DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145829	A. BUILDING ________ B. WING ________	04/07/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULEVARD CARE CENTER	3405 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 456 SS=D	483.70(c)(2) SPACE AND EQUIPMENT The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by : Based on observation and record review the facility failed to ensure that 1 of 3 medication refrigerators were maintained at a temperature that was appropriate for the medication that it contained and failed to ensure that 1 of 3 food storage refrigerators in the medication rooms were kept free from rust. Findings include: During the environmental tour on 3/27/06 with E 7 (maintenance supervisor) the 2nd floor medication room refrigerator temperature was observed to be 22 degrees Farenheit. the refrigerator contained several vials of Tuberculin inoculations, 15 vials of Procrit and 2 syringes of Arunesp, all which contained manufactures precaution labels to store between 36 and 48 degrees Farenheit. All three shelves in the food storage refrigerators were observed to be heavily rusted with particles of rust in the lower bottom of the refrigerator. No thermometer was noted inside of the refrigerator, which contained residents milk based supplements and cartons of milk.	F 456		4/14/06

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F9999	FINAL OBSERVATIONS	F9999		

LICENSURE VIOLATIONS

300.3240a)
300.3240b)
300.3240e)

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse a resident.

b) A facility employee or agent who becomes aware of abuse of a resident shall immediately report the matter to the facility administrator.

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending outcome of any further investigation, prosecution or disciplinary action against the employee.

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

Based on observation, interview and record review the facility failed to ensure that staff implemented the abuse policy after an incident of verbal abuse between E5 and R5 was witnessed by E4 and survey staff on 3/25/06. The failure of the staff to act quickly and begin the abuse investigation led to a potential for further harm to R5 and other residents by E5.

Findings include:

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F9999	Continued From page 37	F9999		

On 3/25/05 at 6:15 p.m., upon entrance to the 2 nd floor from the elevator, loud yelling and screaming was heard, coming from down the hall . This surveyor approached the nurses station where E4 (Licensed Practical Nurse-LPN) was standing in full view of the corridor and should have also heard the yelling. Surveyor proceeded down the hall in the direction of the yelling. E4 watched as the surveyor walked in the direction of the noise. Upon approaching the residents common shower/bathroom this surveyor encountered E5 (CNA) who was still standing in the bathroom with the door open. E5 was observed yelling loudly "Why did you do this?" in response to R5' s incontinence. R5 was standing in the bathroom with his pants down around his ankles and his shirt pulled up around his upper abdomen. R5 is a 75 year old male who has a diagnosis of dementia. R5 was confused and disorientated repeating over and over again " What should I do? What should I do?" in response to staff confrontation.

E5 approached the entrance of the door where she was completely visible to this surveyor and E 4. During the interview of E5 by the Surveyor, E5 burst into tears, and began to explain that she was trying to assist R5.

E4 remained at the nurses station watching and never intervened, nor did she remove the resident or staff member from the area. E4 was interviewed regarding abuse and the facility abuse protocol. E4 was aware of the abuse protocol instituted by the facility and should have immediately notified administration and removed the staff from further contact with R5 and other

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F9999	Continued From page 38 residents. This was not done and E4 put R5 and all other residents at risk for verbal abuse from E 5 by failing to act. The surveyor returned to the unit at 11:00 p.m. and observed E5 still on the unit providing care to residents. An interview was conducted with E1 (administrator). E1 was not in the facility at the time of the incident. During his interview on 3-25-05 at 11:45 p.m. E1 stated that no incidents of abuse had been reported to administration by facility staff that evening. E1 further stated that all staff had been in-serviced to report any incident of abuse immediately. After informing E1 of the incident, he proceeded to investigate the allegation and attempted to remove E5 from the facility, but found out that E4 and E5 had already left the facility at the end of their assigned shifts on 3/25/06. E1 stated that E4 and E5 would be contacted at home and informed not to return back to work pending investigation. (A)	F9999		