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 07/26/2024

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 Complaint Investigation 2485013/IL174841 Investigation of Facility Reported Incidents of: 6/26/24/IL175228 6/27/24/IL175736 6/28/24/IL175233	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.3210t) 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.	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 _____	C 07/26/2024

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
S9999	Continued From page 1 These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident remain free from physical abuse for 1 out of 3 residents (R2) reviewed for abuse. These failures resulted in R2 sustaining multiple injuries, including bruising to R2's eye, swelling and blood to R2's mouth, bruising to R2's cheek and R2's fingernail hanging halfway off, requiring a hospital emergency room evaluation. Findings include: R2 is 66 years old, initially admitted in the facility on 9/27/2022 with diagnosis of bipolar disorder, major depressive disorder, and mood disorder. Per notes of V14 (PRSC) dated 6/29/2024, documents that R2 was transferred to the hospital due to receiving physical aggressive behavior from R3. R2 was punched on his right jaw and his fingernail was halfway off. R2 was not present during review. R3 is 66 years old, initially admitted in the facility on 10/29/2014 with diagnosis of schizoaffective disorder, major depressive disorder, and dementia. Per notes of V14 dated 6/29/2024, documents that R3 punched R2 on the face unprovoked. Per facility reported incident the physical aggression of R3 towards R2 happened on 6/29/2024 at 10:30 AM. R3 was physically aggressive towards R2. R3 physically attacked R2 resulting to R2 swollen jaw. It was concluded by the facility that R3 became agitated while asking R2 to give back his (R3's) jacket.	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 _____	C 07/26/2024

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
S9999	Continued From page 2	S9999		

On 7/23/2024 at 1:10 PM, R3 was seen sitting in his wheelchair alert and verbally able to respond. During conversation, R3 nodded indicating yes, when asked if he knew R2. R3 stated "he made me mad, getting my stuff. I punched him all over his face." R3 was asked if R2 hit him back. R3 replied "no, he did not hit me back."

On 7/24/2024 at 10:09 AM, V9 (Social Service Director) after reviewing the full care plan of R3 stated that the only aggression of R3 that was addressed on the care plan was the most recent dated 6/29/2024. V9 stated that smoking is important to R3 and becomes aggressive when triggered by another person affects his smoking schedule. V9 was informed that per facility incident report, it was concluded that R3 physical aggression to R2 was due to R3's jacket. V9 was asked if it was addressed on R3's care plan? V9 also stated that personal space and personal belongings is important to R3. But it was not addressed in the care plan.

Per R3's behavioral notes multiple aggressive behavior (verbal and physical) were documented on the following dates: 6/29/2024, 2/5/24, 11/27/2023, 7/26/2023 and 6/27/2023.

On 7/24/2024 at 10:39 AM, V5 (Registered Nurse) stated that around 7:00 AM she was informed by V8 (Certified Nursing Assistant) that R2 had bruising to his eye and swelling on his mouth. V5 stated that after interviewing R2, he stated that it was R3 his roommate who did it. R2 was transferred to the hospital per doctor's order. V5 stated that R3 was asked but was not able to explain what happened. And that she (V5) does not know that R3 has a history of aggression. Per V5 it happened to the shift prior (11:00 PM to 7:00 AM shift) because the injuries are present at the

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 07/26/2024

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
S9999	Continued From page 3	S9999		

beginning of her (V5) shift (7:00 AM to 3:00 PM).

On 7/24/2024 at 12:10 PM, V8 stated that the incident between R2 and R3 happened on 11:00 PM to 7:00 AM shift (the shift prior to V5 and V8). V8 stated because R2 needs to be fed during breakfast and dinner. And when she (V8) got ready to feed R2, R2 had bruising to R2's cheek, and R2's mouth was swelling. R2 opened his mouth, V8 saw dry blood. R2's injuries were apparent and hard to miss. But no report was received from 11:00 PM to 7:00 AM nursing staff. V8 stated that R2 and R3 were her resident every day that she worked. And R2 and R3 were roommates. R3 will be aggressive if there is a trigger and it is possible that his belongings were placed on R2's bed that made R3 upset.

On 7/24/2024 at 1:20 PM, V1 (Administrator) stated nursing staff who worked on 11:00 PM to 7:00 AM (prior shift when the incident was reported) were not included in the investigation because it was V5 and V8 who reported it. After pointing out to V1 facility's abuse policy on investigation procedure to interview anyone likely to have direct knowledge of the incident, V1 said "I understand they should be included." V1 was asked if facility addressed the concern of personal belonging that triggered R3's aggression, that per facility incident report under conclusion, jacket of R3 was the reason there was a conflict between R2 and R3 occurred. V1 stated that it should have been addressed to avoid recurrent aggression because R3 has history of aggression.

Abuse policy dated 3/2022, reads:

This policy affirms the right of our consumers to be free from any forms of abuse. This facility

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 07/26/2024

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
S9999	Continued From page 4	S9999		

therefore prohibits abuse. In order to do so, the facility has attempted to establish a consumer sensitive and secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse.

This will be done by:

Establishing an environment that promotes consumer sensitivity, consumer security and prevention of mistreatment.

Identifying occurrences and patterns of potential mistreatment.

Filing accurate and timely investigative reports.

(B)

Statement of Licensure Violations 2 of 2

300.610a)
300.1210a)
300.1210b)
300.1210c)
300.1210d)6)

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.

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 07/26/2024

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
S9999	Continued From page 5	S9999		

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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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 07/26/2024

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
S9999	Continued From page 6	S9999		

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:

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.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to implement fall prevention interventions and include each fall in the residents care plan. These failures affect one of three residents (R1) reviewed for falls. These failures resulted in R1 falling and sustaining right leg, right hip and pelvic fractures.

Findings include:

R1 was 65 years old, initially admitted on 7/17/2011 with diagnoses including schizoaffective disorder, muscle weakness, dependence on wheelchair and dementia. Per V13 (Licensed Practical Nurse) notes dated 6/27/2024, R1 was sent to the hospital due to right leg/hip swelling. Per R1's census record, R1 was discharged on 6/27/2024.

The facility reported incident dated 6/26/2024 documents R1 was found on the floor in his room. R1 was noted with right leg swelling and grunting. R1's right leg x-ray revealed right hip inter and subtrochanteric fractures with varus deformity. R1's x-rays also showed R1's pelvis with inter and

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 07/26/2024

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
S9999	Continued From page 7	S9999		

subtrochanteric fracture of the right femur with varus deformity.

On 7/24/2024 at 10:39 AM, V5 (Registered Nurse) stated that R1 was placed on the bed after giving medication. After 45 minutes later she (V5) heard R1 screaming. She (V5) went to R1's room, R1 was on the floor with facial grimace during assessment. Per V5 this happened around 10 to 10:30 PM. V5 stated that R1 needs extensive assistance as to ADL (Activities of Daily Living) including transfers, and that R1 cannot ambulate. Per V5 he never saw R1 ambulate or transferred. And that R1 may have rolled out of the bed when he was found on the floor on 6/26/2024 because R1 cannot get up by himself.

R1's notes by V13 (Licensed Practical Nurse) dated 4/12/2024 documents that R1 had a previous fall and was found on the floor on his buttocks. Per V9 (Social Service Director) notes dated 4/17/2024 documents that R1 stated that he rolled out of the bed and R1 was educated.

On 7/24/2024 at 12:27 PM, V12 (Restorative Nurse / Licensed Practical Nurse) stated that every fall should be in the care plan and should be addressed. V12 reviewed R1's care plan and was unable to find details for R1's fall that occurred on 4/12/2024. Per V12, R1 can get up without help and can transfer by himself, which makes R1 at an increased risk for falls. Per V12, since staff identified the possibility that R1 may have rolled out of bed, this should also be included in the care plan. V12 stated that it is possible that R1 may have a decline. After reviewing R1's BIMS (Brief Interview on Mental Status) dated 4/29/2024, V12 stated that it is possible that some interventions that involved understanding, and instruction may not be

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 07/26/2024

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
S9999	Continued From page 8	S9999		

effective. All fall assessments for R1 document R1 is a high risk for falls.

On 7/24/2024 at 1:00 PM, V4 (Director of Nursing) stated that staff should know the resident's ability to transfer and ambulate. V4 stated that R1 can ambulate and can transfer contrary to what V5 stated. V4 stated that she does not believe that R1 rolled out of bed, because R1 can get up and transfer and does not need extensive assistance. V4 stated that care plan needs to be updated after every fall.

Review of R1's notes shows that multiple nurses (V16/Registered Nurse and V17/Registered Nurse) document that R1 required extensive assist, not limited assist contrary to what V4 had stated.

The facility provided a full care plan with history, including resolved care plans. R1's fall on 4/12/2024 was not included in R1's care plan.

The facility's Fall Program Policy dated 3/2021, reads:

The goal of this program is to provide guidance to facility staff on the fall program.

All residents will be evaluated for falls and after every fall. Upon completion of the fall evaluation a care plan is developed or updated. New fall interventions are reviewed with the resident and/or responsible party and applicable staff. Education regarding the residents' risk for falls and interventions to prevent falls is provided.

(A)