STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G097	A. BUILDING ______ B. WING ______	02/15/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW LIVING CENTER	7270 SOUTH SHORE DRIVE CHICAGO, IL 60649

(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 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that hypodermic needles and medications, in the 2nd floor supply room, were stored in a secure manner. Findings include: The second floor was toured on 2/7/07 at 6: 40 AM. Room # 219 was found with the door wide open and unobserved by staff at 6:55 AM. A medication refrigerator was located immediately inside the doorway with an open box of hypodermic syringes with needles on top of it. The unlocked refrigerator contained multiple ampules and vials of medications. This was confirmed 2/7/07 at 7:10 AM, by the LPN on duty, E9. She stated the room is designated as a doctors office/ medical supply room and is usually locked.	W 381		3/20/07
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1060a) 350.1060c)1) 350.1060d) 350.1060e) 350.1060h) 350.3240a)	W9999		

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W9999	Continued From page 19 350.3240d) 350.3240e) Section 350.620 Resident Care Policies 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 350.1060 Training and Habilitation Services a) The facility shall provide training and habilitation services to facilitate the intellectual, sensorimotor, and effective development of each resident in the facility. c) There shall be written training and habilitation objectives for each resident that are: 1) Based upon complete and relevant diagnostic and prognostic data. d) There shall be evidence of training and habilitation services activities designed to meet the training and habilitation objectives set for every resident. e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. h) There shall be available sufficient, appropriately qualified training and habilitation personnel, and necessary supporting staff, to carry out the training and habilitation program. Supervision of delivery of training and habilitation services shall be the responsibility of a person	W9999		

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W9999	Continued From page 20	W9999		

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who is a Qualified Mental Retardation Professional.

Section 350.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
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.
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 the outcome of any further investigation, prosecution or disciplinary action against the employee.

These Requirements were not met as evidenced by the following:

Based on record review and interview, it was determined the facility failed to implement written policies and procedures for 1 of 1 incident (R42, R39) involving an allegation of possible neglect and abuse.

Findings include:

The Facility incident reports were reviewed for the months of 9/06 to present. An Incident Accident Report, dated 10/21/06, included documentation that a LPN witnessed inappropriate sexual behavior between R42 and R39.

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W9999	Continued From page 21	W9999		

R42's Individual Program Plan (IPP), dated 3/7/06, included the following documentation: R42 is a 42 year old male whose diagnoses include Profound Mental Retardation and Psychosis; he is verbal, ambulatory and is currently on a behavior program for impulsive behavior including inappropriate sexual touching of others; and his supervision level is close monitoring.

R39's IPP, dated 2/15/06, included the following documentation: R39 is a 40 year old male whose diagnoses include Profound Mental Retardation and Psychosis; he is verbal, ambulatory and is currently on a behavior program for impulsive behavior; and his level of supervision is general. The impulsive behavior was not of a sexual nature.

The nurse's note, dated 10/21/06 at 9:15 PM, stated, "Resident [R42] observed in [R39's] room, both residents naked and in bed, with R42 on top of R39, no penetration noted. Both residents redirected and separated." The "Facility Review of In-House Incident" included interviews from R42 and other residents, however it lacked staff interviews and an interview with R39. The Review follow up actions, dated 10/26/06, were as follows, "[R42]= Referral to sex therapist. [R42]= Maintain current monitoring status and document all behaviors."

1) The Facility policy titled, "Level of Supervision" stated that Close Monitoring "includes the above...[General Supervision: It is staff responsibility to ensure that resident's rights and dignity are upheld and they are free from abuse and neglect.]... as well as keeping the resident whereabouts known at all times..."

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W9999	Continued From page 22 E16, the QMRP for R42 and R39, was interviewed on 2/9/07, at 12:00 PM. She stated that, at the time of the incident, direct care staff were doing bed checks. The facility did not follow the close monitoring procedure of knowing where R42 was at all times. 2a) The Facility's policy titled, "Abuse and Neglect and Injuries of Unknown Origin" included sexual abuse as "sexual harassment and sexual coercion," and that "the Administrator will notify ...within 24 hrs...Illinois Department of Public Health (IDPH)." The incident report and records lacked evidence that the IDPH was notified. E1, the Residential Services Director, was interviewed on 2/7/07, at 1:40 PM. E1 stated the reason it was not reported to IDPH was because the facility viewed it as an in-house behavioral incident. 2b) The policy contained the following, "Investigation #5. The nurse will perform a head to toe assessment on the resident as soon as practical, after an incident is reported." R42's and R39's complete clinical records, along with the incident report, lacked documentation that a physical assessment/body check was completed on either resident. E12, the Assistant Director of Nursing, was interviewed on 2/7/06, at 3:00 PM. She confirmed the lack of documentation and stated that the nurse on duty the day of the incident is no longer working at the Facility. E17, the Qualified Mental Retardation	W9999		

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Professional (QMRP) who performed the investigation, was interviewed on 2/7/07 at 10:10 AM. He stated that he assumed the nurse had done a body check, but had no documentation.

2c) The policy contained the following, "Investigation # 4. All persons involved in or having direct knowledge of the alleged incident will be asked to write a detailed report of the incident."

There is no evidence in the investigation that direct care staff were interviewed. In addition, there is no evidence that the investigation included how R42 got to R39 when he was on close supervision.

E17 was interviewed on 2/7/07, at 10:10 AM. He stated that he did not interview any of the staff. He also stated that he did not interview one of the involved residents, R39, due to his echolaic (repetitive) speech.

E1, the Residential Service Director/Assistant Administrator, was interviewed on 2/7/07 at 1:40 PM. She stated that an attempt should have been made to interview R39, because sometimes he is able to communicate.

The Facility failed to follow it's policy regarding close observation and incident investigations.

(A)