STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

LAKEVIEW LIVING CENTER — Facility Name
0028134 — I.D. Number

7270 SOUTH SHORE DRIVE, CHICAGO, ILLINOIS 60649 — Address

FEBRUARY 16, 2005 — Date of Survey

LICENSURE ANNUAL — Type of Survey

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date of which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

350.620a)
350.700a)
350.3240a)b)d)f

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 operation; the facility and staff shall be reviewed at least annually.

The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department.

AN OWNER, LICENSEE, ADMINSTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act)

A FACILITY EMPLOYEE OR AGENT WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A RESIDENT SHALL IMMEDIATELY REPORT THE MATTER TO THE FACILITY ADMINISTRATOR. (Section 3-610 of the Act)

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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)

RESIDENT AS PERPETRATOR OF ABUSE. WHEN AN INVESTIGATION OF A REPORT OF SUSPECTED ABUSE OF A RESIDENT INDICATES BASED UPON CREDIBLE EVIDENCE THAT ANOTHER RESIDENT OF THE LONG-TERM CARE FACILITY IS THE PERPETRATOR OF THE ABUSE, THAT RESIDENT'S CONDITION SHALL BE IMMEDIATELY EVALUATED TO DETERMINE THE MOST SUITABLE THERAPY AND PLACEMENT FOR THE RESIDENT, CONSIDERING THE SAFETY OF THAT RESIDENT AS WELL AS THE SAFETY OF OTHER RESIDENTS AND EMPLOYEES OF THE FACILITY. (Section 3-612 of the Act)

1.) Based on review of incidents and incident investigation and staff interviews the facility staff failed to implement abuse and neglect policies and procedures by not reporting one of one incident of sexual abuse observed on 01/14/05 sometime during the pm shift. The staffs' failure to report the incident placed R29 as well as 28 other female clients residing on the second floor at risk of being sexually abused by R30 between 01/14/05 and until the facility was made aware of the incident on 01/16/05.

R29, per her face sheet is a 38-year-old female whose diagnoses include Profound Mental Retardation and Hypothyroidism. Per her annual dietary assessment and vital signs sheet R29 is 4' 0" tall and weighed 86.7 lbs. on 12/10/04.

R30, per her face sheet is a 30-year-old female whose diagnoses include Moderate Mental Retardation and Maladaptive Behavior defined as Physical Aggression, Property Destruction, Elopement, Inappropriate Sexual Behavior (making sexual advances toward others that are not mutually agreed upon and flirting) and stealing. Per her annual dietary assessment and vital signs sheet, R30 is 5'5" tall and weighed 134.5lbs. on 01/05/05.

An incident dated 01/14/05 stated "Per written documentation of E5, team leader, peer (R30) had R29 pushed against the wall trying to put her (R30's) hand /inserted in R29's vagina." The facility's investigation stated, "During Z1's visit on January 16, 2005, Z1 informed E3, Director of Investigations and E6, nurse of written documentation from 1/14/05."

The facility's investigative conclusion stated "There is not sufficient evidence to collaborate the initial report made by staff, E5 due to inconsistency in staff reports; therefore, the allegation of sexual abuse is not substantiated as an actual act did not occur."

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The facility's abuse and neglect program states under policy "Residents are not to be subjected to abuse, corporal punishment, misappropriation of property or neglect by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals." Sexual abuse under definition is defined as," includes, but not limited to, sexual harassment, sexual coercion or sexual assault."

The facility's program continued under procedure-training "The training will include the following: B. how to report any instance of abuse, neglect or misappropriation of property."

Interview with E3, Director of Investigation on 02/08/05 at 1:50pm stated "E5 reported it to E11, Qualified Mental Retardation Professional (QMRP) and neither E5 nor E11 reported it." E11's written statement stated "E5 said that R30 was angry at her because she was trying to redirect her away from R29. E5 said that R30 had R29 pinned behind the door (in Room 210) and was trying to touch R29 inappropriately and that R29 was pushing R30's hands away." E5's statement stated "I was showering in the bathroom by Room 213 and then I walked across the hall to use powder and soap when I saw R30 's red shirt sticking out of Room 210 door crack, R30 was facing the wall I walked into the room; R30 was standing in front of R29. R29 was naked, she had just got out the shower, using R30's left hand to pin R29 to the wall while using her right hand to try to insert her fingers into R29's vagina. I verbally prompted R30 to stop and redirected R29 into the hallway. I then ran and knock on E11's office door and told E13, team leader what happened."

E11 was interviewed on 02/16/05 at 9:45am via phone. E11 stated "What I remember was that I came out of my office and R30 was on the floor and was upset with E5. E5 told me that she (E5) saw some kind of clothing through a crack on the door and when she went into the room she saw R30 face to face with R29 who was naked. R29 was up against the wall with R30's hand near R29's genital area. E5 then said that R29 was pushing R30's hand away." E11 was asked if she reported this incident. E11 stated "E14 was aware of R30's behavior in the hallway and I thought I told her what happened in the room prior to this behavior but E14 said I didn't tell her and honestly I can't remember if I did."

Interview with E3 on 02/08/05 at 1:50pm stated "E5, direct care staff reported the incident to E11, Qualified Mental Retardation Professional (QMRP) and neither E5 nor E11 reported it to the Administrator." E3 clarified that the facility was made aware of the incident by Z1 on 01/16/05, after Z1 reviewed the baseline data.

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E13 was interviewed on 02/16/05 at 9:35am via phone. E13 stated "I did hear it from E5 about R30 having her finger inside R29 during the later part of the day." E13 further stated that E5 told her that R29 is naked in the bathroom. E13 then proceeded to give R29 a bath then changed her and brought her to the middle dayroom. E13 then stated, "I left R29 in the dayroom, I don't know/I can't remember which staff was in the middle dayroom with the clients."

E12, Residential Services Director (RSD) was interviewed on 02/09/05 at 2:10pm, E12 stated, "R29 and R30 was placed on 1:1 monitoring on 1/16/05." E12 added, "Both R29 and R30 weren't on 1:1 monitoring from 1/14/05 to 1/16/05 that I know of."

The facility staffs failure to report the incident of sexual abuse immediately to the Administrator placed R29 and R28 other female clients residing on the second floor at risk of being sexually abused by R30 during the two-day period (01/14/05 to 01/16/05) when appropriate actions and safeguards were not in place.

2.) Per review of an incident that took place on 01/27/05, R15, a 58-year-old severely mentally retarded man, fell going up the stairs. R15 received an x-ray by a portable x-ray. The x-ray indicated that R15 had no fractures or dislocations. The incident report contained no notation that Public Health had been notified of this incident.

During an interview on 02/09/05, Director of Investigations, E3, said that the facility didn't report the use of a portable x-ray to Public Health since it was not an emergency trip to get the x-ray.

3.) Per review of an incident that took place on 02/04/05, R14, a 45-year-old profoundly mentally retarded man, allegedly tried to make a co-worker at the workshop who resides in the community "…go down on his penis." Staff intervened prior to any contact and immediately put R14 on 1:1 monitoring. This incident was not reported to Public Health until 02/07/05.

During an interview on 02/09/05, E3 was asked why if this incident occurred on 02/04/05, it wasn't reported to Public Health until 02/07/05. E3 said that she would look into this situation.

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