STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145958	A. BUILDING _____ B. WING _____	08/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHANY REHAB & HCC	3298 RESOURCE PARKWAY DEKALB, IL 60115

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from the wrongful use of the resident's belongings or money.** Based on interview and record review the facility failed to prevent unauthorized use of a resident's debit card by a staff member for one of three residents (R1) reviewed for misappropriation in the sample of 3. Findings include: On August 13, 2020 at 12:05 PM, V1 (Administrator) said V4 was a housekeeper involved in exploiting money from a resident (R1). At 2:00 PM, V8 (R1's family member) said R1 called her and said the bank notified him someone tried to steal $2000 out of his bank account. V8 said she contacted the bank and discovered there were three unauthorized withdrawals from his bank account on July 7, 2020. The first amount was $20 which was transferred to V10 (V4's friend). The second and third unauthorized withdrawals were made on July 7, 2020 to V11 (V4's mother). These money transfers were in the amounts of $100 and $300. The withdrawals were made through a mobile application that transfers money electronically. A fourth money transfer for $2000 was declined by the bank on July 7, 2020 after the first three went through. The names of V10 and V11 showed on the bank statement. V8 said she looked up V10 on a social media site and determined they had a mutual friend. V8 contacted this mutual friend. The mutual friend had V10 contact V8. On August 14, 2020 at 9:00 AM, V10 said she and V4 have been best friends since fifth grade, and V4 is the only person she knows who worked at this facility. V10 said V4 texted her on July 7, 2020 and told her to hang on to the $20 she sent electronically. V10 confirmed with her money transfer application that V4 sent her $20 on July 7, 2020 at 9:37 AM via a cash application. V4's time sheet for July 7, 2020 showed she was at the facility working from 7:30 AM-3:00 PM. V4's assignment for July 7, 2020 showed she was assigned to work in R1's hall. On August 14, 2020 at 9:30 AM V1 said an email to notify families of the financial exploitation was sent out on July 10, 2020. The facility's investigative notes showed on July 13, 2020 at 8:45 AM, V4 told V1 and V2 (Director of Nursing) she sent V10 $20 on July 7, 2020. V4 also confirmed she gave V11 $100 but was unsure of the date. V4 was unable to give an explanation how her family members could have received monies from a resident's bank account. The facility's email alert sent to resident families showed financial exploitation of a resident by a staff member occurred the week of July 7, 2020. The facility's Abuse Prevention and Prohibition Policy dated November 2018 showed the facility prohibits misappropriation of resident property and residents must not be subjected to abuse by anyone. Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to thoroughly investigate an allegation of misappropriation of resident funds for one of three residents (R1) reviewed for abuse in the sample of 3. Findings include: R1's face sheet printed August 13, 2020 showed a [AGE] year old male. R1's admission note dated May 27, 2020 showed he was admitted to the facility for short term rehab from a local hospital after frequent falls at home. R1's electronic record showed a discharge date of [DATE] (the day after the misappropriation). R1's facility assessment dated [DATE] showed R1 was cognitively intact. On August 13, 2020 at 10:10 AM, V3 (Housekeeping Manager) said all housekeeping, laundry, and dietary employees are contracted through Health Care Services Group (HCSG). V3 said V4 (Housekeeper), the alleged perpetrator, worked July 7, 2020 from 7:30 AM-3:00 PM and only punched out for 15 minutes. At 10:45 AM, R1 said I don't even know what happened. My wallet was on the bedside table while I was sleeping. At 12:05 PM, V1 (Administrator) said V4 was a housekeeper at the facility and employed through HCSG. V4 tried to exploit and take money from a resident. It happened on July 7th, but we didn't realize an employee was involved until V8 (R1's family member) told us on July 9, 2020. V1 said the facility held an inservice (referred to the July 9, 2020 in service sign in sheet) to educate staff regarding the facility's abuse prevention plan and reporting requirements. At 12:40 PM, V5 (Registered Nurse/RN) verified on R1's electronic medical record that she was R1's nurse on the day shift on July 7, 2020. V5 stated I did his COVID screening and vital signs so I was his nurse. I didn't attend the inservice; my name is not on the sign in sheet. V1 and V2 (Director of Nursing/DON) never talked to me about an allegation of misappropriation of resident funds or about V4. This is the first I heard about it. At 1:00 PM, V6 (Certified Nursing Assistant/CNA) checked her cell phone and verified on her shift scheduler that she was assigned to R1 on July 7, 2020 on the day shift. V6 said V4 always talked to R1 a lot. I heard she (V4) was let go but don't know why. V1 or V2 have not talked to me at all about R1 or V4. I went to the inservice on July 9, 2020 but it was just general stuff. Nothing was discussed about misappropriation of resident money. At 1:05 PM, V1 said There is no evidence that facility residents were interviewed about V4 or missing money or funds. At 1:20 PM, V7 (Social Services Director) said she did not talk to any residents in the north hall. V7 stated I didn't specifically talk to south hall residents about V4 and any concerns. I don't recall why or if we recorded any information after talking to residents but it's important to document interviews to prove we talked to residents. V7 said there is no evidence she spoke to any residents about this allegation. At 1:35 PM, V9 (Social Services Assistant) said she didn't talk to any residents on the north hall. V9 stated I didn't ask south hall residents specific questions about V4 and did not document anything. At 1:45 PM, V1 said he had sufficient evidence elsewhere to come to a conclusion, so he didn't need to take any additional information from the facility staff. V2 added they were taking direction from the police as the police investigation was ongoing. On August 13, 2020 at 2:00 PM, V8 (R1's family member) said R1 called her and said the bank notified him someone tried to steal $2000 out of his bank account. V8 said she contacted the bank and discovered there were three unauthorized withdrawals from his bank account on July 7, 2020. The first amount was $20 to V10 (V4's friend). The second and third unauthorized withdrawals were made on July 7, 2020 to V11 (V4's mother). These money transfers were in the amounts of $100 and $300. The withdrawals were made through a mobile application that transfers money electronically. A fourth money transfer for $2000 was declined by the bank on July 7, 2020 after the first three went through. The names of V10 and V11 showed on the bank statement. V8 said R1 also told her he gave $100 to V4 for change and he never received any money back. V8 said I feel like I've done this whole investigation myself. On August 14, 2020 at 9:00 AM, V10 said she hasn't been contacted by the facility to provide information. At 9:30 AM, V1 said he didn't contact V10 for an interview (V10's phone number is listed in the facility's investigative notes). V1 stated I did not interview R1 after I became aware the perpetrator was an employee. I spoke to V8. The facility's investigative notes showed on July 13, 2020 at 8:45 AM, V4 told V1 and V2 (Director of Nursing) she sent V10 $20 on July 7, 2020. V4 also confirmed she gave V11 $100 but was unsure of the date. V4 was unable to give an explanation how her family members could have received monies from a resident's bank account. There are no other facility initiated interviews with staff or residents. The majority of the information included in the investigation notes were obtained from and a police officer. There is no evidence of a facility initiated investigation other than a brief interview with R1 on July 7, 2020 and V4 on July 13, 2020. There is no evidence the facility reached a conclusion of the allegation. The facility's Abuse Investigation Checklist for R1 showed management level staff conducted interviews using an Investigative Questionnaire for every employee working on a specific hall that the affected resident resided on and if the incident occurred on a specific shift all staff for the individual shift will

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145958	A. BUILDING _____ B. WING _____	**08/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BETHANY REHAB & HCC	**3298 RESOURCE PARKWAY DEKALB, IL 60115**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) complete a questionnaire and a written statement if indicated. This was indicated as done by a check in the box next to item #12. The facility's Resident Abuse Investigation Report showed law enforcement was notified of an Abuse Investigation being initiated on July 9, 2020 at 10:52 by V1. The facility's investigative notes showed V1 left a voicemail for a police officer on July 9, 2020 at 10:52AM. The facility's Final Report of Alleged Financial Exploitation form sent to IDPH (Illinois Department of Public Health) dated July 17, 2020 showed R1's family and police were notified. The investigative notes showed the family (V8) actually contacted the police and the facility of the allegation. The facility was unable to provide evidence of staff or resident interviews done for the purposes of their investigation. The facility's investigative file included a sign in sheet for a staff in service on July 9, 2020. There were no housekeeping, laundry or dietary employees in attendance. The facility's schedule for July 7, 2020 showed V5 and V6 were assigned to R1's hall. V4's time sheet showed V4 worked on July 7, 2020 from 7:30 AM - 3:00 PM and punched out from 12:15 PM - 12:30 PM. The facility's resident council meeting minutes were reviewed for June, July and August 2020. The August 4, 2020 minutes showed a resident was concerned that no inventory was completed for his clothes on admission and now has missing items. The facility's grievance log was reviewed and the resident concern of missing clothing is not included. The facility's Abuse Prevention and Prohibition Policy dated November 2018 showed the facility prohibits misappropriation of resident property and residents must not be subjected to abuse by anyone. The facility Administrator will ensure a thorough investigation of alleged violations of individual rights. Two management level staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Witnesses will be asked to assist with completing a questionnaire and statements if indicated that will be attached to the Abuse Investigation Format. Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on. If the allegation occurred on a specific shift, all staff for the identified shift only will complete a questionnaire and complete a statement if indicated. Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.