STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145625	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Terrace	2829 South California Blvd Chicago, IL 60608

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45110 Based on interviews, and record reviews the facility failed to ensure one of five sampled residents [R1] was free of sexual abuse and financial exploitation from an employee [V3]. This was identified as an Immediate Jeopardy which began on 05/31/22 when R1 made it known about his personal relationship with V3. On 06/24/22 at 9:42 am the administrator was notified of the immediate jeopardy. The facility presented a final removal plan on 06/24/2022 at 4:49PM. The facility's removal plan was accepted at 2:44 PM on 06/27/2022. The surveyor conducted additional interviews and record reviews on 06/28/2022 to verify the plan was implemented. The immediate jeopardy was removed on 06/24/2022 based on actions from the removal plan. Although the immediacy was removed, the deficiency remains at the second level of harm until the facility determine the effectiveness of the implementation of the removal plan. Finding include: R1 was admitted to the facility on [DATE] with medical diagnosis of: Complete traumatic amputation of two left lesser toes, Schizoaffective Disorder, Bipolar Type, Edema, Secondary Hypertension, Chronic Kidney Disease, Total Retinal Detachment, Gastro-Esophageal Reflux, Insomnia, Type II Diabetes, and Foot ulcer to left heel. R1's Minimum Date Set [MDS] dated 04/25/22, Section C-brief interview for mental status summary score is (15) indicates R1 is cognitively intact. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/07/22 at 10:45 AM, R1 stated, I called the complaint line because I was angry with V3 (Certified Nursing Assistant) for playing with my emotions, making me feel bad about being so nice. Then we made up and got back together. So then, I called the complaint line back and said all the information previously given was a lie. However, it was not a lie, everything I reported was the truth. After I called the IDPH compliant line to say it was a lie, a few days later V3 blocked me from calling her cell phone. I feel like V3 was only nice to me and wanted to get back together so I would not talk about our relationship. Since you are here, I'm going to be honest about everything, V3 and I had started a sexual relationship in March 2022. I paid V3's taxicab fees to and from work so many times I can't count since March 2022. V3 asked me for the taxi money and said they will pay me back on her paydays, which never happened. I also would order V3 food, sometimes when V3 was hungry working here at the facility. Also, sometimes V3 would ask me to order food, and have it delivered to her location. I would say I gave V3 at least $600 since March 2022, which included taxicab fees, food, and money. Here read our last text message excuse all the curse words, we were arguing. On 06/07/22 at 10:50 AM, Surveyor observed the text message from R1's cell phone. V3's text messages with R1 documents in part: R1 cursing at V3 for not responding to his call or text messages. R1 stating that V3 must have been out cheating on R1. V3 responded that she was not out cheating on R1. The messages went back and forth with cursing. On 06/07/22 at 12:11 PM, V3 [Certified Nurse Assistant] stated, I knew R1 from other facilities that I worked at in the past. On Mother's Day (May 8, 2022), R1 was sick with vomiting and diarrhea. R1 called my cell phone while I was working on the second floor (R1 does not reside on the second floor) , to come help him to clean up. I went up to R1's floor to help R1, while providing assistance R1 kept vomiting and it got all over my uniform. I went into R1's bathroom took off the scrubs, but I still had on my underwear, and started to clean myself up. V8 [Certified Nurse Assistant] busted into R1's room, without knocking on the door, then V8 saw me with my underwear on sitting on the bed next to R1. I was sitting on the bed, but R1 was laying down, and R1 was still not feeling well. I tried to explain what happened to V8, but V8 said V7 [Nurse Supervisor] was looking for me, then V8 left out the room. I went to V7, who told me to punch out and go home. I told V7 why, I had on my underwear, but V7 said I will have to talk to V2 [Director of Nursing] tomorrow. I was suspended from 05/8/22 to 5/19/22. V4 [Human Resource] called me to come into the facility. The next day 5/20/22, I met with V4 and explained everything to V4, the reason why I had on my underwear in R1's room. V4 said due to the situation, it was best for me to resign. So, I wrote my resignation on a sheet of paper and that was it. I received abuse training when I was hired. Some types of abuse are, physical, mental, verbal, sexual, and exploitation. R1 and I was not having any type of sex on 05/08/22. We are close friends and call/text each other all the time. R1 did pay for my taxi cabs often, to help me get back and forth to work. The taxicab service would only take cash, so R1 would give me cash to pay for my rides. There was times R1 would buy me food and have the food delivered to the job. R1 gave me approximately $300 over time for my taxicab rides and food. I did not ask R1 for the money or food, R1 offered to help me. Facility's Staff assignment sheet dated 05/08/22, documented V3 was scheduled to work 3PM-11PM on the first floor and 11PM-7AM on the second floor. V3's timecard dated 05/08/22 read; punch in at 2:56 PM and punched on at 12:28 AM. Reviewed R1's progress notes dated: 05/06/22, 05/07/22, 05/09/22, and 5/10/22, no documentation regarding the incident on 05/08/22, nor signs or symptoms of any diarrhea or emesis that R1 was experiencing. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/07/22 at 1:29 PM, V8 (Certified Nurse Assistant) stated, V7 [Nurse Supervisor] asked me to go check R1's room to see if R1 was in there. I went to R1's room and saw V3 siting on R1's bed, while R1 was laying in the bed. I told V3 that V7 wanted to talk with them. I told V7 what I saw. On 06/07/22 at 1:40 PM V7 (Nurse Supervisor) stated, V3 worked 3PM-11PM shift and picked up to 11PM-7AM on 05/08/22. Around 12:30 AM, the floor nurse notified me that V3 was not on the assigned floor. I asked V8 (Certified Nurse Assistant) to go look for V3. Little while later, V8 told me that V3 was sitting on R1's bed. I told V3 to punch out, go home and talk to administration in the morning. V3 nor V8 told me that V3 was in R1's room without clothes on. When I saw V3, her uniform was in place and clean. I sent V3 home because, she (V3) was not authorized to be off their assigned floor, and for sitting on a resident's bed. I called V2 (Director of Nursing) and V2 was made aware of the incident. I received abuse training a few times a year. Some types of abuse are sexual, physical, verbal, exploitation and financial. The abuse coordinator is the administrator. On 06/07/22 at 3:10 PM V2 (Director of Nursing) stated, I received a phone call on 05/08/22 around midnight. V7 told me that V8 was making rounds on the unit, and knocked on a door and entered, where V8 observed V3 laying in the bed sleeping. I do not know which room V3 was in, and I did not ask V7. It is not appropriate for staff to be sleep in a bed. If a staff member gets emesis, or bowel movements on their uniform, I expect the staff to get an extra uniform from administration or they will be allowed to go home to clean up and change their uniform. Staff should not accept any money, gifts, or food from residents, that would be considered abuse. I completed an investigation regarding V3 sleeping in a bed. I made mental notes in my mind, I do not have an investigation on paper, because I did not write anything down. I was not made aware of any sexual or financial abuse allegations regarding R1 and V3. I will start an investigation today. On 06/07/22 at 3:40 PM, V1 (Administrator) stated, I interviewed R1, R1 said he called the state, because V3 stop taking his phone calls. R1 did not tell anyone about the sexual encounters between R1 and V3. R1 also said he gave V3 money for food and taxicab services. That was all the questions I asked R1, I did not want to [NAME] R1 with questions today, I have 5 days to investigate. It was not appropriate for V3 to be in R1's room at midnight (since V3 was not assigned to R1), nor for V3 to accept money from R1 if the allegations are true. On 06/09/22 at 10:15 AM, R1 reported to surveyor, not to turn in the statement from 06/07/22, R1 stated, I spoke with V3 and do not want V3 to lose her children. V3 has a child in the system, and V3 is afraid that my statement can hurt the chances of getting her child back out of the system. I enjoyed having those sexual encounters, V3 did not make me do it. I gave V3 all that money, V3 did not ask me for the money. On 06/09/22 at 3:30 PM V6 (Director of Social Service) stated, I spoke with R1 on 06/07/22, to obtain a statement. R1 said, the sexual encounters were consensual and R1 was not violated, in fact R1 said they enjoyed it. R1 said on 05/08/22, V8 caught V3 lying in R1's bed, and they both R1 and V3 was naked. Also, that from March 2022, R1 gave V3 cash money to pay for V3 taxicab service to and from work, and purchased food through R1's cash app. On 06/21/22 surveyor returned to the facility and follow up interviews were obtained. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	0n 06/21/22 at 10:54 AM, V1 (Administrator) stated, After I was notified of the allegations on 06/07/22, I called V3 (CNA) a few times, but I could not make contact. I spoke to V7 between 06/07/22-06/08/22. V7 told me he [V7] sent V3 home because she was insubordinate being off her [V3] assigned floor and was sleeping in a resident's bed on the fourth floor. I did not ask V7 who's bed V3 was in. I should have asked, but I did not. I took a basic interview from R1 on 06/07/22. R1 said he was in a relationship with V3 and he [R1] was giving V3 cash for cab fees and sending money through a cash app to pay for food deliveries. R1 said he did engage in oral sex with V3 and did not report it because he[R1] enjoyed it. On 06/09/22 R1 told me that V3 stopped taking his[R1] phone calls and that is what made him mad and phoned the state. Later R1 said he realized V3 did not work here anymore in the facility and that he [R1] did not want to pursue with the complaint, because he does not want to get V3 in trouble. I do not have V7 or V8 written statements. After I was informed about the allegations of abuse, all staff abuse education training was completed. Along with the types of abuse, how, when and who to report abuse to. The policies regarding abuse and employee conduct are documented in the facility abuse policy, resident's rights, and the employee handbook. I believe the employee handbook talks about staff should not accept gifts or money for residents. The resident's rights policy talk about residents should not be sexually exploited. The abuse policy speaks to different types of abuse and what exploitation is. New employee orientation for V3 and for all new staff, receives abuse training first day of orientation and they receive the employee handbook the same day. In regard to R1's allegation final reportable sent, I believe the allegations was unsubstantiated, because R1 engaged in oral sex voluntary and R1 did not feel abused or exploited. R1 called in a complaint to the IDPH, in retaliation for V3 not returning his [R1] phone calls. On 06/21/22 at 11:05 AM, surveyor and V1 observed the final incident investigation report faxed into IDPH on 06/10/22 documents in part: Upon further investigation of this matter, staff reports that on 05/09/22 on 3rd shift (approximately 1am), V3 was observed unclothed and sitting on R1's bed. When asked why she [V3] was there [V3 was not assigned to this unit] V3 response was he [R1] called me and asked for help. V3 further stated that R1 vomited and pooped all over her [V3] and that is why she [V3] removed some of her clothing. V3 and R1 was informed that V3 should not be in R1's room, sitting on the bed and was asked to leave R1's room. The supervisor [V7] on duty asked V3 to punch out and go home. V1 stated, I got this information on the final reportable from V7 and V8 mixed together. I did not write down V7 or V8's statement. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/21/22 at 11:39 AM, V2[Director of Nursing] stated, On 05/08/22 after midnight I received a phone call from V7 [Nurse Supervisor] said that he sent V3[Certified Nurse Assistant] home due her missing off her assigned unit and she was found on the fourth floor in one of the resident's rooms. V7 said that V8 [Certified Nurse Assistant] informed him that she [V8] observed V3 in R1's room sitting on R1's bed. V7 sent V3 home because she [V3] was not supposed to be in R1's room and it was inappropriate conduct to be in a resident's room and sitting on R1's bed. I [V2] called V3 on 05/09/22 to meet regarding V3's behavior and proper adequate in a clinical setting and that it was not appropriate to sit on a resident's bed, but V3 did not show up for the meeting. V5[Nurse Scheduler] called V3 on 05/09/22 to meet with me, but V3 did not show up at 10:00 AM. I called V3 and she [V3] said she will come that Tuesday, but she never showed up on 05/10/22. I[V2] was out of the office a few days, upon my return I met with V3 on 05/20/22. V3 said, she [V3] was just assisting R1, but I [V2] explained to V3 it is not appropriate even with helping a resident to sit or use resident's belongings. At that time V3 felt I was making a big deal out of nothing and did not want to discuss the situation any further. V3 never acknowledged she [V3] was sitting on R1's bed, gave her [V3] resignation and left the facility. No investigation was done, I only spoke to the staff members, and nothing came from it. I was only informed V3 was sitting on R1's bed, no reportable was done on 05/08/22, because R1 did not allege abuse. V3 was sent home. When staff is disciplined, normally a write up is done with the reason the staff member was sent home, what the incident was about, and the results of the investigation. An employee discipline investigation is a collaboration between human resources and that employee's manager. On 05/08/22, I did not complete a write up on V3. She [V3] was sent home due to her behavior, being sent home and suspended is the same thing and it is pending investigation if a resident is alleging abuse. V3 was sent home and suspended on 05/08/22, and never returned to the facility to work. Anytime there is a discipline, an investigation and report will follow, and it placed in the staff member's personnel file. On 06/21/22 at 12:17 PM, V2 looked thru V3's personnel file for the discipline documentation from 05/08/22 and she could not find the discipline form in V3's personnel file. V2 stated, A discipline form for V3 is not in her[V3] personnel file. Usually V4[Human Resource] will complete the discipline form. I Spoke to R1 on 05/09/22 and made R1 aware it is inappropriate for staff to sit on his [R1] bed. R1 did not allege any abuse. I do not have any written statements from V7 or V8. On 06/21/22 at 12:42 PM V4 [Human Resource] stated, If an employee is disciplined or sent home, that employee's supervisor will let me know what happened. When an employee is suspended or disciplined, I get involved to make sure the union and the employee handbook guidelines are followed. Typically, the employee's supervisor investigates the situation and then the final investigation is forward to me, to make sure we are following the rules that are set forth. On Monday 05/09/22 or Tuesday 05/10/22, I was informed by V5 [Nurse Scheduler] that V3 was sent home for inappropriate behavior and was removed off the schedule. I did not get the specifics from V5 why V3 was sent home and removed off the schedule. V3 kept calling the facility trying to talk to V2 and staff would send the calls to me. I told V3 that V2 was unavailable. On 05/20/22, V3 came in and spoked with V2 regarding her[V3] being in a resident's room and I did not know which room V3 was in. V3 then spoke to me and kept saying she [V3] did nothing wrong. V3 was asking me did she have a job and kept looking at her[V3] cell phone, saying I got to go. V3 said I will just quit, and I told her [V3] to put it in writing. V3 wrote out her resignation letter. I never received any discipline documentation or write up from V3's supervisor [V2] for 05/08/22 discipline. The supervisor completes the discipline paperwork. Since V3 was set home, and removed from the schedule, a discipline form should have been completed by V2. Once V3 was taken off the schedule, there should have been a discipline written by V2 and V3 should have received a copy of the discipline for being taken off the schedule. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/21/22 at 1:22 PM V1 (Administrator) stated, Any staff member in a resident's room late at night, sitting on their bed is in appropriate behavior. Yes, we should have reported the incident, and should have investigated and sent a reportable to IDPH. I started working here at this facility on May 23, 2022. There was no administrator on site, the allegation was not clear it was abuse, the story changed and evolved along the way. I was not the administrator 05/8/22, I started to work here on 05/23/22. V11 [Previous Administrator] last day of work was 04/26/22, when V11 left the facility, it was a gap in between. On 06/22/22 at 9:31 AM V7 [Nurse Supervisor] stated, On 05/08/22 around midnight the second-floor nurse called me and said that V3 was missing since the start of the shift at 11PM. I called up the fourth floor and V8 [Certified Nurse Assistant] answered the phone. I asked V8 to go to R1's room and check to see if V3 [Certified Nurse assistant] was in R1's room. I asked V8 to check R1's room because, when V3 is missing off her assignment, she [V3] has the tendency to be in R1's room. Sometime in April 2022, I found V3 in R1's room several times. V3 would be standing in R1's room talking with R1 with the door open. Sometimes when I found V3 in R1's room, V3 and R1 stated he[R1] was ordering food delivery for V3. Other times V3 said she would be in R1's room eating, taking her[V3] lunch break. Each time I would explain to V3 it was not appropriate for her to be in R1's room. That she [V3] needs to be on her assigned floor taking care of those residents. R1's room was not the employees break room, and she [V3] was not allowed to be in R1's for any reason. I did not report the incidents to anyone, because I did not see a reason to report anything, V3 was just visiting with R1. A little while later, V8 called me and said, she [V8] found V3 in R1's room with the door closed and V3 was sitting on R1's bed, while R1 was lying on the bed. V8 said she told V3 to come see me[V7]. V3 told me[V7] that she was in R1's room taking a lunch break eating her food. I explained to V3 that I told her [V3] before not to be in R1's room for any reason. Also, I told V3 she had been missing since 11PM over an hour and her [V3] lunch break is only for 30 minutes. It is not appropriate to be in R1's room taking your lunch break. Then I called V8 down, to repeat what she saw. V8 stated, she found V3 in R1's room with the door closed and V3 was sitting on R1's bed, while R1 was lying on the bed. I asked V8 was V3 eating, and V8 said no, V3 was not eating. V8 went back to her assignment. I told V3 to punch out and leave the facility. Because I have warned her several times in the past to stay out of R1's room, not to leave her[V3] assignment, and it was inappropriate for her[V3] to be sitting on R1's bed. I also told V3 I was going to report the incident to V2, and to follow up with V2 tomorrow. I did not ask V3 if she had on clothes, because I had no reason to think V3 was naked. V3 uniform was clean, and dry. I immediately called V2 and made her aware of the incident. V2 did not asked me to write a statement. A couple of weeks later in May the new administrator, V1 asked me what happened on 05/08/22. I told V1 everything, that happened with V3 and R1. V1 did not ask me to write a statement or sign a statement. I did not hear anything else about 05/08/22 incident with V3 and R1, until you (surveyor) came into the facility 06/07/22. On 06/22/22 at 10:17 AM, During a telephone conversation requesting abuse training information for V7, V1 stated, I told you yesterday that V8 [Certified Nurse Assistant] and V7 [Nurse Supervisor] gave me the information documented on the final investigation report dated 06/10/22 faxed in to IDPH. Documents in part that: [Upon further investigation of this matter, staff reports that on 05/09/22 on 3rd shift approximately 1am, V3 was observed unclothed and sitting on R1's bed. When asked why she was there, she was not assigned to this unit, V3 response was R1 called me and asked for help. She [V3] further stated that he vomited and pooped all over her and this is why she removed some of her clothing]. [V1] stated, I was confused with another reportable, V8 did not tell me any of that information. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/22/22 at 10:29 AM V8 [Certified Nurse Assistant] stated, V7 called the nursing station [fourth floor] and asked me to let him [V7] know if I see V3 on the floor and to send her [V3] to see me[V7]. During making rounds, I knocked on R1's door and entered, the main light was off just the night light was on. I saw V3 sitting on R1's bed fully clothed and looked very surprised, while R1 was lying down on the bed covered up. I told V3 that V7 was looking for her [V3] and to go see V7. I went back to the nursing station and called V7, made him [V7] aware that I found V3 in R1's room with the door closed, the main light was off and V3 was sitting on R1's bed, while R1 was lying in the bed. Around 15 minutes later V7 called the nursing station and asked me to come down to speak to him [V7]. I entered the room and V3 and V7 was present. V7 asked me to repeat what I witnessed in R1's room. I said, during making rounds, I knocked on R1's door and entered, the main light was off. I saw V3 sitting on R1's bed fully clothed and looked very surprised, while R1 was lying in the bed covered up. V7 asked me was V3 eating, I said no, V3 was not eating. At that time V7 told me I can go back to my floor. I received abuse training when I was hired 06/2021. Some types of abuse are physical, and sexual. I'm not sure who the abuse coordinator is. If I witness abuse I would report it to my nurse, then maybe the nurse would tell me what to do. R1's Social Service Progress note documents in part 06/07/22 at 16:11(4:11PM): Writer asked R1 has they ever had any relationships with V3 at this facility, R1 stated yes. Writer asked resident has they ever been involved in a sexual relationship with V3, resident stated yes. Writer asked R1 what their sexual relationship was, R1 stated oral sex, I was going down on V3. Writer asked R1 if the relationship with V3 was consensual, R1 stated yes. Writer asked R1 if they felt violated, R1 stated hell no, I did that because I wanted to do. R1 reported that this sexual relationship with R1 and V3 started in March. R1 could not confirm date. R1 reported buying V3 food when V3 needed on cash app card. R1 also reported spending cash money in the amount of approximately $400 in cab service money. Writer asked R1 if they told any other than today, R1 stated no, why would I tell anyone anything. Writer asked R1 if they think they resides a safe environment, R1 stated yes. R1 stated Honestly, I'm going to be honest with you, I called state because V3 blocked my number from V3 phone, and I was mad. R1 admitted to calling IDPH to get back at V3. Writer asked R1 if they wanted to call police, R1 stated no. R1 did not have any additional issues, questions or concerns. Writer provided R1 with emotional support. Writer encouraged R1 to seek staff assistance when needed. Writer encouraged R1 to attend psychosocial groups. Staff to continue to monitor resident accordingly. R1's (06/07/22 at 17:18 (5:18PM) Social Service note documents: Writer met with R1 to discuss interview and to obtain signature for statement that they provided. R1 refused to sign paper as evidenced by saying yeah I called state but I'm not going to sign that because I don't want to incriminate V3 or get V3 in trouble, I just called to get back at V3. I lied about everything, everything I said is a lie now because I don't want to get V3 or their kids in trouble. Writer provided R1 with emotional support. Writer asked R1 was they forced to say this allegation was a lie R1 frowned and said NO I just don't want to get V3 in trouble, nobody is forcing me to do anything. Writer ensured R1 that they reside in a safe environment. Writer to continue to follow-up accordingly. Facility's Abuse Prevention Program Policy(undated) documents in part: -Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. -Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats or coercion. (continued on next page)

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	145625	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Terrace	2829 South California Blvd Chicago, IL 60608

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility's Employee Handbook dated (04/2018) documents in part: page 12 Titled: Rules of Conduct and Other Expectation: All employees have an ethical and professional responsibility to support and promote the highest standards of conduct. It is the policy of the facility to comply with all applicable federal, state, local laws and regulations. Every employee will voluntarily assume the obligations of self -discipline, honor, and integrity as set forth by the facility. We will not accept conduct, which limits, restricts or interferes with our ability to respond to the needs of our facility, residents or vendors. The facility has a zero-tolerance policy for abuse and neglect. It is imperative that every employee commit to maintaining the dignity of each resident at all times. -The facility shall take all appropriate actions to ensure that the responsibility of that employee do not affect the quality of care rendered to any patient or resident, or the accuracy of any claims submitted to any Federal or State health care program. Page 13- As part of the compliance and Integrity Commitment, employees must be aware that the acceptance of gifts is strictly prohibited. There are times when residents, resident family members or vendors want to show appreciation by giving gifts or money. It is strictly prohibited to accept any gifts from any resident, resident family member, or vendor. If a resident or family member is insistent on giving a gift, please refer them to the administrator or department head. The surveyor confirmed on 06/28/22 through observation, interview, record review, that the facility took the following actions to remove the Immediate Jeopardy: The facility implemented all measures on the removal plan. [1] R1 received wellness checks daily from 06/24/22 thru 06/27/22 by Social Services. Order dated 06/24/22 Starting on 06/28/22 and the wellness checks will be completed weekly. R1 received abuse training. -R1 was notified that all staff are being educated on all types of abuse and are to avoid engaging with residents on any type of personal level. Completed 06/24/22 -R1 understands that he is to report immediately to Administrator or supervisor on duty if he ever feels abused, neglected or otherwise violated. Completed 06/24/22 -R1 agreed to refrain from offering staff members gifts, money or tokens of appreciation. Completed 06/24/22 -R1 understands that he is not to engage in any type of sexual relations with staff. Completed 06/24/22c -R1 received an order from primary physician to see Psych Services for counseling services. Completed 06/24/22 [2] V3 is no longer works in the facility. Last day of work was 05/08/22. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[3] Facility RN's, LPN's, Nursing Managers, Housekeeping staff, Laundry staff, Dietary staff, Social Service staff, Reception staff, and Human Resource staff were educated on Abuse reporting, investigating and prohibition. (Discuss the guidelines and the measures the facility takes to prevent the staff from developing an inappropriate sexual relationship with any resident. Included will be misappropriation. Types of Abuse (Financial, Sexual, Mental, Verbal, Physical, Misappropriation of funds or property and Involuntary seclusion). Additional Staff education including Abuse Fact Sheet and Abuse, Neglect and Exploitation Quiz to be completed by all staff. Staff will not be allowed to work unless they complete the education. This staff education has been initiated as of 6/24/2022 and will continue until all staff receive the education. [4] The facility has a zero-tolerance policy on any form of abuse and once identified staff member will be immediately suspended pending investigation. If found to be substantiated, staff member would be terminated. Completed 06/24/22 [5] Resident interviews will be conducted by department managers to ensure that no other resident has been affected by the same deficient practice. Initiated as of 6/24/2022 - Residents who are unable to be interviewed (vulnerable) will have a Potential for Abuse and Neglect Assessment completed and care planned accordingly. Initiated as of 6/24/2022 [6] The administrator will monitor continued compliance via the following Quality Improvement Programs: - Quality Assurance Tool- Abuse, Neglect and Injury of Unknown Origin Investigation, Reporting and Documentation -Type of Abuse Physical Mental Verbal Sexual (Prevent any staff from developing an inappropriate relationship with any resident). Financial/Theft Neglect Injury of unknown Origin Involuntary Seclusion (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Abuse Officer (Administrator or designee) immediately made aware of the allegation and an investigation initiated immediately. Y/N - Date when the Initial Report faxed to IDPH. Provide a copy of the transmission report in the QA Binder. - 3-day wellness checks post incident done and documented in the medical record. (Social Services Department) Y/N- Indicate immediate actions taken to keep the resident(s) safe. - Abuse Assessment completed, and Care Plan updated. (Social Services Department) Y/N - Date when the Final Report faxed to IDPH. (Within 5 days) Provide a copy of the transmission report in the QA Binder.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45110 Based on interviews and record reviews, the facility failed to follow their Abuse Prevention Program Policy to report an allegation of abuse to IDPH (Illinois Department of Public Health) for 1 [R1] of 5 residents reviewed for abuse. Findings include: R1 was admitted on [DATE] with medical diagnosis of: Complete traumatic amputation of two left lesser toes, Schizoaffective Disorder, Bipolar Type, Edema, Secondary Hypertension, Chronic Kidney Disease, Total Retinal Detachment, Gastro-Esophageal Reflux, Insomnia, Type II Diabetes, and Foot ulcer to left heel. R1's Minimum Date Set [MDS]dated 04/25/22, Section C-brief interview for mental status summary score is (15) indicates R1 is cognitively intact. On 06/07/22 at 10:45 AM, R1 stated, I called the complaint line because I was angry with V3 (Certified Nursing Assistant) for playing with my emotions, making me feel bad about being so nice. Then we made up and got back together. So then, I called the complaint line back and said all the information previously given was a lie. However, it was not a lie, everything I reported was the truth. After I called the IDPH compliant line to say it was a lie, a few days later V3 blocked me from calling her cell phone. I feel like V3 was only nice to me and wanted to get back together so I would not talk about our relationship. Since you are here, I'm going to be honest about everything, V3 and I had started a sexual relationship in March 2022. I paid V3's taxicab fees to and from work so many times I can't count since March 2022. V3 ask me for the taxi money and said they will pay me back on her paydays, which never happened. I also would order V3 food, sometimes when V3 was hungry working here at the facility. Also, sometimes V3 would ask me to order food, and have it delivered to her location. I would say I gave V3 at least $600 since March 2022, which included taxicab fees, food, and money. Here read our last text message excuse all the curse words, we were arguing. On 06/07/22 at 10:50 AM, Surveyor observed the text message from R1's cell phone. V3's text messages with R1 documents in part: R1 cursing at V3 for not responding to his call or text messages. R1 stating that V3 must have been out cheating on R1. V3 responded that she was not out cheating on R1. The messages went back and forth with cursing. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/07/22 at 12:11 PM, V3 [Certified Nurse Assistant] stated, I knew R1 from other facilities that I worked at in the past. On Mother's Day (May 8, 2022), R1 was sick with vomiting and diarrhea. R1 called my cell phone while I was working on the second floor (R1 does not reside on the second floor) , to come help him to clean up. I went up to R1's floor to help R1, while providing assistance R1 kept vomiting and it got all over my uniform. I went into R1's bathroom took off the scrubs, but I still had on my underwear, and started to clean myself up. V8 [Certified Nurse Assistant] busted into R1's room, without knocking on the door, then V8 saw me with my underwear on sitting on the bed next to R1. I was sitting on the bed, but R1 was laying down, and R1 was still not feeling well. I tried to explain what happened to V8, but V8 said V7 [Nurse Supervisor] was looking for me, then V8 left out the room. I went to V7, who told me to punch out and go home. I told V7 why, I had on my underwear, but V7 said I will have to talk to V2 [Director of Nursing] tomorrow. I was suspended from 05/8/22 to 5/19/22. V4 [Human Resource] called me to come into the facility. The next day 5/20/22, I met with V4 and explained everything to V4, the reason why I had on my underwear in R1's room. V4 said due to the situation, it was best for me to resign. So, I wrote my resignation on a sheet of paper and that was it. I received abuse training when I was hired. Some types of abuse are, physical, mental, verbal, sexual, and exploitation. R1 and I was not having any type of sex on 05/08/22. We are close friends and call/text each other all the time. R1 did pay for my taxi cabs often, to help me get back and forth to work. The taxicab service would only take cash, so R1 would give me cash to pay for my rides. There was times R1 would buy me food and have the food delivered to the job. R1 gave me approximately $300 over time for my taxicab rides and food. I did not ask R1 for the money or food, R1 offered to help me. Staff assignment sheet dated 05/08/22, read V3 was scheduled to work 3PM-11PM on the first floor and 11PM-7AM on the second floor. V3's timecard dated 05/08/22 read; punch in at 2:56 PM and punched on at 12:28 AM. Reviewed R1's progress notes dated: 05/06/22, 05/07/22, 05/09/22, and 5/10/22, no documentation regarding the incident on 05/08/22, nor signs or symptoms of any diarrhea or emesis that R1 was experiencing. On 06/07/22 at 1:29 PM, V8 (Certified Nurse Assistant) stated, V7 [Nurse Supervisor] asked me to go check R1's room to see if R1 was in there. I went to R1's room and saw V3 siting on R1's bed, while R1 was laying in the bed. I told V3 that V7 wanted to talk with them. I told V7 what I saw. On 06/07/22 at 1:40 PM V7 (Nurse Supervisor) stated, V3 worked 3PM-11PM shift and picked up to 11PM-7AM on 05/08/22. Around 12:30 AM, the floor nurse notified me that V3 was not on the assigned floor. I asked V8 (Certified Nurse Assistant) to go look for V3. Little while later, V8 told me that V3 was sitting on R1's bed. I told V3 to punch out, go home and talk to administration in the morning. V3 nor V8 told me that V3 was in R1's room without clothes on. When I saw V3, her uniform was in place and clean. I sent V3 home because, she (V3) was not authorized to be off their assigned floor, and for sitting on a resident's bed. I called V2 (Director of Nursing) and V2 was made aware of the incident. I received abuse training a few times a year. Some types of abuse are sexual, physical, verbal, exploitation and financial. The abuse coordinator is the administrator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/07/22 at 3:10 PM V2 [Director of Nursing] stated, I received a phone call on 05/08/22 around midnight. V7 told me that V8 was making rounds on the unit, and knocked on a door and entered, where V8 observed V3 laying in the bed sleeping. I do not know which room V3 was in, and I did not ask V7. It is not appropriate for staff to be sleep in a bed. If a staff member gets emesis, or bowel movements on their uniform, I expect the staff to get an extra uniform from administration or allowed to go home to clean up and change their uniform. Staff should not accept any money, gifts, or food from residents, that would be considered abuse. I completed an investigation regarding V3 sleeping in a bed. I made mental notes in my mind, I do not have an investigation on paper, because I did not write anything down. I was not made aware of any sexual or financial abuse allegations regarding R1 and V3. I will start an investigation today. On 06/21/22 at 1:22 PM V1 stated, Any staff member in a resident's room late at night, sitting on their bed is in appropriate behavior. Yes, we should have reported the incident, and should have investigated and sent a reportable sent to IDPH [Illinois Department of Public Health]. I started working here at this facility on May 23, 2022. There was no administrator on site, the allegation was not clear it was abuse, the story changed and evolved along the way. I was not the administrator 05/8/22, I started to work her on 05/23/22. V11 [Previous Administrator] last day of work was 04/26/22, when V11 left the facility, it was a gap between. On 06/22/22 at 9:31 AM V7 [Nurse Supervisor] stated, On 05/08/22 around midnight the second-floor nurse call me and said that V3 was missing since the start of the shift at 11PM. I called up the fourth floor and V8 [Certified Nurse Assistant] answered the phone. I asked V8 to go to R1's room and check to see if V3 [Certified Nurse assistant] was in R1's room. I asked V8 to check R1's room because, when V3 is missing off her assignment, she [V3] has the tendency to be in R1's room. Sometime in April 2022, I found V3 in R1's room several times. V3 would be standing in R1's room talking with R1 with the door open. Sometimes when I found V3 in R1's room, V3 and R1 stated he[R1] was ordering food delivery for V3. Other times V3 said she would be in R1's room eating, taking her[V3] lunch break. Each time I would explain to V3 it was not appropriate for her to be in R1's room. That she [V3] needs to be on her assignment taking care of those residents. R1's room was not the employees break room, and she [V3] was not allowed to be in R1's for any reason. I did not report the incidents to anyone, because I did not see a reason to report anything, V3 was just visiting with R1. A little while later, V8 called me and said, she [V8] found V3 in R1's room with the door closed and V3 was sitting on R1's bed, while R1 was lying on the bed. V8 said she told V3 to come see me[V7]. V3 told me[V7] that she was in R1's room taking a lunch break eating her food. I explained to V3 that I told her [V3] before not to be in R1's room for any reason. Also, I told V3 she had been missing since 11PM over an hour and her [V3] lunch break is only for 30 minutes. It is not appropriate to be in R1's room taking your lunch break. Then I called V8 down, to repeat what she saw. V8 stated, she found V3 in R1's room with the door closed and V3 was sitting on R1's bed, while R1 was lying on the bed. I asked V8 was V3 eating, and V8 said no, V3 was not eating. V8 went back to her assignment. I told V3 to punch out and leave the facility. Because I have warned her several times in the past to stay out of R1's room, not to leave her[V3] assignment, and it was inappropriate for her[V3] to be sitting on R1's bed. I also told V3 I was going to report the incident to V2, and to follow up with V2 tomorrow. I did not ask V3 if she had on clothes, because I had no reason to think V3 was naked. V3 uniform was clean, and dry. I immediately called V2 and made her aware of the incident. V2 did not asked me to write a statement. A couple of weeks later in May the new administrator, V1 asked me what happened on 05/08/22. I told V1 everything, that happened with V3 and R1. V1 did not ask me to write a statement or sign a statement. I did not hear anything else about 05/08/22 incident with V3 and R1, until you came into the facility 06/07/22. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/22/22 at 10:29 AM V8 [Certified Nurse Assistant] stated, V7 called the nursing station [fourth floor] and asked me to let him [V7] know if I see V3 on the floor and to send her [V3] to see me[V7]. During making rounds, I knocked on R1's door and entered, the main light was off just the night light was on. I saw V3 sitting on R1's bed fully clothed and looked very surprised, while R1 was lying down on the bed covered up. I told V3 that V7 was looking for her [V3] and to go see V7. I went back to the nursing station and called V7, made him [V7] aware that I found V3 in R1's room with the door closed, the main light was off and V3 was sitting on R1's bed, while R1 was lying in the bed. Around 15 minutes later V7 called the nursing station and asked me to come down to speak to him [V7]. I entered the room and V3 and V7 was present. V7 asked me to repeat what I witnessed in R1's room. I said, during making rounds, I knocked on R1's door and entered, the main light was off. I saw V3 sitting on R1's bed fully clothed and looked very surprised, while R1 was lying in the bed covered up. V7 asked me was V3 eating, I said no, V3 was not eating. At that time V7 told me I can go back to my floor. I received abuse training when I was hired 06/2021. Some types of abuse are physical, and sexual. I'm not sure who the abuse coordinator is. If I witness abuse I would report it to my nurse, then maybe the nurse would tell me what to do. Policy: Documents in part: Abuse Prevention Program Policy(undated) -When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has been made, the administrator, or designee shall notify the Department of Public Health regional office immediately by telephone or fax. -Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. -Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriating of resident property they observe red, hear about, or suspect to the administrator immediately or the designated person.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45110 Based on interviews, and record reviews the facility failed to document and investigate inappropriate staff behavior. This affected 1 [R1] of 5 residents reviewed for inappropriate staff behavior and abuse. Findings include: On 06/07/22 at 10:45 AM, R1 stated, I called the complaint line because I was angry with V3 (Certified Nursing Assistant) for playing with my emotions, making me feel bad about being so nice. Then we made up and got back together. So then, I called the complaint line back and said all the information previously given was a lie. However, it was not a lie, everything I reported was the truth. After I called the IDPH compliant line to say it was a lie, a few days later V3 blocked me from calling her cell phone. I feel like V3 was only nice to me and wanted to get back together so I would not talk about our relationship. Since you are here, I'm going to be honest about everything, V3 and I had started a sexual relationship in March 2022. I paid V3's taxicab fees to and from work so many times I can't count since March 2022. V3 ask me for the taxi money and said they will pay me back on her paydays, which never happened. I also would order V3 food, sometimes when V3 was hungry working here at the facility. Also, sometimes V3 would ask me to order food, and have it delivered to her location. I would say I gave V3 at least $600 since March 2022, which included taxicab fees, food, and money. Here read our last text message excuse all the curse words, we were arguing. On 06/07/22 at 10:50 AM, Surveyor observed the text message from R1's cell phone. V3's text messages with R1 documents in part: R1 cursing at V3 for not responding to his call or text messages. R1 stating that V3 must have been out cheating on R1. V3 responded that she was not out cheating on R1. The messages went back and forth with cursing. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/07/22 at 12:11 PM, V3 [Certified Nurse Assistant] stated, I knew R1 from other facilities that I worked at in the past. On Mother's Day (May 8, 2022), R1 was sick with vomiting and diarrhea. R1 called my cell phone while I was working on the second floor (R1 does not reside on the second floor), to come help him to clean up. I went up to R1's floor to help R1, while providing assistance R1 kept vomiting and it got all over my uniform. I went into R1's bathroom took off the scrubs, but still had on my underwear, and started to clean myself up. V8 [Certified Nurse Assistant] busted into R1's room, without knocking on the door, then V8 saw me with my underwear on sitting on the bed next to R1. I was sitting on the bed, but R1 was laying down, and R1 was still not feeling well. I tried to explain what happened to V8, but V8 said V7 [Nurse Supervisor] was looking for me, then V8 left out the room. I went to V7, who told me to punch out and go home. I told V7 why I only had on my underwear, but V7 said I will have to talk to V2 [Director of Nursing] tomorrow. I was suspended from 05/8/22 to 5/19/22. V4 [Human Resource] called me to come into the facility. The next day 5/20/22, I met with V4 and explained everything to V4, the reason why I had on my underwear in R1's room. V4 said due to the situation, it was best for me to resign. So, I wrote my resignation on a sheet of paper and that was it. R1 and I was not having any type of sex on 05/8/22. We are close friends and call/text each other all the time. R1 did pay for my taxi cabs often, to help me get back and forth to work. The taxicab service would only take cash, so R1 would give me cash to pay for my rides. There was times R1 would buy me food and have the food delivered to the job. R1 gave me approximately $300 over time for my taxicab rides and food. I did not ask R1 for the money or food, R1 offered to help me. On 06/07/22 at 1:29 PM, V8 (Certified Nurse Assistant) stated, V7 [Nurse Supervisor] asked me to go check R1's room to see if R1 was in there. I went to R1's room and saw V3 siting on R1's bed, while R1 was laying in the bed. I told V3 that V7 wanted to talk with them. I told V7 what I saw. On 06/07/22 at 1:40 PM, V7 [Nurse Supervisor] stated, V3 worked 3PM-11PM shift and picked up to 11PM-7AM on 05/08/22. Around 12:30 AM, the floor nurse notified me that V3 was not on the assigned floor (second floor). I asked V8 [Certified Nurse Assistant] to go look for V3. Little while later, V8 told me that V3 was sitting on R1's bed. I told V3 to punch out, go home and talk to administration in the morning. V3 nor V8 told me that V3 was in R1's room without clothes on. When I saw V3, her uniform was in place and clean. I sent V3 home because, staff is not authorized to be off their assigned floor, and for sitting on a resident's bed. I called V2 [Director of Nursing] and V2 was made aware of the incident. On 06/07/22 at 3:10 PM V2 [Director of Nursing] stated, I received a phone call on 05/08/22 around midnight. V7 told me that V8 was making rounds on the unit, and knocked on a door and entered, where V8 observed V3 laying in the bed sleeping. I do not know which room V3 was in, and I did not ask V7. It is not appropriate for staff to be sleep in a bed. If a staff member gets emesis, or bowel movements on their uniform, I expect the staff to get an extra uniform from administration or allowed to go home to clean up and change their uniform. Staff should not accept any money, gifts, or food from residents, that would be considered abuse. I completed an investigation regarding V3 sleeping in a bed. I made mental notes in my mind, I do not have an investigation on paper, because I did not write anything down. I was not made aware of any sexual or financial abuse allegations regarding R1 and V3. I will start an investigation today. (continued on next page)

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	145625	A. Building B. Wing	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Terrace	2829 South California Blvd Chicago, IL 60608

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/09/22 at 3:30 PM V6 [Director of Social Service] stated, I spoke with R1 to obtain a statement. R1 said, the sexual encounters were consensual and R1 was not violated, in fact R1 said they enjoyed it. R1 said on 05/08/22, V8 caught V3 lying in R1's bed, and they both R1 and V3 was naked. Also, that from March 2022, R1 gave V3 cash money to pay for V3 taxicab service to and from work, and purchased food through R1's cash app. On 06/07/22 at 3:40 PM, V1 [Administrator] stated, I interviewed R1, R1 said he called the state, because V3 stop taking his phone calls. R1 did not tell anyone about the sexual encounters between R1 and V3. R1 also said they gave V3 money for food and taxicab services. That was all the questions I asked R1, I did not want to [NAME] R1 with questions today, I have 5 days to investigate. It was not appropriate for V3 to be in R1's room at midnight (since V3 was not assigned to R1), nor for V3 to accept money from R1 if the allegations are true. On 06/09/22 at 10:15 AM, R1 reported to surveyor, not to turn in the statement from 06/07/22, R1 stated, I spoke with V3 and do not want V3 to lose her children. V3 has a child in the system, and V3 is afraid that my statement can hurt the chances of getting her child back out of the system. I enjoyed having those sexual encounters, V3 did not make me do it. I gave V3 all that money, V3 did not ask me for the money. On 06/21/22 at 10:54 AM, V1 [Administrator] stated, After I was notified of the allegations on 06/07/22, I called V3 a few times, but I could not make contact. I spoke to V7 between 06/07/22-06/08/22. V7 told me he [V7] sent V3 home because she was insubordinate being off her [V3] assigned floor and was sleeping in a resident's bed on the fourth floor. I did not ask V7 who's bed V3 was in. I should have asked, but I did not. I took a basic interview from R1 on 06/07/22. R1 said he was in a relationship with V3 and he [R1] was giving V3 cash for cab fees and sending money through a cash app to pay for food deliveries. R1 said he did engage in oral sex with V3 and did not report it because he[R1] enjoyed it. On 06/09/22 R1 told me that V3 stopped taking his[R1] phone calls and that is what made him mad and phoned the state. Later R1 said he realized V3 did not work here anymore in the facility and that he [R1] did not want to pursue with the complaint, because he does not want to get V3 in trouble. I do not have V7 or V8 written statements. After I was informed about the allegations of abuse, all staff abuse education training was completed. Along with the types of abuse, how, when and who to report abuse to. The policies regarding abuse and employee conduct are documented in the facility abuse policy, resident's rights, and the employee handbook. I believe the employee handbook talks about staff should not accept gifts or money for residents. The resident's rights policy talk about residents should not be sexually exploited. The abuse policy speaks to different types of abuse and what exploitation is. New employee orientation for V3 and for all new staff, receives abuse training first day of orientation and they receive the employee handbook the same day. In regard to R1's allegation final reportable sent, I believe the allegations was unsubstantiated, because R1 engaged in oral sex voluntary and R1 did not feel abused or exploited. R1 called in a complaint to the IDPH, in retaliation for V3 not returning his [R1] phone calls. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/21/22 at 12:42 PM V4 [Human Resource] stated, If an employee is disciplined or sent home, that employee's supervisor will let me know what happened. When an employee is suspended or disciplined, I get involved to make sure the union and the employee handbook guidelines are followed. Typically, the employee supervisor investigates the situation and then the final investigation is forward to me, to make sure we are following the rules that are set forth. I never received any discipline documentation or write up from V3's supervisor [V2] for 05/08/22 discipline. The supervisor completes the discipline paperwork. Since V3 was set home, and removed from the schedule, a discipline form should have been completed by V2. Once V3 was taken off the schedule, there should have been a discipline written by V2 and V3 should have received a copy of the discipline for being taken off the schedule. On 06/21/22 at 1:22 PM V1 stated, Any staff member in a resident's room late at night, sitting on their bed is in appropriate behavior. Yes, we should have reported the incident, and should have investigated and sent a reportable sent to IDPH. I started working here at this facility on May 23, 2022. There was no administrator on site, the allegation was not clear it was abuse, the story changed and evolved along the way. I was not the administrator 05/8/22, I started to work her on 05/23/22. V11 [Previous Administrator] last day of work was 04/26/22, when V11 left the facility, it was a gap between. On 06/22/22 at 10:29 AM V8 [Certified Nurse Assistant] stated, V7 called the nursing station [fourth floor] and asked me to let him [V7] know if I see V3 on the floor and to send her [V3] to see me[V7]. During making rounds, I knocked on R1's door and entered, the main light was off just the night light was on. I saw V3 sitting on R1's bed fully clothed and looked very surprised, while R1 was lying down on the bed covered up. I told V3 that V7 was looking for her [V3] and to go see V7. I went back to the nursing station and called V7, made him [V7] aware that I found V3 in R1's room with the door closed, the main light was off and V3 was sitting on R1's bed, while R1 was lying in the bed. Around 15 minutes later V7 called the nursing station and asked me to come down to speak to him [V7]. I entered the room and V3 and V7 was present. V7 asked me to repeat what I witnessed in R1's room. I said, during making rounds, I knocked on R1's door and entered, the main light was off. I saw V3 sitting on R1's bed fully clothed and looked very surprised, while R1 was lying in the bed covered up. V7 asked me was V3 eating, I said no, V3 was not eating. At that time V7 told me I can go back to my floor. I received abuse training when I was hired 06/2021. Some types of abuse are physical, and sexual. I'm not sure who the abuse coordinator is. If I witness abuse I would report it to my nurse, then maybe the nurse would tell me what to do. Reviewed R1's Face Sheet reads; admitted on [DATE], Physician order sheets, Care plans, medication administration record, Minimum Date Set [MDS] Section C -Brief Interview for mental status summary score = 15 indicates R1 is cognitively intact. R1's Face Sheet reads; admitted on [DATE]. Physician order sheets, Care plans, medication administration record, Minimum Date Set [MDS] Section C -Brief Interview for mental status summary score = 15 indicates R1 is cognitively intact. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical diagnosis: Complete traumatic amputation of two left lesser toes, Schizoaffective Disorder, Bipolar Type, Edema, Secondary Hypertension, Chronic Kidney Disease, Total Retinal Detachment, Gastro-Esophageal Reflux, Insomnia, Type II Diabetes, Foot ulcer to left heel. Reviewed R1's progress notes dated: 05/06/22, 05/07/22, 05/09/22, and 5/10/22, no documentation regarding the incident on 05/08/22, nor signs or symptoms of any diarrhea or emesis that R1 was experiencing. Staff assignment sheet dated 05/08/22, read V3 was scheduled to work 3PM-11PM on the first floor and 11PM-7AM on the second floor. V3's timecard dated 05/08/22 read; punch in at 2:56 PM and punched on at 12:28 AM. On 06/07/22 at 16:11 R1's Social Service Note-Documents in part: Writer asked R1 has they ever had any relationships with V3 at this facility, R1 stated yes. Writer asked resident has they ever been involved in a sexual relationship with V3, resident stated yes. Writer asked R1 what their sexual relationship was, R1 stated oral sex, I was going down on V3. Writer asked R1 if the relationship with V3 was consensual, R1 stated yes. Writer asked R1 if they felt violated, R1 stated hell no, I did that because I wanted to do. R1 reported that this sexual relationship with R1 and V3 started in March. R1 could not confirm date. R1 reported buying V3 food when V3 needed on cash app card. R1 also reported spending cash money in the amount of approximately $400 in cab service money. Writer asked R1 if they told any other than today, R1 stated no, why would I tell anyone anything. Writer asked R1 if they think they resides a safe environment, R1 stated yes. R1 stated Honestly, I'm going to be honest with you, I called state because V3 blocked my number from V3 phone, and I was mad. R1 admitted to calling IDPH to get back at V3. Writer asked R1 if they wanted to call police, R1 stated no. R1 did not have any additional issues, questions or concerns. Writer provided R1 with emotional support. Writer encouraged R1 to seek staff assistance when needed. Writer encouraged R1 to attend psychosocial groups. Staff to continue to monitor resident accordingly. ON 06/07/22 at 17:18 R1's Social Service note: Writer met with R1 to discuss interview and to obtain signature for statement that they provided. R1 refused to sign paper as evidenced by saying yeah I called state but I'm not going to sign that because I don't want to incriminate V3 or get V3 in trouble, I just called to get back at V3. I lied about everything, everything I said is a lie now because I don't want to get V3 or their kids in trouble. Writer provided R1 with emotional support. Writer asked R1 was they forced to say this allegation was a lie R1 frowned and said NO I just don't want to get V3 in trouble, nobody is forcing me to do anything. Writer ensured R1 that they reside in a safe environment. Writer to continue to follow-up accordingly. Policy: Documents in part: Abuse Prevention Program Policy(undated) -Reports will be documented, and a record kept of the documentation. Supervisor shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property. Upon learning of the report, the administrator or a designee shall initiate an incident investigation (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility shall promptly and aggressively investigate all reports and allegations of abuse and making the necessary changes to prevent future occurrence. - The facility shall identify occurrences and patterns of potential mistreatment