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	01/26/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that call lights were answered in a timely manner for one (R1) out of three residents reviewed for accommodation of needs.Findings Include:R1's face sheet listed diagnoses, but not limited to, orthostatic hypotension, end staged renal disease, and polyosteoarthritis. R1's Minimum Data Set (MDS) assessment dated [DATE] shows R1 is cognitively intact with BIMS (Brief Interview for Mental Status) score of 15.On 1/25/26 at 9:57 AM, R1 was sitting up in bed alert and oriented to person, place, and time. Able to verbalize needs with no difficulty. R1 stated that his call light was on for more than two hours on 1/21/26 around 4:20 PM to get his urinal emptied and get water to drink. R1 said nobody answered his call light until 6:45 PM. R1 said he called the reception four times to send someone, and nobody came. R1 said that the facility is always short on staff.On 1/25/26 at 1:09 PM, R4 was sitting on the side of her bed alert and oriented to person, place, and time with bouts of forgetfulness. R4 said that sometimes staff are delayed in answering call lights and providing showers due to lack of staff.On 1/25/26 at 11:51 AM, a phone interview was conducted with V8 (Receptionist), and she stated she's been working in the facility part time for one and a half year and works 4:00 PM to 8:00 PM. V8 said residents sometimes call the front desk when their call lights are not being answered timely by the floor staff. V8 said she remembers R1 called her sometime last week in the afternoon and told her that R1 had been waiting a while for someone to answer his call light. V8 said R1 did not exactly specify how many hours or minutes he's been waiting. V8 said she went to the floor and found the nurse and informed her about R1's concern. V8 said she does not remember the female nurse's name. V8 said that the nurse said she will send someone in R1's room.On 1/25/26 at 3:01 PM, a phone interview was conducted with V19 (Registered Nurse) and she stated she was the nurse assigned to R1 on 1/21/26 evening. V19 said that when she entered R1's room to give his pain medication, R1 informed her that he was waiting for a while for someone to answer his call light. V19 said R1 said he was waiting for over an hour and his call light was on. V19 said that R1 told her no one was emptying his urinal. V19 said that staff should be answering call light timely and anyone can answer call light. On 1/25/26 at 4:43 PM, a phone interview was conducted with V22 (Certified Nursing Assistant/CNA) and stated she was the CNA assigned with R1 on 1/21/26 evening shift. V22 said that the nurse (does not remember name) informed [V22] that R1's call light was on. V22 said when she entered R1's room, R1 informed her that he's been waiting more than two hours for someone to answer his call light. V22 said that she did not hear and did not see R1's call light because she was sitting at the end of the hallway on the opposite side of R1's room. V22 said R1 needed water, and his urinal emptied. V22 said that anyone can answer the call light and should be attending to the resident's needs.On 1/25/26 at 1:33 PM, a phone interview was conducted with V2 (Director of Nursing) and stated that staff have to answer call lights timely. V2 said anybody can answer call light and they have to answer it in a timely manner no longer than 15 minutes.On 1/25/26 at 12:57 PM, V11 (Certified (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	Nursing Assistant) stated that sometimes facility is short staffed that affects the timelines in providing care to the residents.The facility's CALL LIGHTS (no date) policy reads in part: It is the policy of the facility to have a system in place to allow the staff to respond promptly to a resident's call for assistance and to ensure that the call system is in proper working order. Call lights are to be answered promptly by staff who see that the call light has been activated. Even if you are unable to meet the need of a resident, you can report the need to the appropriate staff member.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide sufficient staffing to ensure ADL (Activities of Daily Living) needs are met in a timely manner for two residents (R4, R8) and medications are being administered as ordered by the physician. The facility's short staffing has the potential to affect all residents residing on the first floor of the facility.Findings include:On 01/25/26 at 10:07 AM, via telephone interview V3 (Staffing Coordinator/Central Supply) stated she does the staffing schedule for all the nurses including RD/LPN and CNAs. V3 stated the nurses do 12 hours shifts 7AM-7PM and 7PM-7AM and the CNAs do 7-3, 3-11 and 7-11 shifts. There are three floors in the building and the second and third floors usually have a higher acuity level than the first floor, so those floors are staffed with more CNAs. V3 stated the first floor is staffed with one nurse depending on the what the census is and V3 will sometimes go up to two nurses. V3 stated when there are 32 residents or more on the first floor that unit will be staffed with two nurses on the 7AM-7PM and 7PM-7AM shifts. V3 stated the first floors runs with three CNAs on the 7-3 and 3-11 shift and two to three CNAs on the 11-7 shift.On 01/25/26 at 10:30 AM, observed one Licensed Practical Nurse (V4) and two Certified Nursing Assistants (V7, V9) working on the first-floor unit. Review of the daily assignment sheet had one nurse (V4) and three CNAs listed on the form. Census not included on the daily assignment sheet.On 01/25/26 at 10:35 AM, facility provided surveyor with document titled, Daily Census dated 01/24/26 which indicated the first floor had 40 residents.On 01/25/26 at 10:45 AM, via telephone interview V3 stated today there is one LPN scheduled to work on the first floor, there were no nursing call outs that is what was scheduled. V3 stated if there are 40 residents on the first floor then it should be staffed with two nurses for continuity of care. V3 stated if the first floor is only staffed with one nurse with the census at 40 there is the potential that there will be an overall delay in care, including the dispensing of medicine which may also be delayed. V3 stated there was a CNA who called out this morning on the first floor, so she found another CNA who agreed to come in to help out.On 01/25/26 at 10:50 AM, V4 (Licensed Practical Nurse) stated they usually have two nurses working on the first floor on the 7AM-7PM shift but today she was the only nurse scheduled. V4 stated she is not aware of any nurse calling out sick she just does not think one was scheduled. V4 stated there is another nurse (V5/LPN) who was working on the 2nd floor who just came downstairs to help because she (V4) is behind with passing morning medications. V4 stated she is getting ready to start passing medications from the second medication cart. V4 stated she has not passed any of her 9 AM medication to those residents yet but she is getting ready to start doing that now.On 01/25/26 at 10:55 AM, V5 (Licensed Practical Nurse) stated today she is assigned to the second floor. V5 stated she was told that the first-floor nurse needed help so when she was done passing her 9AM medications she came down to the first floor at 10:30 AM to help the nurse (V4). V5 stated she has two residents on the first medication cart which still need their medication passed out to them and after that she will be starting to do Accu-Chek readings for the diabetics before lunch is served.On 01/25/26 at 12:07 AM, V4 stated she is still passing out 9 AM medications to the residents. V4 stated the 9 AM medications are late because of staffing. V4 stated she had to pass two carts of medication since it was only her and as a result she fell behind.On 01/25/26 at 12:21 PM, V11 (Certified Nursing Assistant) stated she has been working at the facility since April 2025 and she usually works the 3-11 shift on the first floor. V11 stated V3 Staffing Coordinator/Central Supply) called her this morning and asked her to come in to work early. V11 stated she arrived at the facility at 11:00 AM. V11 stated before she arrived there were two CNAs covering the first-floor unit. V11 stated she (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is now taking care of 14 residents of which nine residents require total care and two residents require assistance with care. V11 stated she has checked on all her residents and changed three of them and the other CNAs had changed three other residents before she arrived, so she still has five more residents to change. V11 stated on the 7-3 and 3-11 shift the minimum number of CNAs they run the floor with is three with a maximum four CNAs.On 01/25/26 at 12:30 PM, V9 (Certified Nursing Assistant) stated when she arrived there was one other CNA covering the unit with her this morning. V9 stated they are supposed to have at least three CNAs on the first floor. V9 stated she was told there was a CNA who called out. V9 stated because of the call out there were two CNAs to cover 40 residents meaning they each had 20 residents to take care of. V9 stated they usually cover 11-12 residents which is doable based on the resident's level of care. V9 stated it is not realistic for two CNAs to be able to take care of 40 residents. V9 stated the residents that require total care and those that wanted to get up out of bed were complaining this morning because everything took longer to complete which resulted in a delay in care. V9 stated they (V7 and V9) were also the only CNAs passing out breakfast trays, feeding residents that needed to be fed, picking up dirty trays and because of this she could not check and do changes every two hours because there was not enough staff. V9 stated she still needs to give a resident a shower and if they were fully staffed with three CNAs from the beginning of the day she would have gotten to giving the resident the shower already. V9 stated the residents who get up out of bed are usually taken out of bed after breakfast, but they are still getting some of the residents out of bed now. At 12:40 PM, V9 stated V7 (CNA) is in the process of getting R8 out of bed right how.On 01/25/26 at 12:40 PM, surveyor knocked on R8's door. V7 (CNA) stated she is giving R8 care.On 01/25/26 at 12:41 AM, observed R4 lying in bed. R4 stated the staff usually gets her out of bed before breakfast. R4 said, there is not enough staff working here. R4 stated they only have two CNAs working today and they are supposed to have three CNAs. R4 said, if they had 3 CNAs I've be out of bed by now.On 01/25/26 at 1:18 PM, observed R8 sitting in his motorized wheelchair. R8 stated he wanted to get out of bed at 9:30 AM today but when he asked the staff to get him out of bed, they told him they could not do it because there were only two CNAs working the unit. R8 stated he was frustrated that he had to wait and could not get up when he wanted to. R8 stated the CNA got him up out of bed after lunch. R8 stated he's okay now but he would have preferred to get out of bed earlier.On 01/25/26 at 1:06 PM, V7 (Certified Nursing Assistant) stated there are usually three to four CNAs working on the unit per shift. V7 stated this morning when she arrived at the facility it was only herself and V9 cover the unit because there was a call out. V7 stated only having two CNAs to cover the unit made it hectic and chaotic. V7 stated breakfast was our top priority so the two of us had to pass out the breakfast trays, feed the residents that needed to be fed, and collect the dirty trays. V7 stated after breakfast she was able to start on her rounds and giving care to the residents. V7 stated V11 arrived around 10:30-11:00 AM. V7 stated R8 usually get up out of bed at 10:00 AM however there was a delay getting him out of bed today because of the schedule and shortage of staff. V7 stated she got R8 out of bed after lunch around 12:30 PM.On 01/25/26 at 1:34 PM, via telephone interview V2 (Director of Nursing) stated the nursing staff is supposed to pass medication on time (one hour before or one hour after) and medication should be given as prescribed by the physician. V2 stated the number of CNAs assigned to work on a unit is based on census. V2 stated the facility has been assigning three to four CNAs on the first floor. V2 stated if there is a census of 40 residents on the 1st floor there should be three to four CNAs working on the unit. V2 stated if there are less than three to four CNAs on the first floor unit with a census of 40 this could potentially have an impact on resident care specifically it could cause a delay in answering call lights, (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	delay in providing care to residents, and delay in getting residents out of bed. V2 stated if there are any call outs in the building the other staff in the building should be stepping in to assist with giving care to the residents.R4's diagnosis includes but not limited to Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Dysphagia, Spastic Diplegic Cerebral Palsy, Neuromuscular Dysfunction of Bladder, Limitation Of Activities Due To Disability, Weakness. R4's MDS (Minimum Data Set) dated 12/19/25 indicates R4 requires substantial maximal assistance with ADLs.R8's diagnosis includes but not limited to Fusion of Spine, Cervical Region, Unspecified Pedal Cyclist Injured In Collision with Car, Pick-Up Truck Or Van In Nontraffic Accident, Sequela, Quadriplegia, C1-C4 Incomplete, Acute Respiratory Failure With Hypoxia, Dysphagia, Neuromuscular Dysfunction of Bladder, Chronic Embolism And Thrombosis Of Deep Veins Of Right Upper Extremity,, Muscle Wasting And Atrophy, Limitation Of Activities Due To Disability,, Other Reduced Mobility, Weakness, Emphysema, Unspecified Displaced Fracture Of Seventh Cervical Vertebra, Sequela, Fracture Of Nasal Bones, Sequela, Unspecified Injury At Unspecified Level Of Cervical Spinal Cord, R8's MDS dated [DATE] indicates intact cognition and functional limitations in range of motion to upper and lower extremity to both side and substantial/maximal assistance to dependency for self-care ADLs and mobility.Facility provide Daily Census report dated 01/24/26 which indicates there are 40 residents on the first floor.Facility provided copy of daily assignment for the first-floor days dated 01/25/26 indicating V4 as the only nurse assigned. V7 V9, V11 are listed as the CNAs covering the unit.Per V1 (Administrator) the facility does not have a policy on staffing.Refer to F755 and F558 for additional information.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure medications were administered as scheduled per physician orders for two (R1, R4) out of three residents reviewed for medication administration.Findings Include:On 1/25/26 at 9:57 AM, R1 was sitting up in bed alert and oriented to person, place, and time. Able to verbalize needs with no difficulty. R1 stated that he did not receive his scheduled morning medications at 6:00 AM today and received it at 8:00 AM instead. R1 also stated that on 1/21/26, he did not receive his scheduled Eliquis, Multivitamin, and Midodrine.1/25/26 at 2:14 PM, a phone interview was conducted with V18 (Registered Nurse) and stated he was R1's nurse on 1/21/26 night shift until 1/22/26 and leaves at 7:30 AM. V18 denied giving R1's Midodrine late on 1/21/26. V18 said that there could be other factors that medications might not be administered either the medication is not available, or it is not ordered.On 1/25/26 at 3:01 PM, a phone interview was conducted with V19 (Registered Nurse) and stated she was the nurse assigned to R1 on 1/21/26 evening. V19 stated R1's Midodrine was on order meaning she had to order more. V19 stated that the Midodrine was not administered to R1 because his BP (Blood Pressure) was high and if needed, the medication is available in the emergency medication dispensing system.R1's face sheet listed diagnoses but not limited to orthostatic hypotension, end staged renal disease, and polyosteoarthritis. R1's Minimum Data Set (MDS) assessment dated [DATE] shows R1 is cognitively intact with BIMS (Brief Interview for Mental Status) score of 15. R1's Order Review Report and Medication Admin Audit Report printed on 1/25/26 revealed that on 1/21/26, R1 had ordered and scheduled medication of Midodrine 10 mg by mouth every eight hours (Hold if systolic BP is more than 135) to be administered at 10:00 PM but was documented administered on 1/22/26 at 5:19 AM, more than seven hours past the scheduled administration time. R1's progress notes dated 1/21/26 at 5:02 PM documented by V19 reads in part: Midodrine HCl Oral Tablet 10 MG Give 1 tablet by mouth every 8 hours ON ORDER. No documentation of R1's BP readings on 1/21/26 progress notes. R1's blood pressure summary revealed on 1/21/26 at 6:17 AM, R1's BP was 110/68. No other BP readings recorded on 1/21/26.R1's Medication Admin Audit Report printed on 1/26/26 revealed that on 1/25/26, R1 had ordered and scheduled medications of Midodrine 10 mg by mouth every eight hours (Hold if systolic BP is more than 135) to be administered at 6:00 AM but was documented administered at 8:02 AM, Protonix 40 mg one time a day by mouth to be administered at 6:00 AM but was documented administered at 8:03 AM, and Ferrous Sulfate 325 mg by mouth one time a day to be administered at 6:00 AM but was documented administered at 8:02 AM.On 1/25/26 at 11:09 AM, surveyor started the medication administration observation on the first floor with V4 (Licensed Practical Nurse). V4 stated that she documents in the resident's chart that medications were administered after and not before administering medications. V4 stated she signs off the resident's EMAR (Electronic Medication Administration Record) what were administered and the time they were administered will be recorded. V4 stated she is not finished with passing the residents' 9:00 AM medications. V4 said she was by herself when she came in this morning and there are 39 residents to pass medications this morning. V4 said there are supposed to be two nurses working on the first floor, but someone might have called in sick. On 1/25/26 at 11:14 AM, V4 took R4's blood pressure reading and read 136/80 with heart rate of 94 bpm (beats per minute).On 1/25/26 at 11:16 AM, V4 prepared R4's 9:00 AM medications consisted of Aspirin 81 mg (milligrams), Amlodipine 10 mg, and Vitamin D3 125 mcg (microgram) all by mouth.On 1/25/26 at 11:21 AM, R4 took all of her 9:00 AM pills.On 1/25/26 at 1:09 PM, R4 stated that sometimes facility has short staff and would receive her medications late.R4's face sheet listed diagnoses but not limited to cerebrovascular disease and essential hypertension. R4's (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS dated [DATE] shows R4 has cognitive impairment with BIMS of 6. R4's Order Review Report and Medication Admin Audit Report printed on 1/25/26 shows that on 1/25/26, R4 had ordered and scheduled medications of Aspirin 81 mg by mouth one time a day, Amlodipine 10 mg 1 tablet one time a day, and Vitamin D3 125 mcg by mouth one time a day. All to be administered at 9:00 AM but were documented administered at 11:18 AM, more than two hours past the scheduled administration times.On 1/25/26 at 1:33 PM, a phone interview was conducted with V2 (Director of Nursing) and stated that medication administration is done one hour before and one after the scheduled administration times. V2 stated that if the nurses give the medications late, they must call the doctor. V2 stated that after a resident takes their medications, the Nurses are documenting the time they administered the medications in the EMAR. V2 said nurses are supposed to follow policy when administering medications to the residents following the correct resident, right route, right dosage, right medication, and right time. V2 said physician orders are followed for medication administration. V2 stated that it is important to administer all medications to the residents based on the prescription of the doctor to minimize the diagnosis worsening. For example, for hypertensive medications to control hypertension. The facility's 5.1: DRUG ADMINISTRATION--GENERAL GUIDELINES (no date) reads in part: Medications are administered in accordance with written orders of the attending physician. Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administrated precisely as ordered. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility. The right time: administer drugs as instructed on the MAR and within the time frame established by your facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure (a) signage for Enhanced Barrier Precautions (EBP) was posted and (b) staff / visitor wear proper personal protective equipment (PPE) for resident on contact precautions. These failures affected two (R1 and R3) out of four residents reviewed for Infection Control. The findings include:R1's admission record face sheet showed admit date on 12/6/25 with diagnoses not limited to Chronic Obstructive Pulmonary Disease, End Stage Renal Disease, Acquired absence of kidney, Dependence on renal dialysis, Hypertensive heart and chronic kidney disease, Anemia, Chronic diastolic congestive heart failure. MDS (Minimum Data Set) dated 12/13/25 showed R1's cognition was intact.On 1/25/26 at 9:58AM Observed R1 resting in bed, alert and oriented x 3, verbally responsive. Stated he has been residing in the facility since 12/6/25. Stated his Immune system is low due to diagnosis of ESRD (End Stage Renal Disease) and he is on hemodialysis. R1 showed dialysis access site on right chest area with dressing in place. Observed dialysis access catheter with dressing on right chest area. There was no EBP signage posted by R1's door / room entrance. R1's POS (Physician Order Sheet) dated 1/25/26 showed order not limited to: Enhanced Barrier Precautions due to diagnosis of Dependence on Renal Dialysis. Hemodialysis (3) times per week. Venous Access Site: (Right SVC - supervisor vena cava). Care plan dated 12/9/2025 showed in part: R1 is on enhanced barrier precautions for: Invasive Dialysis access site. Follow Enhanced Precaution Guidelines when providing care and coming in direct contact with potentially infected material or devices that put me at risk. Direct Care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting and incontinence care, Device use, Catheter, Trach/Vent, central lines, feeding tube, wounds care or any skin opening requiring a dressing. Set up isolation per facility protocol. Follow the enhanced precautions guidelines.R3's admission record face sheet showed admit date of 1/9/2026 with diagnoses not limited to End stage renal disease, Encounter for attention to gastrostomy, Type 2 diabetes mellitus, Acute hepatitis c without hepatic coma, Dysphagia oropharyngeal phase, Other seizure, Essential (primary) hypertension, Kidney transplant infection, Liver transplant rejection, Alcoholic cirrhosis of liver without ascites, Methicillin resistant staphylococcus aureus infection, Hyperlipidemia, Enterocolitis due to clostridium difficile. On 1/25/26 At 11:17AM Observed R3 with room signage indicating Contact Precautions - Everyone must Put on gloves, gown before room entry. Observed R3 resting in bed, alert and verbally responsive with bouts of confusion, appears well groomed and comfortable. Observed V13 (R3's visitor) sitting and talking to R3 inside the room without wearing proper PPE, no gloves, no gown. On 1/25/26 At 1:11PM Observed V11 (CNA / Certified Nursing Assistant) went inside R3's room and assisted R3 with lunch wearing gloves but not wearing gown. Observed V11 inside R3's room not wearing proper PPE.On 1/25/26 at 12:34PM V12 (IP / Infection Preventionist nurse, LPN / Licensed Practical Nurse) stated she has been working in the facility for 10 months. She said R1 is on EBP (Enhanced Barrier Precautions) for his dialysis venous access site. V12 said if residents are on EBP staff should wear proper PPE (gloves and gown) when providing high contact resident care activities such as bathing, oral care, or ADL (activities of daily living) care. She said there should be a signage at the door and PPE supplies accessible to staff. V12 said door signage indicating EBP should be posted by residents' room entrance to alert or notify the visitors / staff what to do or what PPE should be worn when entering the room. V12 said R3 is on contact isolation for ESBL (Extended Spectrum Beta Lactamase) in the urine. She stated there should be door signage and PPE supplies available before entering the room. V12 said staff / visitor should wear proper PPE such as Gloves and gowns when entering the room to prevent cross contamination and spread of infection. She said contact precautions should have a physician (continued on next page)

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	01/26/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order put in resident's electronic health record. V12 said contact precautions should have a care plan to direct staff what to do or how to care for the residents. Reviewed R3's EHR (Electronic Health Record) with V12 and there was no care plan and physician order for contact precautions found. Surveyor went to R1's room with V12 and there was no signage for EBP posted by the door or room entrance. On 1/25/26 At 1:38PM V2 (DON / Director of Nursing) was interviewed via phone and said staff should follow the guidelines for whatever precautions that are placed or ordered for residents. She said resident on contact precautions, staff / visitor should wear proper PPE such as gloves and gown when entering the room to prevent further infection, spread of infection or cross contamination. V2 said residents on contact precautions should have a physician order so staff are aware of the type of infection. She said contact precautions should have a care plan to provide interventions that are necessary for the residents. V2 said residents on EBP should have a door signage posted by room entrance to make the visitor and staff are aware that resident is on EBP, the sign will inform them what the proper PPE needed to enter the room.On 1/25/26 at 1:50PM V12 (IP nurse) printed R3's physician order showing order for contact isolation related to diagnosis of ESBL urine. Order date 1/25/26 at 1:33PM. V12 also provided a copy of R3's care plan for contact precautions that was added after reviewing R3's EHR.Facility's visitor sign in sheet dated 1/25/26 showed V13 visited R3. Facility's door signage for EBP showed in part: everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the flowing high-contact resident care activities: dressing, bathing / showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use - central line, urinary catheter, feeding tube, tracheostomy. Facility's door signage for contact precautions showed in part: everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also put on gloves and a gown before room entry. Facility's Enhanced Barrier Precautions (EBP) policy dated 12/19/22 showed in part: It is the policy of the facility to ensure that additional and appropriate PPE (Personal Protective Equipment) is utilized, when indicated, to prevent the spread of Multidrug-resistant Organisms also known as MDROs. Who is at High Risk for acquiring or spreading a MDRO? Resident(s) with an indwelling medical device including but not limited to: Central Venous Catheters, Indwelling Catheters. Ensure that proper signage is posted on the resident's room door instructing those who plan to enter the room to check first at the Nurses' Station for education/instruction.Facility's infection control/isolation guidelines policy dated 2/2023 showed in part: To prevent unprotected exposure of residents, visitors and staff to potentially infectious microorganisms or diseases and to decrease the spread of in-house or community acquired infections. Contact Precautions---Intended to prevent transmission of infectious agents which are spread by direct contact with the resident (hand or skin-to-skin contact that occurs when performing resident care activities that require touching the resident) or indirect contact with an intermediate object/person (e.g., environmental surfaces or items in the resident's environment/room). Contact Precautions require the use of gloves and a gown when entering the room regardless of resident contact. When placing a resident on any type of isolation precautions, an order must be obtained from the physician for the specific isolation precautions. Any Isolation Precautions need to be care planned.