STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145994	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inverness Rehab	1800 W Colonial Parkway Inverness, IL 60067

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 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** 46560 Based on interview and record review, the facility failed to investigate the allegation of sexual abuse for one of three residents (R1) reviewed for abuse. Findings include: On 04/11/2025 at 10:23AM, R1 was sitting quietly on her wheelchair by the nurse's station. R1 stated that an incident happened about a month ago around 7:00PM - 7:30PM when a male staff, unsure if he was a nurse or a CNA (Certified Nursing Assistant), tried to pick her up, took her clothes off, and touched her legs and arms inappropriately. R1 stated that she tried to pull away, but the male staff was grabbing R1's body. R1 stated that she has reported it to nurses and staff. On 04/11/2025 at 12:47PM during interview with V8 (Licensed Practical Nurse), V8 stated that he takes care of R1. V8 stated that on 03/06/2025, R1's sister visited R1 and mentioned to V8 that R1 could have been raped. V8 immediately reported the concern to V1 (Administrator). On 04/11/2025 at 12:50PM during interview with V1 (Administrator), V1 stated that on 03/06/2025, V8 told him that R1's sister has concerns with R1's comfortability of who's providing care to R1. V1 denied being told by V8 about R1's sister's concern that R1 could have been raped. V1 stated that together with R1's sister, he interviewed R1. V1 stated that R1 told him that while being transferred using a mechanical lift, R1 feels vulnerable & feels like the CNA has power over R1, and if the staff would want to, they could have raped R1. V1 stated that he asked R1 a couple of times if R1 was touched inappropriately before in which R1 answered no. V1 stated that no investigation was initiated at that time and no staff member were pulled out from schedule because there was no allegation of abuse made. V1 stated that no allegation of abuse has been made since then. On 04/11/2025 at 10:54AM during interview with V3 (Complainant/Hospice Social Worker), V3 stated that R1 reported to hospice staff that R1 was raped by male CNA/nurse on 03/07/2025. V3 said that since the allegation was made, R1 has been increasingly aggressive, and having crying spells. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/11/2025 at 11:00AM during interview with V4 (Hospice CNA), V4 stated that on 03/07/2025, she was having a conversation with R1 when R1 suddenly told her that R1 has something to tell her. V4 stated that she encouraged R1 to talk to her, then R1 told V4 that she was raped. V4 stated that she asked R1 to take a breath and asked R1 what happened. V4 stated that R1 told her that she was hanging on the mechanical lift, and was raped. V4 stated that R1 was able to describe to her the male nurse or CNA but unable to name him. V4 stated that she informed V9 (Registered Nurse/RN) of the allegation, and V5 (Hospice Nurse) per hospice protocol. V4 stated that she has been taking care of R1 for the past 6 months, and R1 has been quieter, sleeping more, and appears depressed ever since R1 reported she was raped. On 04/11/2025 at 1:56PM during interview with V9 (RN), V9 stated that she sees V4 when she comes in to take care of R1. V9 stated that V4 might have mentioned to her that R1 made a statement that R1 was raped but V9 did not report it to V1 because she already heard from a colleague that the same allegation was made. On 04/11/2025 at 2:00PM during interview with V1, V1 stated that if there were any allegation abuse, he would report it immediately to IDPH (Illinois Department of Public Health), and he would initiate an investigation. V1 stated that V9 should have informed him immediately when V4 told her about R1's rape allegation. On 04/16/2025 at 9:35AM, V1 stated that V13 (Psychiatric Nurse Practitioner) should have communicated with him about R1's statement to her when she visited R1 on 04/07/2025. V1 stated that if V13 communicated with him, he would have initiated an investigation and reported the allegation to IDPH. Review of R1's Order Summary Report dated 04/11/2025 indicated admitted [DATE] and diagnoses of not limited to Anxiety Disorder, Unspecified Dementia, and Major Depressive Disorder. Review of R1's Hospice Communication Log dated 03/07/2025 indicated CNA visited R1, R1 saying something happened, sat with R1, reported to the nurse and hospice. Review of R1's Hospice Communication Log dated 03/07/2025 indicated RN visited R1, R1 was being monitors for the alleged complaint. Review of R1's Psychiatric Nurse Practitioner Progress Notes dated 04/07/2025 indicated the following: R1 was seen today due to staff concerns about an incident that occurred approximately one month ago. R1 reported feeling that she was left undressed for too long and touched inappropriately during care, though she denied any penetration. R1 stated, I felt like I was placed in the [NAME] lifts for too long, possibly referring to feeling vulnerable or exposed. R1 experiences intrusive thoughts and sadness when seeing staff members who resemble the individual involved in the incident. Review of facility's policy entitled Abuse Prevention Policy revised 01/05/2024 indicated the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, and mistreatment of residents. This will be done by: - Orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse neglect, exploitation, and misappropriation of property; V. Internal Reporting Requirements and Identification of Allegations Employees are required to report any incident or allegation of neglect, exploitation, mistreatment or appropriation of resident property they observe or suspect to the administrator immediately, to an immediate supervisor who must then report it to the administrator or to compliance hotline or compliance officer. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence.