

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 02/06/2017
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NAME OF PROVIDER OR SUPPLIER SOUTHVIEW MANOR NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3311 S. MICHIGAN AVE. CHICAGO, IL 60616
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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
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S 000	Initial Comments COI 1780540/IL91370	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6 300.3240a) 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 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. 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.	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

02/17/17

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S9999	<p>Continued From page 1</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on interviews, record review and incident report review, the facility failed to safely provide bed mobility for 1 of 3 residents (R1) reviewed for staff assistance for bed mobility. This failure resulted in R1 rolling out of bed onto the floor requiring hospitalization and being treated for an Oblique Fracture involving proximal portion of Left Femur with minimal displacement.</p> <p>Findings include;</p> <p>In review of the Incident and Accident log, the facility did have a report dated 1/12/17. This incident was reported to the Illinois Department of Public Health in a timely manner, R1 was sent out to the Hospital on 2-2-17 at 11:00 a.m. for Shortness of Breath. Not able to be interviewed.</p> <p>R1 was admitted to facility on 7/24/11 and re-admitted on 1/21/17. R1 is 81 years old. Diagnosis includes Parkinson Disease, Altered Mental Status, Muscle Weakness, Hypotension, , Malaise Dysphasia, Hearing Loss, Cerebella Stroke Syndrome .</p> <p>A review of the investigation Report for Fall indicated that on 1/12/17, while E3 (Treatment Nurse) was administering treatment to the resident in company of E4 (Certified Nurse Aide), it was noticed that the residents roommate</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>attempting to roll out of bed and both rushed to prevent the roommate from falling. During the period R1 rolled out of bed and fell. Z3 (Physician) was notified and gave an order to transfer R1 to the Hospital for medical evaluation and possible treatment. The order was carried out with R1 transferred to Hospital. R1's family was notified.</p> <p>Interview was conducted with E3 (Treatment Nurse), 2/6/17 at 10:30 a.m. in Conference Room. E3 stated she was the Nurse giving treatment with getting help from E4 (Certified Nurse Aide) when R1 fell out of bed. E3 indicated that R1's bed was waist high when both E3 and E4 observed roommate from rolling out of low bed. Both E3 and E4 ran to prevent roommate from falling when R1 then rolled out of bed falling to fall.</p> <p>Interview was conducted with E4 (Certified Nurse Aide), 2/6/17 at 10:45 a.m. in Conference Room. E4 stated that Both E3 (Treatment Nurse) and self, observed R7 rolling out of low bed .Both left R1 to attend to roommate when R1 rolled out of bed.</p> <p>Interviews were conducted with E1 (Administrator) and E2 (Director of Nursing) indicated that the fall for R1 was an accident.</p> <p>On 1-12-17 R1 was transferred to Hospital for further evaluation and treatment. Follow up call to the Hospital and X ray result received from the Hospital revealed that R1 sustained a suspicion of oblique fracture deformity involving proximal portion of left femur with minimal displacement. Hospital record was obtained.</p> <p>According to the hospital record dated 1-12-17</p>	S9999		
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S9999	Continued From page 3 CT scan exam indicates R1 was involved in a fall incident, and the exam resulted in a fracture involving the left proximal humeral shaft with intramuscular hematoma and soft tissue swelling. Displaced fracture is also seen at the tuberosity with overlying subcutaneous contusion. Vertebral hemangioma is suggested at the L4 and S1 level. (B)	S9999		
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