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	IL6001895	A. BUILDING: _____ B. WING _____	07/21/2023

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SOUTHVIEW MANOR	3311 S. MICHIGAN AVE. CHICAGO, IL 60616

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S 000	Initial Comments Facility Reported Incident of June 9, 2023/IL161239 Facility Reported Incident of June 20, 2023/IL161243 Facility Reported Incident of June 20, 2023/IL161578	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.3210a) 300.3210t) Section 300.3210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of a facility. (Section 2-101 of the Act) t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These regulations were not met as evidenced by: Based on interview and record review, the facility failed to prevent three physical resident-to-resident abuse incidents and ensure five residents [R15, R63, R83, R111, R127, R143] reviewed on the sample list of 56, were free from physical abuse. This failure resulted in R83 being sent to the hospital and requiring sutures for a laceration to the nose, R15 sustaining a swollen, lacerated lip and R143 being choked.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Findings Include: The facility's Abuse policy dated March 2022 documents the facility is committed to protecting the residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other consumers, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. Physical abuse is the infliction of injury on a consumer that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. The document titled Long-Term Care Ombudsman Residents' Rights (undated) documents, "Your rights to safety- You must not be abused, neglected, or exploited by anyone- financially, physically, verbally, mentally, or sexually." 1. R15's medical record documents R15 admitted to the facility on 9/23/01 with diagnoses including Schizophrenia, Heart Disease, Cataract Disease, Anemia and Bipolar without Psychotic Features. Minimum Data Set [MDS] documents R15 is mildly cognitively impaired for daily decision making. R15's Care plan dated 6/2/23 documents R15 is at risk for abuse based on a comprehensive assessment. R15 will be treated with respect, dignity, and free from mistreatment, and abuse while residing in this facility. R127s medical record documents R127 admitted	S9999		

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S9999	Continued From page 2 to the facility on 8/23/19 with diagnoses including Schizophrenia and Anxiety Disorder. Facility document titled "abuse risk assessment," dated 6/1/23 indicates R127 has a history of socially inappropriate behaviors and abuse. R127's Care Plan dated as follows documents: 2/20/23 R127 has a history of aggressive behavior and has exhibited verbal, physical, abusive behavior. 2/20/22 R127 was involved in a physical altercation with a peer. 8/14/22 R127 was involved in physical altercation with staff and co-peer. Facility document titled "Initial (State Survey Agency) Incident Report Notification", dated 6/20/23 at 3:00PM documents R127 touched R15 who threw room temperature coffee on R127. R15 was punched by R127. R15 sustained a swollen area near R15's mouth. On 7/18/23 at 11:52 AM, R15 stated, "R127 and I had an altercation. R127 grabbed me from the back, holding my waist tight like a bear hug. I yelled out, telling him [R127] to let me go, but he [R127] continued to hold me tight. Then R127 took one of his hands and rubbed my a**. At that point I turned myself around tried to push him [R127] off me, but he kept holding on to me like a dog in heat. I then through my cup of coffee on R127 to make him let go, because I could not get lose. I am in my sixties and R127 is a strong young man in his twenties, I could not break free. The cup of coffee was room temperature and did not burn me or R127. He [R127] let me go, then fast as lightening he punched me in the mouth.	S9999		

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S9999	Continued From page 3 My lip was bleeding and swollen with a cut. The nurse tried to send me to the hospital, but I refused. I was offered a room change, but I refused to move out of my room. I feel safe here at this facility." On 7/18/23 at 12:20 PM, R127 stated, "Me and R15 got into a fight. I was touching R127, hugging him from the back, because I like to do it. R15 then splashed his cup of coffee all over me, and that made me very mad. I punched him in the mouth, and his tooth cut my knuckle. The coffee did not burn me, it was not hot." On 7/18/23 at 12:30 PM, V4 (Licensed Practical Nurse, LPN) stated, "I was the nurse on 6/20/23, and observed when R127 punched R15 in the mouth. I was standing here at the nursing stating when I heard R15 yelling, I saw R127 holding R15, from behind with his [R127] arms wrapped around R15's waist. R15 turned and threw coffee on R127, then R127 punched R15 in the mouth. R15's mouth was bleeding with a cut on his lip, and R127 has a small cut on his knuckle from punching R15 in the mouth. I yelled out and R127 stopped, did not hit R15 anymore. I provided first aide to both residents and called for social service to come and assist. I also called each resident physician, emergency contact, and administrator, and director of nursing was made aware of the incident. V15 [Psychiatric Nurse Practitioner] order was to closely monitor R127's behavior and call if R127 is not redirectable or have increase adverse behaviors. R15 and R127 both refused to have their room change. R15 said he felt safe in the facility. R127 has a history of physical abuse since his admission. Some of his behaviors is to hug people from the back and becoming easily agitated. All staff and social services monitor R127's behaviors to deescalate	S9999		

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the situation, R127 attends group therapy, activities, and 1:1 counseling by the social service department and V15 to help R127 use appropriate coping skills and anger. I did not call the police and was not instructed to call the police."

On 7/20/23 at 9:48 AM, V1 [Administrator] stated, "I have been the administrator for this facility since May 2023. However, I been an administrator since 1984. I received a phone call that R127 hugged R15 tightly from the back, then R15 threw his coffee on R127. Then R127 punched R15 in the mouth. I reported the initial allegation to (State Survey Agency) on 6/20/23 and sent the final report on 6/23/23. R127 was sent out the hospital, because he was verbally redirectable and did not intentionally strike R15. Both residents refuse for their rooms to be changed and that is their right. The staff in vigilant and will closely monitor R127's behavior. R127 is closely followed by social services, group therapy and physiatrist. I did not call the police; the staff usually call the police. I was not able to locate the police report or police report number related to the physical abuse incident on 6/20/23. There is no documentation in R15 or R127 clinical chart of the police being called."

On 7/20/23 at 11:10 AM, V12 [Psychiatric Rehabilitation Services Coordinator-Social Work] stated, "I was the social worker on 6/20/23. R15 stated, he was hugging R12 from the back, and R127 threw his coffee on him [R127]. Then R127 punched R15 in the mouth. R127 and R15 was separated. The nurse provided first aide. R15 lip was cut open and bleeding, but he [R15] refused emergency room evaluation. V15 [Psychiatric Nurse Practitioner] made aware, administrator, and director of nursing. Both residents R15 and

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S9999	Continued From page 5 R127 refuse for their rooms to be changed. R15 said he felt safe in the facility. R127 is being closely monitored for increase in adverse behaviors, and inappropriate peer to peer interactions. Normally, if there is any physical abuse with an injury the police are called. I was not told to call the police by the administrator, and I did not call the police." 2. R111's Face Sheet documents R111's diagnoses including Schizoaffective Disorder, Hemiplegia, Muscle Weakness, Unsteadiness on Feet, and Unspecified dementia with other Behavioral Disturbances. R111's Care plan (dated 01/26/2023) documents that R111 is at risk for aggressive behavior. R111's Aggression Assessment dated 04/20/2023 documents that R111 has a history of aggression. R143's Face Sheet documents R143's diagnoses including Schizoaffective Disorder, Hypertensive Heart Disease, Spinal Stenosis, and Benign Prostatic Hyperplasia. R143's MDS/Minimum Data Set dated 05/31/2023, documents R143 has a BIMS/Brief Interview for Mental Status of 15/15, indicating that R143 is cognitively intact. R143's Abuse Assessment dated 06/01/2023 documents that R143 is at risk for abuse. R143's Care plan (dated 06/09/2023) documents that R143 is care planned for risk for abuse. The facility's Initial Incident Report (dated 06/09/2023) documents: It was reported to the administrator on 06/09/2023, that R111 got out of his wheelchair and became physically aggressive with R143. A CNA was in the day room and	S9999		

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overheard R111 tell R143 to leave his woman alone. R111 grabbed R143, both residents were immediately separated. R111 and R143 were assessed and had no injuries.

On 07/18/2023 at 12:50PM, R143 stated "Yes, I remember the altercation with R111 very well. About a month ago, I was sitting in the dining room talking to another resident (Identified as R125). When R111 saw me talking to R125 he got mad because R111 thinks that R125 is R111's girlfriend. R111 is in a wheelchair and began to roll pass me while in his wheelchair. I thought that R111 would keep rolling pass me but once R111 got behind me, that's when R111 grabbed me by the neck and put me in a choke hold. That's when I placed my fingers underneath R111's hands to release his grip around my neck, then I knocked R111 to the ground and R111 fell out of his wheelchair and onto the floor. The staff came and assisted R111 back into his wheelchair. The staff separated us and told me to go to my room. The staff also told me that I should be able to defend myself against R111 since R111 is in a wheelchair. My neck was a little sore after that, but I did not have to go to the hospital. R111 was not hurt and did not go to the hospital either. I don't feel safe here at the facility because I think that this will happen again. I got into an altercation with R111 before this last altercation. The first altercation with R111 was in May 2023. I told the facility about it, but they did not do anything about it; they ignored it. I wanted someone to take my statement, but no one ever asked me about the altercation, and they did not call the police. The facility doesn't report things because they don't want to get into trouble."

On 07/19/2023 at 9:29AM, R111 stated "I choked R143 because I was mad at R143 because he

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took my girlfriend (identified as R125). R143 said something about R125, and I don't like anybody talking about her. I wasn't physically hurt that day, but I don't like that R143 still talks to R125. R125 told me that R143 is her man now and I don't respect that; it's really hard for me. R125 never comes to see me anymore either. The staff told me not to hit anyone, so I'll try not to, but it's still hard for me to handle this."

On 07/19/2023 at 9:49AM, V6 (Certified Nursing Assistant, CNA) stated "I was here that day on 06/09/2023. R125 plays R143 and R111 against each other, she goes back and forth between being with them. R111 really likes R125. You can see it in R111's body language that it bothers him to see R143 and R125 together. R111 and I was in the hallway, R111 was sitting in his wheelchair. R143 and R125 was inside the fourth-floor dining room talking. I had to make rounds so I wheeled R111 inside the dining room with R143 and R125. Another male CNA monitored the halls while I made round to the other resident rooms. When I was returning from performing my rounding, I could hear R143's voice getting louder. I entered the dining room and that's when I saw R111 stand up from his wheelchair and R111 grabbed R143 by the neck and began forcing R143 down to the floor. The male CNA helped me to separate R111 and R143, but he did not witness the altercation between R111 and R143. The altercation happened on the evening shift around 7:00PM. I was the only person who witnessed the physical altercation between R111 and R143 on 06/09/2023. I notified the nurse on duty (identified as V16/LPN) and saw the nurse assess both residents. R111 and R143 did not have any injuries and did not have to go out to the hospital. The police were not called and both residents were sent back to their rooms. Sometimes, R143

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S9999	Continued From page 8 says things to R111 to antagonize him and rubs the situation into R111's face. R111 acts on emotional impulses because he really likes R125 and R111 has no control over his emotions. R111 and R143 still reside on the same floor (identified as the fourth floor) without any further incident that I am aware of." On 07/19/2023 at 12:00PM, V7 (Licensed Practical Nurse/LPN) states, "I was not working at the facility the day of the incident on 06/09/2023. I do know that R111 and R143 both share the same love interest (identified as R125). I was informed by other staff that a physical altercation took place with both residents. I'm not sure who the aggressor was but if I had to take a guess, I would say that R111 was the aggressor because R111 can get hot-headed. R111 ambulates in a wheelchair, but R111 will stand up when he gets mad. Yes, I was trained on abuse about two weeks ago and if abuse is reported to me then I will report it to V1 (Administrator)." On 07/19/2023 at 2:08PM, V14 (Psychiatric Rehabilitation Service Counselor/PRSC), states "I was informed by V6 (CNA) that R111 and R143 had a physical altercation. I spoke to and counselled both residents. R111 told me that he hit R143 because R143 was with his woman and R111 didn't like it. I spoke with R111 about not using violence and to use coping skills. I also spoke to R143 and made sure he felt safe in the facility. R111 does have a history of aggression. R111 had a verbal altercation with his former roommate, and we had to change them to different rooms." Nursing Progress Note written by V16 (LPN) (dated 06/09/2023) documents, "Staff intervened in a timely manner to separate them and R143	S9999		

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was redirected back to his room. The charge assessed R143 for any injury. R143 body checked with no physical injury noted. No further sign of agitation noted. V/S (vital signs) T (temperature) 98.2 Respirations 18 Pulse 78 B/P (Blood Pressure) 138/80. Alert and oriented X 3. The psychiatrist was notified, she said continue to monitor resident. R143's Sister was notified."

Nursing Progress Note written by V16 (LPN) (dated 06/09/2023) documents, "R111 body checked with no sign of physical injury noted. R111 Remain up about with aid of wheelchair. C/O (complaints of) no pain or discomfort. Refused vital signs check. Alert and oriented x 3. Dr. (doctor) notified with no new orders given. Said continue to monitor R111. No family members or correspondent listed. The administrator and DON (Director of Nursing) made aware of incident. Remain closely observed."

Social Services Progress Note written by V14 (PRSC) (dated 06/09/2023) documents, "R143 was involved in a physical altercation with a co-peer in the dining room on his floor. R143 verbalized to writer that the co-peer put him on a choke hold unprovoked. Staff separated and redirected to their rooms and placed on 1:1 close monitoring by staff. Writer counseled him and comforted R143 to make him feel is in a safe space and all the staff of the facility will do all they can to protect him and make him feel safe. R143 was assessed by the charge nurse for any injury or pain. His physician was notified as well. He verbalized he is fine and has no injury. Writer will continue to monitor and document all progress."

Social Services Progress Note written by V14 (PRSC) (dated 06/09/2023) documents, "Data: It

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S9999	Continued From page 10 was reported to writer that R111 was physically aggressive towards a fellow peer. He put on a choke hold. Action: Staff intervened in a timely manner and separated the residents. R111 was redirected back to his room and placed on a 1:1 close monitoring. The charge nurse was notified, and he notified the physician. Writer reported to the abuse coordinator and DON. Writer counseled R111 on applying his coping skills and reporting to staff whenever he feels agitated. Response: R11 verbalized to writer that "I told him to leave my woman alone and he would not listen." R111 is calm at this time, and he was receptive to counseling. Staff will continue to monitor and document all progress." 3. R83's diagnoses include Dementia, Hypertensive Heart Disease, Schizophrenia and Alzheimer's. R83's Minimum Data Set (MDS) dated 4/19/23, Section C documents R83 has severe cognitive impairment. Section E documents R83 has hallucinations and delusions. R83's Care Plans document R83 is at risk for abuse/neglect as evidenced by behavior that might be characterized as provoking, antagonizing, disrespectful, angry, socially inappropriate yelling, initiated 4/23. R8's Care Plans, document R83 exhibits verbally/physically abusive behavior. R63's diagnoses include Disorganized Schizophrenia, Hypertensive Heart Disease and Manic Episodes. R623's MDS dated 6/2/23, section C documents R63 is cognitively intact. Section E documents R63 has hallucinations and delusions and exhibits physical and verbal	S9999		

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S9999	Continued From page 11 behavioral symptoms toward others. R63's Care Plans document R63 exhibits verbally/physically abusive behavior with a date initiated of 6/20/23. These Care Plans document multiple verbal and or physical altercations with co-peers and or staff. R63's Care Plans also document R63 is at risk for abuse/neglect as evidenced by diagnosis of mental illness. The State Survey Agency Incident Report Form, dated 6/21/23, documents 6/20/23 as the date of a resident-to-resident physical altercation where R63 claimed that R83 pushed R63 so R63 hit R83. R83 had a small laceration on the nose, was sent to emergency department and returned with sutures to the nose. Progress note, date 6/20/23, documents R83 was punched and knocked on the floor by R63. R63 admitted to punching R83 after brief altercation. On 7/18/23 at 12:28 PM, R83 stated R63 took a swing at me in the elevator and knocked me out. R83 stated R83 was talking to someone else to stop slamming doors and R63 thought R83 was talking to R63. R83 stated R83's nose got hurt and was bleeding and that R83 went to the hospital. R83 stated it was just R83 and R63 on the elevator. On 7/18/23 at 12:35 PM, R63 stated I was getting on the elevator. R63 stated R83 cussed at and pushed R63, so R63 hit R83 in the face. On 7/19/23 at 3:10 PM, V21 (Registered Nurse) stated V21 was at the nursing station on the 6th floor when R63 and R83 had an altercation on the elevator. V21 stated both R63 and R83 had just left the dining room and had both entered the	S9999		

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S9999	Continued From page 12 elevator. V21 heard a loud noise before the elevator door closed and went to the elevator. R83 was lying on the floor and there was blood from R83's nose. V21 removed R63 and R83 from the elevator. R63 stated to V21 that R83 was in R63's business and R63 told R83 to stop. R83 grabbed R63's shoulder. R63 told V21, when R83 touched R63 shoulder, R63 punched R83. R83 did not deny grabbing R63's shoulder. R63 was sent to the hospital per physician's orders. On 7/19/23 at 3:48 PM, V1 (Administrator) stated V1 started V1 is the Abuse Coordinator. If there is any physical contact, the resident is sent out for evaluation. V1 stated R83 complained R63 was talking to self and slamming doors as they were coming down the elevator to smoke. R83 pushed R63 then R63 punched R83. On 7/19/23 at 4:55 PM, V12 (PRSC/Psychiatry Rehabilitation Service Counselor); V22 (PRSC) stated R63 and R83 had a physical altercation. R83 stated R63 was slamming doors in the hallway. R83 was trying to remove self by getting on the elevator and R63 got on the elevator too. R83 mumbled something to self and R63 believed R83 was saying something to R63. R63 said something out loud and R83 believed it was directed at R83. R83 became physically aggressive toward R63. R83 said R83 pushed R63 and R63 then became physically aggressive, punching R83. V22 stated R63 said R83 was trying to get in R63's way so R63 pushed R83. V22 stated R83 had an injury to R83's nose and was sent to the hospital for the nose injury. V22 stated R63 was sent out for psychiatric evaluation per the doctor's order. (B)	S9999		

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 _____	07/21/2023

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

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