

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001895	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/20/2025
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Investigation of Facility Reported Incident of March 2, 2025/IL188061 Investigation of Facility Reported Incident of March 6, 2025/IL188065	S 000		
S9999	Final Observations Statement of Licensure Violations 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	S9999		

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/09/25

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001895	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/20/2025
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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 failed to provide a safe environment by not protecting four residents from physical abuse. This failure affected 4 residents (R1, R3, R4 and R5) out of six reviewed for physical abuse. This failure resulted in R5 sustaining a black eye and verbalizing being fearful of being around the perpetrator. Findings include: 1.) R1 is 56-year-old with diagnosis including but not limited to: manic episode, schizophrenia, hypertensive heart disease and umbilical hernia. R1 has a BIMS (Brief Interview of Mental Status) score of 15, indicating cognitively intact. R1's Care Plan documents, R1 has a history of aggressive behaviors; R1 is at risk for abuse; monitor R1 behavior to prevent predisposition to abuse. 2.) R5 is 63-year-old with the following diagnosis: paranoid schizophrenia, anemia, schizoaffective disorder and other symptoms and signs involving appearance and behavior. R5 has a BIMS (Brief Interview of Mental Status) score of 13, indicating cognitively intact. R5's Care Plan documents, R5 has a history of aggressive behaviors; R5 is at risk for abuse; monitor R5 behavior to prevent predisposition to abuse. On 3/17/2025 at 10:26 AM, V1 (Administrator) said that R1 and R3 were both hospitalized for psychiatric evaluations after assaulting another resident in the facility and that R1 will be returning to the facility today. V1 state R5 sustained a black	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001895	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/20/2025
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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 eye from the incident that took place with R1, but R5 said that he didn't need to go to the hospital. The doctor was notified and R5 has been monitored daily by nursing. On 3/17/25 at 1:05 PM, V12 (Licensed Practical Nurse/LPN) said, "R1 is very paranoid and delusional. He (R1) had accused R5 of calling him a N***** and began to punch him (R5). " On 3/17/25 at 1:07 PM, R5 said, "I don't feel safe with R1 on this unit. He knocked me on the floor, had his knee on my head and kept hitting me for no reason. I didn't call him N***** that day. He always bothers me for no reason." On 3/19/25 at 11:00 AM, R1 said, "I hit R5 because he called me a N*****". On 3/19/25 at 11:15 AM, V3 (Director of Nursing/DON) said that there were several forms of abuse including: physical, verbal, sexual, seclusion, emotional, and misappropriation of funds. (State Surveying Agency) Incident Report form dated 3/6/25 documents, R1 was observed to have approached resident R5 on the fourth floor while exhibiting behaviors. While staff attempted to intervene and redirect the residents, R1 extended his fist towards R5 striking him in the face. This altercation resulted in visible bruising to both sides of R5's face. Facility Incident Report Statement dated 3/6/25 and authored by R5 documents, I (R5) was coming from the first floor when R1 saw me in the hallway and grabbed me and started punching me in the face.	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001895	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/20/2025
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Facility Incident Report Statement dated 3/6/25 and authored by V8 (Psychiatric Rehabilitation Services Coordinator) documents, I (V8) was in the office when I heard noises, and I stepped out to check what was going on. I saw R1 punch R5 in the face. Police report dated 3/6/25 documents R5 as the victim of a simple battery. R5's progress note dated 3/8/25 by V27 (LPN) documents, it was noted he (R5) had some discoloration and mild swelling to his right eye. R5's progress note dated 3/9/25 by V7 (LPN) documents, R5 was noted with darkening and swelling under right eye. R5's skin note dated 3/15/25 documents, R5 has a darkened area under right eye. 3.) R3 is 30-year-old with diagnosis including but not limited to: schizoaffective disorder, schizophrenia, extrapyramidal and movement disorder, unspecified psychosis, and violent behaviors. R3's Care Plan documents, R3 has a history of aggressive behaviors; R3 is at risk for abuse; monitor R3 behavior to prevent predisposition to abuse. 4.) R4 is 58-year-old with diagnosis including but not limited to: schizoaffective disorder, lack of coordination, schizophrenia, unspecified psychosis, major depressive disorder, and asthma. R4's Care Plan documents, R4 has a history of aggressive behaviors; R4 is at risk for abuse; monitor R4 behavior to prevent predisposition to	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001895	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/20/2025
NAME OF PROVIDER OR SUPPLIER SOUTHVIEW MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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 abuse. On 3/19/25 at 12:07 PM, R4 said that he had asked R3 to stop walking toward him (R4) punching the air, but R3 kicked him (R4) and that they started fighting. On 3/20/25 at 10:04 AM, surveyor asked V26 (Nurse Practitioner) if it was acceptable for any resident to hit another resident. V26 said, that it is not ok for a resident to hit another resident because it could be considered physical abuse. (State Surveying Agency) Incident Report form dated 3/2/25 documents, in a moment of anger R3 kicked R4, leading to a physical altercation in which R4 punched R3 back. Facility Incident Report Statement dated 3/2/25 and authored by R3 documents, I (R3) was frustrated people telling me not to walk by their room in the hallway. R4 was one of the people telling me not to walk by his room so I was angry, and I kicked him first and he punched me, and we started fighting. Police report dated 3/1/25 documents R4 as the victim of a simple battery. Facility policy titled Abuse documents, this facility affirms the right to our residents to be free from verbal, physical, sexual, mental abuse, neglect, exploitation, misappropriation of property, involuntary seclusion, or mistreatment. "B"	S9999		