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 08/23/2007

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 157	Continued From page 11 E3, the Investigator, was interviewed on 8/15/07 at 1:45 PM. He confirmed the above findings. He said the only corrective action taken was as listed in the report. He stated there was no staff training, nor follow up for R1's "weak bones". He stated that he did not share the investigative conclusions with E2, DON.	W 157		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1230c) 350.1230d)1)2)3) 350.1230e) 350.1230f) 350.1230g) 350.3240a) 350.3240b) 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 350.1230 Nursing Services c) A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel. d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical,	W9999		

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W9999	Continued From page 12 nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. 3) First aid in the presence of accident or illness. e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. f) The individual responsible for providing nursing services shall have knowledge and experience in the field of developmental disabilities. g) Nursing service personnel at all levels of competence and experience shall be assigned responsibilities in accordance with their qualifications. Section 350.3240 Abuse and Neglect 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. These REGULATIONS were not met ase evidenced by: Based on record review and interview, it was determined the Facility failed to implement their policies to prevent medical neglect for one resident (R1) hospitalized with a fractured left arm and shoulder dislocation, when they failed to: 1) Provide prompt and adequate medical attention for R1's arm fracture and shoulder dislocation, even after being notified of abnormal findings by the direct care staff.	W9999		

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W9999	Continued From page 13	W9999		

Continued From page 13

2) Ensure that staff follow the reporting procedure for one injury of unknown origin (R1's injured left arm).

Findings include:

Facility policy titled, "Injuries of Unknown Origin NE-IN75ind" requires the following:
"I) Injuries of unknown origin include any injury that is observed on an individual for which the cause is unknown. These injuries may include...swelling...or any other injury that was not witnessed. D) Staff shall determine whether the injury warrants medical attention and take action immediately."

Facility policy titled, " Abuse / Neglect of Persons Served" requires the following:
" I) C) Definition for Neglect: The failure to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to an individual. Any act or omission by an...employee that endangers an individual's health...or fails to respond to an obvious or immediate need of an individual, regardless of whether or not there is an injury."
"V) 3) The nurse shall be contacted to determine if medical care is needed."

1) R1's records were reviewed. According to the face sheet, R1's date of birth is 7/08/56, her diagnoses include Profound Mental Retardation, Seizures and Lumbar Scoliospastic Paraplegia. The Individual Program Plan, dated 6/19/07, documented that R1 is non-verbal, non-ambulatory, moves all extremities, is dependent on staff for activities of daily living, and that she has an IQ of <17 and functions at an

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W9999	Continued From page 14 adaptive age of 7 months. A nurse's note, dated 7/16/07 contained documentation that at 8:00 AM, on 7/16/07, R1 was sent to the Emergency Department (ED) for assessment of her right arm. The resulting diagnosis was a fractured left humerus (upper arm bone) and dislocation of the left shoulder. The hospital ED records state that R1 was sent from the ED to the Operating Room for a closed reduction of the left humerus. The facility's Internal Investigation Report regarding R1's arm injury, dated 7/17/07, was reviewed. The Report contained the following interviews; a) On 7/11, five days before R1 received medical care for her injured arm, a Direct Staff Person (DSP) (E5) and the Lead DSP (E4) noticed that R1's left arm was "hanging to the side" and brought R1 to the nurse for an assessment. b) On 7/13, DSP (E6) notified the nurse that "R1's arm was slightly swollen." c) On 7/14, E4 again notified the nurse that R1's arm was restless [not moving] and slightly swollen. d) The Director of Nursing (E2) confirmed that she was notified of R1's arm on 7/13, and that her assessment that day was negative for findings, however on 7/16/07 she noticed that R1's arm was swollen, cold to touch and sent her to the ED. The above findings were confirmed by E3, Investigator, on 8/15/07 at 1:45 PM. E4, the Lead DSP, was interviewed on 8/16/07 at 12:30 PM. She stated that on 7/11, she brought R1 to the DON, E2, because her arm was "hanging as if she had a stroke." She stated that R1 usually reaches with and flexes both arms	W9999		

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throughout the day. E4 said that E2, DON, found nothing wrong and said to watch it [R1's arm], but did not give specific instructions. E4 stated that on 7/14/07, she noticed swelling of the arm, along with continued lack of movement, and again informed the nurse on duty. E4 said that she did not document or fill out an incident report about R1's arm.

E5, DSP, was interviewed on 8/16/07 at 1:20 PM. She stated that she cared for R1 on 7/11 and 7/13. She stated that when R1 is stimulated during care, she strongly flexes both arms, however on the mentioned dates, R1's left arm was not moving. Even when R1 was in bed and rolled onto her side, her arm remained behind her. E5 stated that she notified the nurse on 7/11 and 7/13. E5 stated she did not document her findings.

E7, DSP, was interviewed on 8/16/07 at 1:35 PM. She stated that she cared for R1 on 7/14 and 7/15 and noticed that her arm was limp, that she was not using it. She stated she told E4, Lead DSP, but did not document her findings.

E2, the DON, was interviewed on 8/16/07 at 2:10 PM. She verified that direct care staff approached her on 7/11 and 7/13 with concerns regarding R1's arm. She stated that she examined R1 and did not find any problems. She stated that she did not write a nurse's note either day because of her negative findings, however on 7/13 she wrote in the 24hr. nurses log, "R1: Monitor left arm, range of motion... normal limits, no swelling." E2 stated that the log is not part of the resident's record, it is used for nurses to communicate between shifts. She stated that nothing specific was put in place to notify all

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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involved staff to "monitor left arm" as written.

The first note in the record mentioning R1's arm, was written in a nurse's progress note dated 7/15/07 at 7:00 PM, four days after the first DSP notified nursing that something appeared wrong. The nurse documented, "Left arm and hand swollen. Left arm very limble, unable to hold it up - will report it to oncoming nurse and continue to monitor." The progress notes stated that the next morning on 7/16 at 9:00 AM, approximately 14 hours after the prior nurse's note, E2, DON, sent R1 to the ED for an evaluation.

During interview on 8/16/07 at 2:10 PM, E2 confirmed the above findings and stated that prior to 7/16, when R1 was sent to the ED, the physician was not notified of the staff's concerns regarding R1's arm.

Nursing failed to provide R1 with necessary monitoring and medical attention as needed.

2) Facility policy titled, "Injuries of Unknown Origin NE-IN75ind" requires the following: "Staff that discovers the injury should...check daily logs for documentation of an event. Once it has been determined the injury is of unknown origin, staff shall immediately contact the Area Director who is designated Administrator. If there is no documentation of an event that would be consistent with the injury, the injury should be considered an injury of unknown origin."

E3, Investigator, was interviewed on 8/15/07 at 1:45 PM. He stated that any staff person aware of a possible injury to a resident should initiate an injury report. He stated that there were no injury

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W9999	Continued From page 17 reports, nor was he notified, about R1's arm until 7/16/07 when she was sent to the ED. E1, Administrator, was interviewed on 8/15/07 at 2:45 PM. He stated that in cases of a suspected injury of unknown origin, all staff members can and should initiate an incident report and contact administration. During interviews on 8/16/07, at the times mentioned above, E4 the Lead DSP and the staff DSPs, E5 and E7, confirmed that they had not filled out an incident/injury report regarding R1's arm, they had only contacted the nurse and that their observations were not documented. The DSP daily logs for 7/11/07 to 7/16/07 were reviewed on 8/16/07. The logs lacked documentation regarding R1's arm During interview on 8/16/07 as noted above, E2, DON, stated that nursing did not fill out an injury report, nor had they contacted the administrator or the physician prior to R1 being sent to the ED on 7/16/07. Facility staff failed to document and contact administration as required. (A)	W9999		