STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145986	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST PLACE	1100 PEMBRIDGE DRIVE LAKE FOREST, IL 60045

(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
F 431	Continued From page 27 approximately 8 mixed Penicillin intravenous bags, along with 15 tuberculin and 2 insulin vials. The vials were labeled, " Keep between 36 - 46 degrees. " Z2 said the Penicillin bags were already mixed and needed to be stored in a cool refrigerator, between 36 and 48 degrees. According to E2 (Director of Nursing), interviewed on 2/8/12 at 12PM, staff should be logging the medication refrigerator temperature each night, however she could not find the log. During this observation a bag, containing 6 open vials, was in the medication refrigerator. The vials were labeled with a resident ' s name and two were labeled " mold " , two were labeled " mite ' . The other two were not identified. The date the vials were opened was not identified. This was confirmed during the interview with E2.	F 431		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145986	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST PLACE	1100 PEMBRIDGE DRIVE LAKE FOREST, IL 60045

(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
F9999	Continued From page 28	F9999		

the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145986	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST PLACE	1100 PEMBRIDGE DRIVE LAKE FOREST, IL 60045

(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
F9999	Continued From page 29 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 requirements were not met as evidenced by: Based on record review, observation and interview, the facility failed to implement measures to prevent and treat pressure sores, for 1 of 4 residents (R3) reviewed for pressure ulcers, out of a sample of 14. This failure resulted in R3 developing 3 pressure ulcers, the most involved being a Stage 4 with tunneling. Findings include: Facility policy titled " Pressure Ulcer Prevention, NRS - 23 " dated 3/13/07, required " Residents at risk for the development of pressure ulcers will be identified and managed in such a way that tissue damage will be prevented or minimized. All residents with a score of 12 or below [High Risk] on the Braden scale will be considered at risk. The RN or designated skin care provider may determine the need for and implement appropriate skin care treatment. Procedure assessment: Nurse - 2) Visually assess all bony prominences (heels, ankles, hips, sacrum ...) at least daily. 5) Assess educational needs." Facility policy titled, " Pressure Ulcer Treatment, NRS - 24 " dated 3/13/07, requires " To promote healing and to prevent further tissue breakdown by relieving pressure ...and educating the resident	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145986	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST PLACE	1100 PEMBRIDGE DRIVE LAKE FOREST, IL 60045

(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
F9999	Continued From page 30	F9999		

and / or significant others. Nurse: 8) Assess resident ' s educational needs and significant other ' s ability to provide treatment. Intervention: 1) Avoid positioning patient on pressure ulcer. Limit sitting time to one hour at a time whether in bed, chair or wheelchair. Inspect skin at least once a day. 10) Provide education for the resident and / or significant others: b. Observe resident and / or significant other perform treatment. "

According to the Physician Order Sheet (POS), dated 2/12, R3 is a 75 yr old with diagnoses including Left Hip Replacement, Asthma, Mastectomy, Bilateral Knee Surgery, and Rheumatoid Arthritis. R3's Nursing Admission Assessment, dated 12/10/10, did not identify any past or present pressure ulcers.

The facility provided a Pressure Ulcer Report, dated 2/7/12, which documented that R3 had an Unstageable left (lt) bunion pressure ulcer, and a Stage 4 Right (rt) ischial tuberosity (buttocks / hip area) pressure ulcer with tunneling.

On 2/9/12, at 10:15 AM, R3's rt. ischial tuberosity dressing change, done by E3 (Wound Care Nurse), was observed. The skin around the wound was moist, reddened and excoriated. This excoriation extended around the perineal area, the sacrum, the coccyx and the left upper thigh. An area, approximately 2 x 1 centimeters of this excoriated skin, was open near the pressure ulcer. E3 was asked during the dressing change, what caused this broken skin area. E3 stated it occurred when she took off the tape, which was anchoring the old dressing. A second wound was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145986	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST PLACE	1100 PEMBRIDGE DRIVE LAKE FOREST, IL 60045

(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
F9999	Continued From page 31	F9999		

noted on R3's left foot, on the interior bunion area. The middle of this site was dark brown / black in color.

A nurse's progress note, dated 9/15/11 at 2 PM, stated "Noted unstageable wound right ischial tuberosity. Treatment started". E3's Wound Assessment Report (WAR), dated 9/15/11, documented this wound as, "Pressure Ulceration, Facility acquired, Unstageable, 60% necrotic tissue, No tunneling." E3's WAR, dated 11/1/11, identified the wound as "Stage 3, Tunneling present". The WAR, dated 12/6/11, identified the wound as "Stage 4, Tunneling present with a depth of 4.0 cm." The most current WAR, dated 2/7/12, continues to list the wound as "Stage 4, Tunneling present with a depth of 3.8 cm."

Progress notes, dated 9/30/11, at 2:30 PM and 9:30 PM, document that an indwelling [urinary] catheter was inserted because of this pressure sore. A Wound Culture report, dated 11/4/11, showed that the wound became infected and oral antibiotics were started. The Minimum Data Set (MDS) dated 8/22/11, documents R3 is occasionally incontinent and does not have a urinary catheter.

E3 was interviewed on 2/9/12, at 12 PM. She confirmed the above documentation and stated that she was notified of the wound by a Certified Nurse Assistant (CNA), but not until it was Unstageable.

Another progress note, dated 12/22/11, documented that R3 had developed a second pressure ulcer. This was to the coccyx, measuring 2.5 x 0.5 cm. The WAR, dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145986	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST PLACE	1100 PEMBRIDGE DRIVE LAKE FOREST, IL 60045

(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
F9999	Continued From page 32	F9999		

12/22/11, identified the coccyx wound as, "Facility acquired, Stage 2." A progress note, dated 1/17/11, list the coccyx wound as healed.

On 1/2/12, at 10 AM, a progress note documented that a third pressure ulcer had developed. It stated, "Noted with closed blister on left foot, 1x 2 cm". On 1/3/12, 11AM, a progress note stated the physician checked the wound and found it having black eschar. The first WAR, dated 1/3/12, identified the wound as, "Unstageable with 0% necrotic tissue." The Physician wound care note, dated 1/26/12, stated the wound was debrided at the Wound Care Clinic. The most current WAR, dated 2/7/12, identifies the wound as, "Unstageable with 80% necrotic tissue."

Review of MDS, dated 8/22/11, and the following MDS, dated 11/20/11 (annual), identifies that R3 had no pressure sores before admission, had no current pressure sores, but was at risk for developing them. Both MDS state R3 needs "Extensive assistance" with bed mobility and transferring, needing one person's physical assistance.

Review of R3's recent careplan for "potential for skin breakdown" dated 3/29/11, stated, "Assist / teach resident to reposition self. Encourage / Assist to turn and reposition at least every 2 hours in bed and every hour when up in chair to relieve pressure points."

The Wound Care Treatment Plan, dated 10/18/11 and 12/20/11 state, "Nursing interventions: Keep patient off sacrum" and "Reposition every two hours."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145986	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST PLACE	1100 PEMBRIDGE DRIVE LAKE FOREST, IL 60045

(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
F9999	Continued From page 33	F9999		

A Progress note, dated 11/14/11, state that R3 spends most of her day time up in the wheelchair.

The POSs, dated 9/11, 10/11, 11/11, 12/11, 1/12, and 2/12 all list the following orders, "Turn and Reposition every 2 hours while in bed. Reposition every 1 hour while up on wheel chair. Wheel chair cushion".

The Treatment Administration Records (TAR), dated 8/11 (1 month before the first pressure sore was identified), 9/11, 12/11, and 1/12 included a daily check off section for the physician's order "Reposition every 1 hour while up in wheelchair." These TAR sections identifying that this order was carried out, were blank. The TARs also include a daily check off section, "Check skin weekly and document." The record lacked documentation that R3's skin was assessed more frequently once she developed pressure ulcers. This was confirmed by E3, Wound Care Nurse during an interview on 2/9/12 at 12 PM. She said that only the nurses document skin checks, and at the time R3 acquired the three pressure ulcers, the CNA's had no place to document skin checks. According to E3, the CNAs should assess resident's skin when they provide care and notify nursing of any skin alterations. She said that once R3 developed the wounds, her skin was still checked by nursing weekly, except when E3 evaluated the wound condition with dressing changes. E3 said that there is no documentation of skin checks being done more frequently than weekly.

E2 (Director of Nursing) was interviewed on 2/9/12, at 1:15 PM. She said that once a resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145986	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST PLACE	1100 PEMBRIDGE DRIVE LAKE FOREST, IL 60045

(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
F9999	Continued From page 34 has developed a pressure ulcer, their skin should be checked daily, however there is no documentation of this being done for R3. She confirmed that there is no documentation of a careplan revision for R3 following the development of the three pressure ulcers. According to E2, the resident has been instructed regarding changing position in the chair and keeping pressure off the sacrum, but she has been uncooperative. E2 confirmed that there is no documentation that pressure is being relieved hourly when R3 is up in the wheelchair, according to physician orders. E2 validated that there was no alternative for interventions to off load pressure when R3 was non compliant with repositioning while up most of the day in the wheelchair. (B) 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145986	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST PLACE	1100 PEMBRIDGE DRIVE LAKE FOREST, IL 60045

(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
F9999	Continued From page 35	F9999		

representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), 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 and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145986	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST PLACE	1100 PEMBRIDGE DRIVE LAKE FOREST, IL 60045

(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
F9999	Continued From page 36	F9999		

nursing services of the facility, including:

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 requirements were not met as evidenced by:

Based on observation, record review and interview the facility failed to provide resident specific interventions, reevaluate the effectiveness of interventions and provide adequate supervision to prevent reoccurring falls. This is for 2 of 8 residents sampled for falls in a total sample of 14. (R1, R9). These failures resulted in R1 sustaining laceration on right side of the head and R9's fracture of right hip.

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145986	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST PLACE	1100 PEMBRIDGE DRIVE LAKE FOREST, IL 60045

(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
F9999	Continued From page 37 1) R1 has diagnoses that include has diagnoses that include Chronic Venous Insufficiency both legs, Glaucoma, Dizziness and Review of occurrence report documents that R1 had falls on the following dates: - 11/12/11 at 9 PM found in the bathroom - 11/21/11 at 3:45 PM at R1's room, CNA (Certified Nursing Assistant) found the resident on the floor in a lying position. Denies hitting head but noted a laceration on right side of the head. R1 was sent to hospital and returned to facility on the same day with 6 staples in the scalp at right side of the head. - 11/23/11 at 3:15 PM, CNA found resident on the floor in the bathroom in lying position with walker at her side. Per resident stated that she was going to use the toilet and lost her balance - 12/14/11 at 2:45 PM, resident noted on the floor infront of recliner chair. Per resident she was reaching for some thing on the floor and slid off the floor. -1/10/12 at 6:15 PM, CNA was taking the resident to the bathroom. Resident asked the CNA to move the bedside commode outside the room. The CNA moved the commode and that's when resident lost her balance. Resident hit her head in the nearby dresser sustaining a skin tear on top of the R1's head. CNA left resident standing while assisting R1 to move the commode outside the room resulting in R1 loosing balance and falling.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145986	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST PLACE	1100 PEMBRIDGE DRIVE LAKE FOREST, IL 60045

(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
F9999	Continued From page 38	F9999		

Follow up report: Resident is very unsteady on her feet. She has poor posture and at times resident is dizzy and unsafe to walk alone. She tries to be independent and do things alone but needs someone with her. Staff moved away from the resident to take the commode away per resident request and resident lost her balance and fell. Staff may need to call for help or seat the resident before attempting to leave to prevent the resident from falling.

Review of MDS (Minimum Data Set) dated 11/25/11 reflects R1's transfer and walking was scored 2/2 meaning R1 needs limited assistance with one physical assist. Toilet use scored 3/2 meaning R1 needs extensive assistance with one physical assist for transferring to toilet and back. poor balance during transitions and walking. R1 is coded 2 in walking, moving on and off toilet and surface to surface transfer (transfer between bed and chair or wheelchair). This means that R1 is not steady, only able to stabilize with human assistance.

Review of R1's care plan showed that on 11/23/11 bed alarm and chair alarm was initiated.

R1's care plan lacked resident specific interventions after each fall. For example; After the 11/21/11 fall the facility repeated an initial intervention, "Encourage to call for assistance prior to attempting to transfer or walk, orient in call light use, orient to room and bathroom."

On 02/08/12 R1 was observed up in wheel chair during group meeting with no alarm on and again at 12 noon in R1's room with no chair alarm. This

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145986	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST PLACE	1100 PEMBRIDGE DRIVE LAKE FOREST, IL 60045

(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
F9999	Continued From page 39	F9999		

observation was shown to E14 (Nurse) and E14 acknowledge.

E13 Donna CNA was asked if she is aware that R1 need to use chair alarm. E13 stated that she was not aware that R1 is to have an alarm when up in wheel chair.

2. R9 was admitted on 08/22/11 at 10 PM from assisted living after multiple falls. R9 had previous fall on 8/22/11 at 6:50 PM and 7:45 PM all occurring in her room.

MDS assessment dated 08/28/11 documents that under transfer and toilet use, R9 is coded 3/3 meaning extensive assistance with 2 people. Walking in room and corridor coded 2/2 meaning limited assistance with one physical assist.

Review of occurrence report documents that R9 had falls on the following dates:

- On 8/24/11 CNA found resident on the floor in her room. R9 had no preventive measures and care plan was not updated.

- On 09/08/11 at 2 PM resident found sitting on the floor. Again care plan was not updated and no preventive measure.

- On 09/18/11 resident found on the floor next to bed. No care plan update and no preventive measure.

- On 09/25/11 at 7:30 AM, R9 noted lying flat on floor in resident's room. R9 was found on the floor complaining of right hip pain. This resulted in hospitalization with diagnosis of fractured right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145986	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST PLACE	1100 PEMBRIDGE DRIVE LAKE FOREST, IL 60045

(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
F9999	Continued From page 40 hip. R9 was readmitted to the facility on 09/28/11 with ORIF (Open Reduction Internal Fixation). No care plan update and no preventive measure. - R9 fell again on 11/30/11 at 8:30 PM in her room. Care plan preventive measure was to put a personal alarm to be applied. R9's MDS assessment dated 11/10/11 was incomplete and 11/10/11 MDS assessments reflect transfer was scored as 3/2 indicating a need for extensive assistance with one physical assistance and toilet use as 3/2 indicating a need for extensive assistance with one physical assistance. R9 also has a short term memory problem. These identified needs were not applied in R9's care plan and preventive measures. - On 12/01/11 at 9:25 PM, resident found on right side lying on the bathroom floor. Nurses notes dated 12/01/11 at 9:25 PM documents that R9 called CNA to assist her to go to the bathroom. E11 CNA responded and assisted in sitting her on the toilet bowl with call light in her hand. E11 went to the help another resident across the hallway leaving R9 unsupervised. R9 was then found lying on the floor holding wheelchair. E11 left R9 who was already identified as needing physical assistance, supervision with poor memory, safety awareness and periods of confusion This resulted in another fall.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145986	A. BUILDING _____ B. WING _____	02/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST PLACE	1100 PEMBRIDGE DRIVE LAKE FOREST, IL 60045

(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
F9999	Continued From page 41 Nurses dated 12/06/11 at 6:50 PM documents, CNA took tray, done eating dinner. Sat up in wheelchair in room with TV on. -On 12/06/11 7:10 PM found resident on the floor in resident's room on left side with wheel chair closed to the bed and walker by the dresser with TV on. Preventive measures include making sure proper posture and putting personal alarm in the chair. The facility policy for fall prevention include evaluate the care plan and modifies it as needed. (B)	F9999		