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 04/21/2023

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

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S 000	Initial Comments Complaint investigation of 4/21/23 2382714/IL158529	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210d)3)6) 300.3210t) 300.3240 a) 300.3240b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. (Section	S9999		

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S9999	Continued From page 2 3-610(a) of the Act) These Regulations were not met as evidenced by: Based on observation, interview, and record review the facility failed to follow their abuse prevention and policy for one resident (R7) out of four residents reviewed for abuse. This failure resulted in a resident (R7) being threatened and physically abused by a staff member, staff not intervening not protecting the resident (R7) from the perpetrator, staff not reporting the abuse and threatening behavior of a staff member immediately . R7 sustained bruising to her right arm and bruising to her left and right eye Findings include: R7 was admitted to the facility on 2/10/2010 with a diagnosis of Schizophrenia, Anxiety Disorder, Unspecified Psychosis, COPD and HTN. Facility abuse report dated 4/7/23 denotes it was reported to administrator that a staff member was physically inappropriate towards a resident (R7). Employee was suspended, resident with injuries', resident refused hospitalization, police notified. Investigation initiated. During interview on 4/12/13 at 10:30 am, V14 (Cook) stated she arrived to work last Friday, 4/7/23 at 6:05 am. V14 stated as she was coming into the building through the front lobby, she witnessed R7 on the floor and V11 standing over her with the wet floor sign in his hand. V14 stated she jumped in between them while V11 was yelling R7 had busted his lips. V14 stated she got	S9999		

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S9999	Continued From page 3 V11 to calm down. V14 stated then a few minutes later after V11 calmed down V11 escorted R7 down the hall. V14 stated she was nervous when the incident happened because she has a pacemaker and fearful about increasing her heart rate. V14 stated at the time of the incident she noticed another staff member (V16) behind the front desk. V14 stated at time of the incident she was not thinking and should have not let V11 walk away with R7. V14 stated her manager (V18) came in to work around 9:00 am and she reported the incident to V18 but V11 should have not waited and reported the incident immediately. On 4/12/23 at 11:15 am V11 (Psych Rehab Assistant) stated he was at work on Friday (4/7/23) and had cleared the main floor lobby after the residents had finished smoking. V11 stated he came back down to the front lobby and R7 was still there in the lobby. V11 stated he asked R7 to go upstairs then she had started punching him. V11 stated he put up his arm and R7 grabbed him, then R7 fell onto the floor. V11 stated another staff maybe got in between them. V11 stated in the heat of the moment he might have slapped R7 a few times. V11 stated he was blindsided by R7 and felt threatened by her and responded. V11 stated he has been told not to ever strike a resident and did not mean to touch R7. V11 was trained to walk away and call for help but did not do that. V11 stated after the incident he clocked out of work at about 7:00 am. V11 stated he went to the hospital and then later V11 called his supervisor and told her what happened. During interview on 4/12/23 at 11:30 am, V18 (Dietary Manager) stated she got to work around 9am on Friday (4/7/23) when V14 approached her and told her that she saw V11 with a wet floor sign standing over R7 while R7 was on the floor.	S9999		

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S9999	Continued From page 4 V18 stated V14 told her she intervened and calmed V11 down. V18 stated she then immediately reported the incident to the social service director and the administrator. V18 stated she did let R14 know that she was to report any abuse to the managers immediately and never wait until the managers come to the facility. R7 was observed sitting in her room on 4/11/23 at 3:30 pm with bruises under both eyes and black and blue bruises on her shoulder During interview on 4/11/23 at 3:30 pm R7 stated V11 told her to go to her room. R7 stated when they got to her room, she got into the bed then he (V11) started hitting her. R7 stated she started yelling then he stopped hitting her. R7 stated he(V11) left the room then and she just stayed lying down in her bed. R7 stated staff found out about it later that morning and asked her about the bruises on her face. R7 stated she has not seen V11 since it occurred and feels okay. On 4/11/23 at 3:45 pm R8 stated she has been R7's roommate for a few weeks. R8 stated while in her bed resting, she saw V11 come into their room and start hitting R7. R8 stated after the incident she did not see staff and did not tell anyone what had happened. During interview on 4/11/23 at 4:00pm, V16 (Psyche Rehab Assistant) stated he was at work Friday morning (4/7/23) sitting at the front desk in the lobby and V11 was standing next to the front desk. V16 stated he witnessed R7 asking for cigarettes when he heard V11 tell R7 that she had to wait until smoke time and to leave the area. V16 stated while he was sitting at the front desk and his head was down because he was looking at some papers. V16 stated he heard R7 cursing	S9999		

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S9999	Continued From page 5 V11 out. V16 stated he heard some rustling then he got up from the desk. V14 walked through the front door, and she separated V11 from R7. V16 stated he overheard V11 tell V14 that R7 had hit him in the mouth. V16 stated after the incident at around 7:00 am it was time to punch out and he went home. V16 stated he did not report the incident to the administrator or his manager. V16 stated he was trained that he was supposed to report all incidents involving a staff member and a resident as soon as it happens. V16 stated that was the first time that he witnessed a staff member and a resident interacting like that. V16 stated has worked with V11 for six years and never seen him go off on a resident before. On 4/11/23 at 2:30 pm V1 (Administrator) stated she came to work Friday morning (4/7/23) around 9:00 am. V1 stated when she came into work the dietary manager (V18) reported that her staff (V14) witness an incident of abuse involving R7 and the psyche aide (V11). V1 stated V14 should have reported the incident right away to her and should not have waited until her manager to came to work. V1 stated after she was told about the incident, they called the police to report that V11 had hit a resident (R7). V1 stated she sent the initial report to IDPH that day and started the termination of V11. V1 stated after the abuse investigation was started, they discovered that V14 and V16 allowed V11 to walk away with R7 after he was seen being aggressive towards R7. V1 stated V14 was suspended, reprimanded and in-serviced on abuse. V1 stated V16 was suspended and will be terminated. V1 stated when V11 finally answered his cell phone she was able to interview him. V1 stated V11 told her R7 was mad because he didn't give her a cigarette. V1 stated V11 told her she suddenly hit him in the mouth which made him mad, so he slapped her a	S9999		

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S9999	Continued From page 6 couple of times in the face. R7's 4/7/2023 14:09 Daily Note Text reads: The nursing staff approaches the resident to give scheduled medications and notices bruises on her facial area and left hand The nursing staff completes a head-to-toe assessment revealing body part is intact. She is alert and responsive lying in bed quietly. Vital signs WNL. pain 5 from 0-10 pain scale. PRN pain given, well tolerated. 911 call to take the resident to the hospital. She refused. MD Anand was made aware and ordered to do an X-ray of the affected area. All responsible parties were made aware. A family member, ..., made aware of the situation. Staff will keep her updated. The nursing staff will continue to monitor for any change in condition. R7's police report #62144189 dated 4/7/23 denotes battery hand/fists time of occurrence 0600. R7's x-ray report 4/8/23 No evidence of recent fracture for left arm, wrist, and hand. During interview on 4/13/23 at 9:45 am V17 (Doctor) stated R7 did sustain bruises on her face and arm from the staff member hitting her. V17 stated that staff member was fired and will not be allowed to work for the facility. V17 stated R7 did not sustain any significant injuries and her bruises are fading away. V17 stated staff are still monitoring her for any significant changes. V17 stated he did an x-ray of R7's arm, and it was negative for any fractures. On 4/16/2023 12:03 R7 Psychosocial Note Text reads: WELL BEING CHECK NOTE: ... ... met with .....(R7) ... . to see how she is coping. Resident verbalized she was doing fine.	S9999		

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S9999	Continued From page 7 Resident appears to be in good condition. Writer encouraged resident to always verbalize her concerns to staff. Resident is calm at this time. Staff will continue to monitor and document all progress accordingly. R7 and R8 care plan abuse/neglect based on comprehensive assessment updated on 4/17/23. 4/19/2023 18:32 R7 Nurse Practitioner Progress Note Text: Medication management and psychiatry follow up. Subjective: Resident asked to be seen by facility director. I met with resident with psychiatry history due to an abuse sustained from an employee. Resident observed lying down in bed in no distress. Resident engaged with provider, not guided with information at this time. Resident describes symptoms consistent with depression including : anhedonia, low mood, loss of interest and middle insomnia. Resident reports having flash backs of the incidence. During interview, resident reported moving past the problems. She described how she was abused and stated to be tired of talking "too many time". Resident reports mood "good" but affect is anxious and dysphoria. Facility's abuse policy date to be effective 3/2022 denotes this facility affirms the right of our residents to be free from verbal, physical, sexual, mental abuse, neglect, exploitation, misappropriation of property, involuntary seclusion, or mistreatment. Physical abuse is the affliction of injury on a resident 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.	S9999		

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S9999	Continued From page 8 (B)	S9999		