		I AND HUMAN SERVICES			•	FORM	: 08/31/2007 APPROVED
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:]` `	IULTIPLI	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		14G201	B. WII	νG		07/1	C 1/2007
·	OVIDER OR SUPPLIER A LUTHERAN-MON	TGOMERY		120	ET ADDRESS, CITY, STATE, ZIP CODE 5 SOUTH SPENCER RORA, IL 60505		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
7 E a	10 stated she con-	leged sexual abuse. pleted R2's quarterly nursing ver R2 was not physically lothes off.	W :	÷			
3 3 3 3 3 3 3 5 a pri fa in st	The facility shall he cocedures governing the color of the color of the anall be available to	sident Care Policies have written policies and hig all services provided by the formulated with the dministrator. The policies the staff, residents and the hip policies shall be followed in					
le Se	ast annually. ection 350.700 Ser	and shall be reviewed at ious Incidents and Accidents of any	•				

incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis

shall be reported to the Department.

PRINTED: 08/31/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
_			A. BU	ILDIN	IG	ŀ	C	
		14G201	B. WI	NG_			1/2007	
	PROVIDER OR SUPPLIER BDA LUTHERAN-MON	TGOMERY		1.	REET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTH SPENCER AURORA, IL 60505			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	services, in accorda shall include, but are The DON shall part 3) Periodic reeval quality of services at c) A registered nursiappropriate, in plantraining of facility periodic ey Sufficient, appropriated appropriate, appropriated nurses and to carry out the variation of a facility shresident. b) A facility employed aware of abuse or immediately report the doministrator. c) A facility administrator abuse or neglect of report the matter by the resident's repressionable of a facility administration becomes aware of a shall also report the f) Resident as perpensivestigation of a repressident indicates, but that another resident is the perpetrator of condition shall be implement for the resident resident indicates, but the perpetrator of condition shall be implement for the resident resid	Jursing Services be provided with nursing ance with their needs, which are not limited to, the following: icipate in: Illuation of the type, extent, and and programming. It is shall participate, as uning and implementing the ersonnel. It is priately qualified nursing staff which may include licensed to other supporting personnel, ous nursing service activities. It is and Neglect are, administrator, employee or half not abuse or neglect are or agent who becomes reglect of a resident shall the matter to the facility the phone and in writing to sentative. I rator, employee, or agent who are or neglect of a resident matter to the Department. I rator of abuse. When an are of a seed upon credible evidence, to of the long-term care facility the abuse, that resident's imediately evaluated to	W9	999	· · · · · · · · · · · · · · · · · · ·			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l' í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G201	B. WIN	LDING IG			C 1/2007
	PROVIDER OR SUPPLIER	•		120	ET ADDRESS, CITY, STATE, ZIP CODE 5 SOUTH SPENCER RORA, IL 60505		11200
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	Continued From pa	age 44	W99	99			
	by:	s were not met as evidenced					
	failed to implement when they failed to R1, R3 and R6 from The facility: 1. Failed to imme of sexual abuse invite Administrator. 2. Failed to report	ediately report 3 of 3 allegations volving R2, R1, R3 and R6 to	٠				
	abuse involving R2 3. Failed to invest 1 of 3 allegations of and R3. 4. Failed to contar allegations of sexual	, R1 and R3 to IDPH. tigate or thoroughly investigate f sexual abuse involving R2 ct the nurse for 1 of 3 al abuse and failed to have I examine R2 and R6 in a					
	Findings include:						
	male whose diagno Retardation, Down : Developmental Disc QMRP) was interviewerified R1 is essen some gestures to co score of 1 year 9 mg	is face sheet, is a 39 year old leses include Profound Mental Syndrome and Pervasive order. E1 (Program Director / lewed 6/22/07 at 11:55am. E1 litially non-verbal, he uses ommunicate. R1 obtained a onths on his adaptive behavior 1/07. R1 was admitted to the					
	male whose diagnos Retardation, Down S	s face sheet, is a 42 year old ses include Moderate Mental Syndrome and Bipolar atterviewed 6/22/07 at		·			

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 08/31/2007 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILD	DING	COMPL	ETED
		14G201	B. WII	NG		07/	C 11/2007
	ROVIDER OR SUPPLIER DA LUTHERAN-MONT	GOMERY		s	STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SOUTH SPENCER AURORA, IL 60505		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPENDEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	of expressing his wais not consistently re R2 obtained a score adaptive behavior as R3, per review of his male whose diagnos Retardation, Down S Affective Disorder. It 11:55am. E1 verified to understand. R3 of months on his adapt 10/9/06. R6, per review of his male whose diagnos Retardation, Depress Recurring Pneumoni E1 was interviewed R6 is essentially non R6 obtained a score adaptive behavior as The facility's policy "A Served," last revised "Abuse means any por mental injury inflict than by accidental mesexual abuse is defir "Sexual abuse means exual penetration, sexploitation of an indirection	d R2 is verbal and is capable ints and needs. E1 stated R2 diable in relating information. of 8 years 8 months on his issessment of 4/5/07. If face sheet, is a 55 year old des include Severe Mental Syndrome and Bipolar E1 was interviewed 6/22/07 at diable R3 is verbal but is difficult betained a score of 4 years 10 inverbal behavior assessment of respective behavior assessment of respective properties. If a 38 year old des include Moderate Mental sion, Seizure Disorder and a. If a 4 1:15pm. E1 verified everbal. Of 2 years 5 months on his sessment of 7/30/06. Abuse/Neglect of Person 1/12/06, defines Abuse as: hysical injury, sexual abuse ted on an individual other eans." If a 5 is verbal but is difficult between an ervices and another person inployee's genital area, anus, or an individual's genital	W9:	999	9		

(X2) MULTIPLE CONSTRUCTION

PRINTED: 08/31/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY WID PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C B. WING 14G201 07/11/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

1205 SOUTH SPENCER BETHESDA LUTHERAN-MONTGOMERY AURORA, IL 60505 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID Œ (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W9999 Continued From page 46 W9999 individual for another person's sexual gratification, arousal, advantage or profit." The facility's Abuse / Neglect policy also notes the following: "Person served to Person served A. Reporting 1. Person(s) observing or suspecting the occurrence of abuse shall be responsible for reporting it to their immediately supervisor immediately. 2. If the person's immediately supervisor or his/her designee is unavailable, the Program Director shall be notified. 3. The nurse shall be contacted to determine if medical attention is needed. 4. The Administrator will be notified by the PD (Program Director) or on-call designee. 5. The Administrator shall notify the Regional Administrator or corporate designee as soon as possible. 6. The Administrator / Program Director shall notify the family / Guardian of the alleged incident and explain that an investigation is being conducted." 1) The facility's incident reports were reviewed. On 6/15/07 E3 (direct care) documented, via incident report, an allegation of sexual abuse. The incident was noted to have occurred 5 days prior - 6/10/07. E3 documented the following: "(R2) was sitting on the couch pretending to be sleep(ing), when (R1) came to sit down by him (R2) then put his arm around (R1). When I came over to redirect the individuals (R1) continued to hug (R2) and (R2) continued to act sleep. I feel that the behavior displayed was more of a sexual behavior and that (R1) was more so unknowingly

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION	(X3) DATE COMPI	SURVEY
			A. BUIL	LDING	——— COMP	
		14G201	B. WIN	IG	_ 07/	C 11/2007
	ROVIDER OR SUPPLIER DA LUTHERAN-MON	TGOMERY		STREET ADDRESS, CITY, STATE, 1205 SOUTH SPENCER AURORA, IL 60505		11/2007
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
V 9999	Continued From par provoked."	ge 47	W99	99		
1	the incident of 6/10/verified E3 did not in allegation that R2's is sexually abusive to it were roommates; he moved out of the shittold R2 to keep his hagreed to do so. E1 told to conduct 15 m him more closely. Eany documentation of conducted on 3rd shim the 15 minute check on 7/3/07 at approximation of the shift results of the 15 minute check on 7/3/07 at approximation of the checks were considered checks were considered checks were considered in the same saked when mplemented. E1 stated the 150pm. E9 verified acility. E3 was asked the cks were implemented to the check were included on the check set in the check in the ch	6/20/07 at 11:05am regarding 07 involving R1 and R2. E1 inmediately report the behavior was potentially R1. E1 stated R1 and R2 owever, as of 6/15/07 R1 ared bedroom. E1 stated she hands to himself and he stated 3rd shift staff were inute checks of R2 to monitor 1 was asked if the facility had of the 15 minute checks iff or the discussion she had he discussion with R2 and is were not documented. mately 1:10pm E1 provided to for R2 noting that 15 minute checks were atted the 15 minute checks were atted the 15 minute checks were atted the 15 minute checks 15/07. interviewed 7/3/07 at she works 3rd shift at the d when 15 minute bed ented for R2. E3 stated the swere implemented, as heet - 6/28/07. E3 stated the swere not done prior to				
C h a	On 6/20/07 at 11:05a istory of inappropria ny previous allegatio 1 stated it was neve	m E1 was asked if R2 had a te sexual behavior or had ons of sexual abusing others. It is previously reported to her y touched anyone before.				

PRINTED: 08/31/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 14G201 07/11/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SOUTH SPENCER **BETHESDA LUTHERAN-MONTGOMERY** AURORA, IL 60505 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) W9999 Continued From page 48 W9999 On 6/20/07 at 12:44pm Z3 was interviewed regarding R1. Z3 stated she has noted R1 being more agitated lately and also picking at "his bottom" (anal area). Z3 stated R1 will frequently pull at his pants from behind. Z3 stated she talked to a staff from R1's residence about her

E5 (former direct care) worked at the facility from approximately April 2006 thru October 2006. E5 was asked if he was aware of R2 displaying any incidents of inappropriate sexual behavior. E5 stated he was aware of an incident with R1 and R2. E5 stated R1 and R2 were roommates at the time. E5 stated he can not remember the date of the incident. E5 explained that one evening, approximately 7/06 thru 10/06 at 10:00pm, R1 came out of his bedroom and he was naked. E5 stated R1 looked scared. E5 stated R2 was also naked.

concerns. The staff (un-named) told her the facility found R1's roommate (R2) doing

"inappropriate" things with R1. The staff also told Z3 that R2 did the same thing to his previous

E5 stated R2 always sleeps in the nude, however R1 always sleeps in pajamas.
E5 stated he reported the incident to E1 (Program Director/QMRP) and he was told to conduct 15 minute bed checks on R1. E5 stated he also documented the incident, either in progress notes or on an incident report. E5 stated he was also aware of R2 having R3 touch him (R2) in a sexual way. E5 stated this was also reported to E1.

R1, R2 and R3's records, as well as incident reports, were reviewed. There was no documentation of the above noted incidents as explained by E5.

roommate (R3).

TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION		IDENTIFICATION NUMBER		ULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUIL	DING	COMPL		
		14G201	B. WIN	G	07/	C 11/2007	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1205 SOUTH SPENCER AURORA, IL 60505			
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
W9999	Continued From p	page 49	W99	99		,	
	approximately 1 to incident involving roommates at the	1:55pm, E1 told surveyor that to 1 1/2 years ago there was an R2 and R3. R2 and R3 were time. Surveyor requested any garding the incident.					
	to locate any infori	oam E1 stated she was unable mation regarding the incident. or subsequent investigation					
	E1 stated she vagi (from 1 to 1 1/2 ye E1 stated R2 and I time. E1 stated R2 together in a bed.	Coam E1 was again interviewed. Lucly remembers an incident ar ago) involving R2 and R3. R3 were roommates at the 2 and R3 were both found E1 stated she could not recall tion about the incident.					
	reviewed. R3's IPF "(R3) has switch(ed due to inappropriat	ridual Program Plan (IPP) was P noted the following: d) roommates in the past year, e sexual behavior. (R3) was not to the behavior nor was it					
1	switching roommate sexual inappropriate sexual inappropriate sexual behavior. E1 was a sexamined by nursing fit was not in the nursing the sexamined. R2 apast 2 years were reserved.	es and the comment of all behavior." E1 stated the all comment refers to R2's asked if either R2 or R3 were g after the incident. E1 stated turses notes then they were and R3's nursing notes for the eviewed. There was no ursing of an exam, as per or R3.					

	OF CORRECTION	IDENTIFICATION NUMBER:	1	ILDING		COMPL	ETED
		14G201	B. Wil	NG		07/	C 11/2007
	ROVIDER OR SUPPLIER DA LUTHERAN-MO		<u>. </u>	STREET ADDRESS, CITY, STATE, ZIF 1205 SOUTH SPENCER AURORA, IL 60505			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
	The report notes in from a community operated residenti incidents of physic towards lower function in the sexual aggress partners into sexual aggress partners into sexual and lying on top of them until they continappropriate sexual masturbation and E4, E6 and E7 (all regarding R2's histobehavior. E4 states seen R2 hug other told by other staff to (R3)." E4 explaines would have R3 per E6 stated, 6/20/07 R2 be inappropriate she heard rumors to the clients. E6 were as on R3 and R2 E6 stated R3 move because of "rumors to the clients. E6 were stated, 6/20/07 working at the facility operations."	hological report was reviewed. In July 1995 R2 was moved residential facility to a state al facility " due to several al and sexual aggression ctioning clients. The nature of sion included coercing unwilling at activity, undressing, fondling, other residents and holding ald not leave. Other all behaviors included public exposing himself in public." direct care) were interviewed tory of inappropriate sexual ad, 6/20/07 at 2:56pm, she has clients. E4 stated she was hat, "(R2) was sexual with d that other staff told her R2 form oral sex on him. at 2:50pm, that she never saw as with other clients. E6 stated that R2 was inappropriate with as asked if she knew the were no longer roommates. Ad out of R2's bedroom is." at 2:40pm, when she started ty (4 weeks ago), she was told	W9	999			
	ollowing information confidential intervier January 2006 or Fe Staff found R2 and	view was conducted and the n was obtained. The wee stated in approximately bruary 2006 a former 3rd shift R3 in R3 's bed. R2 was m. After the incident E1 was					

PRINTED: 08/31/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		440204	A. BU	ILDING NG			С
*******	TO ADED ON DURBUIED	14G201	——	T		07/1	11/2007
	PROVIDER OR SUPPLIER			120	EET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTH SPENCER URORA, IL 60505		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	informed and R3 n shared with R2. R facility incident rep no documentation The confidential interview (admitted to the fact be R2's roommate confidential interview months there were R2. Then it was not to his bedroom. R grabbing at his behonfidential interview (admitted to the fact behavior).	moved out of the bedroom he R2's and R3's records and borts were reviewed, there was	W99	999			
	allegation that R2 s R6 became R2's ro allegation that R2 v R1. E9 (direct care) was 12:35pm. E9 states 11pm til 7am) the n abuse of R6. E9 st 2007 at approximat R6's and R2's bedrowhen she got R6 up E9 stated R6 had a	eported to surveyor an sexually abused R6. commate 6/15/07 due to an was inappropriately touching as interviewed 7/3/07 at ed she was on duty (working night of the alleged sexual tated that on Sunday July 1, tely 12:15am she was entering room to toilet R6. E9 stated p he looked like he was crying. I look of fear and helplessness ated she asked R6 if R2 had					
	bothered him. R6 v E9 stated she also a "frontal" area (penis E9 stated she then a "rear" area (buttock E9 stated she was o						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G201	A. BUI	ILDING NG	-		C 11/2007
	PROVIDER OR SUPPLIER	ITGOMERY	1_	120	EET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTH SPENCER JRORA, IL 60505	<u> </u>	1/2007
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX.	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	"yeah" she knew so stated she then ask first R2 denied touch took R6 to the living comfortable on the living room area and asked R2 why he with touching R6 in the "stated she notified It approximately 7:00% hours after the allegasked why she wait am to notify the Administrator was not abuse of R6 on 7/1/administrator was not abuse of R6 on 7/1/administrator was not 7:50am (7 1/2 hours occurred). E10 (facility nurse) with 1:05pm, via telephonand R2 were examinalleged sexual abuse a full body assessment approximately 2:00 E10 stated there was R6's chart/nursing not 7/3/07. There was not assessment complete asked if she docume in the record. E10 sin R6's record because E10 was asked if R2	bomething was wrong. E9 ked R2 about touching R6. At ching R6. E9 stated she then g room area and made him couch. R2 then came into the lot told E9 he was sorry. E9 was sorry and R2 admitted to "frontal" and "rear" areas. E9 E1 and the on-call person at am 7/1/07, approximately 7 ged sexual abuse. E9 was ted until approximately 7:00 ministrator. E9 stated it was view 7/3/07 at 1:35pm, the on iffied of the alleged sexual	W99	999			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		14G201	B. WIN		ľ		C 11/2007	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 1205 SOUTH SPENCER AURORA, IL 60505				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
:	assessment. How examined with his E1 was interviewed asked why R6, who report unwanted so to room with R1 (winappropriate sexu functiong clients). R2's roommate and problems. E1 also	ted R2's quarterly nursing ever R2 was not physically	W99	99				
		(A)						
<u>.</u>			<u> </u>					