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ARBOR ROSE OF MONTICELLO	1009 SOUTH IRVING MONTICELLO, IL 61856

(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
A 000	Initial Comment Original Investigation of Facility Reported Incident IL 196793. General Violations Cited: 295.2000 a) c) 1) 295.4010 a) e) 295.4060 b) c) e) 295.6000 a) 2) 13)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Violation Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) c) A person shall not be accepted for residency if: 1) The person poses a serious threat to themselves or to others; These requirements were not met as evidenced by:	A2000		

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A2000	Continued From page 1	A2000		

Based on interview and record review the establishment failed to ensure that a resident (R1) who posed a serious threat to others was not admitted to or remained in the establishment. This failure has the potential to affect all residents who reside in the establishment creating the substantial probability of severe harm to a resident or residents.

Findings include:

The facility provided resident roster dated 8/6/25 documents 13 residents reside at the establishment.

R1's service plan dated 6/13/25 documents R1's admission date as 6/13/25 with a diagnosis of dementia with behavioral disturbances.

R1's interdisciplinary discharge summary from his previous long term care facility dated 6/13/25 documents that R1 has inappropriate sexual behaviors at this time.

R1's establishment admitting nurse's note dated 6/13/25 documents that R1 has sexual behaviors.

R1's nurse's notes dated 6/17/25, 6/27/25, 7/7/25, 7/14/25, 7/21/25, and 7/28/25 all document sexually inappropriate remarks being made by R1 to staff.

A facility provided accident and injury report dated 7/29/25 documents that R1 asked E6 Caregiver to assist him with his shower. While E6 Caregiver was attempting to assist R1, he began masturbating and when asked to stop, he closed the door and stood in front of the door preventing E6 from being able to exit the shower. E6 had to scream for another staff member, E5 Business

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A2000	Continued From page 2	A2000		

Office Manager (BOM) to help her get out of the bathroom.

On 8/6/25 at 2:45PM, E6 Caregiver stated that on 7/29/25, R1 asked her to help him with his shower. "When I turned on the water, I turned around and he had dropped his pants to his knees and was masturbating. When I asked him to stop, he said, "No." I moved toward the bathroom door and he stepped in front of it, continuing to masturbate. I asked him to move and he said, "No." I had to scream for help to get out of there. He has grabbed my vagina in the past when I have been passing snacks. He just won't stop."

On 8/6/25 at 12:25PM, E3 BOM stated that she helped E6 Caregiver get out of the bathroom. "I saw E5's face when she got out of the bathroom and she was terrified.

On 8/6/25 at 11:22AM, Z1 caregiver stated that when she was bringing another resident back to the establishment on 8/4/25 at approximately 2:00PM, she walked into the common area and saw R1 with his hands down R2's pants fondling R2. I immediately yelled, "No we don't do that!" and then I ran for help. There were no staff around at that time. When I told R1 no, he gave me a dirty look. He seemed to know what he was doing and what was going on but (R2) was just flat, as if she didn't know what was going on. This was in a public area of the building with other residents present."

The facility investigation dated 8/4/25 confirms that on the same day at approximately 2:00PM, R1 placed his hands inside R2's pants and was subsequently sent to the emergency room due to sexual behaviors.

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A2000	Continued From page 3 On 8/7/25 at 2:00PM, at the exit of this survey, R1 remains a resident of the establishment.	A2000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. e) The service plan shall be reviewed and revised if necessary, immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). These requirements were not met as evidenced by: Based on interview and record review the establishment failed to include in the original service plan and update the service plan a needed for two (R1, R2) of three residents reviewed for service plan documentation. Findings include: 1.) R1's interdisciplinary discharge summary from	A4010		

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A4010	Continued From page 4	A4010		

his previous long term care facility dated 6/13/25 documents that R1 has inappropriate sexual behaviors.

R1's establishment admitting nurse's note dated 6/13/25 documents that R1 has sexual behaviors.

R1's nurse's notes dated 6/17/25, 6/27/25, 7/7/25, 7/14/25, 7/21/25, and 7/28/25 all document sexually inappropriate remarks being made by R1 to staff and on 8/5/25 documentation includes remarks to other resident as well.

A facility provided accident and injury report dated 7/29/25 documents that R1 asked E6 Caregiver to assist him with his shower. While E6 Caregiver was attempting to assist R1, he began masturbating and when asked to stop, he closed the door and stood in front of the door preventing E6 from being able to exit the shower. E6 had to scream for another staff member, E5 Business Office Manager (BOM) to help her get out of the bathroom.

On 8/6/25 at 2:45PM, E6 Caregiver stated that on 7/29/25, R1 asked her to help him with his shower. "When I turned on the water, I turned around and he had dropped his pants to his knees and was masturbating. When I asked him to stop, he said, "No." I moved toward the bathroom door and he stepped in front of it, continuing to masturbate. I asked him to move and he said, "No." I had to scream for help to get out of there. He has grabbed my vagina in the past when I have been passing snacks. He just won't stop."

On 8/6/25 at 12:25PM, E3 BOM stated that she helped E6 Caregiver get out of the bathroom. "I saw E5's face when she got out of the bathroom

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A4010	Continued From page 5 and she was terrified. On 8/6/25 at 11:22AM, Z1 caregiver stated that when she was bringing another resident back to the establishment on 8/4/25, she walked into the common area and saw R1 with his hands down R2's pants. I immediately yelled, "No we don't do that!" and then I ran for help. There were no staff around at that time. When I told R1 no, he gave me a dirty look. The facility investigation dated 8/4/25 confirms that on the same day at approximately 2:45PM, R1 placed his hands inside R2's pants and was then sent to the local emergency room for evaluation for sexual behaviors. R1's service plan dated 6/13/25 documents R1's admission date as 6/13/25 with a diagnosis of dementia with behavioral disturbances, that R1 is ambulatory and does not document any sexual behaviors. 2.) R2's service plan dated 7/25/25 documents R2's admission date as 7/25/25 with a diagnosis of dementia, that R2 requires a wheel chair for mobility, and does not document R2's vulnerability or risk for abuse from any person in the facility. R2's nurse's notes dated 8/5/25 document a late entry confirming the incident involving R1 placing his hands down R2's pants on 8/4/25 in the common room.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs	A4060		

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A4060	Continued From page 6 This Regulation is not met as evidenced by: Section 295.4060 Alzheimer's and Dementia Programs b) No person shall be admitted or retained in an assisted living or shared housing establishment if the establishment cannot provide or secure appropriate care, if the resident requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 150(b) of the Act). c) No persons shall be accepted for residency or remain in residence if the person's mental or physical condition has so deteriorated to render residency in such a program to be detrimental to the health, welfare or safety of the person or of other residents of the establishment. The assessment must be approved by the resident's physician and shall occur prior to acceptance for residency, annually, and at such time that a change in the resident's condition is identified by a family member, staff of the establishment, or the resident's physician. (Section 150(c) of the Act). e) No person shall be accepted for residency or remain in residence if the person is dangerous to self or others and the establishment would be unable to eliminate the danger through the use of appropriate treatment modalities. (Section 150(d) of the Act). These requirements were not met as evidenced by:	A4060		

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A4060	Continued From page 7 Based on interview and record review the establishment failed to properly assess and evaluate one (R1) of three resident behaviors prior to admitting R1 to an Alzheimer's/dementia program. This failure has the potential to affect all 13 residents who reside in the facility and has the probability of causing severe harm to a resident or creates a substantial probability of severe harm to a resident or residents. Findings include: The facility provided resident roster dated 8/6/25 documents 13 residents reside at the establishment. R1's service plan dated 6/13/25 documents R1' admission date as 6/13/25 with a diagnosis of dementia. R1's interdisciplinary discharge summary from his previous long term care facility dated 6/13/25 documents that R1 has inappropriate sexual behaviors. R1's establishment admitting nurse's note dated 6/13/25 documents that R1 has sexual behaviors. R1's nurse's notes dated 6/17/25, 6/27/25, 7/7/25, 7/14/25, 7/21/25, and 7/28/25 all document sexually inappropriate remarks being made by R1 to staff and R1's 8/5/25 nurse's note documents sexual remarks made to residents and staff. A facility provided accident and injury report dated 7/29/25 documents that R1 asked E6 Caregiver to assist him with his shower. While E6 Caregiver was attempting to assist R1, he began masturbating and when asked to stop, he closed the door and stood in front of the door preventing	A4060		

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A4060	Continued From page 8	A4060		

E6 from being able to exit the shower. E6 had to scream for another staff member, E5 Business Office Manager (BOM) to help her get out of the bathroom.

On 8/6/25 at 2:45PM, E6 Caregiver stated that on 7/29/25, R1 asked her to help him with his shower. "When I turned on the water, I turned around and he had dropped his pants to his knees and was masturbating. When I asked him to stop, he said, "No." I moved toward the bathroom door and he stepped in front of it, continuing to masturbate. I asked him to move and he said, "No." I had to scream for help to get out of there. He has grabbed my vagina in the past when I have been passing snacks. He just won't stop."

On 8/6/25 at 12:25PM, E3 BOM stated that she helped E6 Caregiver get out of the bathroom. "I saw E5's face when she got out of the bathroom, and she was terrified. We also had a new employee who was supposed to start work today, but when she saw (R1) she left and said she could not work with him. Apparently, (R1) had been at her previous facility and she said that he had sexually assaulted her on the job and that she didn't know that he was living here now."

On 8/6/25 at 12:20PM, E5 Caregiver stated that R1 has been escalating sexually since admission and that he directs his words and actions at females. "We try to redirect him. Sometimes it works, and sometimes it doesn't."

On 8/6/25 at 11:22AM, Z1 caregiver stated that when she was bringing another resident back to the establishment on 8/4/25, she walked into the common area and saw R1 with his hands down R2's pants. I immediately yelled, "No we don't do

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A4060	Continued From page 9 that!" and then I ran for help. There were no staff around at that time. When I told R1 no, he gave me a dirty look. There were other residents in the area while this was going on, it was the common area." The facility investigation dated 8/4/25 confirms that on the same day at approximately 2:00PM, R1 placed his hands inside R2's pants and was subsequently sent to the emergency room due to sexual behaviors. On 8/7/25 at 2:00PM, at the exit of this survey, R1 remains a resident of the establishment.	A4060		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: 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: 2) The right to respect for bodily privacy and dignity at all times, especially during care and treatment; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor;	A6000		

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A6000	Continued From page 10 These requirements were not met as evidenced by: Based on interview and record review the establishment failed to ensure the dignity and freedom from sexual abuse for one (R1) of three residents reviewed for resident rights and freedom from sexual abuse creating the substantial probability of severe harm to a resident or residents. Findings include: R2's service plan dated 7/25/25 documents admission to the establishment on the same date with a diagnosis of dementia. R2's service plan dated 7/25/25 documents that R2 requires a wheel chair for mobility. R2's service plan dated 7/25/25 does not document R2's vulnerability for abuse, nor any interventions to keep her safe from abuse. On 8/6/25 at 11:22AM, Z1 caregiver stated that when she was bringing another resident back to the establishment on 8/4/25, Z1 walked into the common area and saw R1 with his hands down R2's pants, fondling R2. "R2 just looked blank. I immediately yelled, "No, don't do that!" and then I ran for help. There were no staff around at that time. When I told R1 no, he gave me a dirty look. There were other residents in the area while this was going on, it was the common area, it was not dignified." On 8/7/25 at 1:30PM, E2 Director of Nursing stated that she was around the corner from R1 and R2 when she heard Z1 caregiver yell, "No, he's raping her!"	A6000		

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A6000	Continued From page 11 R1's service plan dated 6/13/25 documents R1's admission date as 6/13/25 with a diagnosis of dementia with behavioral disturbances. R1's interdisciplinary discharge summary from his previous long term care facility dated 6/13/25 documents that R1 has inappropriate sexual behaviors. R1's establishment admitting nurse's note dated 6/13/25 documents that R1 has sexual behaviors. R1's nurse's notes dated 6/17/25, 6/27/25, 7/7/25, 7/14/25, 7/21/25, and 7/28/25 all document sexually inappropriate remarks being made by R1 to female staff and on 8/5/25, inappropriate sexual remarks were made ot both residents and staff. The facility investigation dated 8/4/25 confirms that at approximately 2:00PM, R1 placed his hands inside R2's pants in the common room and fondled R2's body in the common area of the establishment.	A6000		