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Form Approved OMB
No. 0938-0391

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 02/04/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 32819 Based upon observation, interview, and record review the facility failed to follow policy procedures and failed to ensure that call lights were within reach for three of three residents (R3, R4, R7) reviewed for falls. Findings include: R4's (12/10/24) BIMS (Brief Interview Mental Status) determined a score of 3 (severely impaired). R4's (12/10/24) functional assessment affirms resident requires partial/moderate assistance for sit to stand and bed to chair transfers. On 1/27/25 at 11:25am, R4 was observed lying in bed however the call light was on the floor and out of reach. V6 (Licensed Practical Nurse) was at R4's bedside surveyor inquired about R4's fall prevention interventions V6 responded She has floor mats and boosters (referring to bed bolsters) however call light within reach was excluded. Surveyor inquired about R4's cognitive status V6 replied She's alert and oriented 1 to 2 and proceeded to exit the room. Surveyor inquired about the location of R4's call light V6 returned to R4's bedside and stated, It was on the floor. __ R7's (11/14/24) BIMS determined a score of 6 (severe impairment). R7's (11/14/24) functional assessment affirms resident is dependent on staff for sitting on side of bed and bed to chair transfers. On 1/27/25 at 11:33am, R7 (R4's roommate) was lying in bed however the call light was on the floor and out of reach. Surveyor inquired if R7 was able to reach the call light R7 stated No. On 1/27/25 at 11:36am, surveyor inquired about the location of R7's call light V2 (Director of Nursing) entered the room (as requested) and affirmed it was on the floor. V2 inquired if R7 could reach the call light however (R7) was unable to therefore V2 placed the call light within reach. __ R3's (10/28/24) BIMS determined a score of 11 (moderate impairment). (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's (10/28/24) functional assessment affirms partial/moderate assistance is required for chair to bed transfers and walking was not attempted. On 1/29/25 at 1:46pm, R3 was alone in her room and seated in a wheelchair (at the foot of the bed). R3 did not have call light access. On 1/29/25 at 1:53pm, V14 (CNA/Certified Nursing Assistant) affirmed that she's assigned to R3. Surveyor inquired about R3's fall prevention interventions V14 stated Right now, all I know is the floor mats that's all I can remember. You (surveyor) would have to ask restorative about anything else. Surveyor inquired if R3 can stand V14 replied She (R3) can stand with assistance and left the room without providing the call light. The (undated) call lights policy states the call system will be available in the resident's room. Always place the call light in an accessible location to where the resident is located in their room.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32819 Based upon record review and interview the facility failed to timely notify the Physician, Nurse Practitioner, and/or Medical Director of change in condition for one of three residents (R4) reviewed for falls. Findings include: On 1/14/25, IDPH (Illinois Department of Public Health) received allegations that R4 fell out of bed and was not sent to the hospital until V17 (Family) arrived and told staff to call an ambulance. R4 is [AGE] years old with diagnoses which include but not limited to altered mental status and history of falling. R4's (12/10/24) BIMS (Brief Interview Mental Status) determined a score of 3 (severely impaired). R4's (1/13/25) fall incident report states CNA (Certified Nursing Assistant) responded to call light; resident observed laying on her side left side of bed. Roommate witnessed incident; roommate stated, She put her feet out the bed then slid down on the floor. Resident stated, I was trying to get something off my table. Resident denies pain, no signs/symptoms of distress or discomfort voiced or noted. No injuries observed at time of incident. Staff transferred resident back to bed, educated resident on using call light to ask for assistance. Predisposing factors: dementia, confused, history of fall. R4's progress notes state (1/13/25) 12:41am, Writer contacted Medical Doctor awaiting a call back. 8:25am, Residents daughter in building this morning insisting her mother goes out to ER (emergency room) due her mother sliding out of bed. Resident has no injuries and has no change of baseline but due to the families insisting Nurse Practitioner gave order to send out for evaluation. (1/14/25) Writer called Hospital to ascertain resident admitting Diagnosis. Hospital staff Nurse informed writer that resident is admitted for pulmonary thrombosis (blood clot in the lungs). On 1/30/25 at 1:31pm, surveyor inquired when the nurse should notify the Physician of resident fall. V16 (Physician) stated Instantly, I need to know right then and there, and we'll evaluate what happened. I want to be called immediately. Surveyor inquired if a fall could cause a pulmonary embolism V16 responded You have to have it there just standing by (as a preexisting condition) if they (residents) fall down it can move from one area to another one and it can cause more damage. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 3:06pm, surveyor inquired about R4's cognitive status V3 stated This lady is confused. Surveyor inquired if R4's (1/13/25) fall was witnessed V3 responded It was witnessed by the roommate but by staff no. Surveyor inquired about staff requirements when a resident falls V3 replied You call the MD (Medical Doctor), family, and ADON or DON immediately after the fall. Surveyor inquired if the Doctor was notified of R4's (1/13/25) fall V3 reviewed R4's progress notes and stated, Writer contact MD awaiting call back. Surveyor inquired if the Physician called back V3 responded, They contacted the NP (Nurse Practitioner) I see at 8:25 in the morning [roughly 7.75 hours after falling]. Surveyor inquired when R4 fell V3 replied It look like in the middle of the night, like midnight. Surveyor inquired how many hours transpired before the NP was notified of R4's fall V3 stated It was 7 hours and some minutes. Surveyor inquired why R4 was sent to the hospital V3 responded When the family came in the building is what the notes say. Surveyor inquired what staff are supposed to do if the Doctor does not respond and/or call back V3 replied Call the Medical Director. The (undated) change in resident's condition or status policy states it is the policy of the facility to ensure that the resident's attending Physician and representative are notified of changes in the resident's condition or status. The Nurse will notify the resident's attending physician when: the resident is involved in any accident or incident that results in injury including injuries of unknown origin. It is necessary to transfer the resident to the hospital.

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F 0600 Level of Harm - 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. 32819 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 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, 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. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	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 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. 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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32819 Based upon record review and interview the facility failed to follow policy procedures and failed to timely develop comprehensive care plans for two of seven residents (R4, R6) in the sample. Findings include: R4 was admitted to the facility on [DATE] with diagnoses which include history of falling. R4 is [AGE] years old. R4's (6/13/23) Fall Risk Review determined a score of 17 (high risk). R4's comprehensive care plan states resident is at risk for falls (Date Initiated: 1/21/25) therefore completed roughly 1.5 years after admission. __ R6 was admitted to the facility on [DATE] (10 months ago) with diagnoses which include history of alcohol abuse and history of cocaine abuse. R6's comprehensive care plan (received 1/28/25) excludes history of alcohol and/or cocaine abuse. On 1/30/25 at 12:04pm, surveyor inquired about the requirements for developing comprehensive care plans, V15 (Care Plan Coordinator) stated The primary diagnoses, were care planning it. I've (V15) got 24 to 48 hours to get it done but it gets done on Monday if they (residents) come on the weekends. Surveyor inquired if R4 was admitted (6/12/23) with a known history of falling, V15 responded Yes. Surveyor inquired when R4's risk for falls was added to the care plan, V15 replied I initiated it on 1/21/25. Surveyor inquired if R6 was admitted (3/30/24) with a known history of alcohol and cocaine abuse, V15 stated Yes, Social Service is supposed to care plan those. Surveyor inquired if R6's comprehensive care plan includes history of alcohol and/or cocaine abuse, V15 responded I do see something in the interventions about alcohol but not as far as the diagnosis and affirmed that resident diagnoses should be entered under Focus on the care plan. Surveyor inquired if R6's history of alcohol and cocaine abuse were entered under Focus V15 replied No. The (undated) care planning policy states each resident will have a comprehensive assessment completed by the Interdisciplinary team upon admission, quarterly and with significant changes and an individualized care plan will be developed and updated as needed with quarterly assessments, re-admissions, and changes in conditions.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 32819 Based upon record review and interview the facility failed to follow policy procedures and failed to review and/or revise a comprehensive care plan for two of three residents (R3, R7) reviewed for falls. Findings include: R3's (11/26/24) progress notes state writer got report from the Nurse stating that the resident had an unwitnessed fall. R3's (7/4/23) care plan states resident is at risk for falls however the (11/26/24) fall is excluded, and the Goal Target Date is 8/11/24 (outdated roughly 5.5 months ago). R7's (3/15/23) care plan states resident is at risk for falls. Goal Target Date: 11/12/24 (outdated roughly 2.5 months ago). On 1/30/25 at 12:30pm, surveyor inquired about the requirements for care plan review and/or revision V15 (Care Plan Coordinator) responded Every 3 months, which is every assessment and we do it within 7 days. I (V15) would do it if there's a change in condition, new diagnosis or they came from the hospital then I would update the care plan. Surveyor inquired about concerns with R3's (7/4/23) fall risk care plan, V15 reviewed R3's care plan and stated I'm just gonna be blunt and honest that this was assigned to someone that quit. I reviewed it through the documents tab yesterday (1/29/25) and updated it. The last target date was 8/13-8/19 (2024). Surveyor inquired about concerns with R7's (3/15/23) fall risk care plan, V15 reviewed R7's care plan and stated There's no history of falls here so it was never updated. The target date was 11/12/24. The (undated) care planning policy states residents care plans will be reviewed and updated as needed with re-admissions, quarterly, annually and with changes in condition. The fall prevention program (revised 1/25/23) states the care plan addresses each fall. Interventions are changed with each fall, as appropriate.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32819 Based upon observation, interview, and record review the facility failed to follow policy procedures, failed to provide supervision, failed to ensure that staff are aware of required fall prevention interventions, and/or failed to implement fall prevention interventions for three of three residents (R3, R4, R7) reviewed for falls. Findings include: R4 is [AGE] years old with diagnoses which include altered mental status, weakness, lack of coordination, abnormalities of gait/mobility, and history of falling. R4's (6/13/23) admission Fall Risk Review determined a score of 17 (high risk). R4's (1/13/25) fall incident report states CNA (Certified Nursing Assistant) responded to call light; resident observed laying on her side left side of bed. Roommate witnessed incident. Predisposing factors: dementia and history of fall. On 1/30/25 at 3:06pm, surveyor inquired if R4 can transfer herself and/or walk V3 (ADON/Assistant Director of Nursing) stated She's (R4) a 1-person transfer, she can't walk. Surveyor inquired about R4's fall prevention interventions V3 responded Bolsters and floor mat. Surveyor inquired about R4's cognitive status V3 replied This lady is confused. Surveyor inquired if R4's (1/13/25) fall was witnessed V3 replied It was witnessed by the roommate but by staff no. R4's (12/10/24) BIMS (Brief Interview Mental Status) determined a score of 3 (severely impaired). R4's (12/10/24) functional assessment states resident requires partial/moderate assistance for sit to stand and bed to chair transfer. R4's (1/21/25) care plan affirms partial/moderate assistance is also required for bed mobility, interventions: keep call light within reach. On 1/27/25 at 11:25am, R4 was observed lying in bed with bed bolsters and floor mats in place however the call light was on the floor and out of reach. V6 (Licensed Practical Nurse) was at R4's bedside surveyor inquired about R4's fall prevention interventions V6 stated She (R4) has floor mats and boosters referring to the bed bolsters [keep call light within reach was excluded]. Surveyor inquired about R4's cognitive status V6 responded She's alert and oriented 1 to 2 and proceeded to exit the room. Surveyor inquired about the location of R4's call light V6 returned to R4's bedside and affirmed It was on the floor. __ R3 is [AGE] years old with diagnoses include dementia, weakness, reduced mobility, abnormalities of gait/mobility and history of falling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's (10/28/24) Fall Risk Review determined a score of 16 (high risk). R3's (11/26/24) progress notes state writer got report from the Nurse stating that the resident had an unwitnessed fall. R3's (11/26/24) fall incident report states writer made aware that resident was noted sitting on the floor. When writer asked resident what happened resident replied that she was trying to put some cover (blanket) on her daughter that was sitting in the chair, and she slid out of bed on her butt. Resident daughter is not present. Predisposing factors include but not limited to confused/ disoriented, gait imbalance, agitated/anxious, and decreased safety awareness. On 1/30/25 at 1:31pm, surveyor inquired about R3's fall risk V16 (Physician) stated That patient (R3) happens to need replacement of the hip. The Nurses need to make sure that when she (R3) wants to get out of the bed she needs to call for help. Surveyor inquired if R3 can walk unassisted V16 responded No, not yet she needs the surgery. R3's (10/28/24) BIMS determined a score of 11 (moderate impairment). R3's (10/28/24) functional assessment affirms partial/moderate assistance is required for chair/bed to chair transfers. R3's (7/4/23) care plan states resident is at risk for falls as evidenced by decreased strength/endurance and general weakness. Interventions: low bed. Place my call light within reach and encourage me to use it for assistance as needed. Place (Brand Name non-slip material) in my wheelchair to prevent sliding. Position me in my chair while up out of bed within view of staff to allow for closer supervision and safety. Bilateral fall mats in place. On 1/29/25 at 1:46pm, R3's bedroom door was closed surveyor knocked on the door and entered the room. R3 was observed alone in the room and seated in a wheelchair (at the foot of the bed) without call light access. Surveyor inquired who placed R3 in the wheelchair today R3 stated They (staff) get me up in the morning and help me get dressed but after that I'm on my own. On 1/29/25 at 1:53pm, V14 (CNA) affirmed that she's assigned to R3. Surveyor inquired about R3's fall prevention interventions V14 stated Right now, all I (V14) know is the floor mats that's all I can remember. You (surveyor) would have to ask restorative about anything else. Surveyor inquired how long V14 has been caring for R3 V14 responded About a month. Surveyor inquired if R3 can stand V14 replied She (R3) can stand with assistance. V14 assisted R3 to stand (as requested) however the required non-slip material (per 7/4/23 care plan) was not in use. Surveyor inquired if anything was present on the seat of R3's wheelchair V14 inspected the wheelchair and stated No. V14 then left R3 in the room (unattended) and did not provide a call light. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 2:59pm, surveyor inquired about facility fall prevention interventions V3 (ADON) stated We put interventions in place for anyone that had a fall. You have to assess the patient and see what you wanna do with them. Surveyor inquired how staff are made aware of required fall prevention interventions for each resident V3 responded We put a list on the unit, they have a fall binder here (facility). Surveyor inquired if R3 is confused V3 replied Yes, but she have her moments she can be with it one moment and then be confused. Surveyor inquired about R3's required fall prevention interventions V3 stated She have the fall mats, it's a (Brand Name non-slip material) and bed to lowest position. __ R7 is [AGE] years old with diagnoses which include obesity, generalized weakness, reduced mobility, and abnormalities of gait/mobility. R7's (11/14/24) Fall Risk Review determined a score of 9 (moderate risk). R7's (11/14/24) BIMS determined a score of 6 (severe impairment). R7's (11/14/24) functional assessment affirms resident is dependent on staff for sitting on the side of bed and bed to chair transfers. R7's (3/15/23) care plan states resident is at risk for falls as evidenced by impaired coordination and cerebrovascular accident. Interventions: I would like staff to provide me with a working and reachable call light. On 1/27/25 at 11:33am, R7 was lying in bed however the call light was on the floor and out of reach. Surveyor inquired if R7 was able to reach the call light R7 stated No. On 1/27/25 at 11:36am, surveyor inquired about the location of R7's call light V2 (Director of Nursing) entered the room (as requested) and affirmed it was on the floor. V2 inquired if R7 could reach the call light however (R7) was unable to therefore V2 placed the call light within reach. On 1/30/25 at 3:23pm, surveyor inquired about R7's functional status V3 (ADON) stated She's dependent in transfer and affirmed she's unable to walk. The fall prevention program (revised 1/25/23) includes Purpose: to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Direct care staff will be oriented and trained in the Fall Prevention Program. The Nurse call device will be placed within resident's reach at all times. Residents will be observed approximately every two hours to ensure the resident is safely positioned in the bed or a chair and provide care as assigned in accordance with the plan of care.