STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001853	A. BUILDING: _____ B. WING _____	09/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARBROOK CENTER	3201 WEST CAMPBELL STREET ROLLING MEADOWS, IL 60008

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Z9999	FINDINGS Licensure Violations: 350.620a) 350.1210 350.1230d) 350.3240a) 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 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1230 Nursing Services 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. 3) First aid in the presence of accident or illness. 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 Requirements are not met as evidenced by:	Z9999		

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Based on interview and record review, the facility failed to implement their policy to prevent neglect by failing to prevent 1 of 1 client outside the sample (R18 with a significant history of falls) from falling and sustaining injuries that required emergency room attention.
The facility failed to:
1. Ensure 1 to 1 supervision was provided to R18 on 6/21/14.
2. Ensure staff implemented safety measures when walking R18 on 7/7/14.
3 Ensure staff implemented safety measures on 7/14/14 when R18 fell and his head after a behavioral incident. R18 received 13 staples to close 2 lacerations to the back of his head.
4. Ensure staff implemented safety measures on 8/14/14 when R18 dropped to the floor, with his head making contact with the floor. R18 was noted to have several pin point lacerations on his forehead, an abrasion under his right eye and a laceration to his right forearm.
5. Ensure staff were retrained on providing 1 to 1 supervision and how to safely assist R18 with ambulation.

Findings include:

The facility's Abuse and Neglect Policy, titled "Client Treatment Policy" last revised October 2013 was reviewed. This policy notes:
"Under no circumstances shall any abuse or neglect of a client be tolerated. ...
Neglect is defined as: The failure to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to an individual or in the deterioration of an individual's physical or mental condition. When care takers do not give a person the care for the goods or services needed to avoid harm or illness. ..."

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The facility's Incident Reports were reviewed and the following was noted:
"On June 21st, 2014 at approximately 5:50am (R18) was found sitting on his toilet with a 3cm (centimeter) laceration to the back of his head. Nursing applied pressure and stopped the bleeding. (R18) was transported to (local hospital) where he received 4 staples to the back of his head. (R18) returned to the (facility) on 6/21/14."
E11 (QAF - Quality Assurance Facilitator) completed the investigation of R18's injury.
E11 documented that R18 is a 47 year old male who has impaired coordination due to tremors. R18 utilizes a walker, a gait belt and AFO's (ankle foot orthotics). E11 also documented that R18 has a bed alarm.
E11 interviewed E15 (DSP - Direct Support Person) for the investigation. E15 stated that she worked the overnight shift on 6/20 - 6/21/14. E15 stated that at approximately 5:35am on 6/21/14 she observed R18 in his bed sleeping. At approximately 5:50am she heard the sound of R18's bed alarm. E15 stated that she was in the hallway at the time she heard the alarm.

E11 concluded that on 6/21/14 at approximately 5:50am R18 got out of bed to use the bathroom. In the process of sitting down on the toilet the back of R18's head made contact with the metal pipe above the toilet. R18 was transported to the local hospital where he received 4 staples to the back of his head.

E1 (Administrator) was interviewed on 8/28/14 at 12:20pm. E1 stated that R18 was on 1 to 1 supervision on 6/21/14 when he was alone in the bathroom. E1 stated that 1 to 1 supervision was not provided to R18 on 6/21/14.

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E5 (Supervisor) was interviewed on 8/29/14 at 11:37am. E5 stated that on 6/21/14 R18 was supposed to be provided 1 to 1 supervision. E5 stated that R18's 1 to 1 supervision is on 3rd shift (10:45pm / 11pm to 6am).
E5 stated that R18 requires 1 to 1 supervision because he falls - his walking is not stable.
E5 stated that on 6/21/14 the facility had, "quite a few call off's" and "we couldn't get staff to come in."
E5 stated that the facility had to prioritize and there were other client's whose condition's were more serious. E5 stated that we were short staff and had to pull staff to other duties.
E5 stated that R18's 1 to 1 supervision was not provided the entire 3rd shift. E5 stated when R18 was injured (approximately 5:50am) 1 to 1 supervision was not being provided.
E5 stated that he did not know how much time on the 3rd shift that R18 was not provided with his necessary 1 to 1 supervision.

R18's Physical Therapy Evaluation, dated 11/14/13, was reviewed. The evaluation includes the following:
- Coordination: Impaired coordination due to tremors
- Transfers: (R18) is able to transfer; however his balance and stability are impaired which affects his safety. He needs staff supervision for safety.
- Gait Deviations: His gait skills are inconsistent and he does have a significant history of falls.
- Summary Recommendations: (R18) continues to receive weekly PT (Physical Therapy) services. He continues to have significantly impaired balance and increased fall risk.

R18's 11/19/13 IPP (Individual Program Plan)

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was reviewed. R18's level of supervision is identified as the following: "(R18) requires 1:1 supervision during the night and on community outings. (R18) requires same room supervision while completing his ADL's (activities of daily living) and during meals."
"Fall/Risk/Safety - 11/19/13 ... (R18) is considered a high fall risk."

On 8/28/14 E1 provided the following additional Incident Reports involving R18 and recent falls:
1. 7/7/14 11pm - R18 fell while walking with staff assistance. The gait belt was being used and staff had two hands on the gait belt. R18 lost his balance by tripping on the threshold between the living room and hallway. No injuries noted by nursing.
2. 7/14/14 - E22 (former Residential Service Director) conducted an investigation and documented interviews that included the following:
E22 interviewed E26 and E27 (DSP - Direct Support Person) and both stated that R18 came home from his Day Training program and R18 was agitated. R18 was spitting, hitting and throwing his shoes. E26 stated that R18 attempted to hit E25. R18 did not make contact with E25, however, he fell and hit his head. E26 went to get the nurse and R18 laid on his back on the floor and held his head.
E27 (nurse) stated, per the investigation, that when she arrived she found R18 laying on his stomach in the middle of the room. E27 assisted R18 to a sitting position and provided First Aid.
E22 concluded that R18 displayed agitation and physical aggression which resulted in his injury. R18 was sent to the Emergency Room as he was noted with 2 lacerations to the back of his head.

Review of R18's Emergency Department records

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Z9999	Continued From page 5 noted that R18 received 4 staples to the first laceration and 9 staples to the second laceration. 3. 8/14/14 10:20pm - R18 was being assisted in the shower when R18 dropped to the floor and hit his forehead on the shower floor. R18 was assessed by nursing and noted to have sustained a 5cm raised area with several pin point lacerations on his forehead. A 1.5cm by 1cm abrasion to his right eye and a 2cm by 0.5 cm laceration to R18's right forearm were noted. 4. 3/19/14 6:40pm - R18 was walking with staff when he lost his balance and fell forward and landed on his knees. No injuries were noted. B	Z9999		