

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145914	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2024
NAME OF PROVIDER OR SUPPLIER Southpoint Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 West 95th Street Chicago, IL 60643	

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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>45000</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were administered as ordered by the residents' physician for one (R5) resident out of three residents reviewed.</p> <p>Findings include:</p> <p>On 11/03/2024, at 9:18 AM, surveyor located on the second floor of the facility with V11 (Licensed Practical Nurse/LPN). V11 observed with a medication cart and performing a morning medication administration pass.</p> <p>On 11/03/2024, at 9:23 AM, V11 observed preparing medication for R6. R6 placed the medications in a clear medication cup and placed it to the side on top of the medication cart. V11 does not administer R6's prepared medications to R6. V11 is observed immediately deploying R7's electronic medication administration record/eMAR and began gathering R7's medications and places them on top of the medication cart. Surveyor asks V11 did she administer R6's prepared medications. V11 states she was preparing both R6 and R7 medication at the same time since they are in the same room but will take it to them separately. Surveyor inquired about the rights of medication administration and V11 states she will then give the medications to R6 and R7 one at a time now. V11 then administers medication to R6 and returns to her computer and immediately deploys R7's eMAR. Surveyor asks V11 what should nurses do after administering medications to residents. V11 states Oh, I have to sign them. V11 then observed deploying R6's eMAR and signs the medication that she administered to R6.</p> <p>V11 observed preparing medications for R7 with R7's eMAR deployed on the computer. V11 then observed gathering all of R7's medication packets and cutting them open with scissors. V11 then poured all of R7's medication into the clear medication cup all at once. One small, white, circle pill did not fall into the medication cup and landed on top of the medication cart. Surveyor inquires to V11 which pill fell on to the medication cart and V11 is unable to immediately identify which pill fell on to the medication cart. V11 states she is aware that she is unable to immediately identify which pill fell because she emptied all of R7's medications into the cup all at once.</p> <p>V11 stated if the rights of medication administration is not followed, then the residents could receive the wrong medication, get sick, or have adverse reactions.</p> <p>On 11/03/2024, at 9:47 AM, V11 now observed preparing medications for R5. Surveyor observes that R5's eMAR has the following order: Vitamin D3 Oral Tablet 50 MCG (2000 UT) (Cholecalciferol).</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 145914	If continuation sheet Page 1 of 3

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>V11 located a house stock medication bottle labeled Vitamin D3 Oral Tablet 25 MCG (1000 UT).</p> <p>V11 inquired to surveyor if V11 could administer the house stock medication to R5. Surveyor does not consult V11 on what actions to take regarding administering medications to R5.</p> <p>On 11/03/2024, at 9:56 AM, V11 observed administering R5's medications and then obtaining R5's blood pressure reading with a wrist blood pressure cuff. Surveyor observes R5's blood pressure reading as 105/70 (Systolic/Diastolic) and heart rate 89.</p> <p>Surveyor asked V11 to deploy R5's physician orders on the computer for medication Metoprolol. Surveyor and V11 reads R5's order which read: Metoprolol Tartrate Oral Tablet (Metoprolol Tartrate)- Give 50 mg by mouth two times a day for HTN (Blood pressure) taken before administration if SBP (systolic blood pressure) is less than 110 or diastolic less than 60 hold medication please.</p> <p>V11 then abruptly begin to walk away stating to surveyor that she has to leave to go to the restroom because she does not feel well. V11 then states that she may even have to go home because she just doesn't feel well. V11 then observed getting onto the elevator and leaving the unit.</p> <p>R5's Physician Order Sheet/POS documents the following order: Start date 10/15/2024- Metoprolol Tartrate Oral Tablet (Metoprolol Tartrate)- Give 50 mg by mouth two times a day for HTN Blood pressure taken before administration if SBP less than 110 or diastolic less than 60 hold medication please.</p> <p>R5's medication administration record/MAR documents that R5's blood pressure reading dated 11/03/2024 is 105/70 (Systolic/Diastolic).</p> <p>R5's medication administration record/MAR audit report documents that V11 administered R5's metoprolol to R5 today on 11/03/2024, at 9:59 AM.</p> <p>On 11/03/2024, at 12:43 PM, V2 (Assistant Director of Nursing/ADON) states it is not acceptable for the nurses to prepare medications for more than one resident at a time. V2 stated if medications are prepared for multiple residents at one time, the residents could get the wrong medication and experience an adverse reaction. V2 stated medications should be administered per physician orders. V2 stated if a resident is given blood pressure medication and their blood pressure is already low, then the resident's blood pressure could further decrease. V2 stated the resident could also become incoherent and would require emergency services. V2 stated if a blood pressure medication is administered outside of the physician orders and parameters then the physician should be notified. V2 stated the resident's family should also be notified, the resident's vitals should be taken more frequently, and follow any orders that the physician may give. V2 states she may also fill out a risk management assessment for the resident.</p> <p>Facility document undated, titled Section 5.0 Medication Administration documents in part, Policy: Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Procedure: 2. Medications are administered in accordance with written orders of the attending physician. 7. Only the licensed or legally authorized personnel who prepare medication may administer it. This individual records the administration on the resident's MAR at the time the medication is given. 18. When medication administration is dependent upon vital sign measures, this monitoring should be performed before the administration of the prescribed medication. The vitals are recorded per facility policy.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility document undated, titled Section 5.2 Medication Administration documents in part, Purpose: To administer all medications safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis. Procedure: 3. Review the resident's Medication Administration Record (MAR). Read each order entirely.</p>		