STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G240	A. BUILDING _____ B. WING _____	C 01/25/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA LUTHERAN-AURORA	**1480 RECKINGER ROAD AURORA, IL 60505**

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W 154	Continued From page 14 Z1 "stated that E9 and R1 approached him (5:45-6PM, 1/7/07) and R1 pointed to his eye. He stated that E9 told him that they both fell to the ground. As he observed the area, he did not see anything. He asked R1 if he wanted an ice pack and R1 said "yes". An ice pack was provided." The facility did not indicate when these interviews were completed. Surveyor asked E1, Administrator on 1/19/07 at 11:16am for the facility's investigation report. E1 stated, "There is no investigation report. The incident report that we had made the bruise of known origin." Surveyor then ask E1 if the facility investigated this incident as an allegation of abuse, E1 answered, "No I did not."	W 154		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATION 350.620a) 350.3240a) 350.3240b) 350.3240e) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.3240 Abuse and Neglect	W9999		

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W9999	Continued From page 15 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. These Requirements are not met as evidenced by: Based on record review and interviews the facility neglected to implement their policies and procedures to ensure that 1 of 1 allegation of abuse was identified and investigated by the facility. R1 on 1/8/07 made some gestures to indicate that someone had punched him on the face and kicked him. R1, once asked by staff, pointed to E9 as the alleged perpetrator. The facility neglected to ensure R1's safety as well as the other 43 individuals in the facility by not identifying his gestures as an allegation of abuse as well as not thoroughly investigating this incident as an allegation of abuse. E9 continued to work in the facility from 1/8/07 until 1/19/07 when he was suspended pending investigation of the allegation of abuse. Findings include:	W9999		

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W9999	Continued From page 16 R1 per his face sheet is a 31 year old male whose diagnoses include Severe Mental Retardation, Bronchial Asthma, Gastroenteritis and Hyperlipidemia. R1's Speech and Language Evaluation Report dated 7/2/06 documents "R1 is essentially non-verbal and relies on staff members to anticipate his wants and needs." R1's Nurses' Progress Notes were reviewed. On 1/8/07 at 6:00am, documentation states, "Pointing to right eye and seemed upset. Only saw a 1/8" darker area at outer edge of eye. Will continue to monitor." The facility presented a sheet with 5 staff interviews on it. The staff interviews documented the following: E4 ,Qualified Mental Retardation Professional (QMRP) - "1/8/07, at approximately 8:30am, staff E6, Supportive Living Assistant (SLA) requested that this worker, E4 come to R1's room. Before entering R1's room, this worker was told by E6 that R1 approached her and another worker as they were coming out of break room. R1 started to hit face-right eye with his right fist closed repeatedly and making a kicking motion with his right leg. E6 reported that she and the other worker asked R1 if someone hit him. R1 nodded 'yes'. E6 asked R1 to show her who he was talking about. E6 stated that R1 left C-wing hall way, walked to the front office window and pointed at the staff person." E6, SLA, "stated that she was with R1 and he pointed to his eye (3 AM, 1/8/07). She pointed to E9, lead SLA when she asked R1 what happened."	W9999		

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W9999	Continued From page 17 E9, Lead SLA, "wrote an incident report that stated that he found R1 (1/7/07, 5:30pm) picking at his toenails. While he was attempted to redirect R1, they began to walk outside of the TV room on C wing. At this point, E9 had his hand on R1's arm. R1 seemed to think that E9 was trying to take some papers from him and pulled backwards. At that point, both R1 and E9 fell to the ground. When they got up, R1 pointed to his eye. E9 and R1 went to Z1. E9 stated that the nurse did not see any sign of injury or physical indication of discomfort. An ice pack was provided. E9 stated that he also informed the supervisor on duty, E7." E7, Lead SLA "stated that E9 told him (1/7/07, 5:45pm) that he and R1 fell to the ground and described the circumstances. He informed E7 that the nurse was notified and saw no injury." Z1 "stated that E9 and R1 approached him (5:45-6PM, 1/7/07) and R1 pointed to his eye. He stated that E9 told him that they both fell to the ground. As he observed the area, he did not see anything. He asked R1 if he wanted an ice pack and R1 said 'yes'. An ice pack was provided." The facility 's interviews did not indicate when the interviews were completed. E8, Supportive Living Assistant (SLA) was interviewed via phone on 1/19/07 at 2:40pm. E8 stated, "I don't think R1 fell. R1 got something from E9 (SLA) off the cabinet. E9 tried to get it and couldn't get it. R1 was on his knees in the dining room and E9 pulled him up by his arms and out of dining room." E8 added, "I don't think R1 ate that night so I was looking for him. He wasn't in his room and maybe a couple of hours	W9999		

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W9999	Continued From page 18	W9999		

later I found him with his hands over his head and acting like somebody hit him. I told E7 (lead SLA) that R1 is acting like somebody hit him in his eyes, E7 said he's fine."

Z1 was interviewed via phone on 1/19/07 at 1:13pm. Z1 stated, "I was in the dining room. E9 was interacting and feeding (clients), suddenly R1 grabbed something from E9 and E9 wanted it back. So E9 took R1 out of dining room. A few minutes later R1 approached me and showed me his face. E9 then came to me and said R1 hit his face. I didn't get into details."

E6, SLA was interviewed via phone on 1/23/07 at 8:47am. E6 stated, "I didn't see the accident myself but R1 approached me and another staff, E5 (SLA) while coming out of break room between 2:30 and 3:00am on 1/8/07. I asked him (R1) what's wrong. R1 started gesturing, punching his face and started kicking his foot. I asked R1 to tell us who did it, R1 went straight to the supervisors' office and pointed to E9. E9 was the only person in the supervisors' office." Surveyor asked E6 if she reported it immediately, E6 answered, "At the time he told us, we didn't react about it. After he was acting strange that morning I reported it to E4. I didn't report it immediately to see if he was persistent about it."Surveyor asked when E6 talked to E1, Administrator. E6 stated, "E1 told me I had to come to his office and write a report, 1/9/07 was when I wrote it and E1 talked to me about the incident."

E5, SLA was interviewed via phone on 1/19/07 at 2:05pm. E5 stated, "We (E6 and I) noticed that R1's eye was red and puffy. E6 asked what happened. R1 motioned (gestured) punching and

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W9999	Continued From page 19 kicking motion. E6 asked R1 who did it. R1 walked ahead of us and pointed to E9. E6 asked again, R1 pointed again. The next night (1/9/07) R1 pointed to E9 again. Surveyor asked E5 if somebody from the facility had interviewed her about this incident, E5 answered, "No, nobody had asked me about the incident." E4, Qualified Mental Retardation Professional (QMRP) was interviewed on 1/19/07 at 11:45am. E4 stated, "E6 had approached me that morning to request that I come down to R1's room. E6 had said to me that R1 had approached her and another staff leaving the break room and R1 motioned to E6 and other staff punching towards the right eye and kicking motions. E6 said she asked R1 if anyone hit him, he nodded 'yes.' E6 said for R1 to show her who; R1 led her down the hallway to supervisor's window and pointed at E9. E9 was sitting inside." E4 added, "When we walked in, R1 was in bed on his knees with bed sheet over him and he was shaking. He was drooling, he was wet. I looked at his face and there was a mark on the right eye. I asked R1 if he can tell me what happened, he didn't respond. I asked him if anyone hit him, no respond." Surveyor asked E4 if R1 acted as usual after that incident, E4 answered, "R1 stayed home a couple of days after that which is not common for him." E9 was interviewed on 1/19/07 at 2:51pm. E9 stated, "I'm getting to the door and his pants were too long. I don't know if I step on his pants or toes and we both fell so I then told my supervisor what happened and the nurse said to put ice." Surveyor asked if R1 took any of E9's stuff, E9 answered "No R1 did not take anything from me."	W9999		

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W9999	Continued From page 20 R1 was interviewed at his day training site on 1/23/07 at 10:10am. R1 was asked what happened to your eye, no answer. Surveyor asked if anyone was mean to him, R1 shook his head no. Surveyor then asked if somebody hit him. R1 again shook his head no. R1 during this time period would not look at surveyor, he was continuously looking down on the table. Z2 was interviewed on 1/23/07 at 10:15am. Z2 stated, "Since I've been working with R1, I haven't known him to make false accusations. He's actually very helpful and very observant. If a peer leaves a room or starts seizing, he'll let me know right away." Surveyor asked E1, Administrator, on 1/19/07 at 11:16am for the facility's investigation report. E1 stated, "There is no investigation report. The incident report that we had made the bruise of known origin." Surveyor then asked E1 if the facility investigated this incident as an allegation of abuse, E1 answered, "No I did not." Surveyor asked if any other employees were interviewed regarding this incident, E1 answered, "I did not interview the rest of the staff on duty." The facility's Abuse/Neglect of Person Served policy was reviewed. It defines physical injury as "any physical harm to an individual caused by any non-accidental act or omission. Examples include hitting, kicking, pinching, choking, shoving, punching, biting, slapping, punching, striking with an object, burning, dragging or cutting with or without an injury." Neglect is defined as "any act or omission by a community agency or program or employee thereof that endangers an individual's health or safety or fails to respond to an obvious and immediate need of	W9999		

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W9999	Continued From page 21 an individual, regardless of whatever or not there is an injury ..." The facility's policy includes reporting defined as "Person(s) observing or suspecting the occurrence of abuse shall be responsible for reporting it to their supervisor as soon as possible." Under investigation, the facility's policy includes these steps: 1. Any reported case of suspected abuse/neglect shall be investigated swiftly and thoroughly by the agency representative or designee. This person may not directly supervise the alleged perpetrator. 2. All witnesses present shall make a written statement regarding the incident. 3. All parties will be interviewed separately (staff and person served). 4. Only after all facts are ascertained shall a decision be made. 5. The suspect shall be put on leave of absence without pay pending the investigation. E9's punch card was reviewed. It showed that E9 worked these following date and hours: 1/7/07 from 2:27pm to 7:30am 1/8/07 from 2:30pm to 7:30am 1/10/07 from 5:50am to 12:03pm 1/10/07 from 10:57pm to 2:30pm 1/11/07 from 11:00pm to 2:30pm 1/12/07 from 10:54pm to 7:31am 1/15/07 from 2:25pm to 7:30am 1/16/07 from 10:58pm to 2:30pm 1/17/07 from 10:59pm to 2:31pm 1/19/07 from 2:32pm to 3:05pm when he was suspended following surveyor notification of an Immediate Jeopardy The facility neglected to implement their policy on	W9999		

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W9999	Continued From page 22 Abuse and Neglect when they failed to identify's R1's gestures as an allegation of abuse, failed to report the allegation immediately, failed to thoroughly investigate the incident and failed to ensure the safety of 44 of 44 clients (R1-R44) in the facility during this time period when they allowed E9 to continue working following R1's allegation. (A)	W9999		