

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014781	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/04/2025
NAME OF PROVIDER OR SUPPLIER SOUTHPPOINT NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 Survey: 2580252/IL184120	S 000			
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 300.1210 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.	S9999			

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

TITLE

(X6) DATE

Electronically Signed

02/21/25

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S9999	Continued From page 1 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. These Requirements were NOT MET as evidenced by: Based upon interview and record review the facility failed to follow the abuse prevention program, failed to provide supervision, failed to implement preventive interventions, and failed to ensure that two of seven residents (R1, R2) in the sample remained free from abuse. These failures resulted in (8/9/24) physical altercation between R1 and R2. R1 sustained a displaced fracture of the left 5th metacarpal, right shoulder deformity and right eye discoloration. R2 sustained a scratched forehead. Findings include: On (1/10/24) IDPH (Illinois Department of Public Health) received allegations that R1 reported a resident was threatening physical violence (for about 2 weeks) prior to actual assault resulting in R1 sustaining bruises and fractured finger. On 1/27/25 at 10:22am, surveyor inquired if R1 was assaulted by a facility resident, V2 (Director of Nursing) stated "(R2's name) was in an altercation with him (R1) several months ago" and subsequently affirmed that the incident occurred on 8/9/24. R2's diagnoses include dementia, metabolic encephalopathy, and psychoactive substance	S9999			

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S9999	Continued From page 2 abuse. R2's (6/18/24) BIMS (Brief Interview Mental Status) determined a score of 3 (severe impairment). R2's (6/7/24) care plan states resident displays behavioral symptoms related to severe mental illness. Interventions: Intervene when any inappropriate behavior is observed. Refer resident to consulting psychiatrist for a psychiatric evaluation as warranted. R2's progress notes state (7/22/24) Resident wandering down hallway and went into another resident's room. When staff asked resident to come out he became verbally aggressive and began yelling and cursing at staff that this was his house. Staff explained that this was another resident's room, and he had another room. Resident continued to yell and curse. Staff left resident in room and called (V11/Family) from cell phone to get her to speak to resident. Resident yelled and cursed at (V11) as well and refused to leave room. Received an order for IM (Intramuscular) injection of Zyprexa (Antipsychotic) 5mg PRN (as needed) every 8 hours. (7/25/24) Resident confused, leaves room and goes into other resident's rooms walking about the hallway asking where is his room. Resident needs constant redirection. (8/9/24) Resident was engaged in a physical altercation with peer. Resident was difficult to re-direct and non-receptive to Counseling as he continues to be aggressive and being disruptive on the unit. Physician was contacted and ordered the resident to be petitioned to hospital for psychological evaluation. Resident is currently placed on behavior monitoring and supervision until paramedic arrives. Staff will continue to monitor,	S9999		

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S9999	Continued From page 3 follow-up and document progress accordingly. Resident transferred to the hospital with petition paperwork. The facility census affirms that R2 was discharged (8/9/24) and did not return to the facility. On 1/29/25 at 12:15pm, surveyor inquired about R2's behaviors, V12 (Social Worker) stated "He (R2) was just a wanderer he was confused." Surveyor inquired about the (8/9/24) incident involving R1 and R2, V12 responded "(V11) just called for staff to come to the room and by the time I (V12) got there the staff was already breaking them up. I guess they had a fight." Surveyor inquired if R1 reported that R2 threatened physical violence prior to (8/9/24) incident, V12 replied "No ma am, not that I'm aware." — R1's diagnoses include (8/12/24) displaced fracture of base of 5th metacarpal bone, left hand. R1's (12/26/24) BIMS determined a score of 13 (cognition intact). R1's (2/10/24) care plan states resident's medical diagnosis may increase his susceptibility to abuse/neglect. Interventions: observe resident for signs of fear and insecurity during delivery of care. Assure the resident that staff are available to help, and department heads maintain an open-door policy. On 1/27/25 at 11:58am, surveyor inquired about concerns at the facility, R1 stated "I was assaulted in August, and I broke my little finger on	S9999			

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S9999	Continued From page 4 my left hand. He (referring to R2) asked me what was I doing in his house and before I could understand what he was saying to me, he swung at me. He said everything in here (referring to the room) belonged to him" and affirmed that (R2) was his roommate at the time. R1's (8/9/24) progress notes state resident was in an altercation with roommate and was attacked by him causing injuries [nothing was documented from 7/10/24 to 8/8/24 - roughly one month]. The (8/9/24) initial incident report states V11 was in facility to visit (R2). When (V11) entered the room (R2) was sitting in (R1's) wheelchair. (R1) was sitting on the side of his bed slightly leaning forward, (V11) asked if (R1) was alright. (R1) informed (V11) that (R2) had just jumped on him. (V11) attempted to speak with (R2) who became aggressive and defensive. (V11) called for assistance. Staff arrived, immediately separated. NP (Nurse Practitioner) made aware, arrived on the unit for head-to-toe assessment and observed (R1) with right 5th digit and shoulder deformity, and right eye discoloration. (R2) with scratch to left forehead. NP gave orders for transfers to acute care settings for further interventions. The (8/9/24) final incident report states (R1) stated that his roommate (R2) accused him of being in his house and told him (R1) to get out. (R1) stated "I tried to defend myself but was overpowered." (R2) was interviewed but could not provide a detailed account of what happened. When asked about the incident, he (R2) only stated that "this was his room." After being transferred to the hospital (R1) was examined and noted with a closed displaced fracture of proximal phalanx of left little finger.	S9999			

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S9999	Continued From page 5 The (undated) abuse prevention program states it is the policy of this facility to prevent resident abuse. Prevention: Resident and family concerns will be recorded, reviewed, addressed, and responded to using the facility's concern/grievance procedure. Random rounds will be made throughout facility assessing the safety of the environment. Staff will identify residents with increased vulnerability for abuse, neglect, mistreatment or who have needs and behaviors that might lead to conflict. (B)	S9999			