STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008726	A. BUILDING: _____ B. WING _____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LAWN SHELTERED CARE	512 SOUTH FRANKLIN BUNKER HILL, IL 62014

(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 Complaint Investigations: #2346531/IL162915: 330.4240 d) #2346454/IL162806: No deficiency	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.4240 d) Section 330.4240 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 of the department. (Section 3-610 of the Act) This Requirement is NOT MET as evidence by: Based on interview and record review, the facility failed to report an allegation of resident-to-resident abuse for 2 of 3 residents (R2 and R3) reviewed for abuse in the sample of 4. Findings include: R3's Progress Note, dated 6/26/23, documents, "(R3) hit another resident on the arm. Resident (R2) hit (R3) in the back of her head with a hairbrush. (R3) put her hands on her first." (signed by V2, Nurse Aide (NA) . R3's Face Sheet documents her diagnoses as History of Epilepsy, Sarcoidosis and Delusions. R2's Face Sheet documents her diagnoses as Paranoid Schizophrenia.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

On 8/16/23 at 3:15 PM, V2 stated she was not in the facility when an incident happened between R2 and R3, but she heard R2 hit R3 with her hair brush. V2 stated R3 saw her doctor the next day and was complaining of a headache and her doctor wanted her to get an x-ray, but she refused; she did go to the emergency room (ER) a few days later and everything checked out "alright". V2 stated she heard R2 was taking a shower and R3 told her to get out and hit R2 in the arm, and R2 hit her in the head with her hairbrush. V2 stated there have not been any other altercations between R2 and R3. V2 stated the nurse aide that was here when the incident occurred (V5,Nurse Aide) was supposed to do an incident report, but she does not know if it was done or not.

On 8/16/23 at 4:12 PM, V1, Owner, stated R2 hit R3 with a brush. She stated R3 tried to tell her to go and R2 hit her. V1 stated she did not report the incident; she stated she guesses she should have but the residents have little conflicts constantly, and she can't report every time they have an argument. V1 stated she told V5 to do an incident report, but doesn't think V5 did it. V1 stated there may have been an incident report done, but she is not sure because the girl who was working that day (V5) no longer works in the facility.

On 8/16/23 at 5:43 PM, R3 stated R2, another resident, hit her with a hairbrush and she got a headache. R3 stated the doctor wanted her to go to the ER for an x-ray, but V1 didn't want her to go because she doesn't want anyone to know about it.

On 8/16/23 at 6:10 PM, R2 was sitting outside

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	IL6008726	A. BUILDING: _____ B. WING _____	C 08/18/2023

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S9999	Continued From page 2	S9999		

smoking. She stated she hit R3 with a hairbrush because R3 hit her on the arm, and she does not like anyone touching her. R2 stated she and R3 get along fine now because R3 knows not to touch her. R2 stated she got into it with one other resident because that resident touched her too, but it's fine now. R2 stated nobody has hurt her and she didn't hurt anyone, but some people don't like to be touched.

The facility's policy, Reporting Abuse to Facility Management, updated 10/99, documents, "It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etc. to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property to facility manager. 4. When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the following persons or agencies of such incident: a. The State licensing/certification agency responsible for surveying/licensing facility."

(C)