Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ILL6001346	A. BUILDING: ______ B. WING ______	C 02/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	COMMENTS Incident Report Investigation IRI of 2/11/2015 - IL 75083	Z 000		
Z9999	FINDINGS 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: R1 was admitted to the facility on 9/25/14 for	Z9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Z9999	Continued From page 1	Z9999		

behavior management with diagnoses which include chronic paranoid schizophrenia, bipolar disorder, and seizure disorder.

On 2/25/15, at 10:21AM, E3 (Clinical Director) stated that R1 was " having a psychotic relapse " on 2/11/15. E3 stated that the psychiatrist was not informed of R1 ' s significant change of condition until 2/19/15. This statement was confirmed by record review of a document titled, " Psychiatric Re-evaluation " dated 2/19/15 and signed by Z1 (psychiatrist).

There was no documentation of Z2 (attending physician) being informed of R1 ' s significant change of condition. On 2/25/15, at 11:30AM, E2 DON (Director of Nursing) stated that R1 started to exhibit delusions in the last few weeks, but denied informing R1 ' s doctors. On 2/25/15, at 12:04PM, E4 (Nurse) stated that R1 was more delusional in the past few weeks, and stated that she did not inform the physician; " social services usually do that. " E4 further stated that the physician should have been informed because when a resident starts to exhibit behavior changes, there could be other medical trigger.

(B)

Section 300.3210 General
o) The facility shall also immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges,

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Z9999	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 emergency contact.	Z9999		

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Z9999	Continued From page 3	Z9999		

(AW)

Section 300.3240 Abuse and Neglect
f) 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. 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).

On 2/25/15, E3 stated that she instructed E6

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Continued From page 4

(Clinical Supervisor) to deal with R2. E6 stated that he spoke with R2, but R2 did not exhibit any change upon his assessment. E6 further stated that he does not know what transpired after his conversation with R2. E6 stated that R1 was separated from R2, but R2 was not monitored during the time until the investigation was completed. On 2/25/15, at 2:00PM, E1 stated that the investigation process was " very fast " but there was no evidence that R2 was monitored to ensure safety of not only R1, but residents and employees of the facility.
Abuse prevention program facility procedures, dated 12/2013, documents in part: " Protection of residents: residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation. " Residents ' rights for people in long term care facilities, page one documents in part: (Residents) must not be abused by anyone - physically, verbally, mentally, financially or sexually.

(B)

Section 300.4020 Reassessments for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S

a) At least every three months, the PRSC shall document review of the resident's progress, assessments and treatment plans. If needed, the PRSC shall inform the appropriate IDT members of the change in resident's condition. The appropriate IDT member will reassess the individual and update the resident's assessment, assuring the continued accuracy of the assessment.

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Z9999	Continued From page 5	Z9999		

This Requirement is not met as evidenced by:

Based on interview and record review, the facility failed to follow the facility of staff notification of change condition for one of three residents (R1) reviewed for behaviors 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.

On 2/25/15, at 10:21AM, E3 (Clinical Director) stated that R1 was " having a psychotic relapse " on 2/11/15. E3 stated that the psychiatrist was not informed of R1 ' s significant change of condition until 2/19/15. This statement was confirmed by record review of a document titled, " Psychiatric Re-evaluation " dated 2/19/15 and signed by Z1 (psychiatrist).

There was no documentation of Z2 (attending physician) being informed of R1 ' s significant change of condition. On 2/25/15, at 11:30AM, E2 DON (Director of Nursing) stated that R1 started to exhibit delusions in the last few weeks, but denied informing R1 ' s doctors. On 2/25/15, at 12:04PM, E4 (Nurse) stated that R1 was more delusional in the past few weeks, and stated that she did not inform the physician; " social services usually do that. " E4 further stated that the physician should have been informed because when a resident starts to exhibit behavior changes, there could be other medical trigger. The undated facility policy titled, " Change of

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Z9999	Continued From page 6 Condition - staff notification " documents in part: " When indicated, the resident ' s physician is notified of the change of condition. " This was confirmed by E2 who stated that the staff should the physician when there is a change of condition. E1confirmed that members of IDT (Interdisciplinary Team) includes but not limited to: doctors, psychiatrist, nurses, social services and activity staff. (B)	Z9999		