STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146161	A. BUILDING _____ B. WING _____	C 04/08/2022

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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint 2282513/IL145256- F580 & F689-J cited Investigation of Facility Reported Incident of 03/04/22/IL145231- F689-J cited	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 580	**Attachment A** **Statement of Licensure Violations**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to notify the physician and the state guardian of R1 not returning to the facility while being out on an unauthorized community pass. This failure effected R1, who has been missing since going on an unauthorized community pass on February 23, 2022. Findings include: R1's Face Sheet documents resident is a 40-year-old with diagnoses including but not limited to: WEAKNESS, OTHER REDUCED MOBILITY, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED, SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE, OTHER ASTHMA, OBESITY, UNSPECIFIED, SCHIZOPHRENIA, UNSPECIFIED.	F 580		

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F 580	Continued From page 2 On 03/25/2022 at 9:55am, V5 (state guardian) stated, "I arrived at the facility to see R1, I was visiting for a quarterly visit, and I was notified by the front desk receptionist that R1 was not there. R1 is assigned to one of my co-workers and I was going to see R1 while I was in the building visiting other residents. The facility is supposed to call and get our consent for us to approve for the resident to go out on pass". On 03/30/2022 at 10:01am, V3 (R1's state guardian) stated, "On 03/25/2022, my coworker, V5, was at the facility to see V5's resident, and I asked V5 to check on my resident, R1, while V5 was at the facility. When V5 asked for R1's room number, V5 was told that R1 is no longer at the facility and has not been there for over a month. R1 has a mental illness and lacks the decisional capacity to make the right choices. R1 has been under state guardianship since 2012. R1 is under guardianship because R1 uses illegal drugs, hallucinogens and sells R1's body to be able to pay for drugs. It wasn't until today (03/30/2022), that I found out that R1 has been gone since 02/23/2022 and the facility just notified me today. I was told by V1 (administrator) and V7 (social service director) that a man who identified himself as R1's uncle, came to the facility and took R1 out on a community pass for a few hours and never brought R1 back to the facility. The facility never called me for my permission to allow R1 out on pass. I would never agree for the facility to let R1 out on pass, especially with a man, considering that R1 has a heavy history of drug use and prostitution. R1 is not safe to be out on the streets and I never gave the facility permission to leave the facility. R1 is a ward of the state, and I would never consent for R1 to leave the facility at all. I don't know where R1 is, if	F 580		

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F 580	Continued From page 3 R1 is dead or alive and R1 has been gone for a little over a month and the facility never called me to notify me. V7 (social service director) stated that supposedly they called me, but this is a lie, I was never notified and if they did call me to obtain permission, I would have never consented for R1 to leave the facility under any circumstances." On 03/30/2022 at 10:55am, V2 (director of nursing) stated, "R1 was discharged on 02/23/2022. R1 left with the brother on 02/23/2022 for several hours and supposed to be back the same day. The next day we observed that R1 has not returned the to the facility. The social service department followed up as to why R1 did not return to the facility on 02/24/2022. R1's brother verbalized that R1, and the brother have left the city for Wisconsin and will be back on 02/25/2022. Social service department informed the supervisor about the family taking R1 to Wisconsin without notifying the facility. As of 02/25/2022 R1 did not come back so on 02/26/2022 we put that R1 was still on pass. We have the 10-day bed hold policy. As of 03/01/2022, social service followed up with R1's guardian, V3 the V3 said that R1 is at another facility and R1's sister was supposed to come and pick up R1's belongings. The social service director called the other facility but was not able to talk to the resident. The social worker was not able to verify that R1 is at the other facility that the guardian named. On 02/23/2022, this was the first time that R1 was going out on pass. R1's brother never came to the facility to visit R1, so this was the first time that R1 was taken out on pass by R1's brother. If a resident has a guardian, we don't have to get a guardian's approval of visitors, we just have to notify the guardian that a resident is going out on pass. The doctor has to	F 580		

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F 580	Continued From page 4 approve if a resident is capable and safe to go out on pass. We just have to notify the guardian that the resident that is under guardianship went out on pass, but we don't have to get a list of approved visitors from the guardian. R1's brother is not listed as R1's contact. I do not see R1's brother listed anywhere in R1's chart. The only place that R1's brother is mentioned is in social service progress notes otherwise R1's brother is not listed anywhere. R1's cognitive ability was alert and oriented and able to make her own decisions and I am not sure why R1 had a guardian. I never looked into why R1 had a guardian. Because the social service department deals with the guardianship. We did not notify the physician of R1's departure from the facility." On 03/30/2022 at 12:33pm, V7 (social service director) stated, "On 02/23/2022, R1 left on pass with a man who said he was R1's uncle. One of the counselors signed the release for R1 to leave the facility. R1 is mentally capable to make decisions. R1 is still kind of new to our facility so medically nobody was concerned. R1 has a state guardian, but R1 can make her own decisions. Depending on the type of guardianship they have, and when it comes to complicated issues, the guardian has the final say. When a resident is cognitively not sound, the guardian has the final say. I honestly just found out today (03/30/2022) that R1 was a ward of the state and has a state guardian. R1's sister, V11, has been communicating with us. I don't really need a consent for anything because R1 has been new to our facility. For the short time that R1 was with us, I did not require a consent for anything. I was aware that R1 had a guardian prior to R1 leaving the facility. I thought that the guardian was one of	F 580		

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F 580	Continued From page 5 the family members, not a state guardian, because V11 pretended to be R1's guardian. The face sheet stated that R1 had a guardian, so I knew that R1 had a guardian, but we thought that the guardian was V11, but R1 has a state guardian. We have a few residents with family members as their guardian and we thought the guardian was a family member. R1's face sheet stated that V3 was the guardian. V3 is listed as the guardian but I thought it was the sister, because that's the impression that R1's family created. When I spoke to V3 this morning, that's when I realized that R1 is a ward of the state. V11 (R1's sister) gave us permission for R1 to leave the facility. On 02/23/2022, R1's brother called the facility and said that he is taking R1 out on pass for a few hours. Before the incident, if I had known that R1 had a state guardian, R1 would not have been allowed to leave the facility without V3's consent. We were never supposed to release the resident out on pass without V3's permission. When I called V11 (R1's sister) on 03/01/2022, to follow up to where the resident was located since the resident never returned, I was told by R1's sister that R1 is at another facility. It wasn't until today (03/30/2022) that I found out that V11 (R1's sister) was impersonating V3 (R1's state guardian). As of right now, I do not know where the resident is, and R1 has been gone since 02/23/2022, that's over a month. I did not follow the policy to file a missing person report because R1 was not missing." On 03/30/2022 at 2:32pm, V12 (R1's primary physician) stated, "I was not made aware that R1 has left the facility. Nobody had notified me that R1 has not been at the facility since 02/23/2022. I was not aware that R1 had a state guardian. I did	F 580		

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F 580	Continued From page 6 not assess R1 for community pass. R1 had behavioral issues that's why R1 was at the facility. Nobody notified me at all that R1 left the facility on community pass without authorization and never returned back to the facility." On 03/31/2022 at 2:01pm surveyor called the facility/woman's shelter that supposedly R1 was residing and confirmed with V14 (woman's shelter supervisor) that R1 is not residing at the facility and R1 was never a resident of the facility. At 2:05pm, surveyor notified V1 (administrator) and V7 (social worker) that R1 is not residing at the woman's shelter and R1 was never a resident of the facility. On 03/31/2022 at 2:20pm, V11 (R1's sister) stated, "I was never notified by the facility on 02/23/2022 that R1 was going out on pass with a man. The facility never called me to obtain a consent for R1 to leave out on pass, because if they would have called me, I would never have given them consent to let R1 out, especially with a man. The man who picked R1 up is a drug user. My sister is a heavy drug user, and she sells her body for drugs. The facility should not have released R1 out on pass under any circumstances. My sister called on 03/01/2022, stating that she is at a woman's shelter, but I don't know if this is true. A few weeks ago, R1 was seen standing on a street corner selling her body, by a cousin of ours. That's the last we have heard of R1. I don't know if R1 is dead or alive and I honestly thought that you are calling me from the coroner's office to notify me that my sister is dead. The facility dropped the ball, and they are trying to blame me, but I did not speak to anyone on 02/23/2022 about giving my consent to release R1 on pass. I would have never	F 580		

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F 580	Continued From page 7 consented given R1's history. On 03/31/2022, at 2:33pm, V7 (social service director) stated, "I will call the police and file a missing person report for R1." Social Service Progress note (dated 02/24/2022/effective date 02/23/2022) documents NOTIFICATION NOTE: "R1's brother called the facility to take her out for few hours and will be back to the facility before the next shift of the day. Writer will continue to monitor and document all progress upon her arrival." Social Service Progress note (dated 02/24/2022) documents NOTIFICATION NOTE: "Writer observed that R1 had not returned back to the facility. Writer called the family of R1 to find out what had happened, he verbalized to this writer that they had left the city for Wisconsin, and they would be back on Friday. Writer informed the PRSD (Psychiatric Rehab Service Aide) V10 of the situation and what the family had verbalized about R1's going to Wisconsin without the notice of the facility. Writer will continue to monitor and document all progress." Social Service Progress note (dated 03/01/2022) documents Notification: Resident's Guardian and sister, V3 said, the resident is at P.G. (woman's shelter) and we should follow up with R1's (family member) V11, who was supposed to pick her up last week but never showed up. PRSD called the P.G.M. (woman's shelter manager) the intake person, who claimed that, information on clients cannot be revealed, but promised to call the facility back to connect the client with us. Release of Responsibility for Community Pass	F 580		

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F 580	Continued From page 8 (dated 02/23/2022) documents that R1 was released out on community pass on 02/23/2022 with an uncle but did not return to the facility. Pass indicates that R1 was released on buddy pass/escort- may only go out with appointed escort/family. Police Report (dated 03/31/2022) documents that on 03/31/2022 R1 was reported missing and has been missing since 02/23/2022. Against Medical Advice Policy (dated 03/2021) documents: The physician or extender should be notified. R1's Face sheet documents that V3 is R1's guardian Guardianship and Advocacy Commission/The Office of State Guardian (undated) documents: A guardian of the person is appointed by court when a disabled person individual cannot make or communicate responsible decisions his personal care. This guardian will make decisions about medical treatment, residential placement, social services, and other needs.	F 580		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		

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F 689	Continued From page 9 by: Based on interviews and record review, 1) The facility failed to supervise and monitor one resident (R1) by failing to obtain a consent from the state guardian prior to releasing a resident out on pass. This failure effected R1 of 3 residents reviewed for community pass supervision. R1 has been missing since going on an unauthorized community pass on February 23, 2022. 2) The facility failed to implement adequate fall prevention and monitoring interventions for one resident (R3) of 3 residents reviewed for falls. This failure resulted in R3 sustaining two falls with serious injuries requiring sutures and surgery; This was identified as an Immediate Jeopardy which began on 2/23/22. On 04/07/2022 the administrator was notified of the immediate jeopardy. The immediate jeopardy was removed on 04/07/2022. However, the deficiency remains at the second level of harm until the facility determine the effectiveness of the implementation of the removal plan. Findings include: R1's Face Sheet documents resident is a 40-year-old with diagnoses including but not limited to: WEAKNESS, OTHER REDUCED MOBILITY, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED, SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE, OTHER ASTHMA, OBESITY, UNSPECIFIED, SCHIZOPHRENIA, UNSPECIFIED. On 03/25/2022 at 9:55am, V5 (State Guardian) stated, "I arrived at the facility to see R1, I was	F 689		

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F 689	Continued From page 10 visiting for a quarterly visit, and I was notified by the front desk receptionist that R1 is not here. R1 is assigned to one of my co-workers and I was going to see R1 while I was in the building visiting other residents. The facility is supposed to call and get our consent for us to approve for the resident to go out on pass. The facility is supposed to call and get consent from the guardian before a resident is released on pass." On 03/30/2022 at 10:01am, V3 (R1's State Guardian) stated, "On 03/25/2022, my coworker, V5(State Guardian), was at the facility to see V5's another resident. I asked V5 to check on my resident(R1). While V5 was at the facility, V5 asked for R1's room number. V5 was told that R1 is no longer at the facility and has not been there for over a month and that R1 has a mental illness and lacks the decisional capacity to make the right choices. R1 has been under state guardianship since 2012. R1 is under guardianship because R1 uses illegal drugs, hallucinogens and sells R1's body to be able to pay for drugs. R1 wasn't on the unit today (03/30/2022), this is when I found out that R1 has been gone since 02/23/2022 and the facility just notified me today. I was told by V1 (Administrator) and V7 (Social Service Director) that a man who identified himself as R1's uncle, came to the facility and took R1 out on a community pass for a few hours and never brought R1 back to the facility. The facility never called me for my permission to allow R1 out on pass. I would never agree for the facility to let R1 out on pass, especially with a man, considering that R1 has a heavy history of drug use and prostitution. R1 is not safe to be out on the streets and I never gave the facility permission to leave the facility. R1 is a ward of the state, and I would	F 689		

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F 689	Continued From page 11	F 689		

never consent for R1 to leave the facility at all. I don't know where R1 is. If R1 is dead or alive and R1 has been gone for a little over a month and the facility never called me to notify me. V7(Social Service Director) stated that supposedly they called me, but this is a lie, I was never notified and if they did call me to obtain permission, I would never consent for R1 to leave the facility under any circumstances."

On 03/30/2022 at 10:55am, V2 (Director of Nursing) stated, "R1 was discharged on 02/23/2022. R1 left with the brother on 02/23/2022 for several hours and supposed to be back the same day. The social service department followed up why R1 has not returned into the facility on 02/24/2022. The next day we observed that R1 has not returned the to the facility. R1's brother verbalized that R1, and the brother have left the city for Wisconsin and will be back on 02/25/2022. Social service department informed the supervisor about the family taking R1 to Wisconsin without the notice of the facility. As of 02/25/2022 R1 did not come back so on 02/26/2022 we put that R1 is still on pass. We have the 10-day bed hold policy. As of 03/01/2022, social service followed up with R1's guardian, V3 and the V3 said that R1 is at another facility and R1's sister was supposed to come and pick up R1's belongings. The social service director called the other facility but was not able to talk to the resident. The social worker was not able to verify that R1 is at the other facility that the guardian named. On 02/23/2022, this was the first time that R1 was going out on pass. R1's brother never came to the facility to visit R1, so this was the first time that R1 was taken out on pass by R1's brother. If a resident has a guardian, we don't have to get a guardian's

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F 689	Continued From page 12 approval of visitors, we just have to notify the guardian that a resident is going out on pass. The doctor has to approve if a resident is capable and safe to go out on pass. We just have to notify the guardian that the resident that is under guardianship went out on pass, but we don't have to get a list of approval of visitors from the guardian. R1's brother is not listed as R1's contact. I do not see R1's brother listed anywhere in R1's chart. The only place that R!'s brother is mentioned is in social service progress notes otherwise R1's brother is not listed anywhere. R1's cognitive ability was alert and oriented and able to make her own decisions and I am not sure why R1 had a guardian. I never looked into why R1 had a guardian. Because the social service department deals with the whole guardian ship. We did not notify the physician of R1's departure from the facility." On 03/30/2022 at 12:33pm, V7 (Social Service Director) stated, "On 02/23/2022, R1 left out on pass with a man who said he is R1's uncle. One of the counselors signed the release for R1 to leave the facility. R1 is mentally capable to make decisions. R1 is still kind of new to our facility so medically nobody was seeing any concerns. R1 has a state guardian, but R1 can make her own decisions. Depending on the type of guardianship they have, when it comes to complicated issues, the guardian has the final say. When a resident is cognitively not sound, the guardian has the final say. I honestly just found out today (03/30/2022) that R1 was a ward of the state and has a state guardian. R1's sister, V11, has been communicating with us. I don't really need a consent for anything because R1 has been new to our facility. For the short time that R1 was with	F 689		

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F 689	Continued From page 13 us, I did not require any consent for anything. I was aware that R1 had a guardian prior to R1 leaving the facility. I thought that the guardian was one of the family members, not a state guardian, because V11 pretended to be R1's guardian. The face sheet stated that R1 had a guardian, so I knew that R1 had a guardian. We thought that the guardian is a sister, but R1 has a state guardian. R1's face sheet stated that V3 was the guardian. V3 is listed as the guardian but I thought it was the sister, because that's the impression that R1's family created. When I spoke to V3 this morning, that's when I realized that R1 is a ward of the state. V11 (R1's sister) gave us permission for R1 to leave the facility. On 02/23/2022, R1's brother called the facility and said that he is taking R1 out on pass for a few hours. Before the incident, if I knew that R1 had a state guardian, R1 would not have been allowed to leave the facility without V3's consent. So, if I knew that R1 was under state guardianship, R1 would never be allowed to leave the facility. We knew that R1 had a guardian, and we should have never allowed R1 to leave the facility on 02/23/2022 without V3's consent. We were never supposed to release the resident out on pass without V3's permission. When I called V11 (R1's sister) on 03/01/2022, to follow up to where the resident is since the resident never returned, I was told by R1's sister that R1 is at another facility. It wasn't until today (03/30/2022) that I found out that V11 (R1's sister) was impersonating V3 (R1's State Guardian). As of right now, I do not know where the resident is, and R1 has been gone since 02/23/2022, that's over a month. I did not call the police to file a missing person report because R1 was not missing."	F 689		

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F 689	Continued From page 14 On 03/30/2022 at 2:32pm, V12 (R1's Primary Physician) stated, "I was not made aware that R1 has left the facility. Nobody had notified me that R1 has not been at the facility since 02/23/2022. I was not aware that R1 had a state guardian. I did not assess R1 for community pass. R1 had behavioral issues that's why R1 was at the facility. Nobody notified me at all that R1 left the facility on community pass without authorization and never returned back to the facility." On 03/31/2022 at 2:01pm surveyor called the facility/woman's shelter that supposedly R1 was residing and confirmed with V14 (Woman's Shelter Supervisor) that R1 is not residing at the facility and R1 was never a resident of the facility. At 2:05pm, surveyor notified V1 (Administrator) and V7 (Social Service Director) that R1 is not residing at the woman's shelter and R1 was never a resident of the facility. On 03/31/2022 at 2:20pm, V11 (R1's sister) stated, "I was never notified by the facility on 02/23/2022 that R1 was going out on pass with a man. The facility did not call me to obtain a consent for R1 to leave out on pass, because if they would have called me, I would never give them consent to let R1 out, especially with a man. The man who picked R1 up is a drug user. My sister is a heavy drug user, and she sells her body for drugs, so the facility should not have released her out on pass under any circumstances. My sister called on 03/01/2022, stating that she is at a woman's shelter, but I don't know if that was true. A few weeks so, R1 was seen standing on a street corner selling her body, by a cousin of ours. That's the last we have heard of R1. I don't know if R1 is dead or alive and I honestly thought that you are calling me	F 689		

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F 689	Continued From page 15 from the coroner's office to notify me that my sister is dead. The facility dropped the ball, and they are trying to blame me, but I never spoke to anyone on 02/23/2022 about giving my consent to release R1 on pass because I would have never allowed it given R1's history. On 03/31/2022, at 2:33pm, V7 (Social Service Director) stated, "I will call the police and file a missing person report for R1." Social Service Progress note (dated 02/24/2022/effective date 02/23/2022) documents NOTIFICATION NOTE: "R1's brother called the facility to take her out for few hours and will be back to the facility before the next shift of the day. Writer will continue to monitor and document all progress upon her arrival." Social Service Progress note (dated 02/24/2022) documents NOTIFICATION NOTE: "Writer observed that R1 had not returned back to the facility. Writer called the family of R1 to find out what had happened, he verbalized to this writer that they had left the city for Wisconsin, and they would be back on Friday. Writer informed the PRSD of the situation and what the family had verbalized about R1's going to Wisconsin without the notice of the facility. Writer will continue to monitor and document all progress." Social Service Progress note (dated 03/01/2022) documents Notification: Resident's Guardian and sister, V3 said, the resident is at P.G. (woman's shelter) and we should follow up with one of R1's sisters, V11, who was supposed to pick her up last week but never showed up. PSRD (Psychosocial Rehab Director) called the P.G.M. and spoke to the intake person for	F 689		

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F 689	Continued From page 16 women, who claimed that, information on clients cannot be devoid but promised to call the facility back to connect the client with us. Release of Responsibility for Community Pass (dated 02/23/2022) documents that R1 was released out on community pass on 02/23/2022 with an uncle but did not return to the facility. Pass indicates that R1 was released on buddy pass/escort- may only go out with appointed escort/family. Police Report (dated 03/31/2022) documents that on 03/31/2022 R1 was reported missing and has been missing since 02/23/2022. AMA (Against Medical Advice) Policy dated 03/2021 documents: The physician or extender should be notified. Guardianship and Advocacy Commission/The Office of State Guardian (undated) documents: A guardian of the person is appointed by court when a disabled person individual cannot make or communicate responsible decisions his personal care. This guardian will make decisions about medical treatment, residential placement, social services, and other needs. The surveyor confirmed through observation on 04/08/2022, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy: The facility completed all measures on the abatement plan. Therefore, the abatement plan could be approved on 04/07/2022: 1) The facility has taken the following action concerning the IJ component a) R1 is no longer a resident at the facility as of 2/24/22.	F 689		

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F 689	Continued From page 17 b) The facility has filed a missing person report for R1 as of 4/1/22. c) The facility will continue to call local hospitals and WI hospitals to locate R1, Calls initiated on 4/7/22 and will continue thru 4/15/22. 2) Statement regarding residents that have the potential of being affected affect other residents. a) 19 residents in the facility that have guardian have been identified to have potential to be affected. 3) Measures the facility will take or systems to ensure the problems will be corrected and will not recur. a) All residents that have guardian were reviewed on 4/7/22 by PRSD to ensure that none had gone out on community pass without the permission of the guardian. b) All the residents with guardian have notation "OUT ON PASS WITH xxxx name ONLY on their profile sheet (Face sheet) as well as on special instructions on PCC patient care profile implemented on 4/7/22 by PRSD. c) The facility has updated the pass policy/RICMP to include notification of guardian/ State guardian before final approval to proceed on home pass on 4/7/22. d) The facility has developed a tracking sheet for residents on home/community pass on 4/7/22. e) The facility has developed a community/home pass verification process to ensure any residents with guardian has the permission of the guardian before proceeding on pass. PRSD or designee will call guardian to obtain permission from guardian to allow pass with requested person. Process implemented on 4/7/22. f) The facility has reviewed the community pass assessment tool on 4/7/22 by IDT, no changes were made. g) The facility has developed and implemented a	F 689		

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F 689	Continued From page 18 system of notification of State guardian and Guardian for residents leaving out on home or community pass on 4/7/22, monitored by PRSD. h) The facility has compiled a list of all residents with guardian/State guardian and copies placed at all nurse's station and the reception area by the PRSD as of 4/7/22, list will be maintained by SSD/ PRSD or designee. i) The facility has in serviced Facility RN's, LPN's, Psychosocial Staff, Social Services staff, and Reception staff on the updated pass policy/RICMP including notification of guardian for all residents with guardian/ State guardianship. Inservices initiated 4/7/22. j) Facility RN's, LPN's, Psychosocial staff, Social Services staff, and Reception staff were educated on who the resident can go on pass with by verifying the profile information before approval to leave on pass is granted. Inservices initiated 4/7/22. 4) The Director of Nursing or designees will monitor continued compliance via the following Quality Improvement Programs: a) Upon pass request, the PRSD or designee, will ensure that the resident's profile information is checked to ensure resident with guardianship have their guardian contacted before approval is granted. QA tool initiated 4/7/22. b) Upon pass request, The PRSD or designee will ensure that the resident left the facility with an approved person listed on the face sheet. c) Daily the PRSD or designee will ensure that all residents that went on home/community pass are accounted for on the approved date of return. d) The results of the monitoring completed will be submitted to the QA/QI Committee for review and follow-up. Completion Date: 4/08/2022	F 689		

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2) R3's has a medical diagnosis not limited to Catatonic Schizophrenia, Auditory hallucination, bipolar disorder, depression, anxiety disorder, etc. R3's MDS (Minimum Data Set) -BIMS (Brief Interview for Mental Status) score is 2/15 indicating impaired cognitive response. On the section G (Functional Status); Balance during Transition and Walking, notes that R3 as not steady, only able to stabilize with staff assistance. R3 was not in the facility and was admitted to the hospital after sustaining a fall.

On 03/30/2022 at 10:42am, V2(Director of Nursing/DON) said that R3 is currently out of the facility after falling yesterday, (03/29/2022). V2 said that R3 was walking down the hallway towards R3's room when R3 fell, hitting the floor face first. V2 said that the nurse ran to R3 and did an assessment and observed an injury to the mouth. V2 observed a ruptured pallet (upper roof of the mouth), first aid was given to R3. V2 said they were able to control the bleeding and called 911. R3 was sent to the closest hospital. That hospital sent R3 to another hospital which could handle R3 could injury better.
V2 said R3 had another fall on 3/4/2022 and "An employee was passing by the hallway and saw R3 on the floor, The nurse did the assessment and observed that R3 had a laceration to the forehead. R3 was sent by ambulance to the nearest hospital and R3 come back from the hospital with 7 stitches on the forehead."

V2 said the restorative nurse completed R3's the assessments after R3 had a fall on 3/4/2022.

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On 3/30/2022 at 10:30 am, V2 said that V2 is responsible for investigating falls and after R3 fell, V2 made additional fall precaution recommendations. V2 said that additional interventions included R3 wearing nonskid socks while walking. V2 said that when R3 fell, R3 was barefooted. V2 said that CNAs (Certified Nurses' Assistants) are supposed to redirect and assist residents in wearing shoes/nonskid socks to prevent falls.

On 3/30/2022 at 2:50pm, V8 (LPN) said that V8 worked with R3 when R3 first fell on 3/4/2022. V8 said that on that day, restorative nurse V6(LPN) was walking in the hallway and saw R3 on the floor. V8 said that V6 called V8 who checked on R3 and saw blood coming out of R3's head. V8 said that V3 cleaned R3's head and saw a deep cut on R3's forehead. V8 called R3's physician who gave orders for R3 to be sent to the hospital for further assessment, and was sent out of the facility via ambulance. V8 does not remember if R3 was wearing shoes or socks when R3 fell.

On 3/30/2022 at 10:55am, V6(Restorative Nurse/LPN), interviewed via phone. V6 said that he, V6 did R3's restorative assessments on 3/4/22 at about 4pm, before R3 had a fall. V6 said at that time V6 referred R3 to physical therapy. V6 said after R3 come back from the hospital, V6 looked at the nurses notes and assessment. V6 said there was nothing for V6 to change since R3 did not come with any new orders from the hospital. V6 said R3's current orders were continued. V6 said R3's care plan was updated, and R3 was educated on call light use and R3's care plan to be monitored. V6 said that R3 was re-evaluated again on 3/28/2022

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F 689	Continued From page 21 before R3 had another fall on 3/29/2022. On 3/30/2022 at 1:34 pm, V9(Housekeeper) said that on 3/29/2022 at approximately 9:40am to 10:00am, V9 was cleaning a room and was taking the garbage out when V9 heard a thud in the hallway. V9 saw R3 fall to the ground face first and R4 was bleeding from the mouth. V9 called for help. V9 said that R4 usually walks on tippy toes and has a unsteady gait. V9 cannot remember if R4 was wearing nonskid socks or shoes. On 3/31/2022 at 12:39pm, V18(CNA) said that on 3/29/2022 when R3 fell, R3 was walking back and forth on the unit's hallway and was not wearing shoes or socks. V18 said that R3 was required to have shoes and socks on while walking. V18 said that V18 was busy helping with breakfast and did not have time to redirect or encourage R3 to wear shoes or socks. On 3/30/2022 at 2:01pm, V16(Director of Rehab) said that on 3/7/2022, R3 was assessed and evaluated for physical therapy to see if R3 could walk without falling and transfer safely. V16 said that R3 was in physical therapy for gait balance. V16 said R3 needed "someone near R3 when R3 ambulated because R3 was lethargic most of the time because of diagnosis and sleep pattern." On 3/30/2022 at 2:01pm, V17(Physical Therapy Assistant /PTA) said that R3 was always tired and sleepy during physical therapy and PT staff needed to monitor R3 closely while doing physical therapy to prevent falls. V17 said that when physical therapy works with a resident, they document recommendations where the nurse can see it.	F 689		

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F 689	Continued From page 22 On 3/31/2022 at 1:55pm, V15(Physician) said that R3 should have been encouraged to wear shoes and/or nonskid socks and supervised and monitored while walking. V15 said that proper footwear may have prevented the fall. V15 said that R3 was seeing a neurologist for neurological disorders and R3 should have been monitored better. V15 said "Somebody failed R3, or something went wrong somewhere." Progress notes dated 3/5/2022 noted that R3 was transferred back from nearby hospital emergency department for evaluation due to fall. R3 was treated for occipital (back of head) scalp soft tissue injury. Fall Care plan dated 3/5/2022 noted in part that R3 has had an actual fall due to poor balance and unsteady gait, goal was for R3 to resume usual activities without further incident. Interventions for R3 included in part to; monitoring R3's confusion, sleepiness, inability to maintain posture, change in mental status, provide R3 with appropriate footwear (non-skid socks, shoes, slippers) and encourage R3 to wear when out of bed. Physician's orders referred R3 for physical therapy three times per week(3X/week) for balance training, gait training and care giver training. Physical therapy notes dated 3/7/2022, under-Evaluation and Plan of Treatment under Patient Referral and History notes documented that R3 presented with unsteady gait and risk for further falls. On the fall risk assessment section, physical therapy note documented that R3 has fallen in the past and R3 was worried about falling	F 689		

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F 689	Continued From page 23 again. Summary section of the assessments noted in part that R3 had functional, balance and strength impairments and was at risk for falls and further decline in function. Facility Reported Incident Report (FRI) dated 3/4/2022 noted that R3 was observed on the floor and upon assessment, R3 was found to have a laceration on the posterior (back) head. R3 was sent to a nearby hospital for further medical evaluation and treatment. FRI summary noted that R3 returned to facility with 7 staples on posterior head. Conclusion of the FRI report noted that staff will monitor R3 to prevent future falls. FRI report dated 3/29/2022 noted that R3 fell face first in the hallway and sustained a ruptured front palate and was transferred to a nearby hospital for further medical evaluation and treatment. Progress notes dated 3/29/2022 documents that V8 (LPN) received a call from a nearby hospital where R3 has been transferred to after fall. Per note, ER nurse said that R3 was being transferred to another hospital for facial surgery due/to ruptured front palate. Progress notes dated 3/29/2022 noted that a call was received from a nearby hospital where R3 was transferred to and the hospital wanted R3's emergency contact to obtain consent for surgery. Surgery to wire R3's jaws together related to the fall of 3/29/22 that occurred while R3 was at the facility. Fall Assessment dated 3/29/2022 documents: Morse Fall Scale noted R3 has a weak gait and was at moderated risk for falling.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146161	A. BUILDING _____ B. WING _____	C 04/08/2022

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

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F 689	Continued From page 24 Fall Policy dated 4/2020 notes in part that; Upon completion of the fall evaluation, if the resident is identified at risk for falls; the following may occur: 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 resident risk for falls and interventions to prevent falls is provided.	F 689		