STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146161	A. BUILDING _____ B. WING _____	**07/30/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the right to be free from abuse for one of three residents (R1) reviewed for abuse in a sample of 21. This failure affected R1 who provided proof that she was being sexually abused by two staff members. Findings include: On 7/27/20, R1 was no longer residing at the facility, review of R1's face sheet showed that she was admitted [DATE] with [DIAGNOSES REDACTED]. On 7/27/20 at 10:06am, V21 SSD (Social Services Director) was interviewed in the conference room. V21 stated, R1 left the facility through the bedroom window on the 2nd floor unauthorized saying she was fed up with the pandemic COVID - 19, that resulted in a lock down by the State Governor. V21 stated when V1 (Administrator) informed R1 that before she can return to the facility she would have to go to the local hospital to be tested for Covid-19 and upon return would have to be isolated for 14 days for monitoring. R1 became aggressive demanding for her belongs and R1 informed V1 that she was sexually assaulted by staff members and had been having sexual contact with two staff members identified as V19 and V20 PRSA (Psychologist Rehabilitation Services Assistance). R1 stated she had a proof that she presented to V1 and both staff were immediately suspended pending investigation and after the investigation both V19 and V20 were terminated. On 7/29/20 at 11:12am, V1 confirmed that when R1 returned to pick up her belongings, R1 alleged that V19 and V20 were sexually inappropriate with her, sex texting and actual sexual contact. V1 provided the proof of texting and pictures which was sent to the cooperate office. V1 stated both staff were immediately suspended pending investigation. V1 explained that the facility HR (Human Service Record) was able to prove that the text and the pictures was sent from the V19 and V20's phone number listed on their record. V1 stated V19 and V20 were terminated. When the surveyor asked whether this behavior is accepted from employees, V1 replied No, No there should be no sexual contact of any kind with our residents. V1 stated the police and IDPH was notified. According to the facility investigation documentation, on 4/5/2020 V1 documented that, R1 gave a witness statement that V20 called her stating that V20 paid her $50.00 to a perform oral sexual act on him and was afraid afterward when V20 kept approaching her with a request for the same sexual act. The facility concluded after investigation that R1 had a consensual inappropriate interaction with V19 and V20. V1 documented that there was no other facts that determined to support that any other form of abuse occurred. Review of the employee report form presented dated 4/10/2020 documented that V19 and V20 were both terminated for inappropriate sexual interaction with a resident. On 7/30/20, V1 explained that she reached the conclusion that it was not abuse because the local police department did not treat the incident as sexual abuse because money was exchanged. On 7/30/20 after V1 reviewed the facility policy on abuse that was presented, V1 then stated after reading the abuse policy, it was sexual abuse and that is why both V19 and V20 were terminated. The facility policy on Abuse Prevention Program dated 02/07/2017 stated that the willful in the definition of abuse means the individual must have acted deliberately not that the individual must have intended to have inflict injury or harm. The policy also documented that sexual abuse includes, but not limited to a resident for personal gain through the use of sexual harassment, sexual coercion, or sexual assault. The policy also pointed out that exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation threats or coercion.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review, the facility failed to ensure the supervision was put in place for one resident (R1) in the sample. This failure affected R1 who escaped from the facility through the window. Findings include: On 7/27/20, R1, who is no longer residing at the facility, on review of R1's face sheet showed that she was admitted [DATE] with [DIAGNOSES REDACTED]. R1 eloped from the facility through the bedroom window on 4/4/20 without any staff knowledge. On 7/27/20 at 10:06am, V21 PSD (Psycho-social Services Director) was interviewed in the conference room. V21 stated, R1 left the facility unauthorized saying she was fed up with the pandemic COVID - 19 that resulted in a lock down by the State Governor. V21 explained that when R1 was found, V1 (Administrator) informed R1 that before R1 could return to the facility she would have to go to the local hospital to be tested for Covid-19 and upon return would have to be isolated for 14 days for monitoring. R1 became aggressive demanding her belongings. V21 stated R1 refused to sign AMA papers and left without belongings. V21 stated that R1 returned later to the facility and the belongings were given to her. On 7/27/20 at 11:12am, V1 confirmed V21 statements and added that R1 returned to the facility to pick up her belongings and refused to sign AMA. V1 explained that R1 eloped through the window and the staff on duty at the time did not follow the rounds policy by making rounds every two hours to make sure the residents were monitored for safety. V1 stated when investigated, the staff V25 CNA (Certified Nurse's Aide) V26 RN (Registered Nurse), V27 and V28 (Safety Coordinator)'s were not aware that R1 was gone until the morning when R1 did not show up to smoke at 6am, and the staff involved were disciplined for not following the facility policy on safety rounds. On 7/27/20 at 1:00pm, R1's bedroom window was noted with a paper board covering to the frame of the window, V4 (Maintenance Director) stated it was nailed down with a dry wall screw until the facility can get it replaced. On 7/30/20 at 1:10pm, V25 (CNA) stated she made her rounds at the beginning of the shift. V25 stated she did not know the resident (R1) was gone until the morning. The facility policy on Routine Resident Checks presented documentation that To ensure the safety and well-being of our (referring to the facility) residents, the resident check will be made at least every two hours throughout each 24 hour shift by nursing personnel. The facility policy for position titled CNA (Certified Nurse's Aide) pointed out under Duties/Responsibilities/ Function to make rounds on assigned wing(s) /units (s) no less than every two hours.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation, interview and record review the facility failed to provide safe, sanitary and comfortable environment for one (R1) of two residents reviewed for safety. This failure has the potential to affect all the 19 residents residing on the 2nd floor Findings include: On 7/27/20 at 1:00pm to 1:28pm, during environmental rounds with V1 (Administrator) and V4 (Maintenance Director) on the 2nd floor, the following was observed: R1's bedroom window while she was residing in the facility was noted with a paper board covering to the frame of the window, V4 (Maintenance Director) stated it was nailed

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 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) down with a dry wall screw till the facility can get it fixed. Rooms 226, 227 and 228 were noted with missing windows and the windows were covered with paper board nailed down with drywall screws. When the surveyor asked V4 whether the screws can easily be removed, V4 replied Yes. V4 explained that R1 got out from the building through that window and broke the window. On 7/30/20 both V1 (Administrator) and V4 were unable to provide work order for the windows. The facility job description for the Maintenance Supervisor presented documented that the purpose of the position includes but not limited to ensuring that the facility environment, grounds and equipment is maintained in good, safe operating order.