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	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpoint Nursing & Rehab Center	1010 West 95th Street Chicago, IL 60643

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide clean linen for four (R2, R3, R10, R11) residents out of fourteen residents reviewed for linen in a total sample of 17 residents. These failures affected four (R2, R3, R10, R11) residents' availability on accessing clean linens.Findings include: On 01/27/2026 at 12:27PM, surveyor located on the first floor of the facility and observes one linen cart in the hallway. The following items were observed on the first-floor linen cart: approximately 6 gowns, 25 wash cloths, 5 sheets, 7 under pads, 5 body towels. On 01/27/2026 at 12:31PM, surveyor located inside of the clean utility room with V16 (Registered Nurse/RN). Surveyor observes a large utility cart without any linen on the shelves. V16 states the laundry department usually delivers clean linen every morning and places it on the shelves in the clean utility room. V16 states she is not sure if the laundry department delivered clean linen to the first floor today. V16 states the linen usually arrives late to the first floor at around 10:30AM-11:00AM every day. V16 states residents have been complaining of not having enough linen in the facility. On 01/27/2026 at 12:37PM, surveyor located on the second floor of the facility and observes three linen carts in the hallways. The following items were observed on the first linen cart: approximately 4 gowns, 1 flat sheet, 1 under pad. The following items were observed on the second linen cart: no linen. The following items were observed on the third linen cart: approximately 2 gowns, 1 under pad. On 01/27/2026 at 12:40PM, surveyor located inside of the second-floor clean utility room with V23 (Licensed Practical Nurse/LPN). Surveyor observes a large utility cart without any linen on the shelves. V23 states the laundry department delivered clean linen to the second floor but is unsure of what time it was delivered. On 01/27/2026 at 12:46PM, R11 states she was recently admitted to the facility but has been hearing about concerns related to the lack of linen in the facility. R11 states sometimes she has to wait to have linen provided to her from the facility staff. On 01/27/2026 at 12:53PM, R10 is observed with a clean body towel folded on her chest while lying in bed. R10 states she is keeping her towel close to her because if she doesn't, then she will not (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	have a towel to use for her care. R10 states she has witnessed the facility staff hide resident's linen to use for later. R10 states she has also witnessed the staff cut larger body towels to make smaller wash cloths to use for the resident's care. R10 states there is not enough linen for residents to use in the facility. On 01/27/2026 at 1:13PM, surveyor located on the third floor of the facility and observes three linen carts in the hallways. The following items were observed on the first linen cart: approximately 6 gowns, 5 wash cloths, 7 sheets, 10 under pads, 4 body towels. The following items were observed on the second linen cart: approximately 8 gowns, 12 body towels, 10 sheets, 8 under pads. The following items were observed on the third linen cart: approximately 3 bath towels, 1 wash cloth, 2 gowns, 2 under pads, 1 flat sheet. On 01/27/2026 at 1:18PM, surveyor located inside of the clean utility room with V24 (Licensed Practical Nurse/LPN). Surveyor observes a large utility cart without any linen on the shelves. V24 states she saw the laundry department deliver linen to the third floor at approximately 8:30AM. V24 states the utility shelves in the clean linen utility room should have extra linen stored but there isn't any linen on the shelves. Ombudsman Residents' Rights for People in Long-Term Care Facilities dated 11/2018 documents in part, Your facility must be safe, clean, comfortable and homelike. Resident Council Meeting Minutes dated 11/12/2025 documents in part, Housekeeping- Need to get residents and staff to stop hoarding linen. On 01/27/26 at 11:07 AM, R3 stated right now there is no linen, they keep talking about the washer is down, or it was down. They have to do what they have to do; residents have bed sores; I cannot sleep on the same one. R3 said his fitted sheet has not been changed yet because he is still going to finish washing himself up. R3 stated I need to have clean linen because of my bed sores. R3 stated that R3 went to V1 (Administrator) and told her I (R3) don't have any linen, and I have bed sores. R3 stated that V1 said we have some linen coming from another company. And then no linen came. This was a date after I called the state. R3's face sheet documents R3 is a [AGE] year-old individual with diagnoses not limited to: paraplegia, pressure ulcer of sacral region, unspecified stage, pressure ulcer of right hip, stage 4. R3's Minimum Data Set (MDS), dated [DATE], documents R3 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating R3 has intact cognitive response. On 01/28/2026 at 10:44 AM, V11 (Housekeeping Director) stated that linens and personal clothes of residents are washed in the facility. V11 stated that clothes and linens were sent to another facility because washing machines needed to be repaired. Three (3) months ago, one washing machine was working and the other one was being repaired. V11 stated that one washing machine is for personal clothes, the other for facility linen. V11 stated that she needs to order linen frequently from outside vendor due to linen not enough. V11 stated that some residents were hoarding linens that facility staff saw linens in resident room after sweeping. V11 stated that currently single washing machines do both linens and personal clothes. With one washing machine we can only do both. There is a lot of (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	difference when both (washing machines) are functioning. It will make a lot of difference. On 01/28/2026 at 11:20 AM with V11 and V15 (Maintenance Director), V15 stated that there are three (3) washing machines and two are not working. Per V15 stated that one washing machine was newly installed because it was not working three months ago. After installation of the new washing machine, the other two (2) washing machines broke and need to be repaired. Both washing machines that need to be repaired were seen in poor condition as to their rust-like structure that has holes. According to V15, parts needed were new motherboard and new bearings. The new washing machine has sixty (60) pounds capacity, two (2) that need to be repaired at 60 pounds and 80 pounds capacity. Middle washer that needs to be repaired still have linens visible inside the washer. V15 stated that it cannot be taken out because the door cannot be opened. Currently, facility has sixty (60) pounds capacity per wash instead of 200 pounds if all three washing machines are working. V15 stated that facility's washing machines that were replaced and need repair were too old and that it was there when he started working in the facility. And does not have manufacturer's information, the only maintenance he does is to grease it. If we cannot repair it, that is the time we replace it. There are three (3) dryers with one (1) dryer that has a paper tape with out of order written. V15 stated that plastic wheel needs to be replaced. All shelves that were in the laundry area were seen, there are five (5) gowns noted. V11 stated that these gowns are extra. V11 went to her office, and on her office were linens wrapped with plastic were seen on the shelves without any gowns included. Both V11 and V15 were made aware that there were only five (5) gowns were seen available. On 01/30/2026 at 09:29 AM, R2 stated that he has irritable bowel syndrome with diarrhea almost every day. A lot of times you ask CNA (Certified Nursing Assistant) for linen they say they don't have it because the washers have broken down. R2 stated that he has been in the facility for a month and half washers are already broken. R2 stated that he must go to laundry services and spend 30 dollars because he has dirty clothes back up. R2 stated he came back to the facility yesterday 01/29/2026 his clothes are still dirty. I keep putting on dirty clothes. I just wish I had money to go to laundry. R2 is [AGE] year-old initially admitted [DATE]. R2 medical diagnosis includes disease of digestive system and gastroparesis. Per clinical notes dated 01/24/2026, R2 went and was admitted to the hospital due to diarrhea and vomiting. R2 has an order for Loperamide 2 MG for diarrhea.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based upon interview and record review, the facility failed to report an injury of unknown origin to the state surveying agency within regulatory requirements for one (R7) resident. This failure has the potential to affect all 172 residents residing in the facility. Findings include: Findings include: On 01/27/2026 at 2:02PM, Facility Reported Incidents/FRIs were requested from V1 (Administrator) for the past 3 months. V1 provides surveyor with three incident reports via scanned email, that are dated 12/02/25, 12/16/25, and 01/14/2026. V1 states these are the only facility reported incidents that occurred in the facility for the past 3 months. During record review of facility's reported incidents, surveyor observes that they were not submitted to the correct email address. On 01/29/2026 at 2:12PM V1 states she was made aware of R7's incident by V2 (DON). V1 states she reported R7's incident to the state agency via email on 12/16/2025, the same day it was reported to her. V1 is made aware that the state agency is not in receipt of the reported incidents. V1 is asked by surveyor to access her emails electronically and send surveyor email confirmation of the successful submission of the reported incident for R7 to the state agency. V1 states she is unable to access her emails at the current moment and will check for the email confirmation later. On 01/29/2026 at 3:32PM, surveyor receives an email from V1 stating she did not receive email confirmation from the state agency that the reported incident for R7 was received. V1 states the email was kicked back to her email and not sent successfully to the state agency. V1 states R7's reported incident was also sent from V2's email to the state agency. V1 emails surveyor a scanned email documenting a time stamp of an undeliverable blank email to the state agency. V1 also emails surveyor a scanned email documenting a time stamp of a blank email being sent from V2's email to the correct state agency's email. Both scanned emails do not have R7's facility reported incident attached showing proof of submission to the state agency. On 01/29/2026 at 4:07PM, surveyor requests V1 to directly forward surveyor the email that was sent from V2's email to show confirmation of R7's reportable incident that was sent to the state agency. Surveyor asks V1 not to scan the email and send it to surveyor, but to forward the exact email with R7's reportable attached that was sent to the state agency. This email was not provided to surveyor during this survey. On 01/29/2026 at 4:42PM, record review confirms that a facility reported incident for R7 was not received by the state agency from the facility. Further record review documents and confirms that a facility reported incident has not been received by the state agency from the facility since 12/03/2025. On 01/30/2026 at 10:51AM, V1 states that she has been the administrator since 08/2024 and was not aware that she was submitting the facility reported incidents to the incorrect email address. V1 states she never received confirmation that the email was sent to the state agency. V1 states herself and V2 share responsibilities with submitting the facility reported incidents to the state agency. V1 states since being informed by surveyor of using the incorrect email, she has now obtained a fax number to use instead of the email. V1 states the fax number is 708-544-92XX and V1 is made aware by surveyor that this is also an incorrect fax number for communication with the state agency. Surveyor then provides V1 and V2 with the correct fax number to submit reported incidents to the state agency. Surveyor provides V1 and V2 with the fax number 630-645-37XX and V1 successfully repeats the fax number back to surveyor for verification that V1 received the correct fax number. V1 is made aware that the facility not successfully submitting reported incidents to the state agency further puts all residents in the facility at risk for abuse and injuries. V1 states going forward, the facility will now use the fax number provided by surveyor to report facility reported incidents to the state agency. Facility census dated 01/27/2026 documents that a total of 172 residents reside in the facility. Facility policy dated 10/22/2022 titled, Abuse (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Prevention Program documents in part, All personnel must promptly report any incident or suspected incident of resident abuse, mistreatment or neglect, including injuries of unknown origin. (An injury should be classified as an injury of unknown origin when the source of the injury was not observed or known by any person, and the initial Risk Management investigation could not determine the causeof the injury.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a portion of an existing plan related to pressure ulcer care, such as not following treatment/dressing changes as ordered for one (R3) resident out of four reviewed for pressure ulcers in a total sample of 17 residents. However, there has been no evidence of decline or failure to heal. This failure places the resident at risk for more than minimal harm. Findings include:On 01/27/26 at 11:07 AM, R3 stated there have been several days when the wound care treatment was not done. R3 stated I am just wondering why the nurses don't change the wounds. R3 stated my wounds are stage 4 and they are super big and drain a lot, and they are supposed to be changed every day. R3 stated that he didn't call to remind the nurse on duty because R3 stated they can come anytime of the day and I just kept waiting. I am on medications, and I may fall asleep and the day went by.On 01/27/2026 at 12:38 PM, V7 (Wound care coordinator/LPN) stated that R3 has a right Ischium, right trochanter and sacrum pressure ulcer wounds. V7 stated that R3's pressure injuries are documented in R3's comprehensive care plan. V7 stated that when wound care is administered or completed it is documented in the patient's treatment administration record (TAR). Staff nurses are responsible for completing the wound care treatment orders when there is no wound care nurse working. V7 stated that it is important for wound care orders to be followed as ordered to ensure that the wound heals, to follow how the wound is progressing, prevention of decline, no introduction of bacteria or anything to the wound. R3's face sheet documents R3 is a [AGE] year-old individual with diagnoses not limited to: paraplegia, pressure ulcer of sacral region, unspecified stage, pressure ulcer of right hip, stage 4.R3's Minimum Data Set (MDS), dated [DATE], documents R3 has a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating R3 has intact cognitive response.R3's care plan documents in part a pressure ulcer to right trochanter, right ischium, sacrum. Date Initiated: 12/12/2025 Revision on: 12/15/2025. Interventions documents in part Treatment per physician orders Date Initiated: 12/12/2025.R3's treatment administration record for January 2026 documents that R3's wound care treatment was not administered for the following dates 01/05/2026, 01/07/2026, 01/11/2026, 01/12/2026, 01/19/2026, 01/21/2026, 01/22/2026, 01/25/2026.R3's current care plan documents in part, I have a pressure ulcer to right trochanter, right ischium, sacrum. My pressure ulcer will remain free of s/sx (signs and symptoms) of infection and wound will continue to heal without complications daily through next review. Treatment per physician orders.R3's current care plan documents in part, I am at increased risk for impaired skin integrity related to wounds. I will not develop any skin integrity issues thru next review,unless the disease process causes unavoidable deterioration. Administer Wound Care (Treatments) per MD orders (See POS/TAR (physician order set/treatment administration order) for current orders)Facility document not dated titled Guidelines for Prevention/Treatment of Pressure Injuries documents in part it is the intent of the facility to recognize the following and to act on it in such a way as to practice evidence-based recommendations for the prevention/treatment of pressure injuries to the residents who reside in the facility. In accordance with Federal Regulations- and based on resident assessment, the facility will ensure: A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on observation, interview, and record review, the facility failed to provide adequate supervision and monitoring for three (R7, R15, R16) residents in a total sample of 17 residents reviewed. As a result of these failures, R7 sustained a fracture to the left femur on 12/16/2025 while in the facility.Findings include: R7 is no longer in the facility and was reviewed as a closed record. R7's Facesheet documents that R7 has diagnoses not limited to: Essential hypertension, type 2 diabetes mellitus with diabetic neuropathy, cerebrovascular disease, hyperlipidemia, unspecified convulsions, alcohol abuse, other lack of coordination, muscle weakness (generalized), unspecified abnormalities of gait and mobility, muscle wasting and atrophy, weakness, and unsteadiness on feet.R7's Minimum Data Set/MDS dated [DATE], documents that R7 has a BIMS (Brief Interview for Mental Status) of 6/15 indicating that R7 is cognitively impaired. R7's Activities of Daily Living (ADL) Assistance documents that R7 requires supervision assistance with ADL care and mobility. R7 is continent of bowel and bladder, does not have an impairment to extremities, does not use assistive devices, and ambulates via walking.R7's hospital records dated 12/16/2025 documents in part, X-ray imaging demonstrates a left basicervical femoral neck fracture. R7 is a very poor historian, A&O x1. No information provided from nursing home. Family did not pick up the phone when called. Remainder of history obtained from the chart. R7 is unable to give any information as to why he was brought to the ED/emergency department. R7 reports tenderness to palpation of the Left hip. No pain at rest. Unclear of mechanism and timing of injury. R7 says he does not remember. R7 denies living in a facility. R7 also denies any chest pain, palpitations, SOB/shortness of breath, headache, nausea/vomiting N/V.R7's care plan documents in part, R7 will have a safe environment maintained through next review. Staff to anticipate and meet my needs. I would like staff to provide me with a safe environment.R7's community survival skills assessment dated [DATE] documents in part that R7 does not appear to be capable of unsupervised outside pass privileges at this time. On 01/27/2026 at 1:29PM, R15 and R16 observed sitting inside of the second-floor dining room unsupervised and unattended. R15 and R16 were sitting in geri-chairs.On 01/27/2026 at 1:39PM, V4 (Licensed Practical Nurse/LPN) states the Certified Nursing Assistants/CNAs take turns monitoring the residents in the dining room at 30-minute intervals. V4 states residents are monitored to make sure they do not fall, injure themselves, choke, or get into physical altercations with one another. V4 states V12 (CNA) is the person responsible for monitoring the second-floor dining room today from 1:30PM to 2:00PM. V4 states she was the nurse caring for R7 on 12/16/2025 and the off-going nurse informed her that R7 was experiencing leg pain. V4 states R7 usually ambulates via walking but V4 was off work for a couple of days prior to 12/16/2025 and when she returned, R7 was ambulating via wheelchair. V4 states she asked R7 what happened related to his leg pain and R7 told her that he fell while playing basketball. V4 states R7 does have dementia so she informed R7's physician and was given orders to send R7 to the hospital for evaluation. V4 states R7 was sent to the hospital and the hospital informed her that R7's left leg was fractured. V4 states she spoke to V5 (R7's Family Member) in person the same day and V5 told her that R7 experienced a fall while playing basketball a long time ago. Record review of the CNA assignment sheet for the second-floor dining room dated 01/27/2026, documents that V12 is responsible for monitoring the dining room from 1:30PM-2:00PM. R15's fall risk assessment dated [DATE] documents that R15 is at high risk for falls with a fall risk score of 13.R15's care plan documents in part, I have impaired cognition/function or impaired thought process as a history of falling and muscle weakness. loss) Dementia, impaired decision making. Cue, reorient and supervise me as needed. I would like staff to provide me with a safe (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	environment. Observe for fall precautions.R16's fall risk assessment dated [DATE] documents that R16 is at high risk for falls with a fall risk score of 12.R16's care plan documents in part, R16 will have fall interventions in place that will help reduce my risk for falls and injury through the next review. R16 will have a safe environment maintained through next review.On 01/28/2026 at 11:54AM, V6 (Restorative Nurse/LPN) states R7's baseline includes R7 walking without assistive devices with an unsteady gait. V6 states that sometimes R7 would have to hold onto the rails when he walked and was alert and oriented times three. V6 states on 12/11/2025, she received a report from the nurse that R7 was experiencing more than normal unsteadiness in his gait. V6 states she then went to assess R7 and R7 told her that his left knee gives out sometimes. V6 states R7 informed her that he needed to go to the bathroom. V6 states she went to go and get a wheelchair and told R7 not to go to the bathroom until V6 returned. V6 states when she returned, R7 was standing in the bathroom and stated to her I'm fine. V6 states she gave R7 a urinal and wheelchair and educated him on safety and how to use the wheelchair. V6 states R7 told her that he never fell while in the facility and did not complain of pain. V6 states she was informed by V4 (LPN) that R7 was non-compliant with using the wheelchair. V6 states the next time she saw R7, he was sitting in the dinging room without the wheelchair. V6 states R7 told her that he didn't need the wheelchair. V6 states she went to retrieve his wheelchair to place him back into the wheelchair. V6 states the CNAs/Certified Nursing Assistants and other direct staff are responsible for ensuring that R7 uses the wheelchair to ambulate. V6 states if R7 is non-compliant with using the wheelchair, then staff should re-encourage R7 to use it and document if non-compliance persists.R7's progress note dated 12/11/2025 at 4:55PM written by V6 (Restorative Nurse/LPN) documents Received report from nurse that resident is experiencing increased unsteady gait. Resident alert and able to verbalize needs. Upon assessment, resident declines any new/recent incidents. Resident states that his left knee gives out at times. Resident initially declined use of manual wheelchair but is receptive at this time. Wheelchair provided with hands-on education and return demonstration. Resident demonstrated safe use and encouraged to request assistance of staff as needed. Resident also provided with a urinal at bedside. Referral to therapy entered. Assigned nurse and cnas made aware and to Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Functional decline (worsening function and/or mobility).R7's care plan and progress notes were reviewed from 12/11/2025 to 12/16/2025 and does not document that R7 was non-compliant with using his wheelchair.R7's change in condition progress note dated 12/11/2025 at 6:18PM written by V4 (LPN) documents in part, Resident needed two staff members assistance to bed due to left leg weakness, resident proceeded to walk without staff after resting in bed. Gait was not at baseline however had improved from earlier. spoke with medical doctor, md gave no new orders at this time.R7's change in condition progress note dated 12/11/2025 at 6:51PM written by V4 (LPN) documents in part, upon rounding saw resident leaning on bathroom door in room, asked resident was he okay he responded and said he don't know, writer and staff (2nd floor nurse) assisted resident to bed, resident was not able to use his left leg during transfer. Range Of Motion completed, and resident was unsuccessful with using left leg. R7 is alert and oriented times 2-3 with some confusion. (baseline for resident). Resident grip was equal. Vitals stable bp 111/72 p 100 r 19 t 98.2 f sat 97% glucose 141. Resident walked into dining area for dinner without assistance with shuffled gait. (not baseline). Improvement in gait from earlier. Urinal and wheelchair given from restorative nurse until further assessment. Family and physician notified of change, no new orders given at this time. Resident educated on purpose and safety use of wheelchair.R7's progress note dated 12/16/2025 at 12:40PM written by V4 (LPN) documents in part Resident complains of left leg pain starting at groin radiating down thigh, no pain upon (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	light touch, pain with movement rated at about a 6, reported to MD. MD gave orders to send resident to hospital for evaluation. Family (left voicemail for daughter) and DON notified of transfer. Report given to hospital nurse.R7's progress note dated 12/16/2025 at 6:35PM by V4 (LPN) documents in part Spoke with hospital admitting diagnosis of left femur fracture, due for surgery tomorrow. Nurse practitioner and don made aware. Attempted to reach family again, no response at this time.On 01/28/2026 at 12:40PM, V13 (Social Services Director) states he is familiar with R7 and R7 did not go out into the community independently. V13 states that sometimes R7's daughter would take him out on pass into the community. V13 states when a resident goes out on community pass, he always documents a progress note that the resident went out on pass. V13 states if it is not documented that the resident went out on community pass, then the resident did not go out on pass.R7's progress notes were reviewed from 11/28/2025 to 12/16/2025 and does not document that R7 went out on community pass.Review of the facility's document titled Resident Community Access Tracking Tool was performed for the month of December 2025 and does not show that R7 went out on community pass for the month of December 2025.Facility policy undated, titled Standard Supervision and Monitoring documents in part, The facility recognizes supervision and guidance to the resident is an essential part of nursing care in which standard approaches are successful in meeting the resident's physical and psychosocial needs.Facility policy undated, titled INCIDENTS/ACCIDENTS/FALLS documents in part, Based on the results of the incident/accident/fall, the resident's care plan will be addressed to ensure that any needed points of focus have measurable goals with appropriate interventions in place.

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	01/30/2026

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain laundry equipment in good working conditions that provides laundry services to all residents. These failures have the potential to affect all 172 residents living in the facility receiving laundry services. Findings include: On 01/27/2026 at 12:31PM, V16 (Registered Nurse/RN) states she was informed that residents were complaining about their laundry because the facility's washing machine was broken about 2 weeks ago. On 01/27/2026 at 1:18PM, V24 (Licensed Practical Nurse/LPN) states there was a washing machine malfunction that the facility experienced recently. V24 states the facility now has a new washing machine and it is being used to wash linen and resident's clothes. V24 states when the new machine arrived, the facility focused more on washing the facility's linen. V24 states during this time, residents verbalized concerns with their clothing items being washed and returned from the laundry department. Ombudsman Residents' Rights for People in Long-Term Care Facilities dated 11/2018 documents in part, You have the right to keep and wear your own clothing. On 01/28/2026 at 10:44 AM, V11 (Housekeeping Director) stated that linens and personal clothes of residents are washed in the facility. V11 stated that clothes and linens were sent to another facility because washing machines needed to be repaired. Three (3) months ago, one washing machine was working and the other one was being repaired. V11 stated that one washing machine is for personal clothes, the other for facility linen. V11 stated that she needs to order linen frequently from outside vendor due to linen not enough. V11 stated that some residents were hoarding linens that facility staff saw linens in resident room after sweeping. V11 stated that currently single washing machines do both linens and personal clothes. With one washing machine we can only do both. There is a lot of difference when both (washing machines) are functioning. It will make a lot of difference. On 01/28/2026 at 11:20 AM with V11 and V15 (Maintenance Director), V15 stated that there are three (3) washing machines and two are not working. Per V15 stated that one washing machine was newly installed because it was not working three (3) months ago. After installation of the new washing machine, the other two (2) washing machines broke and need to be repaired. Both washing machines that need to be repaired were seen in poor condition as to their rust-like structure that has holes. According to V15, parts needed were new motherboard and new bearings. The new washing machine has sixty (60) pounds capacity, two (2) that need to be repaired at 60 pounds and 80 pounds capacity. Middle washer that needs to be repaired still have linens visible inside the washer. V15 stated that it cannot be taken out because the door cannot be opened. Currently, facility has sixty (60) pounds capacity per wash instead of 200 pounds if all three washing machines are working. V15 stated that facility's washing machines that were replaced and need repair were too old and that it was there when he started working in the facility. And does not have manufacturer's information, the only maintenance he does is to grease it. If we cannot repair it, that is the time we replace it. There are three (3) dryers with one (1) dryer that has a paper tape with out of order written. V15 stated that plastic wheel needs to be replaced. V15 was requested to present installation receipt of washing machine. Order of parts to all washing machines and dryer that were found to be not working. V15 stated that he will inform V1 (Administrator). The same requests for documentation were made to V1. Multiple residents including R2, R3, R10 and R11 express concern related to lack of linens. On 01/27/26 at 11:07 AM, R3 stated right now there is no linen, they keep talking about the washer (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	01/30/2026

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	is down, or it was down. R3 said his fitted sheet has not been changed yet because he is still going to finish washing himself up. R3 stated I need to have clean linen because of my bed sores. R3 stated that R3 went to V1 (Administrator) and told her I (R3) don't have any linen, and I have bed sores. R3 stated that V1 said we have some linen coming from another company. And then no linen came. At 12:46PM, R11 states she was recently admitted to the facility but has been hearing about concerns related to the lack of linen in the facility and must wait for linen to be provided. At 12:53PM, R10 is observed with a clean body towel folded on her chest while lying in bed. R10 states she is keeping her towel close to her because if she doesn't, then she will not have a towel to use for her care. R10 states there is not enough linen for residents to use in the facility. On 01/30/2026 at 09:29 AM, R2 stated that he has diarrhea almost every day. A lot of times you ask CNA (Certified Nursing Assistant) for linen they say they don't have it because the washers have broken down. R2 needs to spend money and service his clothes to outside service company. Per sales invoice new washer was shipped on 01/05/2026. Invoice for washer parts are as follows: A blower wheel order dated 11/20/2025 Washer bad computer door lock board part order dated 12/24/2025. Per V15 the old washer that was replaced broke three (3) months ago after installation of the new washer, the two (2) washers broke. Washer parts for current repair were ordered prior to shipment of new washer that shows two (2) dryers that need repair were already not functioning prior to installation of the new washer. Actual installation of new washer receipt was requested but was not provided. Laundry Policies and Procedure not dated: The laundry room equipment and environment will be inspected and serviced by the Maintenance Department following the policies and procedures in the Preventive Maintenance Manual. Laundry daily inspection (document not dated), Environmental Supervisor will follow manufacturer's guidelines on setting of water temperature.