Illinois Department of Public Health

ILL6001346  ILL6001346  ILL6001346  ILL6001346  ILL6001346  IB. WING    STREET ADDRESS, CITY, STATE, ZIP CODE   CLAYTON RESIDENTIAL HOME    CHICAGO, IL 60614    CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY   Z 000   COMMENTS   Z 000	D BE COMPLETE
NAME OF PROVIDER OR SUPPLIER  CLAYTON RESIDENTIAL HOME  2026 NORTH CLARK STREET CHICAGO, IL 60614  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Z 000  COMMENTS  Incident Report Investigation IRI of 2/11/2015 - IL 75083  Z9999  FINDINGS  STREET ADDRESS, CITY, STATE, ZIP CODE 2026 NORTH CLARK STREET CHICAGO, IL 60614  PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)  Z 000  Z 000  Z 000  Z 000  Z 9999	02/26/2015  ON (X5) LD BE COMPLETE
CLAYTON RESIDENTIAL HOME  2026 NORTH CLARK STREET CHICAGO, IL 60614  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Z 000  COMMENTS  ID PREFIX TAG  PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)  PREFIX TAG  PREFIX TAG  PROVIDER'S PLAN OF CORRECTIVE PREFIX TAG  PROVIDER'S PLAN OF CORRECTIVE PREFIX TAG  PREFIX TAG  PROVIDER'S PLAN OF CORRECTIVE PREFIX TAG  PREFIX TAG  PROVIDER'S PLAN OF CORRECTIVE PREFIX TAG  PREFIX TAG  PREFIX TAG  PROVIDER'S PLAN OF CORRECTIVE PREFIX TAG  PROVIDER'S PLAN OF CORRECTIVE TAG  PREFIX T	D BE COMPLETE
CHICAGO, IL 60614  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Z 000 COMMENTS  Incident Report Investigation  IRI of 2/11/2015 - IL 75083  Z9999 FINDINGS  CHICAGO, IL 60614  ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE DEFICIENCY)  Z 000 COMMENTS  Z 000  Z 000  Z 000  Z 000  Z 000  Z 000	D BE COMPLETE
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Incident Report Investigation  IRI of 2/11/2015 - IL 75083  Z9999 FINDINGS Z9999	
IRI of 2/11/2015 - IL 75083  Z9999 FINDINGS Z9999	
Z9999 FINDINGS Z9999	
Statement of Licensure Violations	
Section 300.1010 Medical Care Policies e) All resident shall be seen by their physician as often as necessary to assure adequate health care. (Medicare/Medicaid requires certification visits.) h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.	
This Requirement is not met as evidenced by:	
Based on interview and record review, the facility failed to inform the physician of a change of condition for one of three residents (R1) in a sample of three residents.  Findings Include:  Attachment A  Statement of Licensure Vi	
R1 was admitted to the facility on 9/25/14 for	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PR

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		ILL6001346	B. WING		1	C <b>26/2015</b>
NAME OF	PROVIDER OR SUPPLIER	CTDEET AF	NDDECC CITY O	TATE 710 OODE	· · · · · · ·	20/2010
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CLAYTO	N RESIDENTIAL HON	I C	), IL 60614	SIREEI		
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				DEFICIENCY)		
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	include chronic para disorder, and seizui		As A 100 for more recommendate and a contract of the contract			
	stated that R1 was on 2/11/15. E3 starnot informed of R1 condition until 2/19/confirmed by record	1AM, E3 (Clinical Director)  " having a psychotic relapse " ted that the psychiatrist was s significant change of 15. This statement was I review of a document titled, aluation " dated 2/19/15 and hiatrist).				
	physician) being inforchange of condition DON (Director of Nuto exhibit delusions denied informing R1 12:04PM, E4 (Nurse delusional in the passhe did not inform the usually do that. " E4 physician should have when a resident star	mentation of Z2 (attending ormed of R1 's significant. On 2/25/15, at 11:30AM, E2 ursing) stated that R1 started in the last few weeks, but 's doctors. On 2/25/15, at e) stated that R1 was more at few weeks, and stated that he physician; "social services if further stated that the we been informed because that the other medical trigger.				
	(B)					
	the resident's family, conservator and any financially responsible whenever unusual ci	hall also immediately notify guardian, representative, private or public agency le for the resident's care rcumstances such as ness, disease, unexplained				

Illinois Department of Public Health

STATE FORM BBSP11 If continuation sheet 2 of 7

Illinois Department of Public Health

NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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1 OEST TOTAL COLUMN TOTAL			STREET		
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billings, or related a	administrative matters arise.	Statutus ylan mai kirinkinosiooon			
This Requirement is	s not met as evidenced by:	ria al Rossia de de Carlos			
failed to notify the factorial condition of one of	amily/guardian of a change of three residents (R1) in a				
Findings Include:		reconstruction and the second control of the			
behavior managem include chronic para	ent with diagnoses which anoid schizophrenia, bipolar				
interviews, but there family/guardian beir 10:21, E3 (Clinical I having a psychotic r 2/15/15, at 11:20PN changes of condition	e was no documentation of the ng notified. On 2/25/15, at Director) stated that R1 was "relapse" on 2/11/15. On 1, E6 confirmed R1 's n, and stated that R1 was				
2/26/15, at 9:50AM, notify the family/gua	E2 stated that the facility rdian when a resident has a				
10/14/14 to 2/11/15, of family being notific as described by E	there was no documentation ed of the "psychotic relapse 3. R1's face sheet				
	PROVIDER OR SUPPLIER  ON RESIDENTIAL HON  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From pa billings, or related a  This Requirement i  Based on interview failed to notify the fa condition of one of sample of three res  Findings Include:  R1 was admitted to behavior managem include chronic para disorder, and seizur  R1 exhibited chang interviews, but there family/guardian beir 10:21, E3 (Clinical I having a psychotic r 2/15/15, at 11:20PN changes of condition delusional and disor being redirected.  When asked about 2/26/15, at 9:50AM, notify the family/gua change of condition statement.  Per review of social 10/14/14 to 2/11/15, of family being notifi  as described by E documents Z3 (fami	ILL6001346  PROVIDER OR SUPPLIER  ON RESIDENTIAL HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  billings, or related administrative matters arise.  This Requirement is not met as evidenced by:  Based on interview and record review, the facility failed to notify the family/guardian of a change of condition of one of three residents (R1) in a sample of three residents.  Findings Include:  R1 was admitted to the facility on 9/25/14 for behavior management with diagnoses which include chronic paranoid schizophrenia, bipolar disorder, and seizure disorder.  R1 exhibited change of condition per employee interviews, but there was no documentation of the family/guardian being notified. On 2/25/15, at 10:21, E3 (Clinical Director) stated that R1 was "having a psychotic relapse" on 2/11/15. On 2/15/15, at 11:20PM, E6 confirmed R1's changes of condition, and stated that R1 was delusional and disorganized and had a tough time being redirected.  When asked about the facility 's policy, on 2/26/15, at 9:50AM, E2 stated that the facility notify the family/guardian when a resident has a change of condition. E1 confirmed E2's statement.  Per review of social service progress notes dated 10/14/14 to 2/11/15, there was no documentation of family being notified of the "psychotic relapse" as described by E3. R1's face sheet documents Z3 (family member) as R1's	PROVIDER OR SUPPLIER  STREET ADDRESS, CITY.  2026 NORTH CLARK CHICAGO, IL 60614  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  billings, or related administrative matters arise.  This Requirement is not met as evidenced by:  Based on interview and record review, the facility failed to notify the family/guardian of a change of condition of one of three residents.  Findings Include:  R1 was admitted to the facility on 9/25/14 for behavior management with diagnoses which include chronic paranoid schizophrenia, bipolar disorder, and seizure disorder.  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Per review of social service progress notes dated 10/14/14 to 2/11/15, there was no documentation of family being notified of the "psychotic relapse" as described by E3, R1's sace sheet documents Z3 (family member) as R1's	PROVIDER OR SUPPLIER  ILL6001346  STREET ADDRESS, CITY, STATE, ZIP CODE  2026 NORTH CLARK STREET CHICAGO, IL 60614  SUMMARY STATEMENT OF DESICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  billings, or related administrative matters arise.  This Requirement is not met as evidenced by:  Based on interview and record review, the facility failed to notify the family/guardian of a change of condition of one of three residents (R1) in a sample of three residents.  Findings Include:  R1 was admitted to the facility on 9/25/14 for behavior management with diagnoses which include chronic paranoid schizophrenia, bipolar disorder, and seizure disorder.  R1 exhibited change of condition per employee interviews, but there was no documentation of the family/guardian being notified. On 2/25/15, at 10:21, E3 (Clinical Director) stated that R1 was having a psychotic relapse " on 2/11/15. On 2/15/15, at 11:20PM, E6 confirmed R1's changes of condition, and stated that R1 was ellusional and disorganized and had a tough time being redirected.  When asked about the facility's policy, on 2/26/15, at 9.50AM, E2 stated that the facility notify the family/guardian when a resident has a change of condition. E1 confirmed E2's statement.  Per review of social service progress notes dated d0/14/14 to 2/11/15, there was no documentation of family being notified of the " psychotic relapse" as described by E3. R1's face sheet documents 23 (family member) as R1's	ILL6001346  B. WING  O2//  PROVIDER OR SUPPLIER  STREET ADDRESS. CITY. STATE. ZIP CODE  2026 NORTH CLARK STREET  CHICAGO, IL. 50614  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  billings, or related administrative matters arise.  This Requirement is not met as evidenced by:  Based on interview and record review, the facility failed to notify the family/guardian of a change of condition of one of three residents.  Findings Include:  R1 was admitted to the facility on 9/25/14 for behavior management with diagnoses which include chronic paranoid schizophrenia, bipolar disorder, and seizure disorder.  R1 exhibited change of condition per employee interviews, but there was no documentation of the family/guardian being notified. On 2/25/15, at 10.21, E3 (Clinical Director) stated that R1 was "having a psychotic relapse" on 2/11/15. On 2/15/15, at 11.20PM, E5 confirmed R1's changes of condition, and stated that R1 was delusional and disorganized and had a tough time being redirected.  When asked about the facility's policy, on 2/26/15, at 9.50AM, E2 stated that the facility notify the family/guardian when a resident has a change of condition. And stated that R1 was delusional and disorganized and had a tough time being redirected.  When asked about the facility on progress notes dated for 1/14/14 to 2/11/15, there was no documentation of family being notified of the "psychotic relapse" as described by E3. R1's face sheet documents 23 (femily member) as R1's

PRINTED: 03/13/2015 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C ILL6001346 B. WING 02/26/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2026 NORTH CLARK STREET **CLAYTON RESIDENTIAL HOME** CHICAGO, IL 60614 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)**PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Z9999 Continued From page 3 Z9999 (AW) Section 300.3240 Abuse and Neglect Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) Based on interview and record review, the facility failed to follow the facility Abuse/Neglect policy for protecting one of three resident (R2), in a sample of three during an allegation of abuse. Findings Include: On 2/11/15, R1 reported an allegation of sexual abuse against another resident (R2). On 2/25/15, at 10:45AM, E9 stated that she was the one who initially received the report from R1.

On 2/25/15, E3 stated that she instructed E6 Illinois Department of Public Health

E9 stated that the report was received before lunch on 2/11/15 but does not remember the exact time. E9 also stated that any alleged perpetrator should be removed from contact with all residents or anyone in the facility. E9 also stated that does not know what happened after

she reported the allegation to her direct supervisor, E3 (Clinical Director).

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Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PR

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		ILL6001346 B. WING		02/26/	C <b>02/26/2015</b>	
			DRESS CITY	STATE ZIP CODE		
CLAYTO	CLAYTON RESIDENTIAL HOME  STREET ADDRESS, CITY, STATE, ZIP CODE  2026 NORTH CLARK STREET					
OLATTO		CHICAGO	), IL 60614			
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Z9999	Continued From pa	ge 4	Z9999			
	that he spoke with I change upon his as that he does not known conversation with R separated from R2, during the time until completed. On 2/25 the investigation prothere was no evider ensure safety of not employees of the fa Abuse prevention produced 12/2013, door residents: residents another resident will with other residents investigation. "Residents investigation." Residents) multipart: (Residents) multipart: (Residents)	to deal with R2. E6 stated R2, but R2 did not exhibit any sessment. E6 further stated ow what transpired after his 2. E6 stated that R1 was but R2 was not monitored the investigation was /15, at 2:00PM, E1 stated that ocess was "very fast" but not that R2 was monitored to conly R1, but residents and cility. Togram facility procedures, uments in part: "Protection of who allegedly abused be removed from contact during the course of the idents' rights for people in ties, page one documents in ust not be abused by anyone -mentally, financially or				
		(B)				
	with Serious Mental Subject to Subpart S	not in qualification of			100 mm	
	shall document review assessments and tree PRSC shall inform the of the change in reside appropriate IDT mer	y three months, the PRSC ew of the resident's progress, eatment plans. If needed, the ne appropriate IDT members dent's condition. The nber will reassess the ethe resident's assessment, ed accuracy of the				

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PR

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND I DAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		2000 NOT		STATE, ZIP CODE		
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Z9999	Continued From pa	ige 5	Z9999			
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	This Requirement in	s not met as evidenced by:				
		o not mot do evidenced by.	E1.000			
	Based on interview	and record review, the facility	Addresidant			
	failed to follow the f	acility of staff notification of	A CONTROL AND A SAN AND A	T T T T T T T T T T T T T T T T T T T		
	change condition for	or one of three residents (R1)	and the state of t			
	reviewed for behavi	iors in a sample of three `	000 2000			
	residents.		00000			
	Findings Include:		róon ann ann ann ann ann ann ann ann ann a			
	r maniga molade.					
	R1 was admitted to the facility on 9/25/14 for behavior management with diagnoses which		9			
				distribution		
	include chronic para	anoid schizophrenia, bipolar		**************************************		
	disorder, and seizur	re disorder.				
	On 2/25/45 at 40 24 444 50 (2): 1 1 7					
	Stated that P1 was	1AM, E3 (Clinical Director)				
	on 2/11/15 F3 eta	" having a psychotic relapse " ted that the psychiatrist was		**************************************		
	not informed of R1	's significant change of				
	condition until 2/19/	15. This statement was				
	confirmed by record	I review of a document titled.				
	" Psychiatric Re-eva	aluation " dated 2/19/15 and				l
	signed by Z1 (psych	niatrist).				
	Thoroware	The supplier of the supplier o				
	nhysician) hains infe	mentation of Z2 (attending			1	l
	change of condition	ormed of R1 's significant			ļ	l
	DON (Director of No	On 2/25/15, at 11:30AM, E2 ursing) stated that R1 started				I
	to exhibit delusions	in the last few weeks, but				
	denied informing R1	's doctors. On 2/25/15, at				
	12:04PM, E4 (Nurse	e) stated that R1 was more			į	I
	delusional in the pas	st few weeks, and stated that				
	she did not inform the	ne physician; " social services			Î	
	usually do that. " E4	further stated that the				
	pnysician should have	ve been informed because				
		ts to exhibit behavior	m mygga anta ana			
	The undated facility	d be other medical trigger.	Address of Property		9900	1
	The undated facility policy titled. "Change of		1			i

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PRO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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			STATE, ZIP CODE				
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Z9999	Condition - staff not "When indicated, the confirmed by E2 when the physician when E1confirmed that me (Interdisciplinary Te	tification " documents in part: he resident's physician is ge of condition." This was no stated that the staff should there is a change of condition.	Z9999	DEPICIENCY)			