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A 000	Initial Comment Annual Licensure Survey. The following were cited: Section 295.4060 - a, 2, B i-v Section 295.4010 -a, d, e, g, 1, A, C FRI /IL00198703 of 11/23/2025 the following were cited: Section 295.2000-a) Section 295.4010 - a, d, e, g, 1, A, C Section 295.6000 - a, 13	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act. These requirements were not met, as evidenced by: Based on observation, interview and record review, the facility failed to evaluate the appropriateness of residency of R1, identified to have a history of sexual assaulting others,	A2000		

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hypersexual behavior, and physical aggression.

These failures resulted in:
1. R1, a resident in Assisted Living identified as "agitated/aggressive/combative," sexually harassing staff by using "sexual remarks," as well as inappropriately touching staff without consent, was moved into the Memory Care Unit.
2. On January 14, 2025, R1 physically abused R4 by punching R4 in the face. R4 sustained a bloody and lacerated left lower lip. R4 glasses flew off and broke and R4 fell onto the ground. R1 sustained bleeding knuckles to the right hand from punching R4.
3. On November 23, 2025, R2 (resident living with dementia) was sexually assaulted by R1. R3 saw R1 touching R2 "all over, on the shoulder, back and on the legs" in the dining room.

This is for one (R1) of five residents in the sample. This failure resulted in severe harm to a resident and has the substantial probability to cause severe harm to other residents.

The findings include:

R1 moved into the establishment on August 26, 2024, with diagnoses to include agitation and dementia.
On December 3rd, 2025, at 12:14 PM, E1 (Executive Director) explain, "R1 was initially admitted into the assisted living [section] and was transferred into the Memory Care Unit due to increasing behaviors such as refusing showers and banging on the table for food. R1 will say something like, 'Give me food.' In the dining room, we do not have assigned seating arrangements, R1 will sit anywhere. The others [residents] wanted to sit where they are used to, so they [residents] get annoyed and agitated with

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R1's behavior." E1 also described R1 as alert and oriented (x2 to 3), independent in ambulation, and requiring one physical assist from staff with most activities of daily living (except mobility, dressing and eating). These are the only behaviors that E1 shared regarding R1.
R1's progress notes show the following event:
- November 5, 2025, R1 was observed putting hands up [underneath] another resident's shirt.
- November 6, 2025, R1 was observed during rounds continuously masturbating in the room numerous times a day. R1 displayed sexual behavior towards female residents.

On November 6, 2025, R1's Power of Attorney for finance and Power of Attorney for care requested a phone conference with E1 (Executive Director/Director of Nursing) regarding concern about R1's recent sexual behavior (not identified). The following were documented:
"Power of Attorney/care states she did speak with the nurse prior about this and that she gave consent at the time [not identified on what was R1's Power of Attorney was consenting to], as long as 'no one was getting hurt and that they were happy.' Her only concern at this time is that it was reported that R1 is no longer engaging in these behaviors [unidentified] with just one woman as R1 was at the time of that call, but R1 is now approaching other women and being sexually suggestive toward them."

R1's Power of Attorney for finance expressed concerns about R1's increased sexual behavior and tendencies.
E1 informed the Power of Attorneys that R1 displays cognitive decline and is no longer appropriate to reside in the assisted living section. E1 also revisits the situation where R1 was becoming agitated/aggressive/ combative

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A2000	Continued From page 3 while in the assisted living side. E1 informed R1's Power of Attorneys that R1 was displaying sexual behavior prior to R1 transitioning to the memory care unit. The reported behaviors included sexual remarks to staff members and inappropriately touching staff without consent. R1 was transferred to the Memory Care Unit due to inappropriateness for Assisted Living. R1's progress notes documented: - November 7, 2025 - R1 attempted to walk into a female resident's room without permission this AM shift. - November 10, 2025 - R1 was observed engaging in an inappropriate physical contact with another resident in public area. - November 14, 2025 - After showering, R1 was observed walking towards another female resident and attempting to touch her. - November 16, 2025 - R1 was observed engaging in inappropriate physical contact with another resident in a public area. The resident was immediately redirected and both residents were separated. Ongoing monitoring will continue to ensure appropriate behavior and safety of all residents. - November 22, 2025 - R1 attempted to expose himself to a female resident with advanced Alzheimer's disease who was identified to be unable to understand or provide consent. Staff will continue to monitor closely, and redirect behavior as needed if it becomes inappropriate and possesses concern. II. The reportable incident submitted to the Department show an incident of sexual assault. This incident was not documented in R1's nurses notes.	A2000		

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A2000	Continued From page 4 On November 23, 2025, at approximately 1:15 PM, it was brought to staff's attention by R3-an assisted living resident who is alert and oriented x4 and independently ambulatory-that R1 was seen inappropriately touching R2 in the main dining area. R2 is a 72-year-old memory care resident, alert and oriented x1 and independently ambulatory. R2 and R3 are common-law husband and wife, residing together for 30 years prior to admission to this facility. R1 was reportedly re-educated on inappropriate touching. On December 3, 2025, at 11:20 AM, E1 (Executive Director/Director of Nursing) explained: R3 lives in the Assisted Living section, the husband of R2. R2 is in the Memory Care Unit, a resident with severe cognitive impairment. R1, the perpetrator, an alert and oriented x2-3, ambulates independently and was moved into the unit from Assisted Living due to disruptive behavior and increasing sexual behavior (per service plan dated August 26, 2025). E1 stated, "R3 was coming to visit R2 and saw R1 touching R2 all over, on the shoulder, back and on the legs while sitting in the dining room. R3 told R1 to go away and was upset. We separated R1 and R2 and educated R1 on inappropriate touching." III. On January 14, 2025, a resident-to-resident physical altercation between R1 and R4 occurred. The incident/investigation report was written as follows: January 14, 2025, approximately 9:40 AM, staff (E2/LPN) was made aware of an altercation between two alert, oriented, independently ambulatory assisted living residents, R1 and R4. R4 sustained a laceration to the left lower lip. R4 stated, "I saw the receptionist [E3] walked into the room, I yelled a warning, to stay away from R1,	A2000		

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that R1's a "pervert!" R1 started running towards me looking angry, so I stood up from my wheelchair and R1 punched me in the face.

R1 sustained an abrasion to the right hand.
E3's undated written statements read as follows: "As I was walking in (no location identified), I saw R1 and told R1 hello. R1 started to get closer and closer to me. R4 came around the corner saying get away from him, he [R1] is a pervert! R1 then ran over to R4 saying, 'What did you call me?' R4 then said it again and before I could get in between. R1 punched R4 in the face. R4's glasses flew off and were broken, and he got a bloody lip. R4 then stood up to try to defend himself, but then R1 tried to put his hands on R4 again, which made R4 fall onto his back. The CNA [unidentified] then came running in and helped R4 up. They took R1 to A-side and helped R1 because R1's knuckles were bleeding. The staff couldn't get R1 to stay away as R1 continued to come back to R4 because they [R1 and R4] continued yell at each other."
On December 3, 2025, at 1:57 PM, R4 was sitting in the wheelchair in the room. R4 stated, "I am scared of R1! Have you seen R1? R1 looks like a weightlifter and a pervert! R1 touches women inappropriately! Yes, I saw R1 several times. Someone has to protect the women against R1. Just like R5, I saw R1 touching R5 and I told R1 to quit touching R5."

R4 also described the incident on January 14, 2025.
R4 stated, "In the common area, R4 was going towards E3 and so I told E3 to stay away from R1 because R1's a pervert. R1 came to me, asked me what I said so, I repeated and said, 'You're a pervert!' R1 punched me in my face, my glasses went flying to the ground and I was knocked

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A2000	Continued From page 6 down, out of my wheelchair sideways. The staff picked me up and R1 tried to hit me again. I once again fell onto the ground. Well, they know about R1 touching female residents, but they [administration] don't do anything, R1's still here!" On December 4, 2025, at 12:38 PM, E3 (receptionist, now resigned) described the incident as follows: "I was in the common area (B side), I was talking to R4. R4 said, 'Don't talk to R1. R1's a pervert!' R1 said, 'What did you say?' R4 was just protecting me so I don't get hurt and R4 won't touch me. Yes, that's what R4 said, that R1 touches female residents. R4 had not put his hands on me but looks flirtatious! R1 came around and punched R4 who was sitting in a wheelchair in the face. R4's glasses went flying, landed on the floor and were broken. R4's lips were busted! R4 tried to stand up to depend himself and R1 tried to hit R4 again which caused R4 to fall on his butt. I started calling for help, a CNA [unidentified] came and assisted R1 away. R1 had bloody knuckles." R1's service plan dated August 26, 2025, show the following: Mental health, changes/comments: Give cues and reminders. R1 has increased sexual behavior. Nurse to give medication as ordered. Staff to distract with other activities. Encourage resident to go to private area. Monitor every hour. On December 10, 2025, E1 stated, "I did my assessment and because of declining cognition, R1 was moved [from Assisted Living] to the Memory Care Unit."	A2000		
A4010	Section 295.4010 Service Plan	A4010		

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A4010	Continued From page 7 This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.4010 Service Plan - REPEAT VIOLATION a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act). e) The service plan shall be reviewed and revised, if necessary, immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living. C) special accommodations for the resident. These requirements were not met, as evidenced by: Based on interview and record review, the facility failed to: 1. Identify the specific risk factors/behavior	A4010		

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exhibited by residents.
A. R1's history/potential for physical aggression (agitated/aggressive/combative behavior) and
B. R1's sexual behavior, history of inappropriately touching staff and residents living with dementia.
2. Identify residents' potential for abuse related to cognitive deficits.
3. Revise the plan of care based on the occurrence of new behavior and/or risk factors.
4. Consistently implement and follow the plan of care to provide R1 with hourly monitoring to keep other residents safe.

These failures resulted in:
1. R4 was physically assaulted by R1 on January 14, 2025. R1 punched R4 in the face. R4's glasses flew off and were broken. R4's lips "were busted", sustaining a bloody lip and laceration. R1 again tried to hit R4 for a second time, causing R4 to fall onto the ground. R1 sustained "bloody knuckles."
2. R2 was sexually assaulted by R1 on November 23, 2025.

This is for 3 (R1,2 and R5) of 5 residents in the sample of 5. These failures resulted in severe harm to a resident and has the substantial probability to cause severe harm to other residents.

Findings include:

1) R1's most recent service plan dated August 26, 2025, was presented by E1(Executive Director) on December 3, 2025. This service plan identified R1 as alert x2-3, staff to give cuing and reminders.

On December 3rd, 2025, at 12:14 PM, E1

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A4010	Continued From page 9 (Executive Director) explained, "R1 was initially admitted into the assisted living and was transferred into the Memory Care Unit due to increasing behaviors such as refusing showers and banging on the table for food. R1 will say something like, 'Give me food.' In the dining room, we do not have assigned seating arrangements, R1 will sit anywhere. The others [residents] want to sit where they are used to so they get annoyed and agitated with R1's behavior." R1 was transferred into the Memory Care Unit (date requested but not provided) due to behaviors. These behaviors were not identified in R1's service plan (August 26, 2025). This was confirmed by E1 (Executive Director) on December 3, 2025 at 3:00 PM. 2) The reportable incident report submitted to the department for the incident dated January 14, 2025, an incident of resident-to-resident physical altercation between R1 and R4 was submitted to the department and read as follows: E3's undated written statements read as follows: "As I was walking in (no location identified), I saw R1 and told R1 hello. R1 started to get closer and closer to me. R4 came around the corner saying get away from him, he [R1] is a pervert! R1 then ran over to R4 saying, 'What did you call me?' R4 then said it again and before I could get in between. R1 punched R4 in the face. R4's glasses flew off and were broken, and he got a bloody lip. R4 then stood up to try to defend himself, but then R1 tried to put his hands on R4 again, which made R4 fall onto his back. The CNA [unidentified] then came running in and helped R4 up. They took R1 to A-side and helped R1 because R1's knuckles were bleeding. The staff couldn't get R1 to stay away as R1 continued	A4010		

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to come back to R4 because they [R1 and R4] continued yell at each other."

On December 3, 2025, at 1:57 PM, R4 was sitting in the wheelchair in the room. R4 stated, "I am scared of R1! Have you seen R1? R1 looks like a weightlifter and a pervert! R1 touches women inappropriately! Yes, I saw R1 several times. Someone has to protect the women against R1. Just like R5, I saw R1 touching R5 and I told R1 to quit touching R5."

R4 also described the incident on January 14, 2025.
R4 stated, "In the common area, R4 was going towards E3 and so I told E3 to stay away from R1 because R1's a pervert. R1 came to me, asked me what I said so, I repeated and said, 'You're a pervert!' R1 punched me in my face, my glasses went flying to the ground and I was knocked down, out of my wheelchair sideways. The staff picked me up and R1 tried to hit me again. I once again fell onto the ground. Well, they know about R1 touching female residents, but they [administration] don't do anything, R1's still here!"

On December 4, 2025, at 12:38 PM, E3 (receptionist, now resigned) described the incident as follows:
"I was in the common area (B side), I was talking to R4. R4 said, 'Don't talk to R1. R1's a pervert!' R1 said, 'What did you say?' R4 was just protecting me so I don't get hurt and R4 won't touch me. Yes, that's what R4 said, that R1 touches female residents. R4 had not put his hands on me but looks flirtatious! R1 came around and punched R4 who was sitting in a wheelchair in the face. R4's glasses went flying, landed on the floor and were broken. R4's lips were busted! R4 tried to stand up to depend

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himself and R1 tried to hit R4 again which caused R4 to fall on his butt. I started calling for help, a CNA [unidentified] came and assisted R1 away. R1 had bloody knuckles."
This incident of R1's physical aggression (incident on January 14, 2025) did not trigger the establishment to conduct a service plan revision for R1. The facility also failed to revise R4's service plan to address R4's risk to be abused. This was discussed and confirmed by E1 during this survey.

3) The incident report of sexual assault of R1 and R2, November 23, 2025, was submitted to the department.
The incident reads: On November 23, 2025, at approximately 1:15 PM, it was brought to staff's attention by R3-an assisted living resident who is alert and oriented x4 and independently ambulatory-that R1 was seen inappropriately touching R2 in the main dining area. R2 is a 72-year-old memory care resident, alert and oriented x1 and independently ambulatory. R2 and R3 are common-law husband and wife, residing together for 30 years prior to admission to this facility.
R1 was reportedly re-educated on inappropriate touching.

On December 3, 2025, at 11:20 AM, E1 (Executive Director/Director of Nursing) explained: R3 lives in the Assisted Living section, the husband of R2. R2 is in the Memory Care Unit, a resident with severe cognitive impairment. R1, the perpetrator, an alert and oriented x2-3, ambulates independently and was moved into the unit from Assisted Living due to disruptive behavior and increasing sexual behavior (per service plan dated August 26, 2025). E1 stated, "R3 was coming to visit R2 and saw R1 touching

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A4010	Continued From page 12 R2 all over, on the shoulder, back and on the legs while sitting in the dining room. R3 told R1 to go away and was upset. We separated R1 and R2 and educated R1 on inappropriate touching." R2's service plan was not revised after the incident to identify risk for abuse related to severe cognitive deficit. This was discussed with E1 during this survey. 4) On December 3, 2025, at 2:09 PM, R4 disclosed, "R1 came to me several times touching me on my shoulder, my back. That bothers me a lot! R1's too touchy! We have a male staff here who touches me on my shoulder too but with R1 it's a different touch. No, it is not a friendly touch, it's more sexual. It's weird and disgusting." R1's sexual behavior, "inappropriate touching," and physical aggression was not identified as a R1's risk factor on R1's most recent service plan submitted by E1 on December 3, 2025. E1 explained and pointed out on the service plan under Mental Health, with diagnosis of dementia, under changes/comments: All staff as needed (PRN) will give cues and reminders. R1 has increased sexual behavior. Nurse to give medication as ordered. Staff to distract with other activities. Encourage resident to go to private area. Monitor every hour. On December 3, 2025, at 2:40 PM, E1 confirmed that these concerns were not specifically identified and addressed.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs	A4060		

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A4060	Continued From page 13 This Regulation is not met as evidenced by: TYPE 3 VIOLATION Section 295.4060 Alzheimer's and Dementia Programs a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act) 2) Staff training: B) Direct care staff must receive 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. Training must cover: i) encouraging independence in and providing assistance with the activities of daily living; ii) emergency and evacuation procedures specific to the dementia population; iii) techniques for creating an environment that minimizes challenging behaviors; iv) resident rights and choice for persons with dementia, working with families, caregiver stress; and v) techniques for successful communication. These requirements were not met, as evidenced by: Based on interview and record review, the facility failed to offer and provide the required 16 hours of dementia training to newly hired staff.	A4060		

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A4060	Continued From page 14 This applies to 4 of 4 (E5-E8) direct care staff. The findings include: On December 3, 2025, at 3:34 PM, the establishment was unable to provide documentation that the 16 hours of dementia training requirements were provided to the staff. The employee files reviewed without this training were the following staff: - E5/LPN, hired on June 18, 2025 - E6/Aide, hired on October 14, 2025 - E7/Aide, hired on July 30, 2025 - E8/ LPN, hired on August 20, 2025 This finding was discussed and confirmed by E1 (Executive Director/Director of Nursing) and stated, "No, we don't do that."	A4060		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.6000 Resident Rights a, 13 a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor.	A6000		

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A6000	Continued From page 15 These requirements were not met, as evidenced by: Based on interview and record review, the facility failed to: 1. Provide a safe environment to residents to be free from sexual and physical abuse. 2. Provide adequate supervision and monitoring of R1, a resident identified as agitated/aggressive/combative and with history of inappropriately touching staff without consent. These failures resulted in: 1. A physical altercation between R1 (ambulatory) and R4 (wheelchair-bound resident) on January 14, 2025. (a) R1 punched R4 in the face. R4 sustained bloody /laceration to the left lower lip. R4 glasses flew off, broke and R4 fell on the ground. (b) R1 sustained bleeding knuckles to the right hand from punching R4. 2. On November 23, 2025, R2-a resident living with dementia-was sexually assaulted by R1. R3 allegedly saw R1 touching R2 "all over, on the shoulder, back and on the legs" in the dining room. This is for 3 of 5 residents (R2, R4 and R5) in the sample. These failures caused severe harm to a resident and has the substanital probability to cause sever harm to other residents. The findings include: R1 moved into the establishment on August 26, 2024, with diagnoses to include restlessness, agitation, and dementia. On December 3rd, 2025, at 12:14 PM, E1 (Executive Director) explained, "R1 was initially admitted into the assisted living and was transferred into the Memory Care Unit due to increasing behaviors such as refusing	A6000		

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showers and banging on the table for food. R1 will say something like, 'Give me food.' In the dining room, we do not have assigned seating arrangements, R1 will sit anywhere. The others [residents] want to sit where they are used to so they get annoyed and agitated with R1's behavior." E1 also described R1 as alert and oriented (x2 to 3), independent in ambulation, and required one physical assist from the staff with most activities of daily livings except mobility, dressing and eating.

On December 3, 2025, at 2:00 PM, E2 (LPN) described R1 as a "flirty man."

The 2025 establishment reportable incidents show the following incidents:
1. January 14, 2025, a resident-to-resident physical altercation between R1 and R4 occurred. The incident/investigation report was written as follows:
January 14, 2025, approximately 9:40 AM, staff (E2/LPN) was made aware of an altercation between two alert, oriented, independently ambulatory assisted living residents, R1 and R4. R4 sustained a laceration to the left lower lip. R4 stated, "I saw the receptionist [E3] walked into the room, I yelled a warning, to stay away from R1, that R1's a "pervert!" R1 started running towards me looking angry, so I stood up from my wheelchair and R1 punched me in the face. R1 sustained an abrasion to the right hand.

E3's undated written statements read as follows: "As I was walking in (no location identified), I saw R1 and told R1 hello. R1 started to get closer and closer to me. R4 came around the corner saying get away from him, he [R1] is a pervert! R1 then ran over to R4 saying, 'What did you call me?' R4 then said it again and before I could get in

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between. R1 punched R4 in the face. R4's glasses flew off and were broken, and he got a bloody lip. R4 then stood up to try to defend himself, but then R1 tried to put his hands on R4 again, which made R4 fall onto his back. The CNA [unidentified] then came running in and helped R4 up. They took R1 to A-side and helped R1 because R1's knuckles were bleeding. The staff couldn't get R1 to stay away as R1 continued to come back to R4 because they [R1 and R4] continued yell at each other."
On December 3, 2025, at 1:57 PM, R4 was sitting in the wheelchair in the room. R4 stated, "I am scared of R1! Have you seen R1? R1 looks like a weightlifter and a pervert! R1 touches women inappropriately! Yes, I saw R1 several times. Someone has to protect the women against R1. Just like R5, I saw R1 touching R5 and I told R1 to quit touching R5."

R4 also described the incident on January 14, 2025.
R4 stated, "In the common area, R4 was going towards E3 and so I told E3 to stay away from R1 because R1's a pervert. R1 came to me, asked me what I said so, I repeated and said, 'You're a pervert!' R1 punched me in my face, my glasses went flying to the ground and I was knocked down, out of my wheelchair sideways. The staff picked me up and R1 tried to hit me again. I once again fell onto the ground. Well, they know about R1 touching female residents, but they [administration] don't do anything, R1's still here!"

On December 4, 2025, at 12:38 PM, E3 (receptionist, now resigned) described the incident as follows:
"I was in the common area (B side), I was talking to R4. R4 said, 'Don't talk to R1. R1's a pervert!' R1 said, 'What did you say?' R4 was just

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protecting me so I don't get hurt and R4 won't touch me. Yes, that's what R4 said, that R1 touches female residents. R4 had not put his hands on me but looks flirtatious! R1 came around and punched R4 who was sitting in a wheelchair in the face. R4's glasses went flying, landed on the floor and were broken. R4's lips were busted! R4 tried to stand up to depend himself and R1 tried to hit R4 again which caused R4 to fall on his butt. I started calling for help, a CNA [unidentified] came and assisted R1 away. R1 had bloody knuckles."

R1's service plan dated August 26, 2025, show the following: Mental health, changes/comments: Give cues and reminders. R1 has increased sexual behavior. Nurse to give medication as ordered. Staff to distract with other activities. Encourage resident to go to private area. Monitor every hour.

II. R1's progress notes dated November 6, 2025, R1's Power of Attorney for finance and Power of Attorney for care, requested a phone conference with E1 (Executive Director/ Director of Nursing) regarding concern about R1's recent behavior (not identified). The following were documented: "Power of Attorney/care states she did speak with the nurse prior about this and that she gave consent at the time [not identified on what was R1's Power of Attorney was consenting to], as long as 'no one was getting hurt and that they were happy.' Her only concern at this time is that it was reported that R1 is no longer engaging in these behaviors [unidentified] with just one woman as R1 was at the time of that call, but R1 is now approaching other women and being sexually suggestive toward them."
R1's Power of Attorney for finance expressed concerns about R1's increased sexual behavior

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and tendencies.
E1 informed the Power of Attorneys that R1 displays cognitive decline and is no longer appropriate to reside in the assisted living section. E1 also revisits the situation where R1 was becoming agitated/aggressive/ combative while in the assisted living side.

E1 informed R1's Power of Attorneys that R1 was displaying sexual behavior prior to R1 transitioning to the memory care unit. The reported behaviors included sexual remarks to staff members and inappropriately touching staff without consent.

III. The November 22, 2025, incident of a sexual assault submitted to the Department had correction date of November 23, 2025, as listed on the community investigation report.
The incident read as follows:
On November 23, 2025, at approximately 1:15 PM, it was brought to staff's attention by R3-an assisted living resident who is alert and oriented x4 and independently ambulatory-that R1 was seen inappropriately touching R2 in the main dining area. R2 is a 72-year-old memory care resident, alert and oriented x1 and independently ambulatory. R2 and R3 are common-law husband and wife, residing together for 30 years prior to admission to this facility.
R1 was reportedly re-educated on inappropriate touching.

On December 3, 2025, at 11:20 AM, E1 (Executive Director/Director of Nursing) explained: R3 lives in the Assisted Living section, the husband of R2. R2 is in the Memory Care Unit, a resident with severe cognitive impairment. R1, the perpetrator, an alert and oriented x2-3, ambulates independently and was moved into the

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A6000	Continued From page 20 unit from Assisted Living due to disruptive behavior and increasing sexual behavior (per service plan dated August 26, 2025). E1 stated, "R3 was coming to visit R2 and saw R1 touching R2 all over, on the shoulder, back and on the legs while sitting in the dining room. R3 told R1 to go away and was upset. We separated R1 and R2 and educated R1 on inappropriate touching." On December 3, 2025, at 2:00 PM, R1 refused to be interviewed; R1 was in the hospital and diagnosed with COVID-19. On December 3, 2025, at 2:09 PM, R4 disclosed, "R1 came to me several times touching me on my shoulder, my back. That bothers me a lot! R1's too touchy! We have a male staff here who touches me on my shoulder too but with R1 it's a different touch. No, it is not a friendly touch, it's more sexual. It's weird and disgusting."	A6000		