

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6001895</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/04/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SOUTHVIEW MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3311 S. MICHIGAN AVE. CHICAGO, IL 60616</b>
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(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  Facility Reported Incident Investigations: FRI of 10-15-22/IL152740 FRI of 10-12/22/IL152724 FRI of 10-15-22/IL152742	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.610a) 300.1210b) 300.1210d)6) 300.3210f)  Section 300.610 Resident Care Policies  a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>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:</p> <p>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.</p> <p>Section 300.3210 General</p> <p>t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on record review and interview the facility failed to follow their abuse policy to prevent resident to resident physical abuse. This failure affected four residents (R1, R2, R3, R4) reviewed for physical abuse. Staff members did not immediately intervene in resident to resident arguments before 4 residents (R1, R2, R3, R4) became physically aggressive and abusive</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>towards their peers: 1. Staff failed to intervene in a timely manner when R1 and R2 were arguing that lead to R1 punching R2 in the face causing swelling to the left eye of R2; 2. Staff failed to intervene in a timely manner when R3 and R4 were arguing that resulted in R3 striking R4 in the head with a wheelchair foot rest. R4 sustained two lacerations to the head. R4 was hospitalized, requiring staples/sutures to two areas of R4's head.</p> <p>Finding Include:</p> <p>1. R1's care plan denotes, "symptoms such as mood swings, impulsive behavior, and attention seeking behavior related to diagnosis of Bipolar Disorder. Monitor for increase signs of signs/symptoms of increased anxiety or change in mood. Provide 1:1 as needed. Date Initiated: 10/05/2022."</p> <p>R1's care plan denotes, "R1 has a history of aggressive, inappropriate, attention-seeking behavior due to R1's mental illness. Intervene when any inappropriate behavior is observed. Communicate assertively that the resident must exercise control over impulses and behavior (Social skills training) Date Initiated: 10/05/2022."</p> <p>On 10/15/2022 at 2:28PM, R1's Behavior Note: DAR Data documents: "It was reported to writer resident was involved in a physical altercation with fellow co-peer at the patio during smoke break. Action: Staff intervened and both were separated from the scene. Writer counseled him to always utilize his coping skills whenever he gets agitated. Police was notified and case number was provided JF**** Response: Resident was receptive to counseling and apologized. Resident is calm at this time. Staff will continue to</p>	S9999			

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S9999	<p>Continued From page 3</p> <p>monitor and document all progress accordingly."</p> <p>On 10/15/2022 at 3:02PM, R2's Behavior Note: DAR Data documents: "It was reported to writer resident was involved in a physical altercation with fellow co-peer at the patio during smoke break. Action: Staff intervened and both were separated from the scene. Charge nurse notified primary doctor who ordered that resident should be monitored for 48 hours as a result of the swollen face. ADMINISTRATOR, D.O.N AND PRSD was made aware. Police was also notified and case number was provided JF**** Response: Resident is calm at this time. Staff will continue to document and monitor all progress accordingly."</p> <p>On 10/15/2022 at 3:06PM, R2'S Daily Note Text documents: "It was reported per staff that his left eye is swollen with no drainage or opening Dr. T.O. (telephone order) Monitor for 24hrs contact me if there are any changes."</p> <p>10/15/2022 at 9:45PM, R2's Daily Note Text documents: "Resident was received with a swollen left eye. Ice was applied to reduce swollen. Swelling has decreased with no drainage or discharge noted. Resident denies pains and is currently in room sleeping. Staff will continue to monitor."</p> <p>Facility's final report of abuse investigation of incident 10/15/22 it was reported that R1 was physically inappropriate with peer R2.</p> <p>On 11/1/22 at 12:20 PM, V3 (Licensed Practical Nurse) stated she has worked at the facility for ten years and R1 and R2 are assigned to her. V3 stated R1 has only been in the facility a few months as for R2, R2 has been in the facility for several years. V3 stated V3 was working on the</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>floor on 10/15/22 when a resident came up and told her that R1 hit R2 while they were on their smoke break. V1 stated asked R1 what had happened and R1 told her that R2 was talking about his girlfriend and R1 hit R2. V3 asked R2 what happened and R2 did not deny making disparaging remark about his girlfriend. V3 stated V3 told R1 that his response was inappropriate and that he was to walk away when he felt himself getting mad. V3 stated R1 apologized to R2 for hitting him and R2 apologized to R1 for speaking badly about R1's girlfriend. V3 stated V3 assessed R2 and noted he had a slightly swollen left eye. V3 called the doctor for both residents and obtained an order to monitor both residents and if any further incidents or escalation by R1 to give R1 Lorazepam (anti anxiety medication)</p> <p>On 11/1/22 at 12:40 PM, V4 (Activity Aide) stated he worked at the facility for eight years. V4 stated on 10/15/22 V4 was inside the smoking patio passing cigarettes. V4 stated V4 went outside onto the patio and saw R1 and R2 arguing then V4 separated them. V4 stated another resident told him that R1 and R2 had been fighting. V4 stated V4 asked R1 what had happened and R1 explained to him that R2 told him he "F*** his girlfriend and was going to take her." V4 stated R1 explained to him that when R2 spoke bad about his (R1's) girlfriend R1 punched R2. V4 stated he escorted R1 back to the floor to his nurse.</p> <p>On 11/1/22 at 12:50 PM, R1 stated he was on the smoking patio when R2 told him that he(R1) was going to take his(R1's) girlfriend from him(R1). R1 stated R1 told R2 to stop talking to his(R1's) girlfriend then R2 told him that he(R2) was going to "FU** his(R1's) girlfriend." R1 stated he got upset because R2 kept saying</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>he(R2) was going to take his(R1's) girlfriend and he(R1) asked R2 to stop saying those things but R2 would not stop so he(R1) punched R2. R1 stated the counselors told him(R1) about getting jealous and he(R1) was upset over his(R1's) girlfriend and has to control his(R1's) anger. R1 stated R1 was no longer upset with R2 and does not want to fight him(R2).</p> <p>On 11/1/22 at 1:15 PM, R2 stated he and R1 got into an argument over a girl. R2 stated R2 told R1 that he(R2) "did get into his(R1's) girlfriend panties and slept with her." R2 stated after telling R1, he(R2) was going to "FU** his(R2's) girl they got into a fight." R2 stated R1 got the best of him(R2) and R1 hit him(R2) in his(R2's) left eye. R2 stated the counselor told him(R2) not to talk to R1 about his(R1's) girlfriend and R2 agreed to do that. R2 stated his(R2's) left eye was a little swollen but now the swelling has went away. R2 stated his vision is okay and his eyes are fine.</p> <p>On 11/1/22 at 12:45 PM, R5 stated he lived in the facility for five years. R5 stated R5 was on the smoking patio and saw R1 and R2 fighting. R5 stated he got V4 and V4 separated both of the residents.</p> <p>On 11/1/22 at 11:50 AM, V1 (Psych Social Rehab Director)) stated she has been the director for three years. V1 stated R1 has been a resident at the facility five months and R2 been a resident at the facility for 10 years. V1 stated R2 can be delusional but is a "sweet little guy and does not start trouble with anyone. V1 stated since R1 came he has been immature and anxious at times." V1 stated R1 had a girlfriend in the facility and is preoccupied with her and they are always together. V1 stated residents have a right to have safe intimate relationships.</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>V1 stated 10/15/22 the nurse(on duty) called her(V1) at home and reported that R1 and R2 got into an altercation. V1 stated the counselor reported that R1 and R2 were talking when R2 told R1 that he slept with his(R1's) girlfriend. V1 stated the nurse reported that R1 responded by smacking R2 in the face. V1 stated the police, family and doctor were called. V1 stated R1 was placed on one to one, was given a certain medication for high anxiety and counseled on anger management. V1 stated R2 did not sustain a serious injury from R1 hitting him(R2) and R2 received one to one monitoring by staff . V1 stated when staff hear/see residents arguing they need to intervene immediately to try to prevent an argument from escalating into a physical altercation.</p> <p>On 11/3/22 at 2:30 PM, V7(Doctor) stated R2 sustained no permanent damage to his eye/vision just some swelling under his left eye when he was hit by the other resident(R1). V7 stated R2 sustained no serious injury to his left eye and the swelling has gone away.</p> <p>2. 10/12/2022 3:55 PM R3's Incident Note Text documents: "Resident(R3) became agitated went to peer's(R4's) room. R3 started verbal and physical altercation with him(R4). Upon hearing the noise (the nurse and CNA) ran toward the room(R4). Resident(R3) had taken the wheelchair foot rest from resident(R4). R3 hit him(R4) on the head with on his(R4's) own wheelchair foot rest. Resident(R3's) body checked with no sign of physical injury noted. His(R3's) attending Psych and Physician was notified, ordered transfer resident(R3) to Hospital for direct admission for psych evaluation. The</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>ambulance was notified said will be in about 120 minutes."</p> <p>10/12/2022 at 3:55pm, R4's Daily Note Text documents: "Resident(R4) was noted with noise coming out of his room both nurse and CNA were rushing toward the room when noted they(R3 and R4) came out in hall way. Resident(R3) had wheelchair foot rest in his hand. Co-resident(R3) took the foot rest out of his(R4's) hand and hit him(R4) on his(R4's) head. R4 received two; lacerations of about two inches to top of (R4's) head and back of R4's head noted bleeding. Resident(R4) said that co resident(R3) came into his(R4's) room to border him(confusing statement from resident) and we started argument. He(R3) hit me(R4) on the head with that thing. Resident's(R4's) bleeding to top and back of head controlled. Dry dressing applied to lacerations. Resident(R4) refused vital signs due to agitation. Neuro signs checked noted normal. R4 sent to Hospital Er. for evaluation."</p> <p>10/12/2022 21:15 R4's Daily Note Text documents: "Resident(R4) returned from Hospital ER. had evaluation done. Noted with 4 staples to suture line to top of head and 6 staples to laceration to back of head. Areas noted closed and intact Alert and oriented X 4. C/o no pain or discomfort. No sign of bleeding or swelling to suture lines. V/S T 98.2 R 18 P 80 B/P 132/80. Received HS meds. Currently in bed laying down awake watching TV. Neuro signs checked noted normal. Remain closely observed."</p> <p>R4's emergency room discharge instruction dated 10/12/22 denotes, "chief complaint: Laceration of head; head injury. Laceration is a cut that goes through all layers of the skin and into the tissue just beneath the skin. Your caregiver will use the</p>	S9999		



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S9999	<p>Continued From page 8</p> <p>stiches, staples or adhesive strips to repair the laceration. Keep the wound clean and dry. You have a head injury that does not appear serious at this time. You should not take sedatives or alcoholic beverages for long as directed by your caregiver after discharge."</p> <p>Facility's final report of abuse investigation denotes dated of incident 10/12/22, R3 was physically inappropriate with co-peer (R4) in the 6th floor hallway.</p> <p>On 11/2/22 at 9:55 am, V6 (Licensed Practical Nurse) stated he has worked at the facility for ten years and has taken care of both R3 and R4. V6 stated V6 was at the nurse's station when he heard a commotion coming from R4's room. V6 stated V6 went down the hall towards R4's room then saw R3 and R4 coming out of the room of R4. V6 stated as he was heading towards them, (V6) saw R3 take a wheelchair foot rest out of R4's hands and hit R4 over the head with it. V6 stated after R3 hit R4, V6 was able to separate both residents and provide R4 with first aide. V6 stated V6 noticed R4 had a laceration on his head that was bleeding. V6 stated (V6) cleaned the laceration and applied a clean dressing to R4's head.</p> <p>V6 stated he(V6) asked R4 what happened and R4 told him that R3 came in his(R3's) room and asked R4 to leave but R4 wouldn't leave so grabbed his foot rest and pointed it at R3.</p> <p>V6 stated (V6) asked R3 what happened and was told by R3 that he was going to talk to R4 in his room when R4 grabbed the foot rest of his(R4's) wheelchair as to threaten him. V6 stated R3 told him he(R3) grabbed the leg rest from R4 to protect himself. V6 stated both resident doctors</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>were called and they(R3 and R4) were sent to the hospital. V6 stated upon return from the hospital, R4 noted with 4 staples to the front of his head and 6 staples to the back of his head. V6 stated R4 has history of pulling his leg rest off his wheelchair when he feels threatened by other residents but usually staff are able to intercept (R4) from hitting other residents or getting hit by other residents. V6 stated R3 is a tall guy that keeps to himself most of time. R3 had a decent relationship with R4. V6 stated before that incident R3 and R4 had never been in any altercation with each other before.</p> <p>On 11/1/22 at 2:55 PM, V5 (Certified Nurse Aide) stated V5 was working on 10/12/22 the 3-11 shift. V5 stated before dinner (V5) was getting ice when (V5) heard a commotion coming from R4's room. V5 stated V5 stopped what V5 was doing, went towards R4's room and saw R4 on the floor outside (R4's) room after getting hit on (R4's) head by R3. V5 stated R3 used R4's own wheelchair leg rest to hit R4. V5 stated both residents(R3 and R4) were separated and both residents sent out to the hospital.</p> <p>V5 stated R4 has a history of when (R4) gets upset, (R4) will take his leg rest off (R4's) wheel chair and wave it at other residents but never hits anyone with it. V5 stated (V5)thinks that R4 pulled the leg rest off (R4's) wheelchair and R3 took it(wheelchair leg rest) from R4 and hit (R4) with it. V5 stated R3 was a long-term resident that does not go around attacking others and is not known to be an aggressive resident. V5 stated that was the first time seeing or hearing of R3 getting so upset that he hit another resident with an object.</p> <p>On 11/1/22 at 11:50 am, V1 (Psyche Social Rehab Director) stated she had been the director</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>for three years and R3 has been a resident at the facility for over five years. V1 stated R3 is uncooperative at times, into his own delusions and responds to internal stimuli. V1 stated on 10/12/22 she was in the building and was told that R3 got into a fight with R4. V1 stated she called 911 and the nurse called the MD to get order to send R3 out for psych eval. V1 stated she asked R3 what happened and R3 told her that "R4 killed the officers in the gang and that made him upset." V1 stated (V1) asked R3 if he hit R4 and R3 denied hitting R4 with the foot rest. V1 stated R4 has history of being verbally abusive towards his peers/residents. V1 stated R4 uses the wheelchair to get around. V1 stated R4 is not physically aggressive but can say things that are inappropriate. V1 stated when staff hear/see residents arguing they need to intervene immediately to try to prevent an argument from escalating into a physical altercation.</p> <p>On 11/3/22 at 10:30 AM, V2 (Administrator) stated they do not want anyone to be a victim of abuse in the facility. V2 stated the goal is to prevent all forms of abuse.</p> <p>On 11/3/22 at 2:30 PM, V7 (Doctor) stated R4 sustained a laceration to his head however the injury he sustained was not a serious injury according to the medical field. V7 stated a laceration does not cause harm to the person body and will heal with proper care. V7 stated a laceration will not leave any lingering harmful effects after it has healed.</p> <p>Facility's abuse prevention policy(undated) denotes: "affirms the right of our residents to be free from verbal, physical, neglect, misappropriation of property or mistreatment. The purpose of this policy is to assure that the facility</p>	S9999		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6001895</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/04/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTHVIEW MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3311 S. MICHIGAN AVE. CHICAGO, IL 60616</b>		
(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 11  is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property or mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. This will be done by establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The facility desires to prevent abuse, neglect, exploitation, mistreatment and misappropriation of resident property by establishing resident secure environment. This will be accomplished by a comprehensive quality management approach."  (B)	S9999			