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	14E134	A. BUILDING ______ B. WING ______	12/20/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALSHORE HOUSE	2840 WEST FOSTER AVENUE CHICAGO, IL 60625

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F 496	Continued From page 53 at the facility. This information was found on E9's employment application dated 9/30/1997. On 12/12/2007 E1 (administration) told the surveyor she did not know E9 needed any follow-up training. E1, after checking with E3 (consultant nurse), told the surveyor a training course was needed if there is more than 24 months break in employment. The surveyor asked for evidence of at least part time employment of E9 during the 4 year absence from the facility. E1 told the surveyor she spoke with E9 and E9 reported she worked part time. However, no evidence was presented during the survey to support this allegation.	F 496		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS LICENSURE VIOLATIONS 300.1210b)6) 300.1220b)2)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision	F9999		

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and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These regulations are not met, as evidenced by the following:

Based on observations, interviews and record review the facility failed to provide the following:

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F9999	Continued From page 55 - consistent monitoring or supervision for residents who are identified with a high risk for falls, -complete fall re-assessments following each resident fall incident, to determine the cause of the fall, and -an updated care plans following each fall incident with specific interventions and approaches for staff to implement to prevent further falls. These failures occurred in 3 of 5 sampled residents identifed as high risk for a fall (R5, R7 and R8). R5 had multiple falls and sustained fractures. R7 had multiple falls and sustained 3 head injuries. R5 and R7 had required multiple trips to the emergency room of a local hospital precipitated by the fall incidents. In addition, R8 had sustained an injury from a fall incident. The facility also failed to eliminate physical features within the facility that may cause an unexpected, unintended event that can cause a resident bodily harm by failing to ensure medications and cleansing agents are not accessible to cognitively impaired residents and the medication cart is not left unlocked and unattended. Findings include: 1) R5 is an 88 year old resident with diagnoses including seizure disorder, dementia and osteoporosis. R5 also has anxiety and depression. Review of assessment dated 11/28/07, 8/28/07 showed that R5 has a score for 1/1 (supervision required) for transfer and ambulation.	F9999		

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F9999	Continued From page 56 Review of record indicated the following incident/fall episodes for R5: -5/27/07 at 11:00 A.M.; R5 fell on the patio, sustained 2.5 cm. lacerated wound on the right upper eyelid and an abrasion on the left thumb. R5 was sent to the hospital for stitches of the lacerated eyelid. -6/10/07 at 5:00 A.M.; R5 was about to go to bathroom in her room, lost balance and fell. R5 was found lying on the floor near the bathroom. R5 complained of right leg pain and was sent to hospital. Record showed that R5 was readmitted back to the facility on 6/21/07, sustained hairline fracture due to the fall incident. -10/11/07 at 7:00 P.M.; R5 was found sitting on the floor near the door in her room. R5 lost her balance. No visible injury from this fall, however, per record, R5 complained of right chest, rib cage and back pain. Z1(attending physician) was made aware and an x-ray of the thoracic/lumbar area was done in which the results were negative for fracture. -10/17/07 at 9:00 A.M.; R5's complained of pain on the left hand. Left hand was swollen. R5 denied fall, however the cause of the left hand injury was unknown. R5 was sent to the hospital on 10/17/07 for evaluation of the left hand injury. Per record, R5 has a fracture on the 5th metacarpal of the left hand. R5 was sent out to the hospital again on 10/20/07 due to continued pain and swelling of the left hand secondary to the 5th metacarpal fracture of the left hand. R5 returned to the facility on same day (10/20/07) with a splint on her left hand and had required an orthopedic appointment related to the fracture. -10/23/07 at 6:55 A.M.; R5 was found sitting on the bathroom floor. R5 complained of pain on the right side upper back, right arm, right shoulder and right side of her head. R5 was sent to the	F9999		

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hospital and returned to the facility on same day (10/23/07). R5 returned with a soft mold cast on her right hand/arm. R5 had required a consultation appointment for further evaluation of the right hand injury which was precipitated by this fall of 10/23/07.

Review of the care plan lists all of the dates of R5's falls. However, after each fall incident there is no thorough re-assessment, no update of any specific interventions/approaches addressing the fall incidents that R5 had sustained for preventions for further fall incident.

Throughout the 3 day observation survey process on 12/10/07, 12/11/07 and 12/12/07, at various intervals during the day, R5 was observed ambulating independently in her room, around corridor, and dayroom/dining room. R5 who is thin, fragile looking also has an unsteady gait. Staff was not observed to supervise nor assist R5 during self ambulation. There was no monitoring by staff of R5's whereabouts.

When interviewed on 12/12/07 at 10:10 A.M., E13(certified nurse assistant) confirmed that R5 does self ambulation, and does self transfer without staff supervision or assistance. E13 also stated that the only time that staff provides supervision and assistance to R5 was during the time R5 takes her shower.

When interviewed on 12/12/07 at around 12:45 A.M., E3 (nurse consultant) stated that the facility's practice for residents who are identified with history of fall will be referred to a physical therapist for assessment and evaluation for possible treatment to prevent further falls.

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F9999	Continued From page 58 Review of R5's record showed that last physical therapy evaluation was on 6/19/07. There were no further physical therapy assessment/evaluation after 6/19/07 as confirmed by E4 (care plan nurse) on 12/12/07 1:30 P.M. 2) R7 is a 63 year old resident admitted to facility on 03/15/07 with diagnosis including seizure disorder, CVA (cerebral vascular accident) alcohol abuse. R7 was admitted to the facility as a high fall risk. The assessment dated 09/29/07 shows that R7 has modified cognition and requires limited assistance for transfers and extensive assist in ambulation, bowel and bladder including two person physical assist. Record review including the facility's incident/accident file indicates a fall history for R7 as follows: 04/24/07 at 5:30pm, R7 found on the floor in his room in front of his wheelchair and sustained an abrasion to nose above nostrils with slight redness and swelling. 06/30/07at 8:30am, R7 was sitting in his wheelchair when fell on floor face down and had petit mal seizure which lasted between 3-5 minutes. R7 sustained 0.5cm x 0.5cm lacerated wound right eyebrow with minimal bleeding. No loss of consciousness. 09/19/07at 6:20pm, R7 was found sitting on floor noted with lacerated wound occipital area 4cms in length with moderate amount of bleeding. No loss of consciousness.	F9999		

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10/24/07 at 1:10pm, R7 found sitting on the floor in his room adjacent to his wheelchair, laceration noted on posterior head area approximately 0.2 x 2cm x 0.2cm, no active bleeding.

Quality Assurance Worksheet dated 06/13/07 states R7 sustained an abrasion to nose above nostrils with slight redness and swelling as a result of a fall on 04/24/07. Nurses noted dated 09/19/07 states R7 sustained a 4cm occipital head injury with a moderate amount of bleeding as a result of the fall. R7 was sent to a local hospital 7:45pm on this day and was readmitted to facility on 09/19/07 at 11:20pm with staples on top of head.

Nurses notes dated 10/24/07 (approximately 1 month 6 days later) states R7 sustained a laceration on posterior head area measuring 0.2 x 2cm x 0.2cm. as a result of a fall. R7 was sent to a local hospital and was readmitted to the facility 11:20pm with 2 staples on occipital area.

Review of R7's care plan indicated no care plan developed for the fall on 04/24/07 nor 06/30/07 even though R7 was sent to a local hospital after sustaining a laceration of the right eyebrow with bleeding. A care plan was developed 09/29/07 (10 days after R7's third fall) in the area of falls and states R7 is at risk for falling due to diagnoses of seizure disorder, psychotropic drug use, CVA (cerebral vascular accident). The goal is for R7 not to sustain a fall-related injury through the next review. There was no date for review. There are multiple approaches listed on the care plan. There is no indication in record that these approaches were monitored for their effectiveness after any of the multiple falls R7 sustained.

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There was also no analysis (comprehensive assessment) following each fall/injury of the circumstances surrounding R7's falls to determine any trends to the falls or to assist staff in developing individualized interventions in an attempt to prevent further falls. There was no alterations in the interventions after each fall to prevent further falls.

3) R8 is a 75 year old resident with diagnoses including depression, vascular dementia and CVA(cerebral vascular accident) with right spastic hemiplegia. Review of assessment dated 08/04/07 and 11/4/07 showed that R8 has a score for 3/2 (extensive assistance/1 person physical assist) for transfer and ambulation.

Review of record indicated the following incident report for R8:
10/16/07 at 1:55 P.M. "(R8) transferred self from bed to wheelchair and lost her balance and fell on the floor near her bed. (R8) sustained right arm abrasion which measures 8 cm x 2 cm with minimal bleeding."

When interviewed on 12/11/07 at 2:10 P.M., E14(CNA-certified nurse assistant) confirmed that R8 does self transfer from bed to wheelchair and vice versa. E14 also stated that R8 does not ask for assistance for transfer. E14 also added that staff only provides assistance when R8 is taken to the toilet for incontinent needs.

Review of the care plan list the date of R8's fall. However, after the fall incident, there was no thorough re-assessment, no updated/revised specific interventions/approaches addressing the fall incident that R8 had to prevent further fall

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F9999	Continued From page 61 incident. If R8 does not ask for assistance for transfer, and yet continued to do self transfer, it is not reflected in her plan of care how to address this problem. On 12/11/07 at 2:05 P.M. R8 was observed doing self -transfer from bed to wheelchair without asking staff assistance. (A)	F9999		