STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145914	A. Building B. Wing	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpoint Nursing & Rehab Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Based on interview and record review, the facility failed to follow their policy & procedure to prevent R2 from being physically abused by R1. This failure affected 1 (R2) resident out of 4 residents reviewed for abuse. The findings include: R2's admission record documented initial admitted on 6/26/2021 with diagnoses not limited to Unspecified convulsions, Bipolar disorder, Major depressive disorder. MDS dated [DATE] showed R2's cognition was moderately intact. On 12/1/24 at 9:53 AM Observed R2 up and about, ambulatory with walker, alert, and oriented x 2-3, verbally responsive. R2 said about 3 weeks ago around dinnertime by the 1st floor dining room. R1 was cursing staff so she went to R1 and told him not curse out loud. She said R1 got annoyed, pushed her away and fell on her side. R2 said R1 attacked and scratched her on the face. She said she was bleeding and staff attended to her. She said they were separated by staff and other residents. Stated she felt abused. R2 said she feels safe in the facility because she can protect herself. Stated R1 was transferred to another floor. At 10:16 AM Observed R1 up and about, ambulatory with steady gait, alert and oriented x 3, verbally responsive. Stated about 3 weeks ago in the 1st floor dining room around dinner time, it started with V4 (Certified Nursing Assitant/ CNA), she was passing juice to residents, but she kept on ignoring him and not giving him a juice despite several requests. R1 stated she was brushing me off. He said he got up and took juice by himself. Stated V5 (CNA) told him you are not supposed to do that, and he replied that he took the juice because V4 kept on ignoring him. He said, you don't care. R1 said V5 stated You're right, we don't F****** care about you. R1 said R2 came to their table and said don't talk to V5 like that and R2 further stated I will kick your ass. R1 stated that he told R2 to go somewhere, it has nothing to do with her. R1 stated that R2 grabbed / squeezed his face while she was standing behind him. Stated he was trying to get her off on him, so he pushed her away, touched, and scratched R2's face. Stated he saw R2's face was red and had blood on it and they were separated by other residents. He said the incident was witnessed by R3 and R4. R1 stated staff constantly picking on him and was not treated equally. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 10:41AM Observed R3 resting on bed, alert, and oriented x 3, verbally responsive. She said about 3 weeks ago around dinner time in the 1st floor dining room. V4 (CNA) was passing juice to residents. R1 was asking her but it was not his turn yet and he can't wait so he got up and took his own juice. She said R1 told staff You b****. She said R2 walked behind R1 and told him don't curse out staff. R1 replied to R2 Shut up or I'll pretend that you are not female and beat your ass. R1 head butted R2's face while she was standing behind him. R1 grabbed R2's face and beat and punched her face. R3 stated she was sitting with R1, she got up and broke it up. R1 and R2 were separated. R1 was transferred to another floor. R3 stated that she saw blood on R2's face. At 11:16AM Observed R4 sitting up on motorized wheelchair, alert, and oriented x 3, verbally responsive. He said about 3-4 weeks ago around dinner time in the 1st floor dining room, R1 was cursing out V4 (CNA) for no reason saying B****, for not giving him the juice and went over and took juice by his own. Stated R1 could not wait for his turn, did not give V4 the chance to give it to him. Stated staff told him not to touch the juice because staff is not sure if his hands are clean. R1 keep on cursing and went back to his table and was seated. R4 then came to R1 and told him not to curse them out, they are women, and they are here to help you. R4 stated R2 went to him saying you can't do that and that R1 called her(R2) a B****. R1 head-butted R2's face while she was standing at the back of him. R1 grabbed, smacked, and beat her (R2) on the face. Everybody grabbed R1 to separate them and the CNA came to grab R2 away from him. R1 and R2 were separated. He said R2 did not scratch R1, and he was not bleeding. R2 was bleeding, there were scratches on her face. R2's face was red; she had a long scratch from cheek down to her mouth. R4 said he came to R1 first and he did not do nothing to him. But when R2 went to him, he punched and scratched R2's face. R4 said there was intent to hurt R2 because she is a woman cause she is weak. At 12:04 PM V5 (CNA) stated has been working in the facility for [AGE] years and regularly assigned on the 1st floor. The incident between R1 and R2 happened about the 2nd week of November, during dinner time in the dining room. R1 was cursing and disrespecting the CNAs (V5 and V4). He took coffee / juice by himself and they told him not to do that. V4 was passing coffee and juice and it was not his turn yet. He got mad. Cursing and saying B****. He was told don't curse out loud and wait until staff will get around to him. V5 stated R4 came to him and told him to stop cursing at staff. V5 stated she was not cursing at R1 or any residents. R2 walked up to him and told him to stop cursing. R2 was standing at the back of R1 telling him to stop cursing the staff. R1 continued cursing at R2. V5 told R2 to go back to her table and she went passing tray down the hall. Did not see scratching or grabbing or punching between R1 and R2. When V5 came back to the dining room. R1 and R2 were separated. V5 stated there was no bleeding found on R1 or R2's face. At 12:23 PM V6 (Social Services) stated has been working in the facility for 2.5 years and did not witness the incident between R1 and R2. She was called down to the floor around dinner time as she was about to get off from the facility. V6 went to the first floor by the nurses' station. R2 was in the hallway. R1 was in the room. Both residents had a disagreement and staff separated them. She said R1 was moved to another floor. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:12 PM V4 (CNA) stated she has been working in the facility for [AGE] years and reguarly assigned on the 1st floor. She said about 3 weeks ago around dinner time in the dining room. R1 started cursing out staff and he was asking for juice. R1 could not wait for his turn, so he got up and got the juice by himself. She stated she did not ignore R1 or any other residents. V4 said she walked to the hallway to tell other residents that it is time to eat. V4 said she did not see R1 and R2 have the physical altercation as she was by the hallway. She heard the argument going on between 2 residents when she came back to the dining room R1 and R2 were separated already. V4 sa she did not see blood on R1 or R2's face. At 2:15 PM V13 (LPN AGENCY) stated she did not see the incident between R1 and R2. V13 did not witness the incident. There were 2 CNAS working at that time. She was told by staff, the incident happened in the dining room. There were 2 residents (R1 and R2) got into arguments and they were separated right away. Did not see bleeding or scratches on R1 and R2 faces. Did not know if there was staff in the dining room during the incident. R1 was moved to another floor. At 2:51 PM V2 (DON / DIRECTOR OF NURSING) stated she started working in the facility April 2024. She said she was not in the building on 11/9/24 and was called by V13. V13 informed her regarding the incident / disagreement between R1 and R2. She stated she was informed by V4 and V5 that there was an altercation or disagreement between R1 and R2. She said R2 was a little agitated because she did not want or like how R1 was talking /speaking to staff in the dining room. She said there was no report of cursing out to her. Both R1 and R2 were separated. Staff is expected to be in the dining room during mealtime. She saw R1 and R2 on Monday on 11/11/24 did not see any scratches on R1 or R2's face. R1 was transferred to another floor to prevent further disagreements. At 3:09 PM V1 (Administrator) started working in the facility in August 2024. She is the Abuse coordinator and investigated the incident on 11/9/24 between R1 and R2. After the investigation, R1 was getting loud and aggressive wanted to get his juice by himself. R2 took it upon herself and told him not to do that. R2 grabbed him when addressing him not to take anything from the cart. R1 could not wait to be served. R2 was cursing and grabbed R1. R2 was the instigator. She said R1 got frustrated at the staff and He pushed away R2. They made contact, his hand by her cheek area. Stated she saw both R1 and R2 on 11/11/24 with no scratches, no bruising, no redness, no bleeding on their face. R1's admission record documented initial admitted on 6/21/2024 with diagnoses not limited to Conversion disorder with seizures, Major depressive disorder, Anxiety disorder, Bipolar disorder, Presence of neurostimulator. MDS (Minimum Data Set) dated 9/24/2024 showed R1's cognition was moderately intact. R1's progress notes dated 11/9/2024 documented in part: resident was involved in a disagreement with another resident in the dining room. staff separated residents involved and moved his room to a different floor. R1's Social Service Note dated 11/9/2024 documented in part: Resident had a disagreement with a peer. Resident was placed on behavior monitoring and supervision at this time to prevent any further aggression. Room change was initiated. R2's Social Service Note dated 11/9/2024: Resident had a disagreement with a peer. Resident was placed on behavior monitoring and supervision at this time to prevent any further aggression. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's admission record documented initial admitted on 1/19/2017 with diagnoses not limited to Type 2 diabetes mellitus, Essential (primary) hypertension, Unspecified psychosis, Schizophrenia, Major depressive disorder. MDS dated [DATE] showed R3 was cognitively intact. R4's admission record documented initial admitted on 3/11/2024 with diagnoses not limited to Paraplegia, Central cord syndrome at c4 level of cervical spinal cord, Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Anxiety disorder, Spinal stenosis. MDS dated [DATE] showed R4 was cognitively intact. Facility's incident dated 11/9/24 with conclusion documented in part: R1 was frustrated with staff and getting him his drinks, he therefore went on the cart to get the items himself. R2 began to curse at him and then grabbed him. R1 to get away from R2 pushed her away from him. Staff immediately intervened and separated residents. 1:1 was given to residents and room changed. Facility's abuse prevention program policy (undated) documented in part: It is the policy of this facility to prevent resident abuse, neglect, mistreatment. The facility will not tolerate resident abuse or treatment by anyone, including staff members, other residents. Abuse: the willful infliction of injury. Facility's resident rights policy (undated) documented in part: Be free from abuse and neglect. You have the right to be free from verbal, sexual, physical and mental abuse. Facility's policy and procedure for standard supervision and monitoring (undated) documented in part: A staff member that has been assigned to care for the resident will visualize the resident at the start and end of the shift, during mealtimes. At any time that the resident is being supervised and requires redirection, the direct care staff member may need to redirect the resident through verbal and / or physical guidance and or care. If the resident cannot be guided, supervised, or redirected during regular intervals of rounds, the resident may require 30minute, 15minute or 1:1 intervention.