STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G204	A. BUILDING _____ B. WING _____	C 03/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARBROOK EAST	3802 SOUTH OLD WILKE ROAD ROLLING MEADOWS, IL 60008

(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
W9999	Continued From page 54 LICENSURE VIOLATIONS 350.620a) 350.3240a) 350.3240d) 350.3240e) 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) (A, B) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 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)	W9999		

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W9999	Continued From page 55 These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to implement their policy to prevent abuse and neglect of 15 of 15 clients (R#'s 1 thru 15) when they failed to: - Ensure a system is in place for reporting 1 allegation that 3 of 15 clients (R3, R5 and R2) were given cold showers. - Ensure a system is in place for investigating 1 allegation that 3 of 15 clients (R3, R5 and R2) were given cold showers. - Ensure a system is in place for reporting and investigating 1 allegation that 2 of 15 clients (R3 and R6) were found in urine soaked clothing and bedding and 1 allegation that 1 of 1 clients (R4) needing repositioning, with the potential of R1, R2, R5, R7, R8, R9, R10, R11, R12, R13, R14 and R15 being neglected. - Ensure a system is in place to protect the safety of 15 of 15 clients (R#'s 1 thru 15) when the main exit of the building was blocked. - Ensure a system is in place for reporting and investigating 1 of 1 allegations that 15 of 15 clients (R#'s 1 thru 15) were verbally abused. Findings include: The following information was obtained from a facility resident roster dated 12/4/09: R1 is a 26 year old female diagnosed with Severe Mental Retardation. R2 is a 56 year old female diagnosed with Moderate Mental Retardation. R3 is a 45 year old female diagnosed with Moderate Mental Retardation.	W9999		

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W9999	Continued From page 56 R4 is a 51 year old female diagnosed with Severe Mental Retardation. R5 is a 53 year old female diagnosed with Moderate Mental Retardation. R6 is a 68 year old female diagnosed with Moderate Mental Retardation. R7 is a 22 year old female diagnosed with Moderate Mental Retardation. R8 is a 71 year old female diagnosed with Mild Mental Retardation. R9 is a 70 year old female diagnosed with Mild Mental Retardation. R10 is a 50 year old female diagnosed with Profound Mental Retardation. R11 is a 55 year old female diagnosed with Mild Mental Retardation. R12 is a 49 year old female diagnosed with Profound Mental Retardation. R13 is a 46 year old female diagnosed with Severe Mental Retardation. R14 is a 50 year old female diagnosed with Severe Mental Retardation. R15 is a 64 year old female diagnosed with Severe Mental Retardation. The facility's policy, titled "Client Treatment Policy" (undated) was reviewed and notes the following: "Under no circumstances shall any abuse or neglect of a client be tolerated. All staff receive Developmental Disabilities Aide Course training in their probationary period and as an annual refresher training. This training among other things, pertains to the rights of clients and proper staff behavior when dealing with different aspects of client care. Training includes such topics as neglect, respect, dignity of the client during personal care, and privacy. ... Any report of abuse or neglect of a client shall be	W9999		

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W9999	Continued From page 57 communicated to the Administrator for immediate and thorough investigation and proper action. The Administrator will ensure that reports of abuse or neglect and suspected abuse or neglect are provided to the Illinois Department of Public Health and are communicated to the client's guardian or representative. ... Abuse is defined as: Any physical injury, sexual abuse, or mental injury inflicted on an individual other than by accidental means. The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Neglect is defined as: The failure to provide adequate medical or personal care or maintenance, which failure results in physical injury to an individual or in the deterioration of any individual's physical or mental condition. When care takers do not give a person they care for the goods or services needed to avoid harm or illness. ... Mental Injury is defined as: Harm caused by an act or omission that precipitates emotional distress or maladaptive behavior in the individual, or could precipitate emotional distress or maladaptive behavior, including the use of words, signs, gestures or other actions toward or about and in the presence of individuals." The facility's policy, titled "Incident and Accident Investigation Policy" (undated) was reviewed and notes the following: "General Policy - It is the policy of Clearbrook to report to the Illinois Department of Public Health (IDPH) within 24 hours of occurrence the following type of incidents: Acts of client to client aggression or aggression that results is an injury, allegations of abuse and neglect, injuries that require outside medical treatment and injuries of	W9999		

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W9999	Continued From page 58 unknown origins. All such incidents will be investigated with the express purpose of: - Attempting to identify the origin of the accidents / injuries - Protecting clients from abuse and neglect - Preventing future accidents / injuries Procedures ... Any staff who witnesses a client incident, injury or accident is requires to complete an "Unusual Incident Report" The nurse must document in the nursing note section of the client's file. ... " 1) Z1 (guardian), Z2 (family friend) and R3 were interviewed on 2/16/10 at 2:15pm. Z1 and Z2 stated that approximately 2 months ago (December 2009) they received a phone call from R3. R3 called Z1 from her DT (Day Training) program. Z2 stated that E4 (COTA/L - Certified Occupational Therapy Aid / Licensed) assisted R3 in calling them. Z1 and Z2 stated that R3 was crying and begging not to go back to her home (facility). R3 told Z1 and Z2 that staff were giving her cold showers and that staff were mean to her. At this time surveyor asked R3 if she could name the staff that was giving her cold showers. R3 stated a name but it was not easily recognizable. Surveyor stated several staff names, R3 then stated yes to E8's (former direct care) name. Z1 and Z2 stated that they called E2 (QMRP) regarding R3's allegations that staff were giving her cold showers. Z1 and Z2 stated that E2 told them there were problems with the water heater. Z1 and Z2 stated they also spoke to E1 (Administrator) regarding R3's allegations that staff were giving her cold showers. On 2/16/10 at approximately 1:15pm surveyor	W9999		

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W9999	Continued From page 59 requested, from E2 and E3 (Assistant Vice President), all allegations of abuse and neglect since June 2009. E2 and E3 did not provide surveyor any documentation of allegations that R3 received cold showers. E1 and E3 (Assistant Vice President) were interviewed on 2/17/10 at 12:10pm. E1 and E3 were asked if there were any allegations that clients were receiving cold showers. E1 stated that sometime in December 2009, R3 reported receiving cold showers. E1 stated the facility checked the water and put in a work order to have the water temperatures checked. E1 stated E2 also spoke to R3 and R3 told E2 everything was fine. E1 was asked if there was any documentation of R3's allegations that staff were giving her cold showers. E1 stated E2 wrote a comment in R3's December 2009 monthly QMRP progress note. E1 was asked if this allegation of abuse was reported to IDPH (Illinois Department of Public Health) and investigated. E1 stated it was not reported to IDPH and it was not investigated. R5 was interviewed on 2/17/10 at 10:17am. R5 was asked if she was aware of any of the residents receiving cold showers. R5 stated, "(E9 and E8 - former direct care) gave us cold showers. We have been complaining about cold showers. (E2- QMRP) knows, we all complain about it- (E12 - House Manager) knows." R5 also stated, "I told (E13 - direct care) that - she said we have to learn how to do the temperature." R5 was asked if there are any other concerns. R5 stated, "Staff use swear words - they said 5 letter words." R5 was asked to explain what a 5 letter word is. R5 spelled out " b i t - -".	W9999		

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W9999	Continued From page 60 R2 was interviewed on 2/17/10 10:35am. R2 was asked if she was aware of any of the residents receiving cold showers. R2 stated, "They gave me cold showers. I asked for warm showers, so they gave me warm showers. I didn't like it - cold showers." E4 (COTA / L) was interviewed on 2/17/10 at 9:55am. E4 was asked about her providing assistance to R3 in calling her guardian. E4 stated that approximately 2 months ago R3 came into the therapy room. R3 told E4, "They gave me cold showers." E4 stated she asked R3 who they were and R3 indicated "they" meant staff. E4 stated R3 stated a name but she could not understand the name R3 was saying. E4 stated she told E14 (DT Director) and E5 (DT Coordinator) about R3's allegations of receiving cold showers. E4 stated the following day R3 came back into the therapy room and asked to call her guardian. E4 stated she assisted R3 in calling her guardian. E4 stated she heard R3 tell her guardian about receiving cold showers. E4 stated R3 was upset and crying. E4 stated she called E2 (R3's QMRP) regarding R3's allegation of receiving cold showers. E4 stated that E2 stated she already contacted R3's guardian and that R3's guardian was upset. E4 was asked if she documented R3's allegations that she was receiving cold showers and who she notified of R3's allegations. E4 stated she did not document R3's allegation of receiving cold showers or who she notified of R3's allegation. E5 (Day Training Coordinator) was interviewed on on 2/17/10 at 10:08am. E5 stated sometime in December 2009 R3 talked to her and E14 (Day Training Director) about receiving cold showers	W9999		

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W9999	Continued From page 61 at her residence. E5 stated E14 immediately notified E1 of R3 allegations. E5 was asked if an incident report and subsequent investigation was completed. E5 stated she did not believe an incident report or investigation was done. E1 (Administrator) and E3 (Assistant Vice President) were interviewed on 2/17/10 at 12:10pm. E1 and E3 were asked if the facility was aware of any facility memo regarding staff's interactions. E1 and E3 stated they were not aware of any type of memo regarding staff's interactions. Surveyor obtained a copy of an internal facility memorandum dated 8/25/09 written by E2 (QMRP). The memo notes the following: "DATE: August 25, 2009; TO: All Wilke Staff; RE: Professionalism It has come to my attention that staff are having conflicts in the Clearbrook East / Wilke house on a continual basis. Behaviors like yelling, screaming, swearing, fighting, and refusal to do your job are unacceptable. Remember that not only is Clearbrook East / Wilke a place of business, but it is also the home for 16 women. The abrasive interactions between staff create a hostile environment for both staff and clients alike. It disrupts the everyday lives of the ladies and creates a negative atmosphere that impacts your ability to work as a team, which is an important part of Clearbrook. Understand that this type of behavior will not be tolerated and failure to comply with the policies and procedures you were trained on regarding professional conduct in the workplace will result in progressive disciplinary action up to and including termination."	W9999		

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W9999	Continued From page 62 E2 and E1 were interviewed on 2/17/10 at 12:40pm regarding the above noted 8/25/09 memo. E2 was asked why the 8/25/09 memo was written. E2 stated she could not remember why and who brought the staff issues to her attention. E2 stated the memo was written for all staff. E2 was asked if any of the "yelling, screaming, swearing or fighting" involved any of the clients or occurred in front of any of the clients. E2 stated the staff's action occurred in the office. E2 was asked how she knew this and how she became aware of the allegations. E2 stated she could not recall. E1 and E2 were asked if the above noted allegations of verbal abuse were reported to IDPH and investigated. E1 and E2 stated the issues identified in the 8/25/09 memo were not reported to IDPH and they were not investigated. 2) On 2/16/10 at approximately 1:15pm surveyor requested, from E2 and E3 (Assistant Vice President), all allegations of abuse and neglect since June 2009. Surveyor asked E2 and E3 if there were any recent instances of staff quitting or if there were any recent terminations of staff. E2 and E3 stated that 4 direct care staff were recently terminated. E2 and E3 identified the following direct care staff: E8, E9 E10 and E11. E1 (Administrator) stated, 2/17/10 at 11:43am, that E8 was not terminated as she resigned her position. E2 stated that E9, E10 and E11 were terminated due to failure to follow proper policies and procedures. Surveyor asked if there was documentation as to why E9, E10 and E11 were terminated. E2 stated there is documentation in each employee's personnel file. Surveyor requested E8, E9, E10 and E11's personnel files. Review of the personnel files	W9999		

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W9999	Continued From page 63 noted the following: - E11 - "Employee Warning Report - (dated and signed by E1 on 2/5/10) Type of Violation, Sleeping on the job, neglect of duty that threatens the well being of clients, endangering the safety of the clients. Falsification of doc. (documentation)." "Company Statement: During the midnight shift of 1/22/10, the Director, (E1) along with the QMRP (E2), entered the (facility) at 3am (1/23/10) and found that the door of the home was blocked off with a propped chair and that (E11) was in the living room of the home on the sofa sound asleep. (E11) had the house paperwork on her lap. Roll Call sheets were incomplete from 11pm to the present time of 3am, and the Midnight checklist was fully completed from 11pm to 8am the next morning, and already signed by (E11), as having been completed." "Observations made by this writer (E1) once (E11) was asked to leave the home: ... (E11) did not complete a client's checklist for monitoring her (breathing) machine overnight, no documentation was on the form, and this was her responsibility for the midnight shift. During roll call checks performed by this writer it was found that two residents were in there beds and had been in need of assistance in changing their urine soaked clothing and bedding. Client who requires re-positioning throughout the night was not attended to." " ... During this time (E11) also failed to complete her roll call and repositioning duties which resulted in neglect of duty that threatens the well being of clients. ... In addition by blocking the main exit of the building, (E11) endangered the safety of the clients in the event of an emergency."	W9999		

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W9999	Continued From page 64 - E8 - Review of E8's personnel file noted that E8 resigned her position of direct care, on 1/27/10. E1 (Administrator) and E3 (Assistant Vice President) were interviewed 2/17/10 at 12:10pm. E1 explained that E8 resigned her position 1/27/10. E1 stated that E8 resigned before she would have been terminated. E1 stated that E8 was also observed sleeping on the job on 1/23/10. - E9 - "Employee Warning Report - (dated and signed by E1 on 2/5/10) Type of Violation, Falsification of documentation, neglect of duty that threatens the well being of clients." "Company Statement: An incident occurred on 01/23/10 that caused management to review the video footage for midnight shifts during the month of January. Upon review of the cameras for the Midnight shift of 1/6, (E9) neglected to perform her 15 minute and 30 minute roll call checks on the women at the (facility) and by doing this she endangers the safety of these clients." " ... The camera on 1/7/10 shows that there is no movement from (E9) from the beginning of the recording from (1:00am) to (5:22am). (E9) is in the living room. During this four hour time period clients are up to go to the bathroom and there is no staff assistance provided by (E9), no roll call checks are being completed and no household tasks are being done resulting in neglect of duty that threatens the well being of clients." "Upon discovery of this incident the cameras were checked on (E9's) overnight shift on 1/11/10. The review began at 11:23pm on 1/11/10 and continued on through 5:55am on 1/12/10. ... During this time there is no movement throughout the house made by (E9) and clients are up and in the hallways at 1:16am,	W9999		

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W9999	Continued From page 65 1:29am, and 2:56am. Clients are moving from their rooms to the bathroom and no staff assistance is given, there are clients that require assistance, as noted in their ISP (Individual Service Plan) and not assisting them in the bathroom results in neglect of duty that threatens the well being of a client. ... This results in falsification of documentation, as well as neglect of duty that threatens the well being of the clients. Roll call is imperative for the safety of the clients." - E10 - "Employee Warning Report - (dated and signed by E1 on 2/5/10) Type of Violation, Falsification of documentation, neglect of duty that threatens the well being of clients." "Company Statement: An incident occurred on 1/23/10 that caused management to review the video footage for midnight shifts during the months of January. Upon the review of the cameras for the Midnight shift of 1/6, (E10) neglected to perform her 15 minute and 30 minute roll call checks on the women at the (facility) and by doing this she endangers the safety of these clients." "During the midnight shift of 01/06 (E10) enters the living room of the (facility) at (2:40am). From the 2:40am to 3:59am (E10) is in the living room. She leaves the living room to go toward the bathroom, turns to look in hallway and then returns to the living room at 4:03am, where she stays until 5:09am. During this time clients are up to go to the bathroom and there is no staff assistance provided by (E10), no roll call checks are being completed and no household tasks are being done, resulting in neglect of duty that threatens the well being of clients." "Upon discovery of this incident the cameras were checked on (E10's) overnight shift on 1/11/10. The review began at 11:23pm on	W9999		

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CLEARBROOK EAST	3802 SOUTH OLD WILKE ROAD ROLLING MEADOWS, IL 60008

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W9999	Continued From page 66 1/11/10 and continued on through 5:55am on 1/12/10. ... During this time there is no movement throughout the house made by (E10) and clients are up and in the hallways at 1:16am, 1:29am, and 2:56am. Clients are moving from their room to the bathroom and no staff assistance is given, there are clients that require assistance, as noted in their ISP (Individual Service Plan) and not assisting them in the bathroom results in neglect of duty that threatens the well being of a client. In addition, it has been noted that (E10) has been in the living room from 3:13am until 5:53am, only exiting for 2 minutes to use the bathroom. (E10) can be seen on camera exiting the living room at 5:53am folding a blanket. (E10) documented that she completed the client roll call sheets from 3:15am til 5:30am. This results in falsification of documentation, as well as neglect of duty that threatens the well being of the clients. Roll call is imperative for the safety of the clients." E1 was interviewed on 2/17/10 at 12:10pm. E1 stated that on 1/23/10 she and E2 (QMRP) arrived at the facility at 3:00am to conduct a spot check. E1 stated when they (E1 and E2) arrived at 3:00am they noted a chair was propped up against the interior door of the facility. E1 stated, at this time (3:00am), E8 and E11 were observed sleeping. E1 stated E8 and E11 were immediately relieved of their duties and sent home. Surveyor asked E1 to identify the 2 clients who were found in their beds in urine soaked clothing and bedding on 1/23/10. E1 identified the 2 clients as R3 and R6. Surveyor asked E1 to identify the client who was not repositioned as necessary on 1/23/10. E1 identified R4 as the client who was not repositioned. Surveyor asked E1 if the above noted allegations were reported	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G204	A. BUILDING _____ B. WING _____	C 03/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARBROOK EAST	**3802 SOUTH OLD WILKE ROAD ROLLING MEADOWS, IL 60008**

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W9999	Continued From page 67 to IDPH and investigated. E1 stated they were not reported to IDPH and they were not investigated. E2 (QMRP) was interviewed on 2/19/10 at 12:25pm. E2 was asked, of the 15 clients currently residing at the facility, how many are in need of staff assistance when using the bathroom. E2 identified 11 clients that are in need of staff assistance when using the bathroom. Those 11 clients are identified as: R1, R2, R3, R4, R5, R6, R8, R9, R10, R13 and R14. (A)	W9999		