STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G080	A. BUILDING _____ B. WING _____	C 06/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEARLES GROUP HOME	3310 SEARLES AVENUE ROCKFORD, IL 61101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 156	Continued From page 13 Person, includes, "At DT (day training) today, staff discovered a bruise on her left wrist. Residential Services Coordinator (E3) was notified when R3 returned home from DT. Staff looked at her wrist and asked where she got the bruise from. She didn't how or when the bruise formed. It is circular in shape and very swollen. Continue to monitor and follow up." The Investigation Report dated 4/26/10 under staff information notes, "Staff indicated the injury may have occurred by R3 bumping into something, laying on her watch, or an incident at work. Staff also indicated R3 stated a staff had done it." The facility's investigation includes statements obtained from Direct Service Persons E6, E7, E9, E11 and E14. Statements from E9 and E11 both state R3 told them E5, Direct Service Person, had hit her. There is no evidence IDPH was notified of the results of the alleged abuse investigation of 4/26/10 of R3 by E5 On 5/27/10 at 10:30am E3, Residential Services Coordinator, was asked if IDPH was notified of the results of the investigation of an allegation of abuse. E3 stated, "No. We considered it an unknown injury."	W 156		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.3240a) 350.3240e)	W9999		

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W9999	Continued From page 14 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 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) 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. (Section 3-611 of the Act) These Regulations were not met as evidenced by: Based on record review and interview, the facility failed to follow their abuse/neglect policy to ensure all 12 of 12 clients (R1 through R12) in the facility were protected from further contact with E5, who allegedly hit R3 on the wrist. Findings include:	W9999		

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W9999	Continued From page 15 R3, per the Investigative Report dated 4/26/10, is a 76 year old female whose diagnosis includes Severe Mental Retardation and Major Depression. The report notes she is verbal and ambulates with the assistance of a walker. Information attained from the client roster on 5/27/10 notes: R1 is diagnosed with Profound Mental Retardation. R2 is diagnosed with Profound Mental Retardation. R4 is diagnosed with Profound Mental Retardation. R5 is diagnosed with Profound Mental Retardation. R6 is diagnosed with Profound Mental Retardation. R7 is diagnosed with Profound Mental Retardation. R8 is diagnosed with Profound Mental Retardation. R9 is diagnosed with Severe Mental Retardation. R10 is diagnosed with Profound Mental Retardation. R11 is diagnosed with Profound Mental Retardation. R12 is diagnosed with Profound Mental Retardation. The facility's policy on Abuse and/or Neglect to an individual served dated 12/05 includes, "Abuse means any physical injury, sexual abuse, or mental injury inflicted on an individual served other than by accidental means in a nursing home."	W9999		

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W9999	Continued From page 16 The Policy's Procedures note, "Immediately after being informed of the alleged incident, the facility administrator shall suspend without pay, the employee allegedly involved or shall evict, pending further notice, any visitor accused." Review of the Health/Medical Status Note dated 4/26/10 written by E5 (DSP/Direct Service Person) includes, "At DT (day training) today, staff discovered a bruise on her left wrist. Residential Services Coordinator (E3) was notified when R3 returned home from DT. Staff looked at her wrist and asked where she got the bruise from. She didn't how or when the bruise formed. It is circular in shape and very swollen. Continue to monitor and follow up." The Investigation Report dated 4/26/10 under staff information notes, "Staff indicated the injury may have occurred by R3 bumping into something, laying on her watch, or an incident at work. Staff also indicated R3 stated a staff had done it." The facility's investigation includes statements dated 4/26/10 obtained from Direct Service Persons E6, E7, E9, E11 and E14. Statements from E9 and E11 both state R3 told them E5 (Direct Service Person) had hit her. There is no evidence E5, the person identified as having hit R3, was suspended per facility policy or other safeguards put in place to ensure the client's safety. Facility staff schedule indicates E5 continued to work on 4/26/10, 4/27/10, 4/28/10, 4/29/10 and 4/30/10 and into May, 2010. On 5/27/10 at 10:30am E3 (Residential Services Coordinator) was asked why E5 continued to	W9999		

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W9999	Continued From page 17 work. E3 stated they did not consider it an allegation of abuse. The facility considered it an unknown injury. (A)	W9999		