STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001895	A. BUILDING: _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHVIEW MANOR	3311 S. MICHIGAN AVE. CHICAGO, IL 60616

(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 Facility Reported Incident of 4/24/21/IL134453 - 300.3240a)b)d) Facility Reported Incident of 5/25/21/IL134666 - 300.690b)c)	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.690b) 300.690c) 300.3240d) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. 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, 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 occurrence. Section 300.3240 Abuse and Neglect 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. (Section 3-610 of the Act) These Regulations were not met as evidenced by: Based upon record review and interview the facility failed to 2) report incidents (resulting in serious injuries) within regulatory requirements to IDPH (Illinois Department of Public Health) for two of six residents (R3, R4) reviewed for incidents/accidents. 2) the facility failed to ensure that an injury of unknown origin and/or abuse were reported to IDPH (Illinois Department of Public Health) within regulatory requirements for three of six residents (R2, R6, R7) reviewed for abuse/neglect. Findings include; On 6/21/21 at 2:28pm, V2 (Director of Nursing) affirmed that she's responsible for reporting incidents & accidents and the Administrator (V1) is responsible for reporting abuse & altercations. Surveyor inquired about the regulatory requirement for reportable incidents and/or serious injuries V2 stated "You have 24 hours to report it to IDPH. You have to conduct an investigation to know how it happened. You have 5 business days to report the final." R3s diagnoses include altered mental status and gastrostomy.	S9999		

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S9999	Continued From page 2 R3's (5/25/21) progress notes state; during feeding resident was agitated, she snatched the piston while writer was flushing the gastrostomy tube. It accidentally caused small laceration between 4th and 3rd finger. Doctor was called, received order to send resident to Emergency Room for evaluation. Resident received from Hospital with 3 sutures to right hand. R3's (5/25/21) final investigation was submitted to IDPH via smart sheet on 6/2/21 (8 days after the injury was identified). On 6/22/21at 9:53am, surveyor inquired if R3's (5/25/21) laceration (requiring sutures) was reported to IDPH within regulatory requirements V2 stated "It was reported on time, the following day." Surveyor inquired if R3's final investigation was submitted to IDPH within regulatory requirements V2 affirmed it was not and stated "It was eight days." R4's progress notes include; (6/2/21) Safety coordinator called the Nurse and said resident tripped and fell. Resident was assessed and noted small laceration at the back of his head with bright red bleeding. The attending physician was notified, ordered transfer to hospital for evaluation. (6/3/21) Resident came back from the hospital with staples on his head. On 6/22/21 at 12:33pm, surveyor inquired if R4's (6/2/21) laceration (requiring staples) was reported to IDPH within regulatory requirements V2 (Director of Nursing) stated "Honestly they can't find the transmittal, I was on vacation for this one. The initial was sent, they can't find the final. They said they faxed it but they can't find the confirmation." On 6/22/21 at 1:20pm, surveyor confirmed with IDPH staff that R4's	S9999		

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S9999	Continued From page 3 (6/2/21) final investigation was received on 6/10/21 (8 days after the injury was identified). R2's diagnoses include dementia. R2's (4/24/21) progress notes state it was reported by CNA (Certified Nursing Assistant) during ADL (Activities of Daily Living) care that there was a bruise to her right breast. The resident was assessed head to toe and writer observed a bruise to her right breast. R2's (4/24/21) incident report affirms she's oriented to person/confused and there were no witnesses found. R2's (4/24/21) initial incident report was submitted to IDPH via email on 4/26/26 (2 days after R2's injury of unknown origin was identified). R2's final investigation was submitted via smart sheet to IDPH on 5/3/21 (9 days after R2's injury of unknown origin was identified). On 6/21/21 at 2:28pm, V2 (Director of Nursing) affirmed that she's responsible for reporting incidents & accidents and the Administrator (V1) is responsible for reporting abuse & altercations. Surveyor inquired about the regulatory requirement for reportable incidents and/or serious injuries V2 stated "You have 24 hours to report it to IDPH. You have to conduct an investigation to know how it happened. You have 5 business days to report the final." Surveyor inquired if R2's (4/24/21) injury of unknown origin was reported to IDPH within regulatory requirements V2 responded "It wasn't, I was out of town. This one happened on the weekend." Surveyor inquired who's responsible for reportable incidents and/or accidents when V2 is unavailable V2 replied "The ADON/Assistant	S9999		

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S9999	Continued From page 4 Director of Nursing (V5) is also responsible but he was also out of town, unfortunately." (6/6/21) incident report states (R6) and (R7) were seen arguing in the hallway. (R6) pulled (R7's) wig off. (R7) retaliated by hitting (R6) in the face. On 6/22/21, surveyor requested R6/R7's (6/6/21) initial/final investigations and transmittals submitted to IDPH. At 1:09pm, V1 (Administrator) stated "I checked, there's not a copy of the fax transmittal for the initial." R6/R7's (6/6/21) final investigation was submitted to IDPH via smart sheet on 6/14/21 (8 days after the incident). The (2/7/17) abuse prevention policy states any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two hours of the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an "injury of unknown source." An injury should be classified as an "injury of unknown source" when both of the following conditions are met: the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury (eg: the injury is located in an area not generally vulnerable to trauma). Within five working days after the report of the occurrence, a complete written report of the	S9999		

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S9999	Continued From page 5 conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health. (C)	S9999		