

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005227</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/08/2021</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LAKEVIEW REHAB &amp; NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>735 WEST DIVERSEY CHICAGO, IL 60614</b>
--	---

(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) COMPLETE DATE
S 000	Initial Comments  20810095/IL129860-F600G cited	S 000		
S9999	Final Observations  Statement of Licensure Violations  300.610a) 300.690c) 300.1210b) 300.3240a)e)  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 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 300.690 Incidents and Accidents  c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695,	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005227</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/08/2021</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LAKEVIEW REHAB &amp; NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>735 WEST DIVERSEY CHICAGO, IL 60614</b>
--	---

(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) COMPLETE DATE
S9999	<p>Continued From page 1</p> <p>notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>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</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6005227	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/08/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LAKEVIEW REHAB & NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 735 WEST DIVERSEY CHICAGO, IL 60614
---	---

(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) COMPLETE DATE
S9999	<p>Continued From page 2</p> <p>investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure that a resident is free from mental abuse for one resident (R1) reviewed for abuse. This failure resulted in R1 feeling ashamed and unsafe in the facility.</p> <p>Findings include:</p> <p>R1's Face Sheet documents R1 is 42 years old with diagnoses including but not limited to: Cerebral Palsy, Paraplegia, Schizoaffective Disorder, Epilepsy, Major Depressive Disorder, Schizophrenia and Type 2 Diabetes Mellitus. R1's BIMS (Brief Interview for Mental Status) documents R1 is cognitively intact.</p> <p>On 01/06/2021 at 1:27 PM, R1 said "It was sometime at the end of December. I was visiting R4. He (V8) came up on me real fast. He told me to get out of R4's room. V8 (CNA) said, "I'm going to knock the black off your a**."</p> <p>On 01/07/2021 at 10:47 AM, R1 said, "It made me feel ...I was angry ...he wanted me to respond when he walked up on me. He (V8) tried to intimidate me. I don't feel safe in the facility now. I feel ashamed.</p> <p>01/06/2021 at 12:22 PM, R3 said, she overheard staff member (V8) being verbally abusive towards resident. R3's signed statement documents, "I was in my room on a video chat with patient (R4).</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005227</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/08/2021</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LAKEVIEW REHAB &amp; NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>735 WEST DIVERSEY CHICAGO, IL 60614</b>
--	---

(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) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>I heard patient R1 arguing with V8. I heard V8 threaten R1 saying "I'll slap the black off your a**."</p> <p>On 01/07/2021 at 10:59 AM, R4 said, "I was sitting in my wheelchair, on a video call with R3. She asked me to invite R1 into my room so that she could say hello to him. R1 came into my room. V8 told R1, "you can't be in here when I'm going to do patient care". He (V8) chased him out of my room, R1 got irate with him (V8). V8 went into R1's room and threatened R1. V8 said I'm going to knock the black off your a**."</p> <p>On 01/07/2021 at 2:03 PM, V6 (Housekeeper) said, "I took (R1) to his room. Four or five minutes later, R1 left his room and went into R4's room. (V8) was passing trays and said to R1, "You better get your a** in that room."</p> <p>On 01/07/2021 at 1:05 PM, V1 (Administrator)</p> <p>"I think it's going to be unfounded (abuse). I haven't spoken with him (V8, CNA) because I haven't had a chance to call him. I thought I would call him today. It's unfounded. I want to speak with him about his standing in the facility. If it was founded, I would have terminated him already. We haven't disciplined him yet. It's unfounded but there needs to be some resolution. I have to determine if he's going to be re-educated, re-assigned or terminated. I don't feel that I should do anything until I talk to him. The situation could have been better handled, he could have asked for help from staff. He shouldn't have raised his voice to the resident."</p> <p>Facility's final incident report of 01/04/2021 (for incident of 12/31/2020) documents, (R1) reported allegations of a staff member treating him</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005227</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/08/2021</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LAKEVIEW REHAB &amp; NURSING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>735 WEST DIVERSEY CHICAGO, IL 60614</b>
--	---

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 4</p> <p>inappropriately. Staff intervened immediately, separated and suspended staff member pending investigation. Thorough investigation was completed which involved interview of residents and staff. (R1) stated that staff member (V8, CNA) spoke with him inappropriately. Based on the findings of the investigation the facility will discipline (V8) per facility protocol.</p> <p>V1 submitted the final investigation to the Illinois Department of Public Health on 01/04/2021 without speaking with V8. V8 was terminated on 01/08/2021, 4 days after the final report was submitted</p> <p>Facility's "Abuse Prevention Program" policy and procedure (undated) notes, it is the policy of this facility to prohibit and prevent resident abuse.</p> <p>(B)</p>	S9999		
-------	---	-------	--	--