STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G084	A. BUILDING ____ B. WING ____	04/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORE HOMES EAST	**503 MICHIGAN AVENUE EVANSTON, IL 60202**

(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) COMPLETION DATE
W 488	Continued From page 29 2:55pm thru 4:40pm. At 2:55pm surveyor observed the 3 dining room area tables set with coffee cups and snacks. No residents were present. E7, Dietary Manager, was observed pouring into each coffee cup either a dietary or regular creamer. Residents were observed eat their snack and drink their coffee independently. On 3/13/12 at 3:05pm E7, Dietary Manager, was asked who set the table and put the snacks on the table. E7 stated she did. E7 was asked why she was pouring the creamers into the coffee cups rather than the residents doing it for themselves. E7 stated, "The residents may pour the whole thing. I manage portion control." 3) During an observation of the evening meal on 3/13/12, E6 (Direct Service Person) was observed placing plastic drinking tumblers at each of the place settings, at the three tables in the dining room. E6 was observed to fill each of the plastic cups with water or milk, before clients were seated at the table. During an interview, E6 was asked why she poured the beverages, instead of allowing the clients to pour their own and she stated, "I usually pour it for them."	W 488		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.681 350.700a) 350.700c) 350.3240a) 350.3240d) Section 350.620 Resident Care Policies	W9999		

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W9999	Continued From page 30	W9999		

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 350.681 Health Care Worker Background Check

A facility shall comply with the Health Care Worker Background Check Act [225 ILCS 46] and the Health Care Worker Background Check Code (77 Ill. Adm. Code 955).

Section 350.700 Incidents and Accidents

a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. 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.

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W9999	Continued From page 31 Section 350.3240 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) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) These Requirements were not met as evidenced by: Based on record review and interview, the facility failed to ensure the safety of clients in the home for 1 of 4 individuals in the sample (R4) by failing to: A) Implement a plan of action to ensure the safety of clients in the home, following an allegation of staff-to-client abuse (R4), by failing to: 1) Conduct a thorough investigation for an allegation of staff-to-client abuse made by a client in the home against an agency staff. 2) Develop and implement a facility protocol for addressing allegations of abuse involving agency staff. 3) Obtain and verify employee screening information for all agency staff assigned to work in the home. 4) Implement the facility's policy for abuse and neglect, for incident management procedures, to ensure that physical examinations are done and that documentation related to the incident is	W9999		

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W9999	Continued From page 32	W9999		

accurate, when a client reports an injury as a result of an alleged abuse.

Findings Include:

A) R4, per the most recent Individual Plan dated 6/1/11, has diagnoses that include Severe Mental Retardation, Aggression and Impulse Control Disorder. The Individual Plan documents that R4 attends an offsite workshop five days per week and a weekly social work group, and receives individual supportive counseling on a weekly basis. The Individual Plan indicates that R4's, "strengths are in the areas of expressive skills."

On 1/17/12, the workshop documented that R4 had been involved in a peer-to-peer altercation. The Incident/Accident/Behavior Report completed by the workshop staff documented a peer, "hit R4 on the right shoulder and cheek." R4 was assessed by the nurse at the workshop and was identified to have redness to the cheek area and was given an ice pack. No further treatment was documented. The staff at the workshop, completed an Incident/Accident/ Behavior Report on 1/17/12. The report indicates that workshop staff notified R4's home of the peer-to-peer altercation on 1/17/12 at 3:30 PM.

During a telephone interview on 3/22/12, Z6 (Workshop Program Manager) stated that she witnessed the peer-to-peer altercation on 1/17/12, involving R4 and another client at the workshop. Z6 stated she was walking a client from her office back to the work area when the client, without provocation, hit R4 on the shoulder and cheek in "one fell swoop." Z6 stated she immediately intervened. Z6 stated that she observed the

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W9999	Continued From page 33 incident and there was "no contact other than on the shoulder and cheek." Z6 stated that she took R4 to the nurse's office for further evaluation. During a telephone interview on 3/22/12, Z5 (Workshop Nurse) confirmed that she assessed R4 following the peer-to-peer altercation at the workshop on 1/17/12. Z5 stated she was informed by staff that R4 was hit in the shoulder and cheek. Z5 stated R4 was observed to have "redness to the cheek area." Z5 further stated that R4 was not observed to have any breaks in the skin and denied complaints of pain. R4 was given a cold compress for the cheek and was able to return to the work area. Z5 stated that it is "highly unlikely" that R4 sustained a foot injury as a result of the incident on 1/17/12. On 1/18/12, R4 was seen by the physician. The Doctor's Visit Report dated 1/18/12, documented that R4 was noted to have a "right big toe black and blue." The physician's reports documented that R4 sustained a "right 1st toe contusion." R4 had an X-ray of the right foot. The physician documented that the X-ray report was "normal." On 1/19/12, during a session with her counselor, R4 reported an allegation of staff-to-client abuse. R4 told Z4 (Counselor) that a staff person in the home (Z8), was physically abusive to clients in the home; and that he caused her to have a foot injury. R4 reported that Z8, "is mean to us" and "he pushes on us." Z4 stated during a telephone interview on 3/21/12 at 2:30 PM, that on 1/19/12 R4 was observed to have a bruise to the upper arm. Z4 stated that bruise was approximately 2-2.5 inches in	W9999		

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W9999	Continued From page 34 diameter. Z4 stated, "it was quite large about the size of the bottom of a soda can." Z4 was not able to recall if it was the right or left arm. Z4 also stated that R4 had a bruise and swelling to the toe. Z4 stated, "I think it was the right toe it was really bad." Z4 stated that R4's foot "appeared to be broken." Z4 stated that the bruising extended from the top of the foot to under the 1st toe. During the telephone interview on 3/21/12 at 2:30 PM, Z4 stated that she called the facility on 1/19/12, to notify them of the allegation of abuse. Z4 stated she was not able to speak to anyone directly and left a message on the facility's answering machine. Z4 stated facility staff never called her back to follow up with the report of abuse, so she called them again on 1/23/12. Z4 stated that E8 (Social worker) called her back on 1/23/12 and confirmed that the facility received the allegation of abuse. Z4 stated E8 informed her that R4's foot injury was self inflicted when she stubbed her toe. The facility completed an Incident/Accident/Behavior Report Form on 1/19/12. Facility staff documented that R4 told her counselor that she had been physically abused by a substitute staff person at the home. The report documented that R4 alleged that the staff person, "pushed her into her room" and "he's mean to us and not coming back." R4 also reported to the counselor that, "he hurt her toenail and her arm" and "he slaps people in the face and kicked her ankle." The Incident/Accident/Behavior Report Form dated 1/19/12 documented, "Although R4 is an unreliable reporter, the substitute staff is no	W9999		

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W9999	Continued From page 35 longer working at the facility." During an interview on 3/13/12 at 3:50 PM, E2 (Program Coordinator) confirmed that a substitute staff person from an outside staffing agency had been named in an allegation of abuse. E2 stated during the interview, "we called the agency and told them not to send Z8 (agency staff) back to our facility." During an interview on 3/15/12 at 12:30 PM, Z2 (staffing agency personnel) stated that facility staff called her on 1/18/12 and informed her of an allegation of staff-to-resident abuse involving Z8. Z2 stated that she was initially told by facility staff that Z8 had been accused of taking a bus pass from a client. Z2 stated that on 1/18/12, facility staff informed her that they did not want the agency to send Z8 back to the facility because he was named in an allegation of abuse. Z2 confirmed that Z8 continues to work for the staffing agency and is being placed in other homes. Z2 stated during the interview, "All you have is an allegation no one has given me proof that anything happened." Z2 stated that she never received any information on the outcome of the facility's investigation. During an interview on 3/14/12, E2 confirmed that the facility continues to use supplemental staff from the same staffing agency. E2 stated during the interview, that the facility does not have a policy that addresses the use of supplemental staff or the facility's responsibilities when agency staff are used. E2 stated that the staffing agency is responsible for obtaining criminal background checks and verification for completion of training. E2 stated that the facility does not obtain and/or review any information from the staffing agency.	W9999		

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W9999	Continued From page 36 The Facility Abuse and Neglect Incident Management Procedure was reviewed. The facility procedure states, "The Director or his/her designee shall ensure that the following activities are carried out upon discovery of an incident: a) protection and care for the victim; b) physical examinations and documentation of same for all injured individuals; c) removing the accused employee from direct care when there is credible evidence; d) reporting for emergency response when necessary." The facility failed to follow the Abuse and Neglect Incident Management Procedure to ensure the safety of clients in the home, following an allegation of physical abuse made against an agency staff person. The facility continues to use the staffing agency for supplemental staff, without having a system to ensure supplemental staff have met the necessary requirements for placement at the facility. (A)	W9999		