STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145598	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seminary Manor	2345 North Seminary Street Galesburg, IL 61401

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 - Minimal harm or potential for actual harm 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** Based on interview and record review, the facility failed to ensure a resident was free from sexual harassment by another resident, for one of three residents (R2), reviewed for abuse, in a sample of three.Th facility policy, Abuse Prohibition and Reporting, dated (revised) 11/28/19 directs staff that the facility prohibits abuse. The purpose of the policy is to protect residents from any kind of abuse such as verbal, sexual, mental, physical. The facility's definition of sexual abuse includes, but is not limited to, sexual harassment, sexual coercion or sexual assault.R1's current Physician Order Sheet, dated March 2026 documents that R1 was admitted to the facility on [DATE].R1's current Minimum Data Seat Assessment, dated 11/29/25 documents R1's cognitive status as 10 out of 15 (moderate impairment).R1's current Care Plan includes the following Problem Areas: (R1) has a history of displaying multiple behaviors including exit seeking, physical and verbal behaviors directed towards others and rejection of care, specifically showers, and use of sunscreen in the summer. Verbal and physical behaviors are directed towards staff and are frequently the result of redirection from rejection of care, or as a result of delusions. At times, verbal behaviors will be inappropriate comments towards female staff during cares. He frequently displays delusions related to needing to find family members, his car, calling the police, etc. Delusions cause him to be agitated, which does contribute to behavioral symptoms. R2's current Physician Order Sheet, dated March 2026 documents that R2 was admitted to the facility on [DATE].R2's current Minimum Data Set Assessment, dated 2/4/26 documents R2's cognitive status as 11 out of 15.A review of R2's current Care Plan, as of 3/17/2026 does not include any Problem areas to indicate that R2 makes false allegations against staff or other residents.The facility form, Final Submission of Alleged Resident to Resident Inappropriate Comment documents, On January eighth at five thirty in the morning, (V7/Certified Nursing Assistant/CNA) made a report to (V3/Agency Nurse) that she was advised by (R2) that (R1) had made an inappropriate comment to her in the facility (North) dining room. (V3) reported the incident to (V21/Licensed Practical Nurse/LPN). (R1 and R2) were no longer in contact when (V21/LPN) reported the issue to V7/Certified Nursing Assistant/CNA). (V21/LPN) advised (R1) that making inappropriate comments to other residents is not acceptable. (V3/Agency Nurse) escorted (R1) to the south side of the building where (R1's) room and dining room are located. (V21/LPN) advised (V2/Director of Nurses/DON). (V2/DON) advised (V1/Administrator). An investigation was initiated immediately. The POAs (Power Of Attorneys) and physician for both were notified of the situation. The initial report was sent to the (State Agency) within two hours of occurrence. No staff members or other residents witnessed the incident per (R2) and staff working in the area. On 1/8/2026, (V2/Registered Nurse Supervisor) interviewed R2. (R2) stated that (R1) told her he would like to see her breast and touch them in a sexual manner. (R2) stated she told (R1) to stop talking to her that way and (R1) did stop immediately. (R2) stated she reported the incident to keep other women from receiving similar comments from (R1). On 1/12/26, (V1/Administrator) interviewed (R1). (R1) stated that he had no memory of the incident. (R1) stated that he knew that speaking to a woman in a sexual manner would be inappropriate and stated he would never talk to a woman that way. (R2) (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 - Minimal harm or potential for actual harm Residents Affected - Few	has trouble remembering events which makes educating him on these manners difficult. Based on review of the situation that occurred on 1/8/26 and both resident's condition, it was founded that abuse was not substantiated due to (R1) not having the capacity to understand his actions.On 3/12/26 at 10:55 A.M., R1 was seated in a wheelchair at the nurse's station, requesting a can of soda. R1 was alert and oriented to person and place. R1 was able to answer questions appropriately. R1 stated he was unable to recall an incident between himself and R2. R1 stated he knows better than to make sexual comments to others.On 3/12/26 at 11:03 A.M., R2 stated she was able to recall the events of 1/8/26. R2 stated it was early morning and both she and R1 were in the dining room waiting for the morning meal. R2 stated R1 told her he wanted to touch her breasts and made other graphic remarks. R2 states she was upset by R1's comments, and told the nurse about it immediately, as she didn't want any other female residents to be spoken to by R1, as she was. R2 states she makes a point to stay away from R1 and goes out of her way to avoid him.On 3/17/26 at 9:11 A.M., V7/Certified Nursing Assistant (CNA) stated she has been an employee of the facility since June 2022. V7/CNA stated R1 often times gets up early and goes over to the facility North dining room for coffee, early in the morning. States at the time of the incident, R2 hadn't been sleeping well and was often up in the facility North dining room also. V2 stated she was working with another staff member down the hall on the date of the incident and heard R2 yelling for staff. V2 stated R2 was wheeling her wheelchair with her feet, looking for staff and R2 was very upset and wanted to report to staff that R1 was making inappropriate comments to her, and she didn't want other female residents to be harassed by R1. V7/CNA stated she and V3/Registered Nurse (RN) immediately went to R1 and V3/RN escorted R1 back to his nurse's station on the facility south side. V7 states at that time, she no longer had any contact with R1 for the remainder of her shift. V7 states both R1 and R2 are oriented to time, place and purpose.On 3/18/26 at 1:01 P.M., V1/Administrator stated she arrived at the decision that the incident between R1 and R2 was not substantiated abuse due to R1 not having the capacity to understand his actions. When asked how she arrived at that decision, V1 stated by reviewing R1's medical chart and based on her interview with R2 and R2's reaction to it all. When asked if R1 understood basic social rules, was able to recognize that certain comments were inappropriate and if R1 was able to follow simple directions or redirections, V1/Administrator agreed R1 was able to do all of those things. V1 verified that R2 has not made any false allegations against staff or residents while residing in the facility. At that time V1/Administrator also confirmed the facility has a responsibility to ensure R2's resident rights to not be sexually harassed, were maintained.