IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

March 06, 2019

Michelle Bush, Registered Agent
Southpoint Nursing and Rehabilation Center, LLC
240 Fencl Lane
Hillside, Illinois 60162

RE: Complaint #: IL0108311
Survey Date: January 08, 2019
Docket #: 19-C0072
Violation Type: Level B

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Southpoint Nrsg & Rehab Ctr.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Enclosure
cc: Administrator
File
Southpoint Nrsg & Rehab Ctr/January 08, 2019//RegAgent/S.Geer

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. SOUTHPOINT NURSING AND REHABILATION CENTER, LLC, D/B/A, SOUTHPOINT NRSG & REHAB CTR, Respondent.	))))))))))	Docket No. NH19-C0072

NOTICE OF TYPE "B" VIOLATION(S); NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "B" VIOLATION(S)

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint IL0108311 Investigation conducted by the Department on January 08, 2019, at Southpoint Nrsg & Rehab Ctr, 1010 West 95th Street, Chicago, Illinois 60643. On March 04, 2019, the Department determined that such violations constitute one or more Type "B" violations of the Act and the Skilled Nursing and Intermediate Care Facilities Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in the Summary of Licensure Violation which is attached hereto and incorporated herein as Attachment A and made a part hereof.

A Type "B" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.

2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$ 2,200.00**, as follows:

Type B violation of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210a), 300.1210b), 300.1210c), 300.1210d)2)3)6) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)6) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
525 West Jefferson, 5th Floor, QA
Springfield, Illinois 62761

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department.

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license; the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of "B" Violation(s); Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation. (Please refer to the Notice of Fine Assessment section on where to send your fine Payment).

Plan of Correction, Hearing Requests and Waivers can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulation

Dated this 06th day of March, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. SOUTHPOINT NURSING AND REHABILATION CENTER, LLC, D/B/A, SOUTHPOINT NRSG & REHAB CTR, Respondent.	)	Docket No. NH 19-C0072

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "B" Violation(s); Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Michelle Bush
Licensee Info:	Southpoint Nursing and Rehabilation Center, LLC
Address:	240 Fencl Lane Hillside, Illinois 60162

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 06th day of March, 2019.

Sammye Geer
Administrative Assistant I
Long Term Care – Quality Assurance
Office of Health Care Regulations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014781	A. BUILDING: _____ B. WING _____	C 01/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHPOINT NURSING & REHAB CENTER	1010 WEST 95TH STREET CHICAGO, IL 60643

(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 Complaint Investigation #1898360/IL108311	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2)3)6) 300.3240a) 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. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999	**Attachment A** **Statement of Licensure Violations**	

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resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning.
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.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
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:
2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
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.
Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

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These requirements are not met as evidenced by:
Based on interview and record review, the facility failed to follow and implement a physician-prescribed psychosocial care plan for a resident with serious mental illness to safeguard a resident from self harm. This failure affects one of three residents (R1) reviewed for care plans from a sample of 3 residents.

Based on interview and record review, the facility failed to protect and prevent physical abuse on a resident with serious mental illness from a visitor who inflected bodily harm to R1 on two separate occasions. This failure affected one of three residents (R1) reviewed for abuse/neglect from a sample of 3 residents who was emergently transferred to the hospital for treatment of injuries on 1 of the 2 occasions.

Findings include:

R1 is a 26 year old with diagnoses of schizophrenia, muscle weakness, bipolar disorder, absence of right leg below knee, abnormality of gait, hypertension, alcohol abuse, conduct disorder, major depressive disorder and psychoactive substance dependence.

Review of incident reports show two altercations involving R1 and an unknown visitor occurring on 12/22/18 and 12/24/18 with one of the incidents in which R1 required medical attention for his injuries.

12/22/18 Nursing progress note states, "Resident had a physical altercation with a visitor. A complete body assessment performed denoting laceration to left upper lip and forehead. Body assessment and first aid provided by wound care

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nurse. 911 notified. Police report. Resident currently at hospital being evaluated."

12/22/18 Nursing progress note states, "Writer received report from hospital. Resident will be returning to facility and refused sutures however, agreed to bond glue to laceration area."

Hospital Emergency Department records dated 12/22/18 shows, "Patient has observable signs of abuse. Patient here from Nursing Home for complaints of being intoxicated and getting in an altercation with a visitor at the nursing home. Per patient he was punched in the face by a visitor and then got in a fight with the man. Patient admits to drinking around 8 beers today. Patient arrived combative, screaming at staff. Security at cart side with patient. "

12/24/18 Nursing progress note states, "Reported by staff, resident was in physical altercation with a visitor." Per the progress note, the resident did not sustain any injuries on this occasion. Resident (R1) decline to be sent to the hospital for evaluation

On 12/24/18, R1 was sent to the hospital for an emergency psychiatric evaluation. After being evaluated, R1 was later transferred to an alternate facility for safety.

Interview with V1 (Administrator) on 1/7/19 at 11:30 AM states, "I did an investigation and there was a visitor that had an altercation with R1 but I did not see any of it. It was a really busy day and a lot was going on." Asked who the unknown male visitor who hit R1, V1 stated, "I don't know who he was." Asked if they tried to determine the identity of the visitor, V1 stated, "No." Asked if the visitor was the same gentleman involved with

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both altercations with R1, V1 stated, "I believe he was."
Asked if they had security on the premises, V1 stated, "Yes, we have a guy and he's here from 8:00 PM to 8:00 AM but this incident happened in the afternoon.

Interview with V2 (DON) on 1/7/19 at 11:45 AM states, "I did not actually see the visitor. The previous director of nursing was present in the room and I heard her shouting for everyone to come and help with the commotion. I heard the previous director of nursing tell the unknown visitor to stop hitting R1 and he did. When I got to the room the altercation had already ended. I think you are getting the incidents mixed up because there were two incidents when R1 got into some altercation with an unknown visitor. The first one happened over the weekend (12/22/18) and the second one happened on Christmas eve." Asked who this unknown visitor was, V2 stated, "I have no idea who he was. I can describe him to you but I don't know who he is. I just know he signed in as some other guest and I saw him get off the second floor." Asked if the visitor was the same person involved in both altercations, V2 stated, "Yes." Asked if there were any efforts to identify the unknown visitor or prohibit the visitor from returning, V2 stated, "No but I know that we never saw him again."

Interview with V3 (Social Service Director) on 1/7/19 at 2:00 PM states, "There was one altercation involving (R1) on the weekend so I wasn't here to witness that one. The other happened during the week a couple days later, I think on Christmas eve. I don't know who the person was that hit R1 but I know he was visiting someone else in the facility. The visitor got on the elevator and went to the second floor. (R1's)

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room is on the first floor. I have no idea who this visitor was but I was told he was just hitting (R1)'s face. I saw that it was red but I did not see any injury on him, the nurses took care of that. The visitor was a tall African American man but I don't know his name or anything like that. I know (R1) did not have any privileges to go out on pass due to his history of intoxication." Asked if there were any instructions given to her by administration to ban the unknown visitor from returning, V3 stated, "Not that I was informed of." Asked why R1 was no longer in the facility, V3 stated, "We met with (R1) and his sister because the sister did not feel like (R1) was safe here although we tried to assure her it was. (R1) is at our sister facility."

Interview with V4 (Psychiatrist) on 1/8/19 at 10:25 AM states, "I am currently seeing him at his other facility now. I also saw him while he was at his last facility. They (facility staff) told me about the incident there but I did not know it happened two times. They said what happened was about a week or so ago. He went out on pass I think and came back intoxicated that is why I will be restricting his privileges here." Asked if he was told as to how (R1) sustained his injuries, V4 stated, "they said it was some visitor." Asked if R1 should have been monitored more closely or not given privileges to go out based on R1's history of alcohol abuse, V4 stated, "Yes you are correct. We should not have allowed him out to begin with and when he came back inside, should have been monitored more closely otherwise this would not have happened to him twice." V4 added that R1 should be placed in a group home instead of where he currently resides for appropriate treatment."

Interview with V5 (security guard) on 1/8/19 at 1:06 PM states, "My hours there at the facility is

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from 8:30 PM to 5:30 AM. I'm just part time. The administrator told me you'd call but I already told her I didn't see what happened with (R1). I don't know who that person is that came in that hit (R1), I just heard about it." Asked what instructions he received for visitors when they came in, V5 stated, "Well before, they'd just sign in but from now on ever since that happened with R1, I'm supposed to look at their picture I.D."

Comprehensive care plan dated 10/22/18 states, "The resident (R1) has a diagnosis and history of severe mental illness. Symptoms are manifested by: Display of known risk factors, poor safety awareness, aggressive behavior, self-harmful behavior, and/or possible victimization. Observe medical/psychiatric/cognitive conditions that may require on-going assessment, consultation and intervention such as personality disorder symptoms; A concomitant substance abuse disorder. Approaches/Interventions: Minimize risk factors through interventions such as assessment, team consultation, supervision, observation."

R1's active physician orders as of 12/7/18 show that resident may only go out on pass with family and medications as ordered. There were no orders allowing R1 to drink alcohol.

A facility policy pertaining to resident guests and visitors was requested from V1 (administrator). V1 stated that there was no written policy and that visitors were only requested to sign in when visiting. However, after the incident involving R1, V1 indicated that a new policy will be enforced asking visitors to provide photo identification when visiting.

Facility policy dated 9/6/17 titled "Abuse

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S9999	Continued From page 7 Prevention Program" states, "It is the policy of this facility to prohibit and prevent resident abuse, neglect, and misappropriation of resident property and a crime against a resident in the facility. Protection of residents: The facility will take steps to prevent mistreatment while the investigation is underway. Residents are protected from any retaliation or possible harm. Accused individuals not employed by the facility will be denied unsupervised access to the resident during the course of the investigation." (B)	S9999		

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: SOUTHPOINT NRSG & REHAB CTR COMPLAINT #: 0108311
LIC. ID #: 0050450
DATE COMPLAINT RECEIVED: 12/27/18 16:27:00

IDPH Code	Allegation Summary	Determination
101	PHYSICAL ABUSE	1
118	RESIDENT RIGHTS	2

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.