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	14G102	A. BUILDING ______ B. WING ______	C 06/11/2007

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CLEARBROOK CENTER	3201 WEST CAMPBELL STREET ROLLING MEADOWS, IL 60008

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W 331	Continued From page 15 on the floor by the fire doors. E15, Habilitation Aide called me and that's how I found her. E15 said, "I think R1 fell, I think R5 pushed her." I said did you see it because R1 does have a behavior of accusing others." E5 added, "I saw her on 5/6/07. I saw her by the couch she was laying down , she was verbalizing but a little quiet. Laying down and sitting up. E16, nurse didn't tell me R1 vomited that day." Surveyor asked E5 how she assessed R1, E5 stated, "I didn't actually go to her. I saw her from the nurses station (which is approximately 15-20 feet away). R1 looked fine and she stood up and walked away like her normal self." Surveyor asked E5 for the transfer form that was sent with R1 to the hospital on 5/7/07. E5 stated, "We don't have a transfer form. We make copies of the physician's orders sheet and their insurance cards. We put these in an envelope then write on the envelope what the chief complains were." E5 then verified that the facility can not verify what was communicated to the Emergency Room Physician on 5/7/07.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATION 350.620a) 350.1210b) 350.1230b)3)7) 350.1230c) 350.1230d)1)2) 350.1230e) 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	W9999		

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W9999	Continued From page 16 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 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 3) Periodic reevaluation of the type, extent, and quality of services and programming. 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. 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, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. 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.	W9999		

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Section 350.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations were not met as evidenced by the following:

Based on observation, interview and record review, the facility failed to implement their policy to prevent neglect when they failed to:

1) Ensure that an incident report was completed on 5/2/07. R1 was lying on the floor on 5/2/07 and when asked what happened R1 stated, "R5 pushed her."
2) Ensure that E5, nurse, completed a body check on R1 at the time of the incident.
3) Ensure that the fall was documented to ensure appropriate follow-up.
4) Ensure that E5 documented the allegation made by R1 that she was pushed by R5.
5) Ensure that a transfer form was completed with all necessary information prior to sending R1 to the hospital

R1 was sent out to the Emergency Room on 5/7/07 and was discharged with a diagnosis of vomiting. R1 was sent to the hospital again on 5/9/07 and was diagnosed with a subdural hematoma and expired on 5/23/07.

Findings include:

R1, per her face sheet, was a 57 year old female whose diagnoses include Severe Mental Retardation, Down's Syndrome,Cataract, Hypothyroidism, Non Insulin Dependent Diabetes

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Mellitus and Osteoporosis. R1's adaptive behavior assessment dated 7/18/06 documented that R1's height was 4 ft. 5 in. and she weighed 97 lbs. R1 had an adaptive behavior score of 5 years and 0 months.

R5, per his face sheet, is a 30 year old male whose diagnoses include Profound Mental Retardation, Pica, Cyclothymic Disorder, Attention-Deficit/Hyperactivity Disorder and Grand Mal Epilepsy. R5's adaptive behavior assessment dated 9/21/06 documented that R5's height is 6 ft. 0 in. and he weighs 192 lbs. R5 had an adaptive behavior score of 1 year and 3 months.

The Investigation Report dated 5/16/07 was reviewed. The date of the incident was noted as 5/9/07 at 6:30pm. The Description of Incident is as follows: "R1 was taken to the hospital for evaluation. She was diagnosed with a subdural hematoma and was admitted to the hospital for surgery." The Conclusion is as follows: "R1 was diagnosed on 5/9/07 with a subdural hematoma , which she sustained on 5/2/07 at approximately 6:10pm when R5 knocked her down. There are no signs of abuse or neglect in this case."

R1's record was reviewed. Review of the nurses notes showed that there was no documentation of an incident dated 5/2/07. There were no entries from 5/1/07 through 5/6/07. The following entries appeared on 5/7/07.

"5/7/07 9am : Emesis x 3 , alert and responsive, oriented x 2.....

5/7/07 11:30am : ...Continues to be very weak, ambulates slowly, able to take a couple of sips of

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apple juice, small amount of soup, complains "My head hurts", some nausea...

5/7/07 12:45pm : ....Very weak.....continues to complain of head pain, denies any other discomfort... "

A hospital discharge form dated 5/7/07 noted a discharge diagnosis of "Vomiting".

E5, nurse, was interviewed on 5/30/07 at 11:40am. E5 stated, "I saw R1 on 5/2/07 sitting on the floor by the fire doors. E15, Habilitation Aide, called me and that's how I found her. E15 said, 'I think R1 fell, I think R5 pushed her.' I said did you see it because R1 does have a behavior of accusing others." Surveyor asked E5 how she assessed R1, E5 stated, "I didn't actually go to her. I saw her from the nurses station (which is approximately 15-20 feet away). R1 looked fine and she stood up and walked away like her normal self." E5 added, "I worked PM shift on 5/2/07 and R1 was fine. She was walking around, eating, causing trouble. I saw her on 5/6/07. I saw her by the couch she was laying down, she was verbalizing but a little quiet. Laying down and sitting up. E16, nurse didn't tell me R1 vomited that day. I worked on 5/8/07, R1 was her usual self. I did her quarterly exam and everything was normal. On 5/9/07, E17, habilitation aide called me because R1 sat up in bed and vomited. I called the physician who ordered anti-emetic medication. I then left for a nurses meeting and when I came back, R1 looked very lethargic so I called the physician again and asked if we could send her out to the hospital." Surveyor asked E5 for the transfer form that was sent with R1 to the hospital on 5/7/07. E5 stated, "We don't have a

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transfer form. We make copies of the physician's orders sheet and their insurance cards. We put these in an envelope then write on the envelope what the chief complains were." E5 then verified that the facility can not verify what was communicated to the Emergency Room Physician on 5/7/07.

E6, Habilitation Aide, was interviewed on 5/30/07 at 2:45pm. E6 stated, "I was the one who took her to the Emergency Room (ER) (on 5/7/07) because R1 wasn't feeling well. Whenever R1 sat, she felt dizzy, she had to lay down and that's also the day that she vomited. R1 was saying to the ER nurse 'my head hurts.' R1 couldn't stand in the ER. So I told the nurse that is what is going on and she vomited. The physician told me - flu like symptoms." Surveyor asked if E6 informed the ER personnel that R1 fell recently. E6 stated, "No, I wasn't aware that R1 fell prior."

E10, Habilitation Aide was interviewed on 5/30/07 at 3:06pm. E10 stated, "R1 kept saying over and over that her head hurt." Surveyor asked when this was noted. E10 answered, "The Tuesday or Wednesday prior to R1 going to the hospital." E10 added, "During this time period, R1 was walking normally but was sitting more which was definitely out of character for R1." Surveyor asked E10 if he reported these observations to the nurse. E10 answered, "People said that the nurses were told and they didn't react."

E11, Habilitation Aide, was interviewed on 5/30/07 at 3:46pm. E11 stated, "I remember R1 was complaining of headaches and was sitting more prior to her hospital visit. I told E14, Qualified Mental Retardation Professional

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(QMRP) and the nurse, E5." Surveyor asked E11 if R1 was known to lie. E11 answered, "I've known R1 for 12 years and she doesn't lie."

The video surveillance for 5/2/07 was viewed by the surveyors and E1, Administrator. It was observed that R1 was turning into a hallway and the next thing showed R1 falling straight down to the floor with R5 running away towards the opposite direction. This occurred at approximately 6:10pm. The sequence of events are noted as follows as noted in minutes and seconds since the tape started:

1:43 - R1 fell to the floor, was laying down and did not move.
1:50 - R1 was observed trying to lift her head up then brought it down again and was lying still.
1:59 - E18, Habilitation Aide, walked by R1 without stopping or checking her out.
2:24 - R1 moved her head a little bit then down again, and was lying still again.
2:41 - R1 moved her head a little bit then back down again, still lying still.
3:00 - E11 stepped out of the restroom and started approaching R1. E13 was seen walking in the hallway towards R1. E13 was then observed going back toward the nurses office. At that time E15 was observed by the nurses office. She then walked towards R1 and sat by her. (Administrator stated E13 and E15 called the nurse at this time).
6:45 - E5, nurse, was observed behind the counter of the nurses station. She then looked towards the directions of R1. At this point , R1 was sitting, then stood up (not clear if E15 helped her up). R1 then proceeded to walk towards her wing with E15.

E1, Administrator was interviewed on 5/31/07. E1

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W9999	Continued From page 22 stated, "Nobody looked at the surveillance video until 5/9/07 because it wasn't made known that R1 alleged that R5 pushed her until 5/9/07." Surveyor asked E1 if the staff are expected to write an incident report in cases wherein a client alleged that a peer pushed her. E1 answered, "We probably do an incident report." Surveyor asked what the facility's policy was. E1 answered, "It is the facility's policy to investigate and write an incident report on any allegations." E14, QMRP/ Quality Assurance Facilitator, was interviewed on 5/31/07 at 10:55am. E14 stated, "R1 has no target behaviors for non-compliance like laying on the ground." Surveyor asked if R1 was known to make false allegations against staff and peers. E14 answered, "Not that we are aware of." E14 was asked why E18 walked by R1. E14 stated, "E18 was thinking R1 was non-compliant. R1 usually will wait until someone leaves the area and she'll do what she wants to do. E18 was thinking somebody was handling R1 at that time and maybe that staff just stepped away for a minute." Surveyor asked E14 how he would describe R1's fall. E14 answered, "It looked like it was a hard fall." The facility's Investigation Report was reviewed further. It included a statement from E20. E20's statement is as follows, "Due to R1's diagnosis of diabetes and the shrinking of her brain caused by aging, R1 is more susceptible to injury." E20 added that "even a small jar to the head could cause a subdural hematoma." Z2 was interviewed via phone on 5/30/07 at 12:08pm. Z2 stated, "While at the Emergency Room on 5/7/07, I don't think there was an initial history of fall. With her symptoms of headache,	W9999		

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dizziness and vomiting, the Emergency Room Personnel would rule out gastrointestinal issues."

E20 was interviewed via phone on 5/30/07 at 2:37pm. E20 stated, "If that had been known (R1's history of fall), the Emergency Room personnel might have looked at another test like CAT Scan (Computerized Axial Tomography Scan) of the head depending on how R1 was when she came in the Emergency Room on 5/7/07."

The facility's Investigation and Notification Procedures were reviewed. It included under General Policy:
"It is the policy of the facility to report all accidents and injuries of unknown origin to the Illinois Department of Public Health within 24 hours of learning of said accident /incident. All such incidents will be investigated with the express purpose of:
1. Attempting to identify the origin or cause of said accident/injuries.
2. Preventing future accidents / injuries.
It is further the policy that the Administrator of the facility must be notified immediately of such accidents /injuries......"
Under Procedures it included:
"In the event that a client sustains an injury, whether witnessed or of unknown origin, staff must report the injury to:
1. The nurse on duty
2. The supervisor on duty
3. The residential staff on duty (if the injury is sustained or discovered by a staff not at the residential program).
At the time the injury is reported, the nurse must perform a body check on the client and complete and "Injury Report" detailing the injury.

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W9999	Continued From page 24 If the nurse completes a body check and no injury is apparent, the nurse must still complete the "Injury Report" and document the absence of injury......" The facility's Client Treatment Policy was reviewed. It noted, "Under no circumstance shall any abuse or neglect of a client be tolerated. All staff shall receive training regarding the rights of clients and concerning proper staff behavior when dealing with different aspects of care.... Any person with witnessing or observing evidence of abuse or neglect of a client shall report it immediately to the Administrator or designee. Failure to do so shall be construed as acceptance of such treatment and shall be dealt with as such......Any report of abuse or neglect of client shall be communicated immediately to the Administrator or designee for thorough investigation and proper action...." There is no evidence that the Client Treatment Policy was implemented. E1, Administrator, verified on 5/31/07 at approximately 3:30pm that the staff are expected to complete an Injury Report for all allegations even if the client did not sustain an injury. There is no evidence to show that staff were re-trained on incident reporting after the 5/2/07 incident. (A)	W9999		