STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510474	A. BUILDING: _____ B. WING _____	C 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE NAPERVILLE	2920 LEVERNEZ ROAD NAPERVILLE, IL 60564

(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 FRI/IL00200279 of 02/14/2026 conducted on 02/25/26. The following were cited: Section 295.2000 a) 1) Section 295.4010 a) d) e) Section 295.6000 a) 13)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: TYPE 1 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) . 1) The person poses a serious threat to himself or herself or to others; This requirement was NOT MET as evidenced by: Based on observation, record review and interview, the establishment failed to ensure that needed services were provided and residency requirements were maintained. This was found in 2 of 3 residents reviewed (R1,R2).	A2000		

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A2000	Continued From page 1 This failure resulted in R1's inappropriate sexual behavior. This failure resulted in R2 being the victim of sexual assault by R1. This failure resulted in R1 not receiving incontinence care. This failure creates substantial probability of severe harm to R1, R2 and all residents. Findings Include: 1. On February 14, 2026, a reportable incident identified as "inappropriate behavioral expression" was submitted to the Department. At approximately 9:10 PM, E2 (Resident Assistant, 2nd shift) found R1 in R2's room, sitting in R2's recliner at the bedside. E2 observed R1's hand to be on top of R2's left breast, while R2 was sleeping. On February 20, 2026, at 1:06 PM, E1 (Resident Care Director/RN), stated that the Unit Manager/Director was currently on leave, but was familiar with R1 and would be able to assist with the investigation. E1 described R1 as, "Quite a walker and walks through the entire unit. R1 is always a busy man! R1 was prescribed with a psychotropic medication (quetiapine fumerate) for wandering. Yes, R1 could have been going into other residents' rooms." At 1:31 PM (on February 20, 2026), R1 was in the TV lounge sitting with other residents. E4 (Resident Assistant, 1st shift) stated, "R1 will sit beside the ladies, will touch female residents, grabbing their hands or putting his hands in between the ladies' legs. Yes, R1 goes around the unit a lot. Yes, at times R1 goes to other	A2000		

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A2000	Continued From page 2	A2000		

residents' rooms."

E1 explained the review of the hallway camera footage: "R1 was busy that evening [wandering in the community]. At 8:44 PM, R1 went to R2's room, leaves at 8:46 PM, walks, then sat on the bench outside, in the hallway. At 9:08 PM, R1 entered R2's room [for the second time]. At 9:11 PM, E2 entered R2's room. Someone triggered the call light in R2 and R3's [double occupancy] room."

On February 20, 2026, at 3:32 PM, E2 (Resident Assistant, 2nd shift), said, "R1 was not my resident that evening. R1 usually roams in the hallways but that day (February 14, 2026) R1 was roaming more than usual. At around 9:00 PM, R2's [call] button was pushed. I do not know who [pressed the call button] or if was pressed by accident. When I got to R2's room, I glanced and saw R1 sitting in R2's recliner at the bedside. R1's right hand was on R2's left breast. It looked like R1 was squeezing R2's breast or groping R2. I think I startled R1; R1 didn't say a word ... Yes, R2 remained sleep. The other two Resident Assistants came to redirect R1, and then I informed the nurse (E3)."

The community abuse prevention, investigating, and reporting policy and procedures under investigation Section 2 reads: "The Resident Services Director or Manager on duty, will assess the residents for physical or emotional harm." This procedure was not followed.

On February 24, 2026, at 4:20 PM, E3 (LPN, 2nd shift) explained, "Around 9:00 PM, my Resident Assistant (E2) went to R2's room and saw R1 touching R2's breast. They [Resident Assistants] brought R1 out from R2's room ... No, I did not

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A2000	Continued From page 3 assess R2 after the incident." 2. On February 20, 2026, during this investigation, R1 was directly observed to be sitting in the TV lounge with a group of residents. R1 had a very strong urine odor. E4 (Resident Assistant, 1st shift) was notified. E4 replied, "R1 can take care of himself." At 1:45 PM, E4 was requested to assist R1 to the bathroom. R1 was observed while walking back to their room; the back and inner sides of R1's pants were visibly wet, with obvious sagging of the pants, presumed to be from a soaked diaper. While E4 was assisting R1 at the toilet, R1 was noted to be wearing two fully saturated disposable adult incontinence briefs. E4 said, "R1 put those diapers on himself." E4 later confirmed, "I have not toileted R1 since this morning [at the beginning of the shift]. R1 can go to the bathroom if he needs to." This finding was discussed with E1 on February 20, 2026, at 4:00 PM. E1 stated, "I doubt that [R1 put two layers of disposable adult incontinence disposable adult incontinence brief on themself]. E4 is one of my lazy Resident Assistants." R1's most current service plan dated September 7, 2025, reads: "R1 is incontinent of bladder. He will receive assistance from care staff to manage the continence [incontinence]." R1's service plan also identified that R1 requires reminders and standby assistance/physical assistance from the staff to maintain continence.	A2000		
A4010	Section 295.4010 Service Plan	A4010		

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A4010	Continued From page 4 This Regulation is not met as evidenced by: TYPE 1 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). e) The service plan shall be reviewed and revised, if necessary, immediately after a significant change in the residents' physical, cognitive, or functional condition (see Section 295.4000). These requirements were not met, as evidenced by: Based on observation, interview and record review, the facility failed to: 1. Follow and implement the plan of service to provide the care and assistance to R1 in areas of toileting. 2. Develop and implement individualized interventions to address R1's specific behaviors of: (a) "Inappropriate touching," putting hands on	A4010		

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A4010	Continued From page 5	A4010		

ladies' (staff and residents') thighs,
(b) use of inappropriate language/verbal comments and
(c) entering other residents' room.

This failure involves 2 of 3 residents reviewed (R1,R2).

These failures resulted in:

1.Episode of R1's pants were visibly wet from the back and on the inner sides. R1 was walking with visibly sagging pants due to two disposable adult incontinence briefs fully soaked with urine.
2. R1's continued behavior of inappropriate sexual behavior, including sexually assaulting R2.

This failure creates substantial probability of severe harm to R1, R2 and all residents.

The findings include:

R1 moved into the community on February 15, 2024, with diagnoses to include dementia, anemia, hypertension, and kidney disease. On February 20, 2026, at 1:05 PM, E1 (Resident Care Director) identified R1 as confused and disoriented. R1 requires one physical assist from staff with activities of daily living and ambulates with the use of an assistive device. E1 described R1 as a "walker who goes around the unit."

On February 20, 2026, at 1:39 PM, E4 (Resident Assistant- 1st shift) described R1 as confused, adding, "We check R1 for incontinence. At times, R1 will not allow us to change his [disposable incontinence] brief. Yes, R1 will sit beside the ladies, will touch female residents, grabbing their hands or putting his hands in between their legs

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A4010	Continued From page 6 ... Yes, R1 goes around the unit a lot ... Yes, at times R1 goes into other residents' rooms." On February 20, 2026, at 3:32 PM, E2 (Resident Assistant, 2nd shift), said, "R1 was not my resident that evening. R1 usually roams in the hallways but that day (February 14, 2026) R1 was roaming more than usual. At around 9:00 PM, R2's [call] button was pushed. I do not know who [pressed the call button] or if was pressed by accident. When I got to R2's room, I glanced and saw R1 sitting in R2's recliner at the bedside. R1's right hand was on R2's left breast. It looked like R1 was squeezing R2's breast or groping R2. I think I startled R1; R1 didn't say a word ... Yes, R2 remained sleep. The other two Resident Assistants came to redirect R1, and then I informed the nurse (E3)." On February 25, 2026, at 9:12 AM, E6 (LPN, 1st shift) said, "R1 is alert and oriented to self only. R1 at times will be touching female residents. Wanders around 90% of his day. At times, staff will find R1 sitting in other residents' rooms. R1 needs to be monitored and supervised because R1 cannot verbalize [their] needs ... Yes, R1 is incontinent ... No, R1 cannot put their own diaper on. R1 needs assistance with all activities of daily living." E6 also stated that staff monitor R1 for "negative behavior" (as documented), such as touching himself and verbalizing inappropriate statements, such as, "I want to see you naked." R1's most current service plan dated September 7, 2025, shows: a. R1's need: Continence supervision. Intervention: Care staff will provide escorts and supervision in bathroom as well as assistance with clothing and briefs.	A4010		

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A4010	Continued From page 7 R1 is incontinent of bladder. R1 will receive assistance from care staff to manage the (sig) continence. R1's service plan also identify R1 will requires reminders and stand by assistance from one care partner to maintain continence ...if he (R1) has an incontinence episode, staff to provide hands on physical assistance. This plan of service was not followed and implemented during this survey. This was discussed with E1 on February 20, 2026. On February 20, 2026, during this investigation, R1 was directly observed to be sitting in the TV lounge with a group of residents. R1 had a very strong urine odor. E4 (Resident Assistant, 1st shift) was notified. E4 replied, "R1 can take care of himself." At 1:45 PM, E4 was requested to assist R1 to the bathroom. R1 was observed while walking back to their room; the back and inner sides of R1's pants were visibly wet, with obvious sagging of the pants, presumed to be from a soaked diaper. While E4 was assisting R1 at the toilet, R1 was noted to be wearing two fully saturated disposable adult incontinence briefs. E4 said, "R1 put those diapers on himself." E4 later confirmed, "I have not toileted R1 since this morning [at the beginning of the shift]. R1 can go to the bathroom if he needs to." b. Psychosocial: Need- Behavior Assistance. - R1 occasionally will need assistance from one care partner (staff) to redirect his behavioral expression. - During shower with female [staff] inappropriate language (no specifics provided). - Putting his hands on ladies' thighs on staff and residents. Intervention: Care staff will provide needed	A4010		

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A4010	Continued From page 8 assistance for residents with symptoms of anxiety, agitation and excessive worry. This is the only intervention listed in R1's service plan. There were no interventions identified or implemented to address R1's specific behaviors listed above. This finding was discussed and acknowledged by E1 on February 20, 2026, at 3:05 PM.	A4010		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.6000 Resident Rights a)13 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: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor. These requirements were not met, as evidenced by: Based on observation, interview and record review, the facility failed to: 1. Provide a safe environment for residents living with dementia. 2. Provide monitoring and supervision to a resident (R1) known for inappropriate behavior, including:	A6000		

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A6000	Continued From page 9	A6000		

(a) touching and "putting hands on ladies (staff and residents') thighs";
(b) going into other residents' rooms.
3. Provide and maintain dignity by providing the necessary care and assistance required by R1 in areas of incontinence care.

This failure involves 2 of 3 residents reviewed (R1,R2).

These failures resulted in:
(1) R2 being sexually assaulted by R1 on February 14, 2026. R1 was found "squeezing R2's left breast, groping R2."
(2) An incident of neglect involving R1 on February 20, 2026. R1 was observed to be walking with the back and inner sides of their pants wet from urine. R1 was found to be wearing two disposable adult incontinence briefs (layered together), fully saturated with urine.

This failure creates substantial probability of severe harm to R1,R2 and all residents.

The findings include:
1. On February 14, 2026, a reportable incident identified as "inappropriate behavioral expression" was submitted to the Department. At approximately 9:10 PM, E2 (Resident Assistant, 2nd shift) found R1 in R2's room, sitting in R2's recliner at the bedside. E2 observed R1's hand to be on top of R2's left breast, while R2 was sleeping.

On February 20, 2026, at 1:06 PM, E1 (Resident Care Director/RN), stated that the Unit Manager/Director was currently on leave, but was familiar with R1 and would be able to assist with the investigation. E1 described R1 as, "Quite a walker and walks through the entire unit. R1 is

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A6000	Continued From page 10	A6000		

always a busy man! R1 was prescribed with a psychotropic medication (Seroquel) for wandering. Yes, R1 could have been going into other residents' rooms."

At 1:31 PM (on February 20, 2026), R1 was in the TV lounge sitting with other residents. E4 (Resident Assistant, 1st shift) stated, "R1 will sit beside the ladies, will touch female residents, grabbing their hands or putting his hands in between the ladies' legs. Yes, R1 goes around the unit a lot. Yes, at times R1 goes to other residents' rooms."

E1 explained the review of the hallway camera footage: "R1 was busy that evening [wandering in the community]. At 8:44 PM, R1 went to R2's room, leaves at 8:46 PM, walks, then sat on the bench outside, in the hallway. At 9:08 PM, R1 entered R2's room [for the second time]. At 9:11 PM, E2 entered R2's room. Someone triggered the call light in R2 and R3's [double occupancy] room."

On February 20, 2026, at 3:32 PM, E2 (Resident Assistant, 2nd shift), said, "R1 was not my resident that evening. R1 usually roams in the hallways but that day (February 14, 2026) R1 was roaming more than usual. At around 9:00 PM, R2's [call] button was pushed. I do not know who [pressed the call button] or if was pressed by accident. When I got to R2's room, I glanced and saw R1 sitting in R2's recliner at the bedside. R1's right hand was on R2's left breast. It looked like R1 was squeezing R2's breast or groping R2. I think I startled R1; R1 didn't say a word ... Yes, R2 remained sleep. The other two Resident Assistants came to redirect R1, and then I informed the nurse (E3)."

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A6000	Continued From page 11 The community abuse prevention, investigating, and reporting policy and procedures under investigation Section 2 reads: "The Resident Services Director or Manager on duty, will assess the residents for physical or emotional harm." This procedure was not followed. On February 24, 2026, at 4:20 PM, E3 (LPN, 2nd shift) explained, "Around 9:00 PM, my Resident Assistant (E2) went to R2's room and saw R1 touching R2's breast. They [Resident Assistants] brought R1 out from R2's room ... No, I did not assess R2 after the incident." 2. On February 20, 2026, during this investigation, R1 was directly observed to be sitting in the TV lounge with a group of residents. R1 had a very strong urine odor. E4 (Resident Assistant, 1st shift) was notified. E4 replied, "R1 can take care of himself." At 1:45 PM, E4 was requested to assist R1 to the bathroom. R1 was observed while walking back to their room; the back and inner sides of R1's pants were visibly wet, with obvious sagging of the pants, presumed to be from a soaked diaper. While E4 was assisting R1 at the toilet, R1 was noted to be wearing two fully saturated disposable adult incontinence briefs. E4 said, "R1 put those diapers on himself." E4 later confirmed, "I have not toileted R1 since this morning [at the beginning of the shift]. R1 can go to the bathroom if he needs to." This finding was discussed with E1 on February 20, 2026, at 4:00 PM. E1 stated, "I doubt that [R1 put two layers of disposable adult incontinence disposable adult incontinence brief on themself]. E4 is one of my lazy Resident Assistants."	A6000		

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A6000	Continued From page 12 R1's most current service plan dated September 7, 2025, reads: "R1 is incontinent of bladder. He will receive assistance from care staff to manage the continence [incontinence]." R1's service plan also identified that R1 requires reminders and standby assistance/physical assistance from the staff to maintain continence.	A6000		