STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G102	A. BUILDING _____ B. WING _____	C 11/07/2007

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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W 331	Continued From page 9 R1's medical records were reviewed. E5 documented the following in R1's nurses notes: "9/16/07 5:45a Hab Aid notified this writer that resident was not waking up, non-responsive. 5:50a This writer went to client room. Res (resident) was pale in color, non-responsive, cool to touch, fingers bluish color. Vitals unattainable. Facility admin. (Administrator), (attending physician), guardian, QMRP, & Paramedics notified. 6:00a Paramedics here to pronounce death. 8:00a Funeral home here to remove body." Review of R1's, Medical Certificate of Death - dated 9/17/07, notes R1's cause of death as Myocardial Infarction. On 10/31/07 at 2pm Z1 was interviewed. Z1 stated the local fire department received a 911 phone call from the facility at 5:59am and 45 seconds. The paramedics arrived at the facility at 6:03am. The paramedics were told the client was last seen alive at 4am. The paramedics noted R1's skin to be cold to the touch with mottling of the skin and pooling of blood to the back. The paramedics confirmed R1 was asystole and called the local hospital to pronounce R1. R1 was pronounced at 6:14am.	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATION 350.620a) 350.1230a) 350.1230b)3) 350.1230c) 350.1230d)2) 350.1230e)	W9999		

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W9999	Continued From page 10 350.1230g) 350.1235a)3)4)5) 350.1235b)1)2) 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 350.1230 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. 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: 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. g) Nursing service personnel at all levels of competence and experience shall be assigned responsibilities in accordance with their qualifications. Section 350.1235 Life-Sustaining Treatments	W9999		

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W9999	Continued From page 11 a) Every facility shall respect the residents' right to make decisions relating to their own medical treatment, including the right to accept, reject, or limit life-sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be: 3) procedures for providing life-sustaining treatments available to residents at the facility; 4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject, or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices; 5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible. b) For the purposes of this Section: 1) "Agent" means a person acting under a Health Care Power of Attorney in accordance with the Powers of Attorney for Health Care Law. 2) "Life-sustaining treatment" means any medical treatment, procedure, or intervention that, in the judgement of the attending physician, when applied to a resident, would serve only to prolong the dying process. Those procedures can include, but are not limited to, cardiopulmonary resuscitation (CPR), assisted ventilation, renal dialysis, surgical procedures, blood transfusions, and the administration of drugs, antibiotics, and artificial nutrition and hydration. Those procedures do not include performing the Heimlich maneuver or clearing an airway, as indicated. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	W9999		

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W9999	Continued From page 12 resident. These Regulations were not met as evidenced by: Based on interview and record review the facility failed to ensure nursing staff initiated CPR (Cardio - Pulmonary Resuscitation) on 1 of 1 clients (R1) who was found non-responsive on 9/16/07 at approximately 5:30am in his bedroom. R1 was pronounced dead at his residence, 9/16/07 at 6:14am. Findings include: R1, per review of his 8/3/07 History and Physical, was a 71 year old male whose diagnoses include Severe Mental Retardation, Senile Dementia, Generalized Osteoarthritis, Osteoporosis and Probably Parkinson's Disease. R1's physical noted that R1 was "chronically bed and chair confined." E3 (RN/Nursing Coordinator) was interviewed 10/30/07 at 12:00om. E3 verified R1 was non-ambulatory and non-mobile. E3 stated R1 was essentially non-verbal. E3 stated that R1 was in need of total care for his ADL's (Activities of Daily Living). E3 stated, that at the time of his death (9/16/07), R1 had no significant (or acute) health care needs. E3 was asked if R1 had a DNR (Do Not Resuscitate) order at the time of his death. E3 stated R1 was a Full Code. E3 explained that a Full Code meant that if a client was found unresponsive, 911 is to be called and CPR is to be initiated. On 9/16/07 the facility notified the Department (IDPH - Illinois Department of Public Health) that	W9999		

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W9999	Continued From page 13 R1 died at approximately 5:45am on 9/16/07. The notification documents staff were doing rounds, notified the nurse (of R1's non-responsive status), and the nurse then contacted paramedics. The paramedics pronounced R1 dead. The facility's investigation regarding R1's death noted the following: On 9/16/07 at approximately 5:30am E4 (direct care staff) noted R1 was non-responsive. E4 then immediately notified the nurse. E5 (Registered nurse) reported that at approximately 5:45am she was notified by E4 that R1 was non-responsive. E5 entered R1's bedroom and observed him to be non-responsive and pale in color. E5 notified the paramedics (via 911 phone call). The paramedics arrived at the facility and pronounced R1 dead. E4 was interviewed 10/30/07 at 3:40pm. E4 stated on 9/16/07 at approximately 5:00am he was in R1's bedroom and began to assist R1's roommate in getting dressed for the day. After assisting R1's roommate, E4 approached R1 to get him up for the day. E4 stated he tapped R1 to wake him up, however R1 did not respond. E4 stated he then tried to shake R1 and turned his head to awaken him. E4 stated R1 was not responding. E4 stated he listened to R1 for signs of breathing and R1 was not breathing. E4 stated R1's body was still warm when he touched him. E4 stated he then went down the hallway to get the nurse (E5). E5 came to R1's bedroom and also checked R1. E5 then left R1's bedroom to get another nurse (E7). E4 stated that E5 called 911.E4 was asked if he performed CPR on R1. E4 stated he did not. E4 stated, "I was	W9999		

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W9999	Continued From page 14 shaky ... never saw a dead person before in my life ... too choked up to do CPR." Review of CPR training records for E4 noted E4 was last certified in CPR 1/30/07. The certification is valid for one year from date of completion. E5 was interviewed 10/31/07 at 10:50am via phone call. E5 stated that on 9/16/07 at approximately 5:45am E4 came and got her at the nurses station, and asked her to look at R1 as he was non-responsive. E5 stated she called R1's name and he did not respond. E5 stated R1's body was cold and clammy, his hands were blue and he was not breathing. E5 could not get a pulse on R1. E5 stated she then went to the nurses station and called E7 who was on the other side of the building. E5 stated she told E7 that R1 was non-responsive. E5 and E7 went to R1's bedroom and again noted that R1 was non-responsive. E5 stated she then went back to the nurses station and called 911. E5 was asked if R1 had a DNR order. E5 stated R1 did not have a DNR order. E5 was asked if she initiated CPR. E5 stated she did not because she assumed R1 was dead for a little bit of time. E5 stated R1's hands were blue and he was cool and clammy. E5 stated, "I know I'm supposed to do CPR but he was cool and clammy. I assumed he was dead. It was my first death." E5 was asked if she should have initiated CPR on R1. E5 stated, "Oh yes ma'am." E5 stated she is trained to do CPR unless the person has a DNR order. Review of CPR training records for E5 noted E5 was last certified in CPR May 26th 2007. The certification is valid until May 2009.	W9999		

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W9999	Continued From page 15 E7 (Registered Nurse) was interviewed, via phone call, on 10/31/07 at 3:35pm. E7 stated on 9/16/07 she was working on the east side of the building (R1 resided on the west side). E7 stated she received a phone call from E5 (could not recall time frame). E7 also stated she could not recall what E5 told her but she recalls that she was asked to come look at R1. E7 stated she went to R1's bedroom. E7 stated she felt for a pulse on R1 and could not obtain one. E7 stated, "(R1) looked dead." E7 stated she assumed E5 had called 911. E7 stated E5 did not need any further assistance so she went back to the east side of the building. E7 was asked in what instances CPR would not be performed. E7 stated if a client has a DNR order CPR would not be done. E7 stated she thought R1 had a DNR order. R1's medical records were reviewed. E5 documented the following in R1's nurses notes: "9/16/07 5:45a Hab Aid notified this writer that resident was not waking up, non-responsive. 5:50a This writer went to client room. Res (resident) was pale in color, non-responsive, cool to touch, fingers bluish color. Vitals unattainable. Facility admin. (Administrator), (attending physician), guardian, QMRP, & Paramedics notified. 6:00a Paramedics here to pronounce death. 8:00a Funeral home here to remove body." Review of R1's, Medical Certificate of Death - dated 9/17/07, notes R1's cause of death as Myocardial Infarction. On 10/31/07 at 2:00pm Z1 was interviewed. Z1 stated the local fire department received a 911	W9999		

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W9999	Continued From page 16 phone call from the facility at 5:59am and 45 seconds. The paramedics arrived at the facility at 6:03am. The paramedics were told the client was last seen alive at 4:00am. The paramedics noted R1's skin to be cold to the touch with mottling of the skin and pooling of blood to the back. The paramedics confirmed R1 was asystole and called the local hospital to pronounce R1. R1 was pronounced at 6:14am. (A)	W9999		