## Statement of Deficiencies and Plan of Correction

### Statement of Licensure Violations

- **Section 330.785** Contacting Local Law Enforcement
  - **b)** The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations:
    - **3)** Sexual abuse of a resident by a staff member, another resident, or a visitor;

- **Section 330.4240** Abuse and Neglect
  - **c)** A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative.
  - **d)** A facility administrator, employee, or agent who becomes aware of abuse or neglect of

### Comments

- Complaint Investigation: 1491745/IL69427-330.785 b)3; 330.3240 c(d)
a resident shall also report the matter to the department.

These requirements are not met as evidenced by:

Based on record review, interview and observation, the facility failed to report to a responsible party and the state agency, and begin an investigation of alleged sexual abuse for a resident (R1) in a sample of 3 residents reviewed for abuse.

Findings include:

R1 is a 61 year old female with a diagnosis including Multiple Sclerosis. R1 is alert and oriented x 3. R1 was admitted to the facility on 9/28/13.

R2 is an 81 year old male resident with a diagnosis including Left Hip Replacement and history of Colon Cancer. R2 was admitted to the facility on 4/3/14 and was discharged to a local hospital mental health center on 4/22/14.

R1 4/23/14 at 10AM stated the following. "I was in my room in my wheelchair when R2 came into my room. I don't remember if I let him in or if he just walked in. We talked. Then R2 touched my leg and tried to kiss me. He also fondled my breasts. I told him to leave. I don't remember the day or time. It was late at night. The next day I told E2 (Director Of Nurses) and E3 (Life Enrichment Director). I asked Laura (E2) not to tell my son. About a week later I told my son about incident. My son called the police. Another time I heard the door handle to my room rattling. I went to the door and had to tell R3 to go away. He left".
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Emeritus at Hoffman Estates  
**Street Address, City, State, Zip Code:** 2150 West Golf Road, Hoffman Estates, IL 60194

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<tr>
<th>ID</th>
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<th>Summary Statement of Deficiencies</th>
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<th>Provider's Plan of Correction</th>
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<td>Z9999</td>
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<td>R1 4/24/14 10 AM was interviewed a second time. &quot;I told E3 the next day. I said R2 kissed me and touched me in the wrong way. E3 said she would handle it. I saw R2 for about a week then he was gone&quot;.</td>
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<td>E4 (Resident Care Giver) 9:30 AM 4/24/14 stated &quot;(R1) told me last Tuesday (4/15/14) &quot;(R2) came into my room and I did not like it&quot;. (R1) said she sat down in a chair and he touched her on her leg. I reported this to E2 immediately. I don’t know what E2 did&quot;.</td>
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<td>E3 (Life Enrichment Director) 11:15 AM 4/23/14 stated that on 4/8/14 before lunch R1 was not acting right. (R1) stated &quot;I don’t want to get anyone in trouble. (R2) came into my room and made me feel uncomfortable. I reported this to (E2). Myself and (E2) talked to (R1) again that day. (R1) did not say (R2) touched her at this time&quot;.</td>
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<td>E3 stated upon further interview on 4/24/14 11 AM stated that &quot;after we initially talked to (R1) on 4/8/14, we talked to (R2) and told him not to go in any other residents rooms and touch them or their things&quot;.</td>
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<td>E2 (Director of Nurses) 4/23/14 9:30 AM stated E3 was notified by R1 4/8/14 that R2 came into her room. R2 asked to come into R1’s room. &quot;We did not do an abuse investigation. We determined no need for an abuse investigation. On 4/19/14 R1 told her family that R2 was physically touching her and kissed her. Both of R1’s sons and other family members came to me and informed me of the incident. The sons called the police. I initiated an Abuse Investigation at this time on 4/19/14. I reported the incident to Illinois Public Health Department 4/20/14. I did not notify</td>
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R1’s physician. R2 was discharged to the hospital 4/22/14.
E2 responded that no information about the incident was documented in R1’s and R2’s clinical records.
Review of R1 and R2’s clinical records show no documentation of the incident. No documentation in clinical records show the physician was notified. No documentation of notification of responsible party was observed in either clinical record.

Police report 14-6437 was obtained from the police department on 4/24/14 and states the following summary of report: 4/19/14 police were called to facility and met by son of R1 who told the officer his mother was a victim of a battery from a male resident. (R2). Officer interviewed R1 who stated about two weeks ago R2 came into her room sometime late in the afternoon. She was in her wheelchair and R2 entered her room and sat down next to her. He had a conversation with her then placed his hand on her thigh. R1 felt uncomfortable but did not ask R2 to remove his hand. He then cupped her breasts with his hands and then leaned over and open-mouth kissed her. R1 told him to stop and leave the room but he stood up and hugged her. R1 insisted he leave so he did. R1 stated she reported the incident to staff but asked them not to tell her family until she had opportunity to do so herself.

Both R1 and Z1 (Son) told police that R2 may not know what he was doing. They did not want him arrested. The report also states E2 was aware of the incident the day it occurred. She was under the impression that R2 only held her hand and hugged her. When she learned of the details of what R2 did she immediately removed him from the facility.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

EMERITUS AT HOFFMAN ESTATES

STREET ADDRESS, CITY, STATE, ZIP CODE

2150 WEST GOLF ROAD
HOFFMAN ESTATES, IL 60194

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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Per interview of E2 4/24/14 11 AM the facility staff did talk to R2 and informed him not to go in other residents rooms on 4/8/14 after the incident was reported to them.

The facility was aware of the alleged abuse on 4/8/14 but did not initiate a investigation. The facility did not notify the residents representative of the abuse. The facility did not notify the state agency until 4/20/14.

Based on interview and observation of documents the facility failed to report a suspected abuse to the local police department. The facility was aware of the alleged sexual abuse on 4/8/14 but no notification was done.

Findings include:

R1 is a 61 year old female with a diagnosis including Multiple Sclerosis. R1 is alert and oriented x 3. R1 was admitted to the facility on 9/28/13.

R2 is an 81 year old male resident with a diagnosis including Left Hip Replacement and history of Colon Cancer. R2 was admitted to the facility on 4/3/14 and was discharged to a local hospital mental health center on 4/22/14.

R1 4/23/14 at 10AM stated the following. "I was in my room in my wheelchair when R2 came into my room. I don't remember if I let him in or if he just walked in. We talked. Then R2 touched my leg and tried to kiss me. He also fondled my breasts. I told him to leave. I don't remember the day or time. It was late at night. The next day I told E2 (
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Director Of Nurses) and E3 (Life Enrichment Director). I asked Laura (E2) not to tell my son. About a week later I told my son about incident. My son called the police.

Another time I heard the door handle to my room rattling. I went to the door and had to tell R3 to go away. He left".

R1 4/24/14 10 AM was interviewed a second time. "I told E3 the next day. I said R2 kissed me and touched me in the wrong way. E3 said she would handle it. I saw R2 for about a week then he was gone".

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E3 stated upon further interview on 4/24/14 11 AM stated that "after we initially talked to (R1) on 4/8/14, we talked to (R2) and told him not to go in any other residents rooms and touch them or their things".

E2 (Director Of Nurses) 4/23/14 9:30 AM stated E3 was notified by R1 4/8/14 that R2 came into her room. R2 asked to come into R1's room. "We did not do an abuse investigation. We determined no need for an abuse investigation."
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On 4/19/14 R1 told her family that R2 was physically touching her and kissed her. Both of R1's sons and other family members came to me and informed me of the incident. The sons called the police. I initiated an Abuse Investigation at this time on 4/19/14. I reported the incident to Illinois Public Health Department 4/20/14. I did not notify R1's physician. R2 was discharged to the hospital 4/22/14.”

E2 responded that no information about the incident was documented in R1's and R2's clinical records. Review of R1 and R2's clinical records show no documentation of the incident. No documentation in clinical records show the physician was notified. No documentation of notification of responsible party was observed in either clinical record.

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Both R1 and Z1 (Son) told police that R2 may not...
## Statement of Deficiencies and Plan of Correction

### Provider/Supplier/CLIA Identification Number:

**IL6015192**

### Multiple Construction

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### Date Survey Completed

**04/28/2014**

### Name of Provider or Supplier

**Emeritus at Hoffman Estates**

#### Street Address, City, State, Zip Code

**2150 West Golf Road**

**Hoffman Estates, IL 60194**

### Summary Statement of Deficiencies

**Z9999**

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They did not want him arrested. The report also states E2 was aware of the incident the day it occurred. She was under the impression that R2 only held her hand and hugged her. When she learned of the details of what R2 did she immediately removed him from the facility.

Per interview of E2 4/24/14 11 AM the facility staff did talk to R2 and informed him not to go in other residents rooms on 4/8/14 after the incident was reported to them.

The facility was aware of the alleged abuse on 4/8/14 but did not contact local law enforcement.

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