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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G344	A. BUILDING ______ B. WING ______	R 07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARBROOK-WRIGHT HOME	34377 NORTH ALMOND ROAD GURNEE, IL 60031

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{W 000}	INITIAL COMMENTS FIRST FOLLOW UP TO ANNUAL OF 4/16/15	{W 000}		
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: REPEAT 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). Findings include: 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. 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	{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}	Continued From page 1	{W 104}		

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.

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.

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.

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

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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(Direct Care Staff) 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}		
{W 125}	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: REPEAT Based on observation and interview, the facility failed to ensure client confidentiality was protected for 1 of 4 clients in the sample(R2) and 1 of 11 clients out of the sample(R5), who had their first and last names printed in line of sight for all staff and clients to view. Findings include: Morning observations were conducted in the home on 7/21/15, beginning at 11:00am. At this time, posted in R2's bedroom was information	{W 125}		

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{W 125}	Continued From page 3 related to safe transfer practices. This form had R2's first and last name printed on it, compromising his right to privacy. Morning observations were conducted at the facility owned Day Training on 7/22/15, beginning at 10:00am. At 10:30am, E7(Direct Care Staff) was noted preparing lunch for the clients. E7 placed all of the plates, cups and silverware out on a counter, in full line of sight of all staff and clients. On R5's plate, printed in bold black marker was R5's first and last name, compromising his right to privacy. During an interview with E1(Director) on 7/22/15 at 1:40pm, E1 was made aware of this finding, and stated that she would address this issue.	{W 125}		
{W 194}	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: REPEAT Based on observation and interview, the facility failed to ensure direct care staff prompted 1 of 1 client in the facility with the known behavior of eating with her hands(R6), to eat with her utensils. Findings include: Morning observations were conducted at the facility owned Day Training facility on 7/22/15,	{W 194}		

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{W 194}	Continued From page 4 beginning at 10:00am. At 10:30am, E7(Direct Care Staff) was noted setting up all of the adaptive equipment, plates, cups etc for lunch. At 11:40am, R6 was observed eating a cut up sandwich, cut up watermelon, and cooked broccoli. R6 had a built up spoon on her plate, but was eating her broccoli, with her hands. R6 dropped food onto the table, and was observed eating the food directly off of the table. E10(Direct Care Staff) was seated at this same table, and observed R6 eating with her fingers. E10 did not re-direct R6 to use her spoon to eat instead of her hands. E10 also observed R6 dropping food onto the table, and eating off of the table with her hands. E10 did not re-direct R6 to stop eating the dropped food from off of the table. During an interview with E10 on this same date and time, E10 was asked if R6 always eats with her hands. E10 stated that they have tried to get R6 to use her utensils in the past, but she never does. E10 stated that she always moves the food off of her plate, and food debris repeatedly falls onto the table. E10 stated that is what always happens when R6 eats her meals.	{W 194}		
{W 340}	483.460(c)(5)(i) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: REPEAT	{W 340}		

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{W 340}	Continued From page 5	{W 340}		

Based on observation and interview, the facility failed to ensure health and hygiene measures were maintained for 2 of 11 clients out of the sample, who ate dropped food from directly off of the table(R6,R7).

Findings include:

Morning observations were conducted at the facility owned Day Training facility on 7/22/15, beginning at 10:00am. At 10:30am, E7(Direct Care Staff) was noted setting up all of the adaptive equipment, plates, cups etc for lunch. At 11:40am, R6 was observed eating a cut up sandwich, cut up watermelon, and cooked broccoli. R6 had a built up spoon on her plate, but was eating her broccoli, with her hands. R6 dropped food onto the table, and was observed eating the food directly off of the table. E10(Direct Care Staff) was seated at this same table, and observed R6 eating with her fingers. E10 did not re-direct R6 to use her spoon to eat instead of her hands. E10 also observed R6 dropping food onto the table, and eating off of the table with her hands. E10 did not re-direct R6 to stop eating the dropped food from off of the table.

At this same time, R7 was observed eating the same meal, also dropping food debris onto the table. R7 was observed eating food off of the table, without staff re-direction to stop doing so.

During an interview with E10 on this same date and time, E10 was asked if R6 always eats with her hands. E10 stated that they have tried to get R6 to use her utensils in the past, but she never does. E10 stated that she always moves the food off of her plate, and food debris repeatedly falls onto the table. E10 stated that is what always

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{W 340}	Continued From page 6 happens when R6 eats her meals.	{W 340}		