Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510103	A. BUILDING: ____ B. WING ____	C 10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADDINGTON PLACE OF SHILOH	**429 S MAIN ST SHILOH, IL 62269**

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A 000	Initial Comment Complaint # 2549658/IL197918 Violations cited: 295.4010 a) d) g) 1) A) c) 295.6010 a) b) 1) 2) 3) 4) 5) 6)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: TYPE 2 VIOLATION 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. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) g) Service plans shall address: 1) The level of service the resident is	A4010		

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receiving, including:

A) assistance with activities of daily living

C) special accommodations for the resident;

Based on interview and record review the facility failed to ensure R2's service plan addressed the potential for sexually inappropriate behaviors from others. This failure creates a substantial probability of harm to residents especially with cognitive impairment in the facility.

Findings include:

Z1's IDPH Intake Report dated 10/7/25 documents, "Alleged date of incident: 7/12/25. R2 and possibly R3 were inappropriately touched in a sexual manner by R1. R1 was witnessed by staff masturbating while rubbing R2's (private parts). There is speculation that any involvement with R2 is out of confusion. Z1 claims the encounter(s) were consensual so did not report them."

On 10/8/25 during a phone interview at approximately 10 AM, E2 (former Executive Director/ED) stated she was the ED at the time of the incident and that on the weekend of 7/12 she was notified by E6/Licensed Nurse, that staff reported R1 and R2 were observed in the couch together, staff was able to separate R1 from R2 and she instructed E6 to notify R2's physician and Z2 (R2's Power of Attorney). E2 added that E6 also reported to her she was notified by an unidentified former caregiver that R3 was

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sexually assaulted. E2 stated she directed E6 to do a full assessment on R3. E2 stated that on Monday morning 7/14, R3's hospice nurse reported to her that E11 (former employee) called R3's family telling them that E2 knew a resident has sexually assaulted R3 in her room. E2 immediately reviewed camera footage with no findings of any resident in R3's room. E2 stated she explained to R3's family that it was a mix up with another female resident with the same last name. E2 stated she called Z2 and explained what happened between R1 and R2 and told Z2 staff are told to closely monitor and redirect R1 and R2 when needed. E2 stated Z2 told her he understand that R1 and R2 are adults with dementia and they have needs.
E2 stated she did not report R1/R2's alleged incident to IDPH because when she notified Z1 about it he said it was ok.

On 10/8/25 at 10:30 AM, E4/Care Partner, stated she witnessed R1 touching R2 with his hand inside her pants while he was masturbating as they sat in the couch in the common area. E4 stated R2 appeared to be sleeping and E4 immediately told R1 to stop what he was doing and R1 got upset but allowed to be redirected and walked to his room. E2 stated she was with E8, Care Partner and they reported the incident right away to E2. E4 stated that was the only time she witnessed R1 doing it while touching R2 but admitted that in the past, she had observed R1 masturbating in his room or in the common area without involving any other resident and always told him to do it in his room and reported each time to the nurse.

E8's Signed Written Statement dated 7/14/25 documents, "I witnessed (R1) hand go inside

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(R2's) pants while sitting in the living area."

R2's record documents multiple diagnoses, in part, of Alzheimer's Disease and a cognitive assessment dated 8/6/25 in the Global Deterioration Scale as Moderate Dementia and needs regular prompting and orientation as needed due to confusion and disorientation.

R2's Nurses Note Entry authored by E2, dated 7/14/25, documents, "7/14/25.Writer got statement from staff reporting resident involvement with another resident (Touching while sitting in common areas). Writer called POA to notify of incident."

R2's Service Plan does not address the sexual action R1 subjected R2 on 7/12/25 and interventions to preserve R2 her rights including freedom from inappropriate sexual behaviors from others.

A6010 Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr — A6010

This Regulation is not met as evidenced by:
TYPE 2 VIOLATION

Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting
a) When the establishment has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the establishment shall:

1) Notify the Department within 24 hours after receiving the allegation, by contacting the

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Assisted Living Complaint Registry by telephone, fax, or other electronic means. The establishment shall document this report and maintain documentation on the premises for 12 months after the date of the report.

2) Investigate and develop a written report within 14 days after the initial report. The establishment shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report.

b) A written report of the investigation conducted pursuant to subsection (a)(2) shall contain at least the following:

1) Dates, times, and description of the alleged abuse, neglect or financial exploitation;

2) Description of any injury to the resident;

3) Description of any change in the resident's physical, cognitive, functional, or emotional condition;

4) Any actions taken by the licensee;

5) A list of individuals and agencies interviewed or notified by the establishment;

6) Names of witnesses to the alleged abuse, neglect, or financial exploitation;

Based on interview and record review the facility failed to ensure two allegations of sexual assault involving residents in the Memory Care were reported to the Department; and failed to conduct

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a thorough investigation and provide written reports of the investigation. These failures create a substantial probability of harm to residents in the facility.

Findings include:

The Facility Policy Abuse, Neglect, and Exploitation dated 6/13/2024, documents, "Policy: Resident abuse, neglect, and exploitation are prohibitied. Should any resident experience abuse (by staff, residents, family, or others) or when abuse is suspected, staff and volunteers are required to immediately provide notification to persons/agencies as described in this policy. The term abuse as used in this policy alsi includes, but is not limited to, neglect, abandonment, exploitation, and any other form of abuse.
4. Upon the notice of reported, observed, suspected, or at imminent risk of any abuse: a. Immediate steps will be taken to ensure the resident is protected from possible future abuse and neglect while the investigation is conducted. c. A thorough investigation will be conducted by the Director of Health and Wellness or Executive Director. 1. A written report will be submitted to licensing within fourteen days of the initial report i. Reporting of any suspected, alleged, or witnessed abuse will be completed according to state reporting requirements. i. The Executive Director will notify the Illinois Department of Public Health Division of Assisted Living within 24 hours of notification.

Z1's IDPH Intake Report dated 10/7/25 documents, "Alleged date of incident: 7/12/25. R2 and possibly R3 were inappropriately touched in a sexual manner by R1. R1 was witnessed by staff

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masturbating while rubbing R2's (private parts). There is speculation that any involvement with R2 is out of confusion. Z1 claims the encounter(s) were consensual so did not report them."

On 10/8/25 during a phone interview at approximately 10 AM, E2 (former Executive Director/ED) stated she was the ED at the time of the incident and that on the weekend of 7/12 she was notified by E6/Licensed Nurse, that staff reported R1 and R2 were observed in the couch together, staff was able to separate R1 from R2 and she instructed E6 to notify R2's physician and Z2 (R2's Power of Attorney). E2 added that E6 also reported to her she was notified by an unidentified former caregiver that R3 was sexually assaulted. E2 stated she directed E6 to do a full assessment on R3. E2 stated that on Monday morning 7/14, R3's hospice nurse reported to her that E11 (former employee) called R3's family telling them that E2 knew a resident has sexually assaulted R3 in her room. E2 immediately reviewed camera footage with no findings of any resident in R3's room. E2 stated she explained to R3's family that it was a mixed up with another female resident with the same last name. E2 stated she called Z2 and explained what happened between R1 and R2 and told Z2 staff are told to closely monitor and redirect R1 and R2 when needed. E2 stated Z2 told her he understand that R1 and R2 are adults with dementia and they have needs.
E2 stated she did not report R1/R2's alleged incident to IDPH because when she notified Z1 about it he said it was ok.
E2 stated she did not notify IDPH regarding R3's alleged sexual assault because she knew it did not happen, it was a disgruntled employee falsely reporting sexual assault on R3 to R3's family and hospice nurse because R2 and R3 have the

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same last names.

a. R1/R2 Incident:

On 10/8/25 at 10:30 AM, E4/Care Partner, stated she witnessed R1 touching R2 with his hand inside her pants while he was masturbating as they sat on the couch in the common area. E4 stated R2 appeared to be sleeping and E4 immediately told R1 to stop what he was doing and R1 got upset but allowed to be redirected and walked to his room. E2 stated she was with E8, Care Partner and they reported the incident right away to E2. E4 stated that was the only time she witnessed R1 doing it while touching R2 but admitted that in the past, she had observed R1 masturbating in his room or in the common area without involving any other resident and always told him to do it in his room and reported each time to the nurse.

E8's Signed Written Statement dated 7/14/25 documents, "I witnessed (R1) hand go inside (R2's) pants while sitting in the living area."

R2's Nurses Note Entry authored by E2, dated 7/14/25, documents, "7/14/25.Write got statement from staff reporting resident involvement with another resident (Touching while sitting in common areas). Writer called POA to notify of incident."

b. R3's alleged sexual assault incident:

On 10/8/25 at 11:35 AM, E5/Care Partner, stated R3 reported to her R1 tried to enter her room and told him to get out. E5 stated she have seen R1 masturbating in the couch in the living room

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covering his hand with his jacket and redirected him to go to his room.

R3's Nurses Note Entry authored by E6/Licensed Nurse, dated 7/12/25, "Late Entry. 7/12/25. This nurse was informed by care staff by prior care staff that another resident was being inappropriate with resident. Nurse reported to (E2/Director of Wellness) and (E2/ED) immediately. Nurse asked to speak with resident in office. Nurse had ED as witness via phone call. Nurse asked resident if anyone was in her room, she stated no. Asked if anyone touched her inappropriately. Resident stated a man touched her chest area. Nurse asked her if she was ok. Resident stated yes. Skin assessment within normal limits. Resident denied pain/discomfort."

R3's Nurses Notes Entry authored by E2 dated 7/12/25 7/12/25 dated, documents,"Late Entry. 7/12/25. Write spoke to with POA re incident that was reported on 7/12/25."

In an email dated 10/13/25, E1 (Executive Director) confirmed that the facility was unable to present a written investigation report with findings of the two allegations, no documented interviews of possible witnesses in conducting the investigation to support whether the R3 sexual assault allegation was substantiated or not substantiated, and that there was lack of documentation in R1's record of R1's sexual behaviors and R1's witnessed/reported sexual behavior towards R2 on 7/12/25.