R1's room, undressing, and touching R1 while she was naked without her consent on 7/25/25 for	A6000		

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A6000	Continued From page 3 1 of 3 residents (R1) reviewed for abuse in the sample of 5. This failure causes severe harm or creates a substantial probability of severe harm to a resident or residents. The findings include: The facility's Incident Report form sent to Illinois Department of Public Health (IDPH) on 7/26/25 showed the incident occurred on 7/25/25. The description of the incident showed the resident was asleep in her bedroom when a staff member who was making her nightly rounds went into her apartment. She noted a light on in the living room, so she went to the bedroom to check on the resident. She observed a male resident that resides in the building standing unclothed over R1 kissing her. The staff member said the male resident told her that R1 wanted him to come into the room. The male resident then asked the staff member to please keep this between the two of them. He shut the bedroom door on the staff member. The staff member quickly went to alert more staff. Another staff member entered the room and saw the male resident undressed and told him to get out of the room. She waited for him to get dressed and watched him leave. The Nurse Practitioner Note dated 8/12/25 for R1 showed her physical exam was done and the resident was alert and oriented x 2; able to participate on conversation. Psychiatric - memory loss. The Progress Note showed, I received a phone call on 7/26/25, patient was found by an aide with her underwear off, laying half on her bed with another male resident laying on top of her with no pants on. Initially the male resident stated it was consensual and they have had sex one other time, however, as staff began to talk with both residents this was found to not be true.	A6000		

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Per staff, the male patient's daughter stated that this has happened before with another female resident and that he should have gone to jail at that time but didn't because no charges were pressed. R1 was sent to the emergency room and had a rape kit completed and the family are pressing charges against the male resident. The male resident has been evicted from the building. I was notified the male patient has a history of herpes and his current provider has stopped the valtrex he was taking. The family would like a herpes test completed. I have educated because there is no visible signs of herpes lesions there is nothing to test at this point but will complete a blood test in the next 12 weeks as it takes time for all the antibodies to build for detection. I have received her rape kit results from the hospital, all samples are negative with the exception of hepatitis A, this appears to be an incidental finding, she is asymptomatic, and no treatment is needed. Will follow up with any additional results from her rape kit as they come in. The patient herself does not appear to understand or comprehend what has happened, at baseline she has memory decline, however, in general she is oriented to self and place. Follow up 8/5/25: I was asked to see the daughter during her visit today, we had a long discussion regarding the recent event that happened on 7/26/25, she tells me she has continued to push on her mom to remember details from the day, her mom continues to say she doesn't remember. We had a lengthy discussion that her mom may be trying to block that it ever happened, at age 92 I would not continue to press her to relive that night.

On 9/14/25 at 10:08 AM, R1 stated she did not know R2 but knew that he lived here (at facility) at the time of the incident. R1 stated since R2 lived here he could go anywhere he wanted and into

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rooms because at that time they didn't lock their doors. R1 stated everything was kind of fuzzy related to the incident. R1 stated she thought R2 was kind of stupid and not all there mentally. R1 stated R2 would say crazy things. R1 stated the night the incident happened she was asleep; E3 Certified Nursing Assistant (CNA) and E4 CNA came in and saw him in her room. R1 stated she was told later that R2 did not have any clothes on and was in her room. R1 did not remember seeing R2 naked in her room. R1 said she was asleep when this was happening. R1 stated R2 is gone now, and she locks her door at night. R1 stated she doesn't feel safe or comfortable being here anymore.

On 9/14/25 at 12:25 PM, E1 Executive Director stated R2 was pleasantly confused at times, still drove his car, and did his own medications. R2 did not have a change in his condition while at the facility. He was very chatty/social person but could be repetitious at times. E1 stated he was not at the facility very long and they did not see anything that would have alerted them to a change in condition. E1 stated staff reported to E2 Director of Nursing (DON) what had happened and then E2 called her between 10:00 PM - 11:00 PM; it could have been at 9:00 PM. E1 stated she was told that R2 was found in R1's apartment naked and on top of R1. E4 had walked into R1's apartment and saw him there. R2 told E4 that R1 wanted him to be there. R2 stated R1 wanted him to come in and that is doubtful. R1 doesn't remember it and did not know he was in the room until she was told. R1 did not lock her door; she is forgetful. E1 stated Z1 (R2's daughter) was contacted about the incident and did not seem surprised. Z2 (R1's daughter) was notified of the incident. The police were notified. E1 stated days after the incident R1 had no clue about what

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happened. R1 had been on a medication that made her very sleepy at night. E1 stated the certified nursing assistants (CNA's) were doing their every two-hour check when this happened. Some of the residents lock their doors and some of them don't. E1 stated she was not sure if R2 knew R1's door would be unlocked.
On 9/14/25 at 1:43 PM, Z3 (R1's daughter/power of attorney) stated at 11:00 PM the night of the incident she received a call from the facility saying R1 was okay but that this had happened. Z2 stated she took R1 to the hospital to be checked out and told the police they could speak to R1 at the hospital. Z2 stated R1 was anxious and just wanted to sleep because her medication was making her feel drugged. Z2 stated R1 was taking a medication for her restless legs, and it made her very sleepy. Z2 stated she talked to R1 the next day about pressing charges so this would not happen to anyone else; R1 agreed to press charges. R1 has beginning dementia; she sometimes knows what is going on and sometimes doesn't. Z2 stated a rape kit was done at the hospital and she was told it would take 3-6 months to receive the results.

On 9/14/25 at 2:32 PM, E4 CNA stated R2 was friendly but was inappropriate with her. R2 would give her a hug and kiss her neck so she told E2 DON about what happened. E4 stated E2 told her that R2 had done that to her as well. E5 Licensed Practical Nurse (LPN) also stated that happened to her. E4 stated that this conversation occurred sometime in June 2025. E4 stated she works second shift, was doing her rounds at 9:00 PM, and went into check on R1 because she was usually watching TV or in bed. E4 stated when she went in, R1 was laying in her bed and R2 was standing next to her bed dressed. E4 stated she thought R2 was intoxicated. E4 asked R2 what

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was going on because she had never seen R1 and R2 together. E4 said R2 told her that R1 wanted him to come see her tonight and told E4 not to tell anyone. R2 then walked E4 to the door and shut it on her. E4 stated she went and got E3 because this did not seem right. E4 stated her and E3 went to R1's room and went in. When they went in R2 was naked and on top of R1. They screamed at him to get out. R1 was asleep when this was happening. R1 had no idea of what was going on. E4 stated she tried to talk to R1, but she was very sleepy. R1 told her she thought she was dreaming. R1 was disoriented. E4 stated R1 is forgetful and sleeps very hard; she is more confused at night.

On 9/14/25 at 2:56 PM, E3 CNA stated she did not work a lot with R2 but knew he was independent and able to drive. E3 stated R1 is a resident that is sweet, funny, and forgetful. E3 stated E4 came and got her because R2 was in R1's room and she was uncomfortable by that. E4 told her that R2 had kicked her out of the room. E3 stated she felt that it was weird, so she went to R1's room with E3. E4 stated she saw R2 next to r1's bed and he was naked. E3 stated she told him to get dressed and get out. R1 was in bed and not participating in anything. R2 said that R1 told him to come over. R2 left the room and was monitored upstairs by another CNA. E3 stated it felt wrong. R2 kept saying R1 told him to come over when it was dark outside. E3 stated she was present when E2 DON talked to R2 and R2 said that him and R1 had been together 2 or 3 times.

On 9/15/25 at 10:09 AM, Z2 (R2's daughter/power of attorney) stated the facility called her and told her that R2 was in a 91-year-old lady's room. R2 was naked and on

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top of the lady and the lady's underwear was on the floor. Z2 stated they told her that R1 was not awake, and she was not able to give consent. Z2 stated they told her that R2 said that they were in a relationship and that is what he told the police. R2 was upset they had contacted her. R2 did not want her to know about it. Z2 stated this was not the first time something like this has happened. R2 had done something like this before to his sister-in-law. it was a couple of years ago. R2 wasn't managing his medications at home and was confused. The sister-in-law was sleeping on the couch in the living room. R2 got up at night with an erection and came toward her; luckily, she woke up in time. Her husband was asleep in another room. He told Z2 they decided not to do anything about it because they said R2 was confused and blamed it on his medication. Z2 stated since R2 has been at the facility he has been like night and day. Z2 stated with his medications on schedule he is driving and independent. Z2 stated she could not believe nothing happened to R2 after this incident and that he got away with it again. Z2 stated this was R2's choice to do this.

The Physician Assessment Form dated 8/5/25 for R2 showed she needed assistance with dressing, bathing, and her medications.

The Mini-mental State Examination for R2 dated 11/21/24 showed a score of 26; normal cognition. The Resident Service Plan dated 12/28/24 for R2 showed he was independent with activities of daily living; verbal time reminders needed for medication. The Physician Order's for R2 dated 7/1/25 showed diagnoses including hyperlipidemia, depressive disorder, anxiety, gastro-esophageal reflux disease, and heart disease.

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A6000	Continued From page 9 The facility's Incident & Events - Abuse & Neglect Reporting Policy including suspected/confirmed Resident-Resident Abuse (6/18/2018) showed the Abuse Policies and Procedures of this community are developed to promote a safe living environment for all residents. Residents must not be subjected to abuse, neglect, or mistreatment by anyone, including but not limited to facility or agency staff, other residents, family members r other visitors. Prevention of abuse/neglect requires the involvement of all staff to monitor, observe, intervene, and report any behaviors/situations that may lead to conflict or neglect.	A6000		