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| A 000 | Initial Comment<br><br>Investigtaion of Facility Reported Incident (FRI) 3/10/26 - IL200649.<br><br>Violations:<br><br>Section 295.4010 Service Plan b)1-3), c-e), g)1-3), h)<br><br>Section 295.4060 Alzheimer's and Dementia Programs a) b) c) e) f) h)3)<br><br>Section 295.6000 Resident Rights a)13)<br><br>Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting c) | A 000 | | |
| A4010 | Section 295.4010 Service Plan<br><br>This Regulation is not met as evidenced by:<br>Type 2 Violation<br><br>Section 295.4010 Service Plan ...<br><br>b) The service plan shall be developed by:<br><br>1) The resident, resident's representative or any individual requested by the resident;<br><br>2) The manager or manager's designee; and | A4010 | | |

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| A4010 | Continued From page 1<br>3) A registered nurse, if the resident is receiving nursing services or medication administration, or is unable to direct self-care.<br><br>c) The service plan shall be signed and dated by all individuals involved in its development.<br><br>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)<br><br>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) ...<br><br>g) Service plans shall address:<br><br>1) The level of service the resident is receiving, including: ...<br><br>C) special accommodations for the resident;<br><br>2) The amount, type, and frequency of health-related services needed by the resident;<br><br>3) Staff responsible for the provisions of the service plan; ...<br><br>h) The service plan shall include all support services provided or arranged for by the establishment ... | A4010 | | |

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| A4010 | Continued From page 2<br>This requirement was not met, as evidenced by:<br><br>Based on interview and record review, the establishment failed to follow their policy and state regulation when residents' representatives were not involveed in the development of the service plan and required signatures were not received. They failed to ensure resident service plans were reviewed and updated as needed. They failed to ensure resident service plans addressed the needs and safety concerns of residents. This applies to 3 of 3 residents (R1, R2, R3) reviewed for this requirement. These failures create a substantial probability of harm to a resident or residents, in that it cannot be determined if the establishment is aware of or addressed the needs or preferences of the resident.<br><br>The findings include:<br><br>On 3/17/26, an investigation of Facility Reported Incident 3/10/26 - IL200649 was initiated, related to R1, who grabbed the breast of R2 on 3/9/26.<br><br>During the investigation, the following concerns were found with service plans:<br><br>1) R1's medical record showed R1 moved into the establishment on 8/8/23, resides in memory care, and has multiple diagnoses, including depression, cognitive decline, and Alzheimer's disease.<br><br>R1's cognitive screen, dated 8/22/25, showed R1 has moderate dementia.<br><br>-R1's Service Plan, dated 9/23/25, was not signed by R1's representative. | A4010 | | |

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| A4010 | Continued From page 3<br><br>-R1's Service Plan did not adequately address the types of inappropriate sexual behaviors R1 displayed or related interventions to protect residents. The service plan did not address the ability of R1 to consent to sexual/intimate communication/contact with R3, what behaviors are/are not allowed, family involvement, staff responsibility, and interventions to protect the resident.<br><br>The service plan showed "(R1) needs redirection and supervision about inappropriate sexual behaviors." "(R1) has a diagnosis of inappropriate sexual behavior."<br><br>R1's Progress Notes and Psychiatric Follow-Up Notes, reviewed for April 2025-March 2026, and interviews conducted with E3 (Licensed Practical Nurse - LPN) on 3/17/26 at 1:09 AM, E4 (Certified Nursing Assistant) on 3/18/26 at 11:29 AM, E5 (LPN) on 3/17/26 at 2:32 PM, and E6 (Personal Care Assistant) on 3/17/26 at 3:39 PM, showed R1 and R3 were interested in each other and they kissed, held hands, and touched. They showed R1 displayed inappropriate touching of female staff and residents, exposed genitalia, and asked staff and residents to touch R1's genitalia.<br><br>Department investigation showed a conflict of understanding between staff and family on what behavior was acceptable, which should have been clarified in the service plan. Staff interviews indicated family did not approve of R1 and R3 interacting at first but were later okay with limited affection if it did not harm either party. During a phone interview with Z1 (R1's Daughter) on 3/18/26 at 12:26 PM, Z1 indicated the establishment informed Z1 of R1's and R3's relationship and R1's behaviors but was not | A4010 | | |

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| A4010 | Continued From page 4<br>aware what a service plan was and was not asked to sign one.<br><br>-R1's service plan did not address the reason for and use of psychotropic medication and psychiatric services. R1's Physician's Orders Sheet showed R1 takes scheduled paroxetine (antidepressant). R1's Psychiatric Follow-Up Notes showed R1 is followed by Z4 (Psychiatric Nurse Practitioner), and paroxetine is used to decrease sexual behaviors.<br><br>2) R2's medical record showed R2 moved into the establishment on 7/25/25, resides in memory care, and has multiple diagnoses, including presence of cardiac pacemaker, congestive heart failure, chronic obstructive pulmonary disease, depression, anxiety, and vascular dementia.<br><br>R2's cognitive screen, dated 7/9/25, showed R2 has moderate dementia.<br><br>-R2's Service Plan, dated 7/25/25, was not reviewed and signed by R2's representative. During a phone interview with Z1 (R2's Daughter), on 3/18/26 at 5:27 PM, Z1 indicated a service plan was not reviewed with Z1, nor was Z1 asked to sign one.<br><br>-R2's service plan did not address the reason for or use of psychotropic mediction and related moods/behaviors to monitor for. R2's POS showed R2 takes scheduled escitalopram (antidepressant).<br><br>-R2's service plan did not address interventions put in place to protect R2 after a sexual abuse incident by R1, where R1 remained at the establishment. The Facility Reported Incident | A4010 | | |

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| A4010 | Continued From page 5 | A4010 | | |

investigated and the establishment investigation that followed showed on 3/9/26, R1 touched R2's breast while R2 slept in a recliner in the common area. The investigation Next Action Steps showed R1 would move to a pod not located by R2's room and would be on one-to-one supervision.

3) R3's medical record showed R3 moved into the establishment on 1/7/25, resides in memory care, and has multiple diagnoses, anxiety, depression, memory loss, dementia, and Alzheimer's disease.

R3's cognitive screen, dated 1/21/26, showed R3 has severe cognitive impairment.

-R3's Service Plan, dated 1/15/26, was signed by E2 (Memory Care Director - MCD) on 3/18/26 (after the entrance date of the investigation on 3/17/26) and was not signed by a registered nurse or reviewed and signed by R3's representative. R3's service plan showed medications are administered by the nurse and R3 is not able to direct self-care, which required a registered nurse to be part of development and sign.

-R3's service plan did not address the ability to consent to sexual/intimate communication/contact with R1, what behaviors are/are not allowed, family involvement, staff responsibility, and interventions to protect the resident's safety.

During interviews conducted with E3 (Licensed Practical Nurse - LPN) on 3/17/26 at 1:09 AM, E4 (Certified Nursing Assistant) on 3/18/26 at 11:29 AM, E5 (LPN) on 3/17/26 at 2:32 PM, and E6 (Personal Care Assistant) on 3/17/26 at 3:39 PM,

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| A4010 | Continued From page 6 | A4010 | | |

staff indicated R3 and R1 were interested in each other and they kissed, held hands, and touched, but also displayed inappropriate sexual behaviors. They indicated R3 often initiated the contact and was upset when staff intervened.

Department investigation showed a conflict of understanding between staff and family on what behavior was acceptable, which should have been clarified in the service plan. Staff interviews indicated family did not approve of R1 and R3 interacting at first but were later okay with limited affection if it did not harm either party. During a phone interview with Z2 (R3's Daughter-In-Law) on 3/18/26 at 10:48 AM, Z2 indicated, they were not okay with interaction. Z3 was not aware what a service plan was and was not asked to sign one.

During interview with E2 (MCD) on 3/18/26 at 1:03 PM, concerns were reviewed and the above findings confirmed. E2 agreed establishment policy and state regulation should be followed.

During interview with E1 (Executive Director) on 3/18/26 at 1:54 PM, concerns were reviewed and the above findings confirmed.

The establishment policy titled Service Plans (Last Revised 01/2022) showed: ...Policy: Each resident will have a written plan of care that is developed based on initial assessment, annual comprehensive assessment, quarterly evaluations, and changes in resident needs ...Responsibility: ...D) The Director of Nursing, or designee, will review the Service Plan every quarter and upon significant change in condition ...F) The Director of Nursing, or designee, will review and update the service plan as directed by

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| A4010 | Continued From page 7<br>changes in resident needs or preferences ...Procedure: ...C) The nursing staff along with the resident and/or family members will identify resident problems, needs and strengths. D) For each problem, need or strength a resident-centered goal is developed ...E) Service plan shall include coordination and inclusion of services being delivered to a resident by an outside entity. F) Staff approaches are to be developed for each problem/strength/need ...G) All service plans are to be reviewed every quarter, upon significant change in condition and as dictated by changes in retirement needs or preferences ... | A4010 | | |
| A4060 | Seciton 295.4060 Alzheimer's and Demential Programs<br><br>This Regulation is not met as evidenced by:<br>Type 1 Violation<br><br>Section 295.4060 Alzheimer's and Dementia Programs ...<br>a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act)<br><br>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 | A4060 | | |

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| A4060 | Continued From page 8<br>such services. (Section 150(b) of the Act)<br><br>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)<br><br>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)<br><br>f) No person shall be accepted for residency or remain in residence if the person meets the criteria provided in subsections (b) through (g) of Section 75 of the Act. (Section 150(e) of the Act)<br><br>h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: ...<br><br>3) Develop and implement policies and procedures that ensure the continued safety of all residents in the establishment including, but not limited to, those who: ...<br><br>(Source: Amended at 28 Ill. Reg. 14593, effective October 21, 2004) | A4060 | | |

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| A4060 | Continued From page 9<br><br>This requirement was not met, as evidenced by:<br><br>Based on interview and record review, the establishment maintained a resident who displayed sexually inappropriate/abusive behavior toward female residents and staff. This applies to 1 of 3 residents (R1) reviewed for this requirement. The resident sexually abused a female resident on 3/9/26 that resulted in harm to the resident, and the Department investigation of the incident showed the resident had previous alleged sexually abusive incidents that were not followed-up on. Maintaining residents that do not meet residency requirements creates a substantial probability of harm to a resident or residents.<br><br>Based on interview and record review, the establishment failed to develop and implement policies and procedures related to sexual consent for residents with cognitive impairment. This applies 2 of 3 residents (R1, R3) reviewed for this requirement and has the probability to affect all residents that reside in the memory care unit and creates a substantial probability of harm to a resident or residents, in that it cannot be determined if the establishment put in place measures to protect resident safety while honoring resident rights.<br><br>The findings include:<br><br>On 3/17/26, an investigation of Facility Reported Incident 3/10/26 - IL200649 was initiated, related to R1, who grabbed the breast of R2 on 3/9/26.<br><br>The investigation showed the establishment | A4060 | | |

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| A4060 | Continued From page 10 | A4060 | | |

maintained a R1, who displayed sexually inappropriate behavior since June 2025, and there was no evidence to show the establishment provided the supervision necessary to prevent incidents, or assessed if R1's behavior posed a serious threat to others and the ability to remain a resident.

R1's medical record showed R1 moved into the establishment on 8/8/23, resides in memory care, and has multiple diagnoses, including depression, cognitive decline, and Alzheimer's disease.

R1's cognitive screen, dated 8/22/25, showed R1 has moderate dementia.

R1's Service Plan, dated 9/23/25, showed R1 needs redirection and supervision about inappropriate sexual behaviors, but did not describe the behaviors or interventions put in place.

The establishment's Critical Event Call Summary showed, on 3/9/26 at 2:55 PM, R1 placed R1's hand on R2's breast while R2 napped in a recliner in the common area of memory care. The report showed R2 yelled "get him away from me" and E4 (Certified Nursing Assistant) intervened and informed E3 (Licensed Practical Nurse). The report showed Z1 (R2's Daughter) filed a police report.

The establishment investigation for the 3/9/26 incident between R1 and R2 showed:
-On 6/3/25, R1 "pulled out (R1's) penis, talking vulgar to care staff, trying to kiss "several women" per PM (evening) shift nurse ..."
-On 6/4/25, R1 "pulled out penis in DR (dining room) to female resident "to touch" per day shift nurse, not redirectable and instead touched staff

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| A4060 | Continued From page 11 | A4060 | | |

member inappropriately ..."
-On 10/17/25, (Z5 - Family Member of Unknown Resident) reported (R1) to be "touching a female resident (R3) "inappropriately" in common area, charting does not specify what was considered inappropriate."
-On 2/24/26, (R1) "observed with "inappropriate behaviors" kissing and touching other resident (also R3)."

R1's Psychiatry Follow-Up reports showed:
-Dated 6/5/25 - (R1) exposed self to staff and residents
-Dated 10/23/25 - on 10/17/25 a family member of a resident observed (R1) inappropriately touch a female resident in the common area. Staff attempted to monitor (R1) and keep away from other residents.
-Dated 11/20/25 - (R1) continued to have sexual behavior with other female residents. The report showed, "(R1) has been touching one of the female residents on her breast and vaginal area at times."
-Dated 2/12/25 - (R1) continued sexual behavior with other residents and was difficult to keep them separated.

During interviews conducted with E3 (Licensed Practical Nurse - LPN) on 3/17/26 at 1:09 AM, E4 (Certified Nursing Assistant) on 3/18/26 at 11:29 AM, E5 (LPN) on 3/17/26 at 2:32 PM, and E6 (Personal Care Assistant) on 3/17/26 at 3:39 PM, staff indicated R1 and R3 kissed, held hands, and touched, but also displayed behaviors where R1 exposed R1's genitalia to R3 and asked R3 to grab it, and did the same to other female residents and staff. Staff indicated that when behavior occurred, they told R1 to stop and moved R1 away from other residents, but it was difficult to keep R1 separated at all times. They

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|---|---|---|---|
| | ASL510199 | A. BUILDING: _____ B. WING _____ | C 03/25/2026 |

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|---|---|---|---|---|
| A4060 | Continued From page 12 | A4060 | | |

indicated, after the incident on 3/9/26, they required staff to monitor R1 one-to-one at all times and keep separated from R2.

The Department investigation showed R1's behaviors were not always documented or reported to administration (see 295.6010).

R2's medical record showed R2 moved into the establishment on 7/25/25, resides in memory care, and has multiple diagnoses, including presence of cardiac pacemaker, congestive heart failure, chronic obstructive pulmonary disease, depression, anxiety, and vascular dementia.

R2's cognitive screen, dated 7/9/25, showed R2 has moderate dementia.

On 3/17/26 at 3:39 PM, E6 (Personal Care Assistant) indicated, in the days after the incident, R2 tried to kick and punch R1. E6 indicated, every time R2 saw R1, R2 recalled the incident and voiced R2 wanted to hit R1.

On 3/17/26 at 11:09 AM, E1 (Executive Director - ED) confirmed the incident and indicated that R2 continued to recall the incident the day after and R2 voiced anger at R1.

On 3/17/26 at 11:42 AM, this surveyor observed and interviewed R2 in the presence of E1. The interview was conducted in the empty common area where R1's and R2's rooms were located. At the beginning of the interview, R1 exited R1's room, pushed by a caregiver. R2 pointed out R1 and had a negative reaction and stated she did not like R1, then proceeded to recall the incident that occurred on 3/9/26. During interview, R2 indicated that R2's breast was sore after the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510199 | A. BUILDING: _____ B. WING _____ | C 03/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HERITAGE WOODS OF HUNTLEY, LLC | 12450 REGENCY PARKWAY HUNTLEY, IL 60142 |

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| A4060 | Continued From page 13<br>incident.<br><br>On 3/18/26 at 5:27 PM, Z1 (R2's Daughter) indicated Z1 arrived right after the incident, and R2's hands were hot and sweaty, R2's stomach hurt, and Z1 applied R2's oxygen to help R2 calm down. During a family dinner on (3/15/26), Z1 indicated, R2 recalled and brought up the incident and indicated R2's boob hurt.<br><br>During interview with E2 (Memory Care Director) on 3/18/26 at 1:03 PM, and E1 (ED) on 3/18/26 at 1:54 PM, they confirmed the 3/9/26 incident and R1's behaviors. They indicated they discussed R1's behavior with R1's family but did not indicate discussion of R1's ability to remain at the establishment.<br><br>During a phone interview on 3/18/26 at 1:54 PM, when Z4 (Psychiatric Nurse Practitioner) was asked if memory care residents could consent, Z4 said, no. Z4 confirmed R1's sexually inappropriate behavior displayed can evolve with dementia/Alzheimer's. When asked if R1 was appropriate for the establishment, Z4 indicated, the medication R1 was put on was effective for a period of time, but behaviors returned, and if the new medication is not effective, then no.<br><br>On 3/17/26, an investigation of Facility Reported Incident 3/10/26 - IL200649 was initiated, related to R1, who grabbed the breast of R2 on 3/9/26.<br><br>Interviews conducted with E1 (Executive Director) on 3/17/26 at 11:09 AM; E2 (Memory Care | A4060 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510199 | A. BUILDING: _____ B. WING _____ | C 03/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| A4060 | Continued From page 14<br>Director) on 3/18/26 at 1:03 PM; E3 (Licensed Practical Nurse - LPN) on 3/17/26 at 12:51 PM; E4 (Certified Nursing Assistant) on 3/17/26 at 1:01 PM, E5 (LPN) on 3/17/26 at 2:32 PM, and E6 (Personal Care Assistant) on 3/17/26 at 3:39 PM indicated R1 and R3 displayed public incidents of affection; some benign like holding hands, kissing, and some not benign, like open mouth kissing, touching, and R1 exposed self to R3. They indicated R1 and R3's interaction was consensual, and many times R3 initiated the behavior or would be combative with staff when they tried to separate the two. They indicated R1's and R3's family was informed and they were now okay with limited contact and displays of affection.<br><br>R1's medical record showed R1 moved into the establishment on 8/8/23, resides in memory care, and has multiple diagnoses, including depression, cognitive decline, and Alzheimer's disease.<br>R1's cognitive screen, dated 8/22/25, showed R1 has moderate dementia.<br>R1's Service Plan, dated 9/23/25, showed R1 needs redirection and supervision about inappropriate sexual behaviors.<br><br>R3's medical record showed R3 moved into the establishment on 1/7/25, resides in memory care, and has multiple diagnoses, anxiety, depression, memory loss, dementia, and Alzheimer's disease.<br>R3's cognitive screen, dated 1/21/26, showed R3 has severe cognitive impairment.<br><br>On 3/17/26 at 4:06 PM, E1 (ED) indicated, they did not have a policy related to sexual consent.<br><br>During a phone interview on 3/18/26 at 1:54 PM, | A4060 | | |

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|---|---|---|---|
| | ASL510199 | A. BUILDING: _____ B. WING _____ | C 03/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| A4060 | Continued From page 15<br>when Z4 (Psychiatric Nurse Practitioner) was asked if memory care residents could consent, Z4 said, no. | A4060 | | |
| A6000 | Section 295.6000 Resident Rights<br><br>This Regulation is not met as evidenced by:<br>Type 2 Violation<br><br>Section 295.6000 Resident Rights<br><br>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: ...<br><br>13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; ...<br><br>This requirement was not met, as evidenced by:<br><br>Based on observation, interview, and record review, the establishment failed to ensure a resident remained free of abuse, when a male resident, who had multiple incidents of inappropriate sexual behavior, grabbed the breast of a female resident, while she slept. This applies to 2 of 3 residents (R1, R2) reviewed for this requirement. The incident resulted in harm the resident, as the female resident suffered emotional and physical harm from the incident. | A6000 | | |

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|---|---|---|---|
| | ASL510199 | A. BUILDING: _____ B. WING _____ | C 03/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| A6000 | Continued From page 16<br><br>The findings include:<br><br>On 3/17/26, an investigation of Facility Reported Incident 3/10/26 - IL200649 was initiated, related to R1, who grabbed the breast of R2 on 3/9/26.<br><br>The establishment's Critical Event Call Summary showed, on 3/9/26 at 2:55 PM, R1 placed R1's hand on R2's breast while R2 napped in a recliner in the common area of memory care. The report showed R2 yelled "get him away from me" and E4 (Certified Nursing Assistant) intervened and informed E3 (Licensed Practical Nurse). The report showed Z1 (R2's Daughter) filed a police report.<br><br>On 3/17/26 at 12:51 PM E3 confirmed the incident.<br><br>On 3/17/26 at 1:01 PM E4 confirmed the incident.<br><br>-R1's medical record showed R1 moved into the establishment on 8/8/23, resides in memory care, and has multiple diagnoses, including depression, cognitive decline, and Alzheimer's disease.<br><br>R1's cognitive screen, dated 8/22/25, showed R1 has moderate dementia.<br><br>R1's Service Plan, dated 9/23/25, showed R1 needs redirection and supervision about inappropriate sexual behaviors.<br><br>-R2's medical record showed R2 moved into the establishment on 7/25/25, resides in memory care, and has multiple diagnoses, including presence of cardiac pacemaker, congestive heart | A6000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
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|---|---|---|---|---|
| A6000 | Continued From page 17 | A6000 | | |

failure, chronic obstructive pulmonary disease, depression, anxiety, and vascular dementia.

R2's cognitive screen, dated 7/9/25, showed R2 has moderate dementia.

On 3/17/26 at 3:39 PM, E6 (Personal Care Assistant) indicated, in the days after the incident, R2 tried to kick and punch R1. E6 indicated, every time R2 saw R1, R2 recalled the incident and voiced R2 wanted to hit R1.

On 3/17/26 at 11:09 AM, E1 (Executive Director) confirmed the incident and indicated that R2 continued to recall the incident the day after and R2 voiced anger at R1.

On 3/17/26 at 11:42 AM, this surveyor observed and interviewed R2 in the presence of E1. The interview was conducted in the empty common area where R1's and R2's rooms were located. At the beginning of the interview, R1 exited R1's room, pushed by a caregiver. R2 pointed out R1 and had a negative reaction and stated she did not like R1, then proceeded to recall the incident that occurred on 3/9/26. During interview, R2 indicated that R2's breast was sore after the incident.

On 3/18/26 at 5:27 PM, Z1 (R2's Daughter) indicated Z1 arrived right after the incident, and R2's hands were hot and sweaty, R2's stomach hurt, and Z1 applied R2's oxygen to help R2 calm down. During a family dinner on (3/15/26), Z1 indicated, R2 recalled and brought up the incident and indicated R2's boob hurt.

The establishment policy titles Resident's Personal Rights Policy and Procedure (Last

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510199 | A. BUILDING: _____ B. WING _____ | C 03/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| A6000 | Continued From page 18<br>Revised 12/2024) showed:...Each resident will have the right to: 1) Be free from mental, emotional, social and physical abuse and neglect and exploitations... | A6000 | | |
| A6010 | Section 295.6010 Abuse, Neglect, and Financial Exploitation Pr<br><br>This Regulation is not met as evidenced by:<br>Type 2 Violation<br><br>Section 295.6010 Abuse, Neglect, and Financial Exploitation Prevention and Reporting...<br><br>c) Establishment employees and volunteers are obligated to report abuse, neglect, or financial exploitation of a resident to the establishment management and to the Department ...<br><br>This requirement was not met, as evidenced by:<br><br>Based on interview and record review, the establishment failed to follow their policy and state regulation when staff failed to report and/or document incidents of possible sexual abuse. This applies to 2 of 3 residents (R1, R3) reviewed for this requirement, but has the probability to affect all residents, and creates a substantial probability of harm to a resident or residents, in that residents' safety, dignity and quality of life is at risk when abuse is not reported.<br><br>The findings include: | A6010 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| A6010 | Continued From page 19<br><br>On 3/17/26, an investigation of Facility Reported Incident 3/10/26 - IL200649 was initiated, related to R1, who grabbed the breast of R2 on 3/9/26.<br><br>During this investigation, it was determined that staff did not report incidents of possible sexual abuse to their manager, or the incident was reported to management, but not to the administrator.<br><br>The establishment investigation for the 3/9/26 incident between R1 and R2 showed:<br>-On 6/3/25, R1 "pulled out (R1's) penis, talking vulgar to care staff, trying to kiss "several women" per PM (evening) shift nurse ..."<br>-On 6/4/25, R1 "pulled out penis in DR (dining room) to female resident "to touch" per day shift nurse, not redirectable and instead touched staff member inappropriately ..."<br>-On 10/17/25, (Z5 - Family Member of Unknown Resident) reported (R1) to be "touching a female resident (R3) "inappropriately" in common area, charting does not specify what was considered inappropriate."<br>-On 2/24/26, (R1) "observed with "inappropriate behaviors" kissing and touching other resident (also R3)."<br><br>R1's Progress Notes, reviewed for the above dates, were consistent with the above documentation. No other incidents were documented in progress notes.<br><br>R1's Psychiatry Follow-Up reports showed:<br>-Dated 6/5/25 - (R1) exposed self to staff and residents<br>-Dated 10/23/25 - on 10/17/25 a family member of a resident observed (R1) inappropriately touch a female resident in the common area. Staff attempted to monitor (R1) and keep away from | A6010 | | |

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|---|---|---|---|
| | ASL510199 | A. BUILDING: _____ B. WING _____ | C 03/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| A6010 | Continued From page 20 | A6010 | | |

other residents.
-Dated 11/20/25 - (R1) continued to have sexual behavior with other female residents. The report showed, "(R1) has been touching one of the female residents on her breast and vaginal area at times."
-Dated 2/12/25 - (R1) continued sexual behavior with other residents and was difficult to keep them separated.

R3's Psychiatry Follow-Up reports showed:
-Dated 6/5/25 - "(R3) and male resident have become close and they are often seen being amorous. Staff has seen (R3) with (R3's) hands in his pants, and they at times are alone in each other's apartments."
-Dated 2/26/26 - "(R3) does have a male friend in the facility who (R3) at times has intimate contact with and (R3's) family is aware. (R3) sometimes initiates the contact and family realizes staff do what they can to keep them apart and redirect them."

During interviews conducted with E3 (Licensed Practical Nurse - LPN) on 3/17/26 at 1:09 AM, E4 (Certified Nursing Assistant) on 3/18/26 at 11:29 AM, E5 (LPN) on 3/17/26 at 2:32 PM, and E6 (Personal Care Assistant) on 3/17/26 at 3:39 PM, staff indicated R1 and R3 kissed, held hands, and touched, but also displayed behaviors where R1 exposed R1's genitalia to R3 and asked R3 to grab it, and did the same to other female residents and staff. Staff indicated, when behaviors occurred, they told R1 to stop and moved R1 away from other residents.

There was no documentation to show any of the above incidents reported to management or the administrator.

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|---|---|---|---|---|
| A6010 | Continued From page 21<br><br>On 3/18/26 at 1:03 PM E2 (Memory Care Director) confirmed R1 exposed R1's genitalia in front of female residents twice in June 2025. E2 indicated, when incidents happened, R1's family and Z4 (Psychiatric Nurse Practitioner) were made aware but did not indicate E1 was made aware, or that an incident report was completed. E2 agreed establishment policy and state regulation should be followed.<br><br>On 3/18/26 at 1:54 PM, E1 (Executive Director) indicated, after the review of documentation for the investigation of R1's abuse allegation, E1 realized incidents were not reported to E1 to the frequency they happened. On 3/24/26, via email, E1 confirmed there were no other incident reports for R1's behaviors, other than for the 3/9/26 incident.<br><br>Establishment teaching content titled Abuse, Neglect, and Financial Exploitation (no date) showed: Why This Matters: Residents in assisted living and memory care depend on staff for safety, dignity, and quality of life. Many residents may have cognitive impairment, making them especially vulnerable. Every staff member is responsible for recognizing and reporting concerns. Types of Abuse: ...Sexual Abuse: Any non-consensual contact. Inappropriate touching or exposure ...<br><br>Establishment policy titled Abuse, Neglect and Financial Exploitation Prevention Policy and Procedures (Last Revised 04/2016): Residents of the facility have the right to be free of abuse, neglect and financial exploitation ...Reporting: It is mandatory for staff members to report suspected incidents of abuse, neglect, and financial exploitation. Staff members are required to immediately report suspect behaviors to their | A6010 | | |

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|---|---|---|---|---|
| A6010 | Continued From page 22<br>Department Manager. Documentation will be initiated by the Department Manager at the time of the initial report. The Department Manager will immediately inform Administrator ... | A6010 | | |