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	IL6001853	A. BUILDING: _____ B. WING _____	C 03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEARBROOK CENTER	3201 WEST CAMPBELL STREET ROLLING MEADOWS, IL 60008

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Z 000	COMMENTS Complaint #2590532/IL00184931 FRI of 1-16-25/IL187756	Z 000		
Z9999	FINDINGS Statement of Licensure Violations 350.620a) 350.1210a) 350.1230d)2) 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 350.1210 Health Services a) Comprehensive resident care plan. A facility, with the participation of the resident and the resident's guardian or resident's representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental health, psychosocial, and habilitation needs that are identified in the resident's comprehensive assessment that allows the resident to attain or maintain the highest practicable level of independent functioning and provide for discharge planning to the least	Z9999		

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restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or resident's representative, as applicable. (Section 3-202.2a of the Act)

Section 350.1230 Nursing Services

d) Direct care personnel shall be trained in, but are not limited to, the following:

2) Basic skills required to meet the health needs and problems of the residents.

These requirements were not met as evidenced by:

Based on record review and interview, the facility neglected to provide a safe transfer to prevent a resident from falling. As a result, R2 sustained a right femur fracture after being improperly transferred. This failure affected 2 of 3 residents (R1, R2) reviewed for transfers.

Findings include:

1.
R2's ISP (Individual Service Plan) dated 4/18/24 identifies R2 as a 60 year old female who functions in the Profound level of Intellectual Disability.

Facility incident report dated, 1/30/2025 documents the following,
R2 was noted to have swelling to her right upper leg. The nurse believed it could be a fracture based on the swelling. R2 was sent out for further evaluation. Lower femur fracture was founded by emergency department (ED). R2 was transferred to hospital for surgery ...Based on information

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gathered through this investigation, the cause of R2's injury is unknown... It is possible that individual R2 had a fall that was not reported, even though staff that were interviewed denied the client having any falls. Based on information gathered throughout this investigation, E3 (Direct Support Person/DSP) proceeded to transfer R2 after notifying the nurse that client would not stand to transfer. The injury was discovered after the transfer when E3 was undressing the R2 for a shower.
Analysis findings based on information gathered: At approximately 5:00pm, nurse went to assess R2. E3 notified the nurse when she entered the room the client's leg was swollen and did not look normal. R2 was transferred to the hospital for further evaluation and treatment of right femur fracture.

R2's Physician's Order Sheet Dated 1/1/25 to 1/31/25, documents the following: Rehabilitation Restorative Therapy: may transfer with gait belt.

R2's Physical Therapy assessment dated 12-17-2024 documents the following,
General programming considerations: Staff will provide minimum assist stand pivot technique during transfer skills using gait belt.

On 3/7/2025 at 2:30pm, E3 stated, "At around 3:10pm on January 22, 2025, I asked R2 to stand up from her wheelchair and hold the rail, R2 refused to stand up, I then transferred R2 to the bed from the wheelchair by grabbing the the back of R2's pants and I lifted R2 up to transfer her into the bed. When I put R2 into the bed, I saw R2's leg looked red and swollen. I then went and notified the nurse."

On 3/10/2025 at 12:42pm, E3 stated, "I was

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trained to do transfers of the residents by Physical Therapy. I was taught when transferring a resident using a stand pivot transfer, the staff should use a gait belt. R2 doesn't use a gait belt, the only people that use gait belts are the people that have them in their rooms." E3 then stated, R2 doesn't have a gait belt available in R2's room.

On 3/7/2025 at 3:01pm, E1 (Administrator) stated, to do a one-person transfer pivot, the staff should use a gait belt, E3 should have used a gait belt to transfer R2 that day. E3 should not have used R2's pants to transfer R2.

On 3/10/25 at 11:50am, E12 (Licensed Practical Nurse) stated, I checked on R2 around 11:00am on January 22, 2025. I entered R2's room and R2 was near her door. R2 did not appear in any pain and did not have any injuries at that time. R2 was trying to exit her room. I approached R2 from the left side. I did not notice anything wrong with R2's right leg.

On 3/10/25 at 11:28am, E10 (Direct Support Person) stated, I provided care for R2 on January 22, 2025, from around 10:00am to 3:00pm. I took R2 to the bathroom around 12:40pm, and she did not have any injuries at that time. R2 was able to grab the grab bar in the bathroom and stand up and transferred to the toilet and then back to R2's wheelchair with no issue. I saw her right hip and right leg at that time and R2's leg looked normal. At 3:00pm, I left for the day and R2 was sitting in her wheelchair in her room and was fine.

On 3/10/25 at 10:45am Z1(Orthopedic Physician Assistant) stated, R2's femur fracture likely happened from a fall or an impact. A femur shaft fracture typically doesn't happen when someone

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is laying in the bed or just sitting in a chair or a wheelchair. There could be swelling, redness, and pain immediately following a femur fracture.

Facilities Policy, "Suspected Abuse, Neglect, Mistreatment of a Client, or Injury of Unknown Origin, Incident, and Accident Investigation Policy", revised 11/5/2018, documents the following,
Purpose: To clarify and outline steps when there is suspected abuse or neglect, death, serious injuries of unknown origin that are not the expected outcome of the client's condition or disease process, missing person, client-to-client aggression, or criminal conduct. An occurrence report may be initiated by the parent, client, staff, or volunteer. Sexual assault and physical assault are subsumed under abuse, while theft is part of a criminal conduct.
Definitions:
Neglect is a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.
Department of Public Health: Neglect, a failure in a facility to provide adequate medical or personal care maintenance, which failure results in physical or mental injury to a resident, or in the deterioration of a resident's physical or mental condition.
Serious incident accident, any incident or accident that causes physical harm or injury to a resident.

2.
Facility Incident report dated 1/27/25, documents, Nursing was called for evaluation of R1 who was in a fully extended lift being moved for changing, somehow R1 had fallen through the sling to the floor striking her head on the tile ...
Analysis/Findings: Based on information gathered

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Z9999	Continued From page 5 ...it can be reasonably concluded that R1 fell through the sling at day program due to a half sling no longer being suitable for R1. R1's Individual Support Plan, dated 5/7/2024, documents the following, Special provisions needed for Safety and Security: ...R1 uses a manual wheelchair and transfers with staff assistance and a gait belt, A mechanical lift is also an option for transfer if needed. On 3/7/25 at 1:16pm, E4 (Direct Support Person) stated, I transferred R1 by myself, using a mechanical lift. The reason R1 fell out of the mechanical lift sling is because it was the wrong sling, it was not the correct size. E4 then stated, certain slings are assigned to specific residents and R1's sling did not belong to R1; it was too small, it was grabbed and used for R1's transfer the day R1 fell out of the sling." On 3/7/2025 at 1:45pm, E2 (Director of Social Services) stated, R1 had the wrong sling, the sling that was used that day was a purple sling and R1's sling is either gray or blue mesh, the staff used the wrong sling to transfer R1 and R1 fell from the lift. E2 then stated, R1 should use a full body sling and the sling that was used that day was a half body sling. On 3/10/2025 at 9:32am, E5 (Director of Physical Therapy) stated, R1 should use a full body sling for mechanical lift transfers, this was recommended by the physical therapist in November of 2023 due to R1's decreased tone and Parkinson's disease diagnosis. Facility Policy titled, "Transfer Assist and Proper Body Mechanics", revised 04/2024, documents	Z9999		

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the following,
Objective: [Facility] strive to ensure that the individuals served are cared for safely while maintaining a safe work environment for employees. It is the policy to adopt and follow a best practice transfer assist program. The goals of this program are to reduce the potential for injury to the individuals served as well as the employees of the facility. Mechanical lifting equipment, anti-friction devices, and or other approved aids will be used to minimize the manual lifting and handling of individuals served except in an emergency situation.
Responsibility: It is the responsibility of all competency validated staff to know, follow, and adhere to this policy when using all provided lift equipment. All direct care staff have the responsibility to exercise reasonable care for their own safety and for the safety of the individuals served and co-workers. Mechanical lifts must be used on the individuals who meet the criteria set forth in the assessment criteria ...
3.Supervisory Compliance.
A. Management and Leadership staff are expected to support the implementation of this policy using every available resource for a lift free environment before making recommendations otherwise.
F. Ensure that proper lifting devices and other equipment aids are available and in proper working condition.
G. Follow procedures for direct care staff compliance. Use proper techniques, lifting devices, and other approved equipment aids during performance of individual handling and movement.
H. Direct care staff do not have the authority to modify the approved transfer method.

"A"

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