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
	IL6016117	A. BUILDING: _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACES AT THE CLARE	55 EAST PEARSON CHICAGO, IL 60611

(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
S9999	Final Observations Statement of Licensure Violations: 300.615e) 300.690b)c) 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information (e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident ' s name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) These requirements were not met as evidenced by: Based on interview and record review, the facility failed to initiate criminal background checks within 24 hours of admission for one resident (R1) of ten in the sample of 12 and one resident (R15) from the supplemental sample reviewed for admission background checks. Findings Include: The facility ' s admission, transfer, and discharge log from 1/1/16 to 4/4/16 indicates that R1 was admitted to the facility on 4/2/16 and R15 was admitted to the facility on 3/29/16. Review of the facility resident admission background checks on 4/6/16, at approximately 4:00 PM, indicated that R1 ' s and R15 ' s criminal background checks were not initiated within 24 hours of admission. R1 ' s Illinois Sex Offender Information sheet and	S9999	Attachment A Statement of Licensure Violations	

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National Sex Offender Search sheet dated 4/4/16 indicate that the background checks on those websites were performed on 4/4/16. R1 ' s signature on the Uniform Conviction Information Act Name Inquiry sheet dated 4/4/16 indicates that R1 ' s inquiry sheet was signed by R1 on 4/4/16.

R15 ' s Illinois Sex Offender Information sheet and National Sex Offender Search sheet dated 4/4/16 indicate that the background checks on those websites were performed on 4/4/16. R15 ' s signature on the Uniform Conviction Information Act Name Inquiry sheet dated 4/4/16 indicates that R15 ' s inquiry sheet was signed by R15 on 4/4/16.

On 4/6/16 at 4:23 PM, E14 (Transitions Manager) stated in part that E30 (Guest Relations Coordinator) is responsible for performing resident background checks.

On 4/6/16 at 4:36 PM, E30 (Guest Relations Coordinator) stated in part that E30 performs resident background checks to see if the residents have sexual assault crimes or criminal charges. E30 checks the Illinois Sex Offender and National Sex Offender websites, when performing resident background checks. The results for those background checks are obtained when websites are checked. Those websites are the only websites that E30 was trained to check. The residents complete the Uniform Conviction Information Act Name Inquiry sheets and E30 completes the inquiry sheets for residents who cannot complete the inquiry sheet themselves. The residents have to sign the inquiry sheet. Then E30 mails the inquiry sheets to the Illinois State Policy for background checks. E30 usually mails the completed and signed inquiry sheets a couple of days after E30 receives them from the residents. Resident background checks should be initiated within 24 hours of the resident ' s

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admission.
On 4/11/16 at 10:48 AM, E1 (Administrator) stated in part that the facility does not have a policy regarding the process for performing resident background checks.

(B)

300.690 Incidents and Accidents
(b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, " serious " means any incident or accident that causes physical harm or injury to a resident.
c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, " notify the Regional Office by phone only " means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department ' s toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.
These requirements were not met as evidenced by:
Based on interview and record review the facility failed to report an incident associated with a serious injury, to the state agency within 24 hours of occurrence, involving one resident (R14) of twelve reviewed for abuse, from the supplemental sample.
Findings Include:
Review of reportable incident report dated 7/11/15

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indicates that R14 had a fall at 8:15 AM. R14 was observed on the bathroom floor, lying supine with the wheelchair behind her. R14 stated that she tried to get up from the wheelchair and wash her hands when she fell and hit her head. R14 ' s physician was notified and R14 was sent to a local hospital for an evaluation. R14 was admitted to a local hospital after sustaining a fall at the facility. The computerized tomography (CT) scan showed a small amount of subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain) space. Also noted were previous hematomas (a localized swelling that is filled with blood caused by a break in the wall of a blood vessel. Initial report was not submitted to the state agency, as the facility was unable to obtain the information from the hospital until 7/16/15.
Nurse note dated 7/11/15 at 958 AM, indicates that R14 was observed by staff lying supine on the floor. R14 stated she tried to get up from her wheelchair after her time in the sink and said " I fell and hit my head " . Cold compress applied to affected, back of the head. Z6 (Medical Physician) was notified.
Nurse note dated 7/11/15 at 12:06 PM, indicates that Z7 (Power of Attorney/Son) was notified of fall. Z7 stated that R14 had history of brain hemorrhage and Z7 had a concern of leaking.
Nurse note dated 7/11/15 at 12:06 PM, indicates that Z5 (Medical Physician) (covering physician) was notified of R14 ' s fall and gave instructions to continue neurological checks and notify Z5 for any abnormalities.
Nurse note dated 7/11/15 at 12:09 PM, indicates that Z7 was notified of the decision for R14 to stay in the facility and be on neurological checks. Z7 was afraid of R14 having hemorrhage and insisted on the facility sending R14 to the hospital.

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Nurse note dated 7/11/15 at 12:14 PM, indicates that Z5 was notified of POA ' s decision. Z5 was okay with Z7 ' s decision. Z5 gave an order to send R14 to a local hospital for an evaluation.
Hospital emergency room records dated 7/11/15 indicate that R14 had an un-witnessed fall and hit her head. Had a brain CT and there is a new small focus of hyperdensity in left temporal, likely acute traumatic subarachnoid hemorrhage. A follow up imaging test will need to be done in 4-6 hours.
Hospital records dated 7/11/15 indicate that R14 ' s brain CT without contrast (7/11/15) showed artifact or possible new left anterior temporal lobe hemorrhage.
Hospital records dated 7/15/15 indicates that R14 was admitted to the local hospital on 7/11/15 and was discharged to the facility on 7/15/15. R14 ' s admission chief complaint was a fall and discharge diagnoses were subarachnoid hemorrhage and fall.
Nurse note dated 7/15/15 at 9:01 PM indicates that R14 was readmitted to the facility from a short hospital stay. R14 had a fall and was sent to a local hospital for an evaluation on 7/11/15.
Nurse note dated 7/15/15 at 11:54 PM indicates that R14 was admitted to a local hospital with a subarachnoid hemorrhage (CT stable) per report.
On 4/7/16 at 2:57 PM, E1 (Administrator) stated in part that there was a reportable incident involving R14. R14 had a fall on 7/11/15, hit her head, and was sent to a local hospital for an evaluation. Brain CT results indicated that R14 had a subarachnoid hemorrhage. R14 also had a subarachnoid hemorrhage prior to admission. There was a question with the CT scan results regarding if the subarachnoid hemorrhage was old or new. If the subarachnoid hemorrhage was from the new fall, the facility should have notified the Illinois Department of Public Health, when the

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facility found out.
On 4/7/16 at 5:53 PM, E1 stated in part that when a resident has a fall, the resident ' s physician is called, report of the fall circumstances is communicated to the physician, and the physician gives orders regarding the course of action the staff should take. If the facility staff receives orders to send a resident to a local hospital for an evaluation, the facility staff either waits for a call from the local hospital or the facility staff calls the local hospital to check on the status of the resident, to see if anything major happened. The facility follows up on a resident ' s admitting diagnosis and checks the status of a resident, but the facility does not have a formal process. The local hospital gets in touch with the facility via referral, when a resident is returning from the hospital. At that time the facility receives the formal diagnosis and some hospital records to understand what happened with the resident.
The local hospital staff told the facility staff that R14 ' s brain CT results were unclear regarding if R14 ' s subarachnoid hemorrhage was old or new. The facility went straight to the final report with R14 ' s fall incident and reported the incident to the Illinois Department of Public Health on 7/17/15.
On 4/11/16 at 1:30 PM, E1 also stated in part that if a resident goes to a local hospital for an evaluation, E1 has to report the incident to the state agency. When E1 receives report from the local hospital, that a reportable incident exists, E1 reports the reportable incident to the Illinois Department of Public Health within 24 hours of that report. The facility ' s Reporting Unusual Occurrences policy indicates that incidents should be reported within 24 hours of the occurrence to the state agency.
When E1 (Administrator) was asked for evidence of R14 ' s injury being reported to the state

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S9999	Continued From page 6 agency, E1 presented a fax transmittal sheet dated 7/17/15 at 4:59 PM, that does not indicate information that the sheet pertains to R14. E1 stated in part that the facility notified the state agency of R14 ' s serious injury on 7/17/15. The facility failed to notify the state agency within 24 hours of notification of R14 ' s serious injury. The facility ' s Reporting Unusual Occurrences with revision date of July, 2013 documents in part the following in the Facility Reporting and Investigation Instructions section: Facility must contact the State Department of Health (SDH) by telephone or by fax within 24 hours upon determining a situation exists (or existed) that is reportable under these guidelines. The initial report should contain a brief description of the occurrence, brief description of investigative action initiated and a description of the action taken by the facility to respond to the situation. (B)	S9999		