

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0056697		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/05/2026	
NAME OF PROVIDER OR SUPPLIER ALLURE OF GALESBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 1145 FRANK STREET , GALESBURG, Illinois, 61401			
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S0000	Initial Comments Original Facility Reported Incident dated 11/26/25/2686112 Original Facility Reported Incident dated 12/9/25/2694197 Original Facility Reported Incident dated 11/25/25/2732260			S0000			
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)4) 300.3210t) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and			S9999			

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. : Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on record review and interview, the facility failed to protect residents from staff-to-resident sexual abuse and verbal abuse; failed to assess a resident's capacity to consent to sexual activity; failed to implement adequate supervision and interventions to ensure resident safety; failed to immediately initiate and complete a thorough investigation of abuse allegations; failed to report allegations of staff-to-resident sexual abuse and exploitation, resident-to-resident physical abuse, and staff-to-resident verbal abuse immediately to the State Agency, Local Police, and Administrator; and failed to submit a final investigation report to the State Agency within five working days for three of seven residents (R2, R3, and R6) reviewed for abuse in a sample of seven. These failures resulted in V7 (Prior Dietary Aide) engaging in behavior indicating an attempt to initiate a personal or romantic relationship with R3 in June 2025; continuing to engage in sexually inappropriate		S9999				

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S9999	Continued from page 2 conversations and video nudity with R3 through electronic communications; sexually exploiting and having non-consensual sexual relations with R3 on at least three occasions while R3 was attending church services; and maintaining continual access to R3 despite known concerns. These failures also resulted in V7 verbally abusing R6 on multiple occasions after R6 witnessed R3 and V7 engaging in inappropriate conversations and video nudity via electronic communications. Findings include: The facility's Abuse, Neglect, and Exploitation dated 2/3/25 documents, "Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit abuse, neglect, exploitation, and misappropriation of property. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Sexual Abuse included but is not limited to, sexual harassment, sexual coercion, or sexual assault. Verbal abuse means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend or disability. Allegations of staff to resident sexual abuse-Nursing home staff are entrusted with the responsibility to protect and are for the residents of that facility. Nursing home staff are expected to recognize that engaging in a sexual relationship with a resident, even an apparently willingly engaged and consensual relationship, is not consistent with the staff members role as a caregiver and will be considered an abuse of power. Also, for some health care professionals to have a relationship with a resident. Investigation of Alleged Abuse, Neglect and			S9999			

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S9999	Continued from page 3 Exploitation. Reporting/Response. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (law enforcement when applicable) within specified timeframes: a. immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Any sexual relationship between a staff member and a resident with or without diminished capacity may constitute sexual abuse in the absence of a sexual relationship that existed prior to the resident admitted to the facility, such as a spouse or partner, and must be thoroughly investigated to prevent abuse and implement policies and procedures to prevent and prohibit all types of abuse, neglect, bribery, misappropriation of resident property, and exploitation that achieves: A. Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship. B. Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, bribery, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms." D. the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect; E. Ensuring the health and safety of each resident with regard to visitors such as family members or resident representatives, friends, or other individuals subject to the residents right to deny or withdraw consent at any time and to reasonable clinical and safety restrictions. V. Investigation of Alleged Abuse, Neglect and Exploitation. A. An immediate investigation is warranted when suspicion of		S9999				

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S9999	Continued from page 4 abuse, neglect or exploitation, or reports of abuse, neglect, bribery, or exploitation occur. Written policies for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation; 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged preparator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, bribery, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: Responding immediately to protect the alleged victim and integrity of the investigation; increased supervision of the alleged victim and residents; room or staffing changes, if necessary, to protect the residents from the alleged perpetrator. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of incident or abuse. Reporting/Response: The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within five working days of the incident, as required by state agencies The facility's current Agreement with the Employees International Union Healthcare Illinois/Indiana documents, "These work and safety rules and regulation shall be applicable to each facility and its employees in the bargaining unit. It is essential to the successful operation of the facility's business and the welfare of its patients and employees that fairly established standards of discipline, health, safety, attendance, workmanship, and honesty be maintained. Employees shall have an opportunity to sign formal warning, acknowledging that such warning has been given and to comment on such warning. Maintaining or attempting to maintain a relationship (whether or not consensual) with a resident that is sexual or romantic in nature unless the resident is the employee's spouse. First offense-Discharge." The Illinois Guardianship and Advocacy Commission Guardianship Fact Sheet (undated) documents,			S9999			

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S9999	Continued from page 5 "Guardianship Facts: Guardianship is needed when a person is unable to make and communicate responsible decisions regarding his personal care or finances due to a mental, physical, or developmental disability. The extent to which a guardian is allowed to make decisions for a ward is determined by the court based on a thorough clinical evaluation and report. Two basic types of guardianship are "person guardianship" and "estate guardianship." A "guardian of the person" is appointed by the court when a disabled individual cannot make or communicate responsible decisions regarding his personal care. This guardian will make decisions about medical treatment, residential placement, social services, and other needs. The court appoints a "guardian of the estate" when a disabled person is unable to make or communicate responsible decisions regarding the management of his estate or finances. The guardian will, subject to court supervision, make decisions about the ward's funds and the safeguarding of the ward's income or other assets. The Illinois Probate Act gives the court the flexibility to tailor guardianship to meet the needs and capabilities of disabled persons. Depending on the decision-making capacity of the disabled person, the court can appoint a limited guardian who is granted the power to make only those decisions about personal care and/or personal finances that the court specifies. The court can also appoint a plenary guardian who generally has the power to make all decisions about personal care and/or finances for the disabled person." R3's Legal Guardianship dated 2/27/15 and signed by V12 (Judge) documents, "Because of (R3's) physical and mental conditions, (R3) is not able to manage her person or property and is therefore a disabled person. Because of (R3's) disability (R3) lacks sufficient capacity to make and communicate responsible decisions concerning the care of her person and because of (R3's) disability, (R3) lacks capacity to manage her estate; and for these reasons it is necessary to appoint a guardian of the person and estate of (R3). A limited guardianship will not provide sufficient protection for (R3). (V3/R3's Plenary Guardian) is qualified to act as a guardian. In order to protect the best interests of (R3), a guardian of (R3's) person and estate should be appointed. (V3) is capable of making residential decisions for (R3). Now, therefore, it is hereby ordered and adjudged: A. That (R3) is a disabled person in need of the appointment of a plenary guardian of her person and or estate." V7's Employee Termination Form dated 6/27/25 and signed by V1 (Administrator), V10 (Prior Dietary Manager), and		S9999				

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S9999	Continued from page 6 V11 (Human Resource Manager) documents, "(V7's) last day worked 6/27/25. Type of termination: Resignation. Reason for termination: Due to (V7's) growing feelings for a resident (R3). (V7) resigned effectively immediately. Eligible for rehire: No." R3's Electronic Health Record dated 2/25/25 (admission) through 1/29/26 does not include an evaluation to determine R3's ability to consent to sexual activity. R3's Progress Notes dated 11/10/25 at 6:27 PM document, "Staff talked to (R3) about roommate (R6) complaint of (R3) getting completely naked in the room with door and curtain open talking or videoing on social media (with another male). Staff reminded (R3) to close curtains and doors and be respectful of roommate's concerns." R3's Face Sheet Form documents R3 is a 28-year-old that was admitted to the facility on 2/25/25 with the diagnoses of Borderline Personality Disorder, Attention-Deficit Hyperactivity Disorder, Major Depressive Disorder, Anxiety Disorder, Suicidal Ideations, and Major Depressive Disorder with Severe Psychotic Symptoms. This same Form documents V3 is R3's Legal Guardian. R3's Emergency Department Provider Notes dated 7/8/25 document R3 was sent to the emergency room for suicidal ideations and had been feeling suicidal for the past couple days and having thoughts of cutting her wrist in order to attempt suicide. This report documents R3 reports that she was living (at the facility) and was physically assaulted by two other resident yesterday and has not been able to sleep since then. This same report documents R3 was transferred to an inpatient psychiatric treatment for the treatment of suicidal ideations. R3's Sign In/Sign Out Report Sheets dated 11/1/25 through 12/31/25 document R3 attended outside church services or the library on 11/9/25, 11/14/25, 11/16/25, and 11/23/25. These sheets do not include the staff/family/friend that R3 attended the library with on 11/14/25 or the church on 11/23/25. R3's Progress Notes dated 11/10/25 at 6:27 PM document, Staff talked to (R3) about roommate (R6) complaint of getting completely naked in the room with door and curtain open talking or videoing on social media. Staff reminded (R3) to close curtains and doors and be			S9999			

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S9999	Continued from page 7 respectful of roommate's concerns. R3's Behavior Note dated 11/20/25 at 8:30 AM and signed by V6 (Psychosocial Rehabilitation Coordinator) documents, "Another resident (R6) approached (V6) to report that (R3) was engaging in sexual conversation. When (R6) asked (V3 and R7) to refrain from doing this while (R6) was in the room, the male (V7) on the call began cursing at (R6) and calling (R6) names. (R6) stated that incidents like this occur often, and it is making (R6) feel uncomfortable." R3 and R6's Medical Records and the facility's Abuse Investigations do not include evidence of R3 and R6's allegations of R3 being sexually exploited by video on social media or R6 witnessing this sexual exploitation on 11/10/25 or 11/20/25 being reported to the State Agency or Local Police. R3's Police Report #25-049356 dated 11/26/25 at 1:17 PM and signed by V27 (Local Police Officer) documents R3 was sexually assaulted by V7 (Prior Dietary Aide) on three separate occasions while R3 was attending church services. This same Police Report documents V27 requested this Police Report be sent to the State's Attorney's Office for a probable cause review for (V7) to be charged with Criminal Sexual Assault. R3's Final Abuse Investigation dated 12/3/25 and signed by V1 (Administrator) documents, "On 11/23/25 R3 had multiple instances of non-consensual sexual contact with a male (V7/Prior Dietary Manager) in the parking lot of a church on Sundays during church services. This same report documents, (R3) stated that (R3) had at least three encounters with (V7) and that none were consensual. (R3) states that the first time it happened, (R3) was in (V7's) vehicle in the church parking lot, and (V7) forced himself on (R3). The second time that it occurred, (V7) told (R3) to get in (V7's) vehicle because (V7) had food for (R3). (R3) stated she ate the food and then started to feel woozy and then blacked out. (R3) states she awoke by herself in the vehicle and proceeded to go to church services. The third time that it happened (V7) lured (R3) into (V7's) vehicle because (R3) offered her snacks and once again, (R3) became woozy and blacked out and woke up alone and went to services after."		S9999				

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S9999	Continued from page 8 R3's Individual Psychotherapy Notes dated 1/9/26 and signed by V8 (Clinical Therapist) document, "(R3) reported ongoing stress related to (V7) who continues attempting to contact (R3) directly and through others. (R3) expressed being "done" with the situation and wanting to leave town to feel safer. (R3) noted an increase in night tremors and shares significant fear that (V7) may approach (R3) when (R3) is not with staff or family, stating (R3) worries that "something bad will happen." (R3) described how this fear has begun to affect her faith, though she continues coping by reading her Bible and listening to sermons." R3's IDT (Interdisciplinary Team) Note dated 11/21/25 documents, "IDT reviewed (R3's) behavior involving smart phones, social media contact, and video calling and potential risk to (R3) and peers. (R3) continues to require assistance to think through logically regarding safety and well-being and refrain from impulsive decisions/actions per behavior documentation. (R3) did not successfully follow (R3's) suggested social media guidelines during walking pass trial. In order to help (R3) better manage impulsivity and better gauge whether (R3's) putting herself at risk of exploitation or abuse or how her choices impact peer residents' safety and well-being, IDT recommended a behavior management program where all phone use occurs with supervision/in supervises area upon request and when not in use as outlines, smartphones are secured at the nurses' station." These safety interventions are not included in R3's current care plan. R3's Progress Note dated 11/25/25 at 5:53 PM and signed by V5 (SSD/Social Service Director) documents V3 (R3's Plenary Guardian) gave authorization for R3 to receive phone calls, receive visits at the facility, or leave for therapeutic outings or scheduled community activities with only V3 (R3's Plenary Guardian, V21-V24 (R3's Family Members) or facility staff. These safety interventions were not included in R3's current care plan. R3's Final Abuse Investigation dated 12/3/25 and signed by V1 (Administrator) documents on 11/23/25 R3 had multiple instances of non-consensual sexual contact with a male (V7/Prior Dietary Manager) in the parking lot of a church on Sundays during church services. This		S9999				

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S9999	Continued from page 9 same report documents, (R3) stated that (R3) had at least three encounters with (V7) and that none were consensual. (R3) states that the first time it happened, (R3) was in (V7's) vehicle in the church parking lot, and (V7) forced himself on (R3). The second time that it occurred, (V7) told (R3) to get in (V7's) vehicle because (V7) had food for (R3). (R3) stated she ate the food and then started to feel woozy and then blacked out. (R3) states she awoke by herself in the vehicle and proceeded to go to church services. The third time that it happened (V7) lured (R3) into (V7's) vehicle because (R3) offered her snacks and once again, (R3) became woozy and blacked out and woke up alone and went to services after." Undated text message screenshots stored on R3's personal cellular phone and provided to this surveyor by V3 (R3's Plenary Guardian) on 1/31/26 documents ongoing personal, romantic, and sexually explicit communication between R3 and V7 (former Dietary Aide). The messages documented expressions of emotional attachment, intimate relationship discussions, and sexual content between V7 and R3. Text messages sent from V7 to R3 included statements such as, "I miss you so much already," with R3 responding, "I miss you more." Additional messages reflected plans to meet in the community, including R3 stating, "Just come inside babe, I don't want to go back outside, it's cold and I'm starting to get a cough," and V7 responding, "The car is warm (though), it's up to you." Further review of the text messages revealed discussions of a committed romantic relationship and future plans together. V7 texted R3, "I really wanted to start a family with you and have a real life together...more than anything," and later stated, "I do love you and miss you...you're my life, but I want more." Additional messages between R3 and V7 contained sexually explicit content. V7 texted R3, "Making love to you means the world to me and I love you," and "I want a real relationship with you." R3 sent a message to V7 stating, "I love you more than I have ever loved anyone," and R3 stated she wanted V7 to "c*m inside her and not pull out." R3's Individual Psychotherapy Follow-Up Evaluation Note dated 12/19/25 and signed by V8 (Clinical Therapist) documents R3 reported continued contact from R3's ex-partner (V7) and V7 gave R3 a note asking R3 to contact V7 however R3 stated she is setting boundaries and telling V7 to leave R3 alone. R3's Individual Psychotherapy Notes dated 1/9/26 and signed by V8 (Clinical Therapist) document, "(R3)		S9999				

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S9999	Continued from page 10 reported ongoing stress related to (R3's) ex-partner who continues attempting to contact (R3) directly and through others. (R3) expressed being "done" with the situation and wanting to leave town to feel safer. (R3) noted an increase in night tremors and shares significant fear that (V7) may approach (R3) when (R3) is not with staff or family, stating (R3) worries that "something bad will happen." (R3) described how this fear has begun to affect her faith, though she continues coping by reading her Bible and listening to sermons." V7's Employee File documents V7 was hired at the facility on 9/26/23. V7's Employee File indicates V7 received Abuse Prevention training on 3/2/25. The Facility's In-Service Training Logs document V7 received training on 2/1/25 on what constitutes abuse, sexual abuse, sexual contact, sexual images, and staff requesting images from the residents, personal boundaries with the residents, and what constitutes all forms of abuse and bribery. The Facility's In-Service Training Logs document V7 received training regarding the facility's Abuse policy on 4/15/25 and 5/20/25. R3's Police Report #25-049356 dated 11/26/25 at 1:17 PM and signed by V27 (Local Police Officer) documents, "On 11/26/25 I (V27) was dispatched to (the facility) in regard to a sexual assault report. Upon arrival I met with (R3) and (V1/Administrator) who had reported the incident. (V1) advised that on 11/23/25, (R3) and (V3/R3's Guardian) had an argument regarding (R3) meeting former facility employee (V7) at (local church) on Sundays and having sex in (V7's) car in the parking lot during Sunday school before church. It should be noted that (V7) chose to resign from (the facility) due			S9999			

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S9999	Continued from page 11 to a romantic interest in (R3), in which (V7) was told (V7) could not work at (the facility) due to a romantic interest in a resident (R3). (V3) also took (R3's) electronic devices after the argument and discovered inappropriate messages between (R3) and (V7). Today, (V1) advised that (R3) told one of her caregivers that (V7) forced (R3) to have sex without (R3's) consent, therefore (V7) was alerted and contacted the police. (R3) stated that she does love (V7) but was not ready to have sex with (V7). (R3) advised there has been three occasions where (V7) lured (R3) to (V7's) vehicle in the parking lot of the church and forced (R3) to have sex with (V7) which has occurred each Sunday, since the first week of November. I asked (R3) to walk me through each occurrence, beginning with the first time it happened. First Occurrence: (R3) stated that the first time this occurred, (R3) went to church on the shuttle that transports (facility) residents to church. Shortly after (R3) arrived at church (R3) received a message from (V7) to come outside to talk. (R3) believed (V7) just wanted to talk and then (V7) asked (R3) to get into his vehicle, which (R3) described as a black SUV (Sport Utility Vehicle). (R3) stated she was hesitant to get in the vehicle, but (V7) kept persisting and it was cold outside, so (R3) got inside the vehicle in the front passenger seat. After (R3) sat down, (R3) stated that (V7) said he wanted to show her how a real man makes loves to somebody, and locked the doors, opened his driver door, and walked around to the back of the car where he opened the trunk. (R3) stated (V7) climbed into the back seat from the trunk. (R3) did not know why he did it this way. (R3) then stated that (V7) pulled her into the back seat and (R3) told (V7) to "leave her alone." (R3) advised that (V7) said, "It'll be fun" and proceeded to remove (R3's) pants and underwear and began to have sex with (R3) without a condom or any protection. After (V7) had sex with (R3), (R3) stated she kicked (V7) to get (V7) off, and to get out of the vehicle, and then ran into the church. At this time, (R3) was advised church was ending, and (R3) departed on a shuttle back to (the facility). Second Occurrence: The second time this occurred, (R3) advised she arrived at church and (V7) told her he had breakfast and coffee in the car. (R3) came out and sat in the car when (V7) told her because (R3) was scared. This time (R3) sat in the back seat because (R3) did not want to sit right next to him. (R3) said (V7) did have breakfast and (R3) began to eat, and (V7) left for five to ten minutes. When (V7) came back (R3) was feeling very tired and disorientated and (R3) said "You're ready." (R3) advised she kept telling (V7) "no" but does not remember what happened after that. (R3) advised that when (R3) started becoming aware again, (R3's) pants			S9999			

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S9999	Continued from page 12 and underwear were off and (V7) was not there. (R3) stated she remembered feeling pain in (R3's) groin area after this occurred but did not seek help. Third Occurrence: On the third occurrence, (R3) advised (V7) told (R3) he had snacks in the car. When (R3) came outside with (R3), (R3) stated that (V7) was sitting in the backset and told (R3) he wanted to apologize, and he asked (R3) to get in the car so he could apologize. (R3) stated that she refused, and then (V7) grabbed her waist and said, "You're mine" and pulled (R3) into the car. (R3) told (V7) she had a headache and said (V7) offered a square shaped red pill that (R3) said was ibuprofen and forced it down (R3's) throat. After that, (R3) said (V7) told her if she ever tells anyone (V7) will stop at nothing to finish her off, and if (R3) screams (V7) would knock her ass out and do (R3) right there. (R3) stated she felt like she blacked (out) shortly after and believed it was from the pill (V7) gave her. (R3) stated that this time, she woke up, she was completely naked and believed (R3) felt semen inside of her, and once again, (V7) was no longer there. (R3) stated that again, (R3) went back inside the building and came back to (the facility) on the shuttle. Follow-up with (V1/Administrator): Following my interview with (R3), (R3) returned to her room. I met with (V1), who advised that (R3) has diagnoses Borderline Personality Disorder, Anxiety Disorder, and Impaired Social Interaction. (V1) advised that there were notes in her file stating that (R3) has a history of lying to and manipulating staff, especially when attempting to leave the building, and using (R3's) phone to manipulate men online and engage in inappropriate communication. (V3/R3's Plenary Guardian) found out (R3) was meeting (V7) at church this past Sunday, which led to an argument with (R3) in which officers had to response. (V3) had gone through (R3's) phone and had found out earlier today that (R3) had been having sex with (V7). After talking with (V1), I departed the facility. On December 17, 2025, I (V27) was able to make contact with (V7) on the phone. I asked (V7) if he was familiar with (R3) and had him describe his relationship with (R3). (V7) advised that he was very close with (R3), and (V7) did resign from (the facility) in the past in order to maintain a relationship with (R3). (V7) did confirm that (V7) and (R3) were conversating over the phone and going to the same church, approximately one month ago and they would talk to each other while in church. (V7) stated that there were times that (V7) and (R3) went to his car and kissed, but they never engaged in any other sexual acts or intercourse. (V3) also called to follow up on 12/17/25. (V3) advised (V3) still has (R3's) phone, and that (V7) is still texting (R3). (V3) provided (V27) with more screenshots of more messages from (V7) and			S9999			

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S9999	Continued from page 13 (R3). In these messages (V7) references "our Sundays" and at one point stated, "If you (R3) are able to leave and also not talk to me and move on after making love, then you (R3) do not love me (V7)." I (V27) will continue investigating this and due to conflicting statements. I will follow up with (R3) again, as well as (V7). On January 3, 2026, I (V27) met with (V7) at the public safety building and (V7) voluntarily gave a statement regarding (V7's) relationship with (R3), and their interactions. The following is a summary of my recollection of (V7's) statements. (V7's) full statement has been captured on body camera, and video recorded in the interview room. (V27) began a recording in the interview room and escorted (V7) to the room. I advised (V7) he was not under arrest but still read (V7) his Miranda Warning from a pre-printed card. (V7) advised that he would speak with me and answer questions. (V7) advised that he did, in fact, resign from (the facility) because (V7) and (R3) had feelings for each other, and (V7) was told he could not remain employed (at the facility) if (V7) was going to have a personal relationship with (R3). (V7) stated that (R3) and (V7) were going to (local church) together for a couple months, and that (R3) enjoyed going to church with (V7), and they would often sit together. (V7) stated that they (R3 and V7) spoke with a pastor, together at one point for guidance in their relationship. (V7) did advise that sometimes he would step out to his car for a cigarette, and (R3) would follow (V7). According to (V7), (R3) came out to his care with him three or four times. (V7) stated that he occasionally brought some pop to drink in his car. (V7) advised that (V7) and (R3) would occasionally hug and kiss in the car, and there was one occasion in the car, at the church parking lot, in which their (R3 and V7's) physical contact escalated to protected sex. (V7) advised the sex was consensual and that (R3) stated to (V7) that (R3) did not withdraw from, or request (V7) to stop during sex at any time. (V7) said that (V7) and (R3) probably did occasionally talk about sex both over phone communication and in person, but they only had sex one time. Due to (V3's) mentioning a letter that was sent after (V3) confiscated (R3's) electronics, I asked (V7) if he ever sent a letter to (R3). (V7) stated he did give a letter to a mutual acquaintance to give to (R3). I asked (V7) if there was any particular reason (V7) could think of that would cause (R3) to feel uncomfortable with (V7), or their relationship all of a sudden, or if (R3) had not been mad at (V7) or uncomfortable with (V7) or told (V7) anything to indicate (R3) was upset, or uncomfortable with (V7). (V7) advised that after (V7) found out (R3) no longer had her phone or computer, (R3) attempted to contact (V7) multiple times from other phones such as her			S9999			

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S9999	Continued from page 14 roommate's phone or landline phone at (the facility). Copies of questions (V27) asked (V7) during the interview and (V7's) personal notes he brought with have been added to the case file, and digital copies have been added to case pictures under this report number. Due to (R3's) statements in the original incident report of not consenting and being forced to have sex, and conflicting statements from (V7), I am requesting that this report be send to the State's Attorney's Office for a probable cause review for (V7) to be charged with Criminal Sexual Assault." R3's current Plan of Care as of 1/30/26 documents, "Focus date initiated 3/6/25: Impaired Social Interaction-(R3) is frequently speaking with, texting, or calling objects of opposite sex. (R3) is easily emotionally involved and makes poor decisions related to opposite sex related to diagnoses of Borderline Personality Disorder, Anxiety, MDD (Major Depressive Disorder), and ADHD (Attention-Deficit Hyperactivity Disorder). Goal: (R3) will embrace positive thinking statement and will participate in social situations. Focus date initiated 7/8/25: (R3) has a behavior problem related to Borderline Personality Disorder, ADHD, MDD, Anxiety Disorder, and history of SI (Suicidal Ideation). (R3) will manipulate situations/peers/staff to be able to leave the building and go where (R3) is potentially not safe and lie about where (R3) is going against guardian's wishes and also use manipulation to be sent to the hospital at will. (R3) takes other belongings thinking that it is comical, uses cell phone to attempt to manipulate men online to come pick her up from facility (unsafe decision making) as (R3) does not know these men. (R3) makes false accusations against staff and peers. (R3) Makes false allegation against other residents stating they have come into her room and hit her, and investigations show untruth." This same care plan does not include any updated interventions since the last update on 6/27/25 to address and protect R3 from sexually inappropriate conversations and video nudity by electronic communication with V7 or any other male and does not address or protect R3 from being sexually assaulted by V7 or any other male. This care plan also does not include R3's cognitive ability to consent to sexual activity. R3's Electronic Health Record dated 2/25/25 (admission) through 1/29/26 does not include an evaluation to determine R3's ability to consent to sexual activity. The facility's Root Cause Analysis Worksheet (undated)		S9999				

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S9999	Continued from page 15 documents, "(R3) was engaged in a relationship with (V7) in the community. (R3) would attend church services with groups from the facility on Sundays, with no staff supervision. (R3 and V7) would meet at a church and attend services together. (R3) was noted to leave church services and go to the parking lot with (V7). It was reported (R3 and V7) were having sexual relations in the parking lot of the church. (V3/R3's Plenary Guardian) was made aware of the sexual relationship between (R3 and V7) and (V3) stopped (R3) from attending church services. (R3) then alleged that the sexual relationship was non-consensual." The facility's QAPI (Quality Assurance and Performance Improvement)/QAA (Quality Assurance Assessment) Meeting Agenda dated 11/26/25 documents the facility immediately implemented protection measures and increased supervision of R3. R3's current Care Plan does not include these increased supervision and protection measures as documents in the QAPI agenda. On 1/28/26 at 10:30 AM V3 (R3's Plenary Guardian) stated, "I am (R3's) legal guardian. At seven years old I adopted (R3). About the age of three to four years old (R3) wasn't reaching goal marks. (R3's) doctor told me I need to file for guardianship to keep (R3) safe from others, so I did. On 6/26/25, (V1/Administrator) called me and told me that (R3's) roommate (R6) had reported to (V1) that (R3) was in a relationship with (V7/Dietary Aide). (V1) told me they (the facility) were going to do an investigation, and I gave permission to look through (R3's) electronics. (V1) reported to me that (R3 and V7) were not having a sexual relationship but (V7) was sending (R3) messages saying, "I love you. I am going to get you out of this place. You are the best thing that has happened to me." (V1) also said (R3 and V7) were video chatting at night. I had a CNA (Certified Nursing Assistant) tell me that she had gone into check on (R3) and saw (R3) was on a video call with (V7). I cannot remember that CNAs name. I was very upset over this whole thing of an employee trying to have a sexual relationship with (R3). I asked (V1) for (V7's) discharge records and I was told (V7) left on his own, so the facility did not have to do the paperwork or report this to IDPH (Illinois Department of Public Health). I told them IDPH needs to know that one of their employees (V7) is trying to have a sexual relationship and boyfriend-girlfriend relationship with my daughter (R3) and this is exploitation of my daughter. I am a nurse and know a staff member should never try to have a relationship with a resident. I told the facility to take (R3's) electronics and that (R3) was not to have		S9999				

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S9999	Continued from page 16 any further contact with (V7). After that (R3) was calling me and screaming at me that "I am the worst mom ever." (R3) wanted to have a relationship with (V7) and started threatening suicide and was sent to a psychiatric unit for treatment. When (R3) returned to the facility, (R3) was put on lockdown and was not to leave the facility without supervision. I allowed (R3) to go to church back in November 2025. (R3) was able to leave to go to church with the facility dropping (R3) off and the church would bring (R3) back to the facility, and I told the facility to ensure (R3) was supervised at church. (R3) has a history of lying and being manipulative and a nurse (unknown name) told me that she thought (R3) was meeting up with (V7) while at church. I decided to drive three hours down and went to that church and sat in the back row. (R3) was not at church when I was there, even though I was told by the facility (R3) was going to church. About an hour into church, (R3) came into church from a side door. After church was over, I waited for (R3) to notice me. I walked up behind (R3) and tapped (R3) on the shoulder. I took (R3) back to the facility myself. I went outside and was looking for her and one of the residents in the facility van said to me, "Just so you know (R3) has not been going to Sunday school for weeks." (R3) was angry at me for questioning her. The van driver (V13) told me he knew for weeks that (R3) had been sneaking around with (V7) at church. (R3) admitted to me that (R3) and (V7) were having intercourse while (V7) was working at the facility and (R3) had even met (V7's) daughter. The facility did not keep (R3) safe, and the facility said they would keep (R3) safe. (R3) is not allowed to leave now. (R3) cannot consent to sex. I told the police officer (V27) that (R3) cannot consent, and I am her legal guardian and did not consent to (R3) having a relationship with (V7). After (R3 and V7) were caught together at church, (V27) and (V1) were made fully aware that (V7) was the male meeting up with my daughter at church. I am legal guardian, and the police and facility should have done a rape kit on Sunday (11/23/25). There was also no STD (Sexually Transmitted Disease) testing done. I have since read all the text messaging done between (R3 and V7) and I turned all those text messages over to (V27). (V7) knows (R3) is disabled and takes advantage of (R3). (V7) needs to leave my daughter alone! The messages between (R3 and V7) started before June 2025. (V7) would send messages to (R3) saying, "I can't wait to see you Sunday. I can't wait to make love to you again. You are amazing. I want you. Where are you?" I finally told (V7) that I have (R3's) phone and he needs to leave (R3) alone. (V7) continued to text me and say he cares about (R3), and they love each other. I do not want (V7) to have any further contact with (R3)."			S9999			

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S9999	Continued from page 17 On 1/28/26 at 11:36 AM V5 (Social Service Director) stated, "I know (V7) no longer works here due to a circumstance between (R3) and (V7). I do not know the exact circumstance just that we were trying to prevent anything from being inappropriate between (R3) and (V7). (V3) had spoken to me about phone calls that (R3) was having inappropriate sexual phone conversations with (V7) on 11/21/25 and supervised phone calls and (V3) had reported (R3) was making contact with (V7) while at church and meeting up with (V7) at church when (R3) was going to church. These concerns were reported to IDT that (R3) was making contact with (V7) through church. That is when I was given the information and called (V3) on 11/20/25 and 11/21/25 and did a follow-up. (V3) requested (R3's) phone be taken away on 11/21/25 and (R3) be supervised while going to church. On 11/26/25 (V3) called and said (R3) could no longer go to church 11/26/25 due to (R3) rendezvousing with (V7) while at church. (R3) admitted to me that (R3) and (V7) were having sex at church in the parking lot and (R3) was getting into a vehicle with (V7). During my conversation with (R3) I talked to (R3) about whether or not (R3 and V7) had used protection. (R3) said they did not use protection. We (the facility) got (R3) pregnancy testing done on 11/26/25. (R3) stated to me that she wanted to press charges on (V7). (R3's) current care plan does not address (R3's) reports of (V7) having nonconsensual sex with (R3) or any interventions to keep (R3) safe from further sexual abuse." On 1/28/26 at 12:51 PM V6 (Psychosocial Rehabilitation Coordinator) stated, "(R3) came into my office and said she was upset because they (R3 and V7) were in love and were texting back and forth and video chatting while (V7) worked here. (R3) let me read text messages and (V7) texting (R3) saying he missed and loved (R3) and knows (R3) is with other people and how (R3) could do that too (V7). I reported this to (V1) immediately and (V7) was given the option to resign or be terminated. On 11/20/25 (R6) reported to me that she saw (V7), who (R6) described as the little guy that used to work here, on a phone video with (R3) and (R3 and V7) were being provocative, having sexually inappropriate conversations, and having sexual acts. (R6) said she told (R3 and V7) to "Knock that off." (R6) said (V7) began cursing at (R6) and told (R6) to "Shut the f**k up" and (R3) continued to yell at (R6). (R6) was frustrated. I reported (R6's) report to (V1) and we discussed it in an IDT (Inter-Disciplinary) meeting and then (R3) was supposed to stop using electronics. After this, thoughts were going around the facility that (R3)		S9999				

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S9999	Continued from page 18 could possibly be seeing (V7) while going to church. I know that is when the iceberg started chipping off and a trickling effect started to occur. (R3) has a guardian and I am not sure if (R3) had the ability to consent to sexual relations. I was told (V3) caught (R3) with (V7) while at church and (V7) was trying to get (R3) pregnant. After this I was told (R3) could no longer go to church because (V7) was meeting (R3) while at church and was suggesting (R3) might be pregnant. It is not appropriate for (V7) to have had a relationship with (R3)." On 1/28/26 at 1:15 PM R3 stated, "I want to leave and get closer to my family. I got involved with a staff member that worked here (V7) while he worked here. I started to play songs that I had written and (V7) would come out and say he was into music. Around March of last year (V7) sent me a message request on Facebook and I said back to (V7), "How did you find me?" (V7) said we (R3 and V7) share mutual friends on Facebook. After that we started text messaging back and forth while (V7) was at work. Eventually (V7) started asking me for phone sex and naked pictures and I was not okay with that. (V7) was living with the mother of his child during this time. (V7) told me that (V1/Administrator) gave (V7) the option to leave and not have legal repercussions or (V7) could stay employed and get both of us in trouble. (V7) started to say I was f**cked up in the head and (V7) did not want me. Our relationship grew and when I started to go to church, (V7) would meet up with me at church. (V7) lured me into his car by saying he wanted to talk to me privately. That should have been my first red flag. I went to (V7's) car and (V7) raped me and it was not consensual. (V7) raped me on three different Sundays. I asked (V7) to stop. (V7) wanted me to tell everyone it was consensual. (V7) told me he wanted our conversations to make it sound consensual. I talked to (V7) once since church by phone here at the facility and told (V7) to leave me the h**l alone. (V7) said he was not going to leave me alone and that he loved me. I told (V7) I am leaving this town because of (V7). (V3) is my guardian, and I am not sure if (V3) decides if I can have sex or not. I told the police and (V1) that (V7) raped me. The police said they were investigating. I am okay with the police seeing my phone messages and I am okay with you (this surveyor) seeing those messages. I feel like I could scream and do not feel comfortable here and I am having night terrors about what happened to me from (V7). I just want to leave this town. (V7) is not allowed on the property, and I am not allowed to leave because I do not want to put myself in an unsafe spot and see (V7). I told (V1) that (V7) raped me, and it was (V7)."		S9999				

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NAME OF PROVIDER OR SUPPLIER ALLURE OF GALESBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 1145 FRANK STREET , GALESBURG, Illinois, 61401			
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S9999	Continued from page 19 On 1/29/26 at 10:30 AM V11 (Human Resources Director) stated, "On 6/27/25 me and (V1) met with (V7) after (V1) read text messages between (R3 and V7). (V7) was inappropriately texting (R3's) cellphone as in boyfriend/girlfriend type texting and telling (R3) he wanted to have a relationship with (R3). (V1) told (V7) to either resign or be fired for having an inappropriate relationship with (R3). (V7) chose to resign." On 11/29/26 at 11:00 AM V14 (Pastor) stated, "I saw (R3) and (V7) attending church services on Sundays and I met (V7). The facility never told me that (R3) needed any kind of supervision. (R3) and (V7) would get up in the middle of church services and leave for a bit and then come back in. (R3) would just say (V7) had to leave for work." On 11/29/26 at 11:10 AM V13 (Deacon) stated, "I was the church van driver and would pick (R3) up for church services on Wednesdays and Sundays. I was never told by the facility that (R3) needed to be supervised. (V7) introduced himself to me and said he was (R3's) boyfriend. (R3) told me (V7) was the head cook at the facility. (R3 and V7) would sit together during church services and would get a little too close and kiss. On 11/23/26 (V3) came to the church and caught (R3 and V7) together. (V3) went crazy and told me I was supposed to be watching (R3). That was the first time I had heard anything about having to supervise (R3)." On 1/29/26 at 12:25 PM V16 (CNA) stated, "We (facility staff) saw (V7) and (R3) flirting and I know (V7) quit so he could have a relationship with (R3)." On 1/29/26 at 12:40 PM V1 (Administrator) stated, "(V10/Prior Dietary Manager) came to me around 6/26/25 and said he was told a dietary staff member (V7) was texting with a (R3). (V7) told (V10) he was not texting with anyone. (R3) gave me her phone. I found out (V7) was texting (R3) and trying to have a relationship with (R3). It did not look like anything sexually inappropriate at that time. I said to (V7), "I thought you weren't texting (R3)". I told (V7) he could not be an employee and have a relationship with (R3). (V7) decided to resign because he wanted to have a relationship with (R3) and was having feelings for (R3). I called (V3) and told (V3) that (V7) decided to resign. Later on, I was told by (V3) that (V7 and R3) were having sex in the parking lot. (R3) said the sex was not sensual and I immediately notified the police.		S9999				

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S9999	Continued from page 20 I had educated staff in February 2025 it is not appropriate to text residents." On 1/29/26 at 1:05 PM V17 (CNA) stated, "There were several evenings that (V7) and (R3) were videochatting sexually back and forth in November. I would report this to the nurses anytime I witness them. I do not recall the nurses I was reporting this to as a lot of them were agency nurses and I do not know their names. I know it was inappropriate and should not have been happening. We (facility) staff were never told whether or not (R3) could consent to sexual relationships. Still today I am not sure if (R3) can consent to sexual relationships or not and have not been told that we need to supervise (R3)." On 1/29/26 at 1:30 PM V10 (Prior Dietary Manager) stated, "While I was the dietary manager at the facility I started noticing (V7) was not doing his job and spending a lot of time around (R3) in the day room and out on the patio. I asked (V7) about it and told (V7) it is not appropriate to have a relationship with a resident. Later, sometime in June (2025), (V7) came to me and said he was starting to have feelings for (R3). I immediately reported this to (V1). (V1) then asked (R3) if he could see her cellphone messages between (R3 and V7) and found out (R3) had more than one cellphone (V1) read the messages that were being sent back between (R3 and V7) while (V7) was an employee and (V7's) messages to (R3) were that (R3) was the love of his (V7's) life and (V7) wanted to get (R3) pregnant. (V7) was trying to have a relationship with (R3). (V1) met with (V7) and told (V7) as an employee it is inappropriate to have a personal relationship with (R3) and if (V7) wanted to have a relationship with (R3) he would either have to resign or be terminated. (V7) stated he had feelings for (R3) and chose to resign." On 1/31/26 at 9:00 AM V29 (LPN/Licensed Practical Nurse) stated, "I have been told (R3 and V7) were caught having a sexual relationship together which is a big no. A staff member should never have relationships with a resident. I have never been told that (R3) needs supervised with her electronics or using the phone. I also have not been told whether (R3) can consent or have sexual relations with other residents or not." 2. R6's Face Sheet documents R6 is a 66-year-old that was admitted to the facility on 2/26/14. R6's MDS (Minimum Data Set) Assessment dated 1/2/26 documents R6 is cognitively intact and has no			S9999			

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S9999	Continued from page 21 behaviors. R3's Behavior Note dated 11/20/25 at 8:30 AM and signed by V6 (Psychosocial Rehabilitation Coordinator) documents, "Another resident (R6) approached (V6) to report that (R3) was engaging in sexual conversation. When (R6) asked them to refrain from doing this while (R6) was in the room, the male (V7) on the call began cursing at (R6) and calling (R6) names. (R6) stated that incidents like this occur often, and it is making (R6) feel uncomfortable." R6's Progress Notes do not include any documentation regarding R6's alleged altercation with V7 on 11/20/25. R6's current Care Plan does not contain safety interventions to keep R6 safe from further abuse from V7. On 1/28/26 at 12:05 PM R6 stated, "I watched (R3) and (V7) having sex on her phone several times (unknown dates) and whenever I would try to make (R3 and R7) stop (V7) would yell at me and tell me to mind my own business and call me a b***h. I asked (R3 and V7) to stop. I didn't want to see or hear that. The last time I asked (R3) and (V7) to stop having phone sex, (V7) yelled at me, "You b***h! You are going to get your a** kicked. I told (V5/SSD) that (V7) threatened me and has threatened me several times. I definitely felt abused and worried that (V7) would do something to me." On 1/28/26 at 1:15 PM R3 stated, "While (V7) was working here (V7) would message my phone and ask me if I would shower naked on video chat with him and that he loved me. (R6) caught us on a video chat several times and (V7) was defending me because (R6) was calling me a white trash wh**e and would cuss out (R6). (R6) was my roommate and heard and saw (V7) talking sexually to me and it would upset (R6). I know (V7) cussed (R6) out several times." On 1/28/26 at 12:51 PM V6 (Psychosocial Rehabilitation Coordinator) stated, "On 11/20/25 (R6) reported to me that she saw (V7), who (R6) described as the little guy that used to work here, on a phone video with (R3) and (R3 and V7) were being provocative, having sexual inappropriate conversations, and having sexual acts. (R6) said she told (R3 and V7) to "Knock that off." (R6) said (V7) began cursing at (R6) and told (R6) to			S9999			

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S9999	Continued from page 22 "Shut the f**k up" and (R3) continued to yell at (R6). (R6) was frustrated." 3. R2's Face Sheet documents R2 is a 33-year-old that was admitted to the facility on 6/6/25 with the diagnoses of Schizophrenia, Disorientation, Violent Behavior, Strange and Inexplicable Behavior, Anxiety Disorder, Psychosis. On 1/29/26 at 12:40 PM V1 verified he has not notified the local police or the State Agency regarding R6's allegations made on 11/20/25 regarding V7. R2's MDS Assessment dated 12/12/25 documents R2 is severely cognitively impaired. R2's Final Abuse Report dated 12/13/25 and signed by V1 (Administrator) documents, "Incident Date: 12/9/25. Reported by staff that (V20/CNA) was verbally inappropriate with (R2). Investigation: Investigation revealed that (V20) was found to have been verbally inappropriate to (R2) and termed from employment." R2's Witness Statement dated 12/9/25 and signed by V16 (CNA) documents, "I (V16) came up front because I heard yelling and chairs being thrown. I got up front and (R2) was over (by) the patio door sitting in a chair crying. I asked what was going on, the (CNA/V20) said (R2's) been having behaviors all night. Then (V20) said to me, "Yea I told (R2) she's being an a**hole." I said don't ever talk to (R2) or anyone here like that. Then I called (V1) and told (V1) that was said and (V1) said to have the nurse send (V20) home for abuse." V20's typed statement dated 12/9/25 documents R2 was having behaviors and V20 responded to R2, "Why are you (R2) being an a**hole?" V20's Termination Form dated 12/11/25 documents V20 was terminated for verbal abuse to R2. On 2/1/26 at 10:10 AM V20 (CNA) stated, "I said to (R2) when (R2) was having behaviors (on 12/9/25) that (R2) was being an a**hole. I was terminated for this. I know it is inappropriate to curse at the residents." A.			S9999			