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 _____	C 05/25/2007

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 341	Continued From page 9 guardians. She states Z1 told her that was too late and the residents needed to receive the IG within 24 hours. The facility elected not to give the IG to R1 - 22. The written statement dated 5/24/07 by E2 notes on 4/16/07 she instructed the med techs to address envelopes to the guardians of R1 - 22 "just in case CDPH had changed their minds about the window in which we could administer the IG. After their task was completed I received verbal report from E3 on Monday morning April 16, 2007 that Z1 had arrived at the facility that Friday evening, April 13, 2007 at approximately 4:30pm and picked up th IG". The facility did not ensure R1 - 22 received the Immune Globulin after initially being informed by the workshop of an outbreak of Hepatitis A on 4/11/07 resulting in the need for all residents, R1 - 88, to require the Immune Globulin treatment. R1 - 22 continued to attend the workshop and on 5/18/07 R1 was diagnosed with Hepatitis A.	W 341		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.700a)1)2) 350.1230b)3) 350.3240a) Section 350.700 Serious Incidents and Accidents a) 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,	W9999		

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W9999	Continued From page 10 hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number. 2) A narrative summary of each serious accident or incident occurrence shall be sent to the Department within seven days of the occurrence. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 3) Periodic reevaluation of the type, extent, and quality of services and programming. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These REGULATIONS were not met as evidenced by the following: Based on record review and staff interview, nursing and other members of the interdisciplinary team failed to ensure immediate health protective measures were taken to protect 22 of 26 residents (R1 - R22) who attended a workshop, as well as other residents of the facility (R23 - R88), from being at risk once they were informed of an outbreak of Hepatitis A at the workshop. R1 was diagnosed with Hepatitis A 37	W9999		

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W9999	Continued From page 11 days after the facility was notified by the workshop that a community participant had contracted Hepatitis A. The facility did not ensure R1 - 22 received the Immune Globulin after initially being informed by the workshop of an outbreak of Hepatitis A. Findings include: R1, per the Nursing Assessment dated 5/22/07, is a 32 year old male whose diagnosis incudes Profound Mental Retardation, Stereotyped Movements, Psychosis Not Specified, Pervasive Developmental Disorder and Hypertension. Per record review, the facility received a memo from the day training site dated 4/11/07. This memo notified the facility the workshop had been informed by the Chicago Department of Public Health (CDPH) of a diagnosis of Hepatitis A within the day training program. The memo noted Hepatitis A is an infection of the liver caused by a virus through fecal-oral transmission. It included the symptoms of Hepatitis A: Flu - like symptoms (fever, fatigue, appetite loss, etc) Diarrhea Nausea Vomiting Jaundice Dark Urine The memo included a recommendation for "prophylactic treatment" (immune globulin injection) for those who may have been exposed (R1 - R22, R42, R69, R71 and R80). A resident transfer form dated 5/2/07 notes	W9999		

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W9999	Continued From page 12 "Resident returned from workshop on the bus. Refused to get up off the seat of the bus. Noted lethargic, unsteady gait. Mouth smell fruity, assisted back to the facility." R1 was sent to the emergency room and was admitted to the hospital. R1 returned to the facility on 5/10/07 with a diagnosis of Altered Mental State. On 5/18/07 the CPDH notified the facility R1 had contracted Hepatitis A. Per a facility notice posted to all staff, "This notice is to inform you that on May 18, 2007 at 4:00pm; the nursing department was informed that one of our residents (R1) tested positive for non - reactive Hepatitis A. Per recommendations and guidelines of the Center for Disease Control all individuals, R1 - 88, (clients and staff) will receive a one time dose of Immune Globulin, IG, for the prevention and spread of Hepatitis A in the facility among individuals and staff." On 5/23/07 at 1:50pm E1, Administrator, was interviewed. E1 was asked if the Illinois Department of Public Health was notified of the workshop having an individual diagnosed with Hepatitis A once they were informed on 4/11/07. E1 did not know but said she would find out. E1 was unable to provide any evidence IDPH was notified. The facility failed to notify the Illinois Department of Public Health of a significant incident that had the potential of adversely affecting the health and well being of residents. On 5/23/07 at 9:35am E2, Director of Nursing (DON), was interviewed. E2 was asked why on 4/11/07 when the facility was made aware of a community member contracting Hepatitis A, the	W9999		

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W9999	Continued From page 13 residents who attend the workshop did not receive the Immune Globulin. E2 stated the facility was in contact with Z1, CDPH nurse, a day after they received the workshop memo. She stated four residents who are wards of the state did receive the IG which had been provided by CDPH but the other 22, R1 - R22, have private guardians and did not. E2 said she asked the CDPH nurse if the facility needed to obtain a consent for the IG and Z1 told E2 she did not know. E2 said she told Z1 it would take a couple of days for the facility to obtain consents from the guardians. She stated Z1 told her that was too late and the residents needed to receive the IG within 24 hours. The facility elected not to give the IG to R1 - R22. The written statement dated 5/24/07 by E2 notes on 4/16/07 she instructed the med techs to address envelopes to the guardians of R1 - R22 "just in case CDPH had changed their minds about the window in which we could administer the IG. After their task was completed I received verbal report from E3 on Monday morning April 16, 2007 that Z1 had arrived at the facility that Friday evening, April 13, 2007 at approximately 4:30pm and picked up th IG." The facility did not ensure R1 - R22 received the Immune Globulin after initially being informed by the workshop of an outbreak of Hepatitis A on 4/11/07 resulting in the need for all residents, R1 - R88, to require the Immune Globulin treatment. R1 - R22 continued to attend the workshop and on 5/18/07 R1 was diagnosed with Hepatitis A. (A)	W9999		