Illinois Department of Public Health

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 04/25/2025

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 Survey: 2583171/IL190014 & 2583158/IL190041	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6 300.3210t) 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	S9999		

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 04/25/2025

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
S9999	Continued From page 1	S9999		

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:

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 300.3210 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 Requirmrnts were NOT MET as evidenced by:

Based on interview and record review, the facility failed to prevent and protect one resident (R1) from resident-to-resident abuse out of four residents reviewed for physical assault. This failure resulted in R1 sustaining a fracture of the left ankle in a total sample of four residents.

Findings include:

On 04/22/2025, at 11:57 AM, R1 states the

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 04/25/2025

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
S9999	Continued From page 2 altercation between himself and R2 began when he refused to lend his Bluetooth speaker to another female resident. R1 states all parties were located on the first floor of the facility during this time. R1 states R2 inserted himself into the situation and began to try to impress the female resident. R1 states R2 then began calling R1 "bit**es" and saying he will "catch R1 outside." R1 states he and R2 then started a verbal argument and that's when R1 decided to remove himself from the situation. R1 states he began to self-propel himself in the opposite direction from R2. R1 states when he turned his back, R2 rammed him really hard with R2's electric wheelchair, knocked R1 onto the floor, and ran over R1's leg. R1 states R2 then reversed his wheelchair and proceeded to run him over again but that's when staff intervened and stopped R2 from doing so. R1 states staff separated them and R1 went back to his room. R1 states the staff only asked him if he was okay and R1 said yes at the time. R1 states the staff was in the process of trying to change his room when he began feeling pain later. R1 states when staff initially asked was he okay, R1 did not feel any pain. It could have been due to his adrenaline. R1 states he does not know the nurse's name, but he informed the female nurse on duty that he believed something was wrong. R1 states he informed the nurse that he may have broken his foot and that he was now in pain. R1 states staff did not assess him or take his vital signs. Staff moved him to another room located on the second floor. R1 states shortly after being moved to the second floor, he attempted to go to the restroom. R1 states he then felt more pain in his foot as he tried to use the restroom and that's when he fell. R1 states he fell in the restroom due to the pain he felt in his foot. R1 states he then told staff again that his foot was in pain, and he needed to go to the	S9999		

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 04/25/2025

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
S9999	Continued From page 3	S9999		

Continued From page 3

emergency room. R1 states he now has an appointment scheduled on 04/24/2025, with an orthopedic surgeon to have plates and screws placed in his foot. R1 states there have been no consequences for R2 and R2 continues to get community pass privileges. R1 states R2 can also come to the floor where R1 now resides anytime R2 feels like it.

On 04/22/2025, at 12:27 PM, R4 states he did not witness the altercation that took place between R1 and R2. R4 states he has witnessed on multiple occasions how R2 is aggressive towards people. R4 states a couple of days ago, while on the smoking patio, R2 was bragging about how he ran over R1's foot and R2 stated to R4 that R2 "would do it again." R4 states he also witnessed R2 roll up to R1 and kick R1's Bluetooth speaker onto the floor. R4 states R2 resides on the first floor of the facility but R2 continuously comes to the second floor where R1 is located just to bother R1. R4 states R2 needs to leave R1 alone.

On 04/23/2025, at 6:34 PM, V6 (LPN) states upon starting her shift at 7:00 PM, she was given report from the off-going nurse that R1 had recently transferred rooms to the second floor. V6 states she was now responsible for caring for R1. V6 states she was located at the second-floor nurses' station when R1 approached her stating he was having pain in his left ankle. V6 states she assessed R1's left leg at the nurses' station and did not see any swelling or redness. R1's leg was not warm to touch. V6 states R1 told her that he wanted to have an x-ray performed on his left leg. V6 states she then called the doctor, but the doctor did not answer. She left a message and was awaiting a call back for further orders. V6 states approximately 30-40 minutes after complaining of left ankle pain, she was made

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 04/25/2025

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
S9999	Continued From page 4	S9999		

aware that R1 had fallen while inside of his room. V6 states she called 911 and sent R1 to the hospital. V6 states when R1 returned from the hospital, she was made aware that R1 had a fracture to his left ankle.

R1's nursing progress note written by V6 on 04/06/2025, at 8:45 PM, documents "While this nurse writer was in the hallway passing meds, cna (certified nursing assistant) informed that R1 fell in the restroom. Upon entering R1's room, R1 was observed lying on his right side on the bathroom floor. Upon assessment, R1 was noted to be unresponsive and diaphoretic with normal vital signs. This writer kept calling R1 until he started to respond. 911 was called. R1 was made comfortable and transferred to bed per facility protocol. All safety precautions were maintained. Neurological assessment initiated.

R1's nursing progress note written by V6 on 04/07/2025, at 4:25 AM, documents "R1 returned from hospital via stretcher accompanied per 2 ambulance attendants. R1 transferred from stretcher to the bed per ambulance attendants without incident. Upon assessment, R1 was noted with a soft cast to the left ankle. Diagnoses closed bimalleolar fracture of left ankle, initial encounter. R1 is to see orthopedic surgeon. Dr. notified. R1's return and new orders."

There is no documentation to show that V6 documented R1's complaint of left ankle pain, assessment of R1's left ankle, and notification to the doctor prior to R1 falling in the facility.

R1's abuse care plan documents in part, "R1 will be treated w/ respect, dignity & reside in the facility free of mistreatment (i.e., abuse/neglect) (on-going). Facility Designee will complete a

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 04/25/2025

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
S9999	Continued From page 5	S9999		

Screening Assessment for Indicators of Aggressive and/or Harmful Behaviors within 72-hours of Admission and Quarterly thereafter. Assure the resident that staff members are available to help & department heads maintain an "open door" policy."

R1's aggression assessments dated 02/05/2025 and 04/15/2025 documents "R1 has no history of aggression." R1's aggression assessment also documents that R1 scores a 2 which indicates that R1 is at minimal and low risk of aggression.

R2's abuse care plan documents in part, "My comprehensive assessment reveals a history of suspected abuse and neglect, exploitation, past trauma and/or other factors that may increase my susceptibility to abuse/neglect. R2 demonstrates: Depression, Diagnosis of Mental Illness. R2 had a disagreement with a peer on 8/28/2023. R2 and his roommate had a verbal disagreement on the unit on 10/13/2023 and 11/15/2024. R2 was involved in an alleged incident with staff on 4/11/2024. R2 will be treated w/ respect, dignity & reside in the facility free of mistreatment (i.e., abuse/neglect) (on-going). Facility Designee will complete a Screening Assessment for Indicators of Aggressive and/or Harmful Behaviors within 72-hours of Admission and Quarterly thereafter.

R2's behavior care plan documents in part, "R2 demonstrates behavioral distress related to verbally abusive behavior when agitated towards and peer. R2 and his roommate had a verbal disagreement on the unit on 08/28/2023, 10/13/2023. Socially inappropriate and disrespectful by using profane languages towards staff members. 01/09/2024,04/24/2024. R2 kick doors instead of asking for assistance from staff 05/13/2024. R2 was socially inappropriate

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 04/25/2025

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
S9999	Continued From page 6	S9999		

Continued From page 6

towards peers on 11/7/2024. R2 playing loud music while ambulating with his power-chair 11/20/2024, 11/22/2024. R2 will refrain from verbally and/or physically abusive behavior following staff intervention by: Explain "Rules of Conduct" and each person's obligation to treat others with dignity & respect at all times. Ask the resident to treat others as he/she would like to be treated."

R2's aggression assessment dated 02/18/2025 documents "R2 was socially inappropriate towards peers on 11/7/2024."

Facility reported incident dated 04/06/2025, documents an altercation between R1 and R2 where R1 became agitated and struck R2. In return R2 bumped his wheelchair into R1's wheelchair.

R1's Hospital records dated 04/06/2025, documents that R1 was diagnosed with a closed bimalleolar fracture of the left ankle.

Ombudsman Residents' Rights for People in Long-Term Care Facilities dated 11/2018 documents in part, "You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually."

Facility policy dated 01/2019, titled "Abuse Prevention Program" documents in part, "It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. 1. Abuse: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish ... ...Willful, as used in this

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 **04/25/2025**

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
S9999	Continued From page 7 definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." (A)	S9999		