

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>14G344</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/23/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CLEARBROOK-WRIGHT HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>34377 NORTH ALMOND ROAD</b> <b>GURNEE, IL 60031</b>		
(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	
W 000	INITIAL COMMENTS	W 000			
W 104	<p>COMPLAINT INVESTIGATION</p> <p>1513638/IL78476</p> <p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the governing body failed to ensure communication of a client's health status was conveyed to their own Day Training staff, for 1 of 1 client in the sample who was observed with a rash to her lower back(R1).</p> <p>Findings include:</p> <p>R1's medical record was reviewed. R1's nursing notes beginning on Sunday, 7/5/15 note that R1 presented with a rash to her left back at the waist line. The rash persisted on Monday, 7/6/15, so the physician was contacted. E5(Physician) ordered Acyclovir and for R1 to be on universal precautions, to keep her left flank covered with her clothes, and stated that R1 could travel outside of the facility for Day Training. E5 was treating R1 for Shingles. E5 saw R1 on 7/8/15, and did not change his order that he verbally gave the day before; R1 was still able to attend Day Training Services.</p> <p>During an interview with E3(Nursing Coordinator) on 7/16/15, beginning at 9:45am, E3 explained that E5 examined R1, and was not sure if R1 had</p>	W 104			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	<p>Continued From page 1</p> <p>Shingles, but started her on Acyclovir right away. E3 stated that E5 did not feel it was necessary to place R1 in isolation, but to cover her left back area with her clothes. E3 stated that it never really opened or drained any discharge. R1 was observed at the Day Training facility on 7/22/15, and her left back area was pink, almost healed, and covered with gauze and her clothing.</p> <p>During an interview E8 (Direct Care Staff) on 7/22/15 at 11:00am, E8 stated that she found out R1 had shingles by reading a log book at the residence on the 8th of July. E8 stated that no Administration staff from DT or from Wright home told her about R1 having Shingles. E8 stated that she has cared for client's in the past who had Shingles, and they were in isolation, so she was confused as to why R1 could still travel to DT. E8 stated that she wished someone would have explained to her the precautions if any that needed to be in place for R1.</p> <p>During an interview with E7(Direct Care Staff) on 7/22/15 at 10:40am, E7 stated that she found out about R1 having Shingles on July 9th when she read a communication log at the residence when she was on bus duty picking up the clients for DT. E7 stated that no Administration staff told her about R1 having Shingles. E7 stated that no meeting was held to discuss if R1 should be in isolation, or if R1 was contagious.</p> <p>During an interview with E2(Assistant Director) on 7/22/15 at 11:05am, E2 was asked if she or anyone else from Administration communicated to their own DT staff that R1 had Shingles, and what precautions needed to be implemented. E2 stated that as she saw DT staff she told each staff member that R1 possibly had Shingles. E2</p>	W 104			

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W 104	Continued From page 2 stated that she spoke with E7, E8 and E9(Direct Care Staff). E2 stated that she did this informally, and has nothing to show in writing.  During an interview with E9 on 7/22/15 at 11:20am, E9 stated that no one from Administration ever told him that R1 had Shingles. E9 stated that he heard a rumor about it from direct care staff talking, but he just used universal precautions, and felt that would be fine. E9 stated that E2 never had a conversation with him about R1 having Shingles.	W 104		