

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Citadel of Skokie, The		STREET ADDRESS, CITY, STATE, ZIP CODE 9615 North Knox Avenue Skokie, IL 60076	
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 Note: The nursing home is disputing this citation.	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** 41758 Based on interview and a record review, the facility failed to prevent an incident of staff to resident sexual assault and inappropriate exposure. This failure resulted in V6 forcibly pushing R1 down onto her back, grabbing her breast, undoing his clothing and exposed his penis to attempting to rape R1. R1 said, she felt hurt and wished for death. R1 said, she felt victimized, traumatized, and feared for her safety. The Immediate Jeopardy began on 04/09/24 when V6 exposed his penis and sexually assaulted R1. V1 (Administrator), V2 (Director of Nursing) and V14 (Chief Operating Officer) was notified of the Immediate Jeopardy on 04/18/24 at 11:40AM. The surveyor confirmed by record review and interview that the Immediate Jeopardy was removed on 04/18/24, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the interventions implemented. Findings Include: R1 was diagnosed with Huntington's disease. Brief interview for mental status dated 02/27/24 documents a score of thirteen which indicates cognitively intact. Screening Assessment to determine abuse/neglect dated 2/21/24 and 4/9/24 documents: a score of (0-2) low risk (risk measure for likelihood of previous/recent mistreatment and psychosocial/psychological symptoms related to history of abuse and or neglect.) On 4/11/24 at 1:08PM, V3 (CNA-Certified Nursing Assistant) said, R1 was her usually self after her lunch. V3 said, she went to lunch and returned, R1 was acting funny, terrible in her chair, moving like she was upset. R1 was anxious. R1 moves all the time based on her disease but R1 was moving more than normal. On 4/11/24 at 2:38PM, V2 (DON) said, he saw R1 after she mentioned the word rape. V2 said, normally R1 is very quiet. V2 said, that was the first time he saw R1 having that much anxiety. (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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 4/11/24 at 2:55PM, V1 (Administrator) said, he was informed by the V5 (nurse). R1 said, something about rape. R1 never used that language before. V1 said, he spoke with R1. R1 was sitting on the bed crying. R1 said, rape, black man. R1 couldn't give any more detail. V1 said, V6 was identified as that black male after reviewing the video footage. V1 said, V6 reported, he did his rounds and then checked on residents he has not seen throughout the day. V1 said, R1 threw a shoe at V6. V6 left the room, unable to determine why R1 threw the shoe. V1 said, maybe R1 was triggered by a past life event. On 4/11/24 3:15PM, V4 (CNA) said, R1 was agitated. V4 said, she worked with R1 in the past but has never seen R1 like that before. On 04/12/24 at 2:49PM, R1 was assessed to be alert and oriented to person, place and time. R1 was observed visibly distraught, crying, anxious and agitated. R1 said, while crying, red face, snot sniffing and increased body movement which included hitting bilateral heels hard on the floor multiple times, V6 came into her room and started to massage her shoulders. V6 forcibly pushed her down on her back by the shoulders, grabbed her breast on top of her clothing, undid his clothing and exposed his penis and tried to force her to have sex. R1 said, she couldn't yell. R1 said, she hit V6 with her phone then V6 left her room. R1 said, V6 tried to rape her. R1 said, she was hurt and would have rather death instead of being raped. R1 said, she felt victimized, traumatized and feared for her safety. On 4/12/24 at 10:06AM, V8 (Family) said, while crying, to watch R1 die from a debilitating disease is one thing but to watch R1 live through almost being raped and victimized was another level of trauma. R1 could not scream due her Huntington's disease. R1 reported, while in the hospital it would have been easier for her to die than to be raped. On 4/16/24 at 10:58AM, V6 (CNA) said, V6 said, he was compelled to check on R1 because he had not seen R1 in about a week to a week in a half. V6 said, he was concerned about R1. V6 said, it bother him to not see certain residents. V6 said, when he returned from an escort, ten of his residents were soaked in urine. V6 said, he did not report the ten residents to the nurse. V6 said, he changed five residents, then realized he had not seen R1 or R5. V6 said, he went into R1 and R5's room. R5 was sleeping/breathing. V6 said, he walked to R1's bed, R1 was sleeping, not moving and really still. V6 said, he stood in R1's room for one to two minutes to ensure R1 was breathing. R6 said, he had no idea who was R1's assigned CNA. V6 said, he did not notify the nurse when he thought R1 wasn't breathing. V6 said, after one to two minutes he saw R1 breathing he knew she was okay. V6 said, no one asked him to check on R1. V6 said, he was suspended pending an investigation for something, but not sure exactly what. V6 said, abuse should always be reported to V1 or the nurse immediately. Sexual, physical, mental, emotional, financial, involuntary seclusion and verbal are all forms of abuse. V6 said, he was not sure which abuse he was accused of but plan to stay away from all of them. V6 said, since he returned to work he did not have any training and nothing was newly implemented related to his suspension. V6 said, R1 did not throw a shoe at him. On 4/16/24 at 3:12pm, V9 (Nurse) said, R1 was alert and oriented to person, place and time. R1 has never made any false allegations. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Health status note dated 4/9/24 documents: Around 3:07PM, nurse on duty observed the resident (R1) being wheeled by two female CNAs in the hallway to the nursing station. Resident was noted to restless and holding her phone with the flash light on. Resident was then approached and asked what is wrong with her but she kept swinging her arms. She was asked if she wanted the nurse to turn off the flash light and she nodded. Afterwards, resident was still noted to be anxious and was again asked if she wanted the nurse to call her son. Resident nodded and the nurse proceeded to call her son but to no avail. Resident was again asked if what is wrong with her and she made an allegation. V1 and V2 was called right away and they went check on the resident. One to one supervision for safety provided. Body assessment and police called. Facility reportable dated 4/9/24 documents: It was reported to V1 (Administrator) that R1 is alleging black male rape. Police were contacted and came to follow up on resident statement. Camera footage reviewed: One employee that entered room for a few minutes with door open has been suspended pending investigation. Police report dated 4/9/24 documents: R1 said, she was raped by a male/black (M/B) about one hour ago. Reviewed video briefly which showed at 1434 hours (2:34PM), a M/B, large build, afro style hair, full facial hair, and wearing all black entered R1's room. At 1438 hours (2:38PM), the M/B subject exits the room. At 1439 hours (2:39PM), R1 exits the room and then walks to a wheel chair. Hospital papers dated 4/9/24 documents: Assault was exposure and an attempt. Video seen on 4/16/24 at 1:15 pm shows V6 was observed entering R1's room whose door was open at 14:34:25 and coming out at 14:38:38 while pulling the door behind him which did not close completely. Abuse Policy dated 12/2020 documents: Our resident have the right to be free from abuse. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse. Sexual abuse id defined as non-consensual sexual contact of any type with a resident. The Immediate Jeopardy that began on 04.09.24 was removed on 04.18.24 when the facility took the following actions to remove the immediacy. On April 18th, 2024, a State Surveyor informed the Administrator that an Immediate Jeopardy had been issued for Citadel of Skokie under F600. This abatement plan is being submitted without any prior knowledge of what specifically the Illinois Department of Public Health surveyor's citations will be. The following Plan of Abatement shall also serve as the Facility's written credible allegation of compliance that will be achieved by stated date of completion. Submission of this Plan of Abatement does not constitute in any way an admission of any facts and/or conclusions of law reflected in the alleged deficiencies, nor does it constitute a waiver of the Facility's right to contest the deficiencies and/or any remedies imposed as a result of this or future surveys. The facility reserves the right to contest the survey findings and the immediate jeopardy as allowed by applicable law and rules. The facility abatement plan includes the following: April 9th, 2024 Incident (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On April 9th, 2024 Facility Administrator was informed that R1 reported black man rape. In response, on that same day, April 9, 2024, the Administrator initiated action consistent with its abuse policy including: Initiating a comprehensive abuse investigation Notifying police immediately. Police came to facility and viewed the facility video footage and interviewed R1. R1 was sent to (local) hospital for evaluation. R1 was seen and assessed at the hospital and refused a complete rape kit. R1 had a partial rape kit done. R1 did change her initial statement to exposed his self to me. R1 was not admitted and was sent to another facility the next day. R1 has not returned to the facility. Identifying and suspending the alleged employee pending investigation. Employee was suspended from April 9, 2024 until the conclusion of the investigation. The investigation as complete by April 11, 2024. Because the investigation could not substantiate that the alleged sexual abuse occurred, employee returned to work April 16, 2024 after Administrator confirmed employee was up to date on his abuse in-service training, including the in-service training referenced below that employee received on April 11, 2024. (No further allegations of sexual abuse were made or received between April 16 - April 18. Employee was suspended April 18 and subsequently terminated for an issue unrelated to the instant sexual abuse allegations.) Notifying the Resident ' s MD (physician) and family. Sending an initial report to (state agency) on 4/9/2024 Sending a final report to (state agency) on 4/11/2024 Administrator completed a comprehensive abuse investigation that included: Interview of facility employees. Administrator interviewed all employees who were observed to be near/outside the room at the time of the alleged incident and none heard, saw, or observed anything inappropriate from resident ' s room. All other employees were interviewed about their knowledge and experience with the alleged perpetrator and no employees have heard, seen, or otherwise observed anything inappropriate about the alleged perpetrator. Interview of facility residents. No residents reported any inappropriate treatment or contact by staff, including the alleged perpetrator. Review of video footage. Video footage that showed employee [NAME] enter R1's room for approx. 3-4 minutes with door left open and exiting R1 ' s room. Administrator reviewed R1's statements about the alleged incident. Completion Date: 04-09-24 (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On April 10 and April 11, 2024, Administrator met with corporate office to review Administrator's investigation where it was confirmed that abuse allegation could not be substantiated. Legal counsel confirmed unsubstantiated investigation was insufficient to support employee termination. (Should this reviewer have questions about this determination, we request you meet with our legal counsel for a discussion.) Completion Date: 04-11-2024 On April 9, 2024, Administrator, DON, Regional Nurse began educating all employees on the facility's abuse /neglect policy with emphasis on sexual abuse-physical-reporting. All employees on duty received education before their shift ended. The remaining facility employees have been educated before to their next scheduled shift and education will continue until 100% of facility employees have been educated. The Administration will be at the facility to conduct education at the start of their shifts. Completion Date: 04-19-2024 The Facility Quality Assurance team (which includes Administrator, Director of Nursing, Medical Director, and Facility Directors met on April 18, 2024 to review R1's incident and will meet monthly to review abuse and neglect policies related to sexual abuse. DON will conduct ongoing audits including any risk management reports to ensure compliance once week on each shift for the next 60 days. QAPI will discuss and revise ABUSE policy as needed through the QAPI process. Completion Date: 04-19-2024 Facility SSD (Social Service Director) audited all resident records on April 18 and April 19, 2024 to ensure all residents have an up-to-date abuse assessment. Completion Date: 04-19-2024 R1 was discharged to another facility 4/10/24. Facility has confirmed R1 is stable according to emergency room report dated 4/9/24. Completion Date: 4-19-2024		