STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014781	A. BUILDING: _____ B. WING _____	C 11/21/2020

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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S 000	Initial Comments Complaint Investigations #2081869/IL120904 and #2088529/IL128150	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)1) 300.1220 b)2) 300.3240 a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to do an accurate pain assessment, failed to provide effective pain medication, failed to document and assess the resident for vitals and pain on a daily basis, and failed to follow their policy on pain management for 1 (R3) of 3 residents reviewed for pain in the sample of 6 residents. This resulted in an oriented, 35 year old male who had multiple gun shot wounds, an abdominal drain, a gastrostomy tube, and a wired shut fractured jaw, being in	S9999		

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S9999	Continued From page 2 excruciating pain for the first 3.5 weeks of admission and not receiving any pain medication. The findings include: On 11/19/20 at 10:15 AM, R3 was laying on his back in bed with a gastronomy tube (G.T.) and abdominal drain exposed. R3 stated he was neglected for over a week. R3 stated he did not get any pain medication for many weeks and no enteral feed for the first 2 days and sporadic the rest of the time. R3 stated that no staff member was coming to the room to even check on him or take his vitals. R3 stated he was in excruciating pain, could not get comfortable, and felt he was left to die in the bed. R3 stated it is with much difficulty, but he managed to go to the nurses' station in manual wheelchair for the Tylenol. R3 stated if he did not go to the nurses' station he would not have gotten the Tylenol. R3 stated he was receiving one oxycodone with 2 Tylenol in the hospital, which worked great. R3 stated he was admitted to the facility on 10/16/20; he was never assessed for his pain, never given any pain medication nor were staff members checking on him for over a week. R3 stated he called his sisters, his mom, and his girlfriend, and told them about his excruciating pain and not getting any pain medication or his enteral (bolus) feed. On 11/19/20 at 8:16 AM, V6 (R3's sister) stated that R3 has been calling everyone in the family complaining about his pain, saying that the nurses are not checking in on him, nurses are not giving him his medications or his bolus feed, and he is in deep pain and feels weak from no nutrition supplement. R3 is alert, oriented 35 year old male who was admitted to the facility on 10/16/20 with diagnoses	S9999		

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S9999	Continued From page 3 that include deep vein thrombosis, jaw fracture with wire, cerebral vascular accident (CVA) due to embolism of the right middle cerebral artery, injured carotid artery, abdominal drain, gastronomy tube due to being NPO (nothing by mouth) per the face sheet and 10/23/20 minimum data set (MDS). R3's current physician order sheet documents oxycodone 5 milligrams (mg) via G.T. every 6 hours for pain as needed, along with Tylenol 650 mg via G.T. every 6 hours as needed for pain. R3 was receiving aspirin 325 mg daily via G.T. as a prophylactic for his CVA. All medications were ordered on 10/16/20, day of admission. On 11/19/20 at 1:55 PM, V3 (Registered Nurse) stated that there is no bingo card of oxycodone for R3. V3 stated that it must not have been ordered because it may have needed prior approval. V3 stated she does not know why there is no documentation to support why the oxycodone was not ordered. V3 stated she just gave R3 some Tylenol, and he did not mention his pain. Asked if she asked him about pain, no response. On 11/20/20 at 10:45 AM, R3 stated that V3 (Registered Nurse) came to his room last evening (11/19/20) to do a pain assessment. R3 stated that this is the first time a comprehensive pain assessment been done. This pain assessment documents that a pain assessment is warranted, R3 has had frequent pain that has affected his sleep, his activities of daily living, and his mental state. R3 has rated the pain at a "7" for severe pain out of a scale of zero to 10, 10 being the worst pain. The pain is from his jaw that was fractured and wired shut. R3 voiced constant aching pain that is alleviated by the medication.	S9999		

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S9999	Continued From page 4 R3 is currently on no scheduled pain medication but has orders for pain medications as needed. The pain assessment, dated 10/16/20 by V7 (Licensed Practical Nurse), documents contrary information. It documents no need to do a pain assessment because R3 has no pain. But then it documents the pain makes it hard to sleep and to do his daily activities. V7 then documents R3's pain at zero and no location is documented. The pain medications documented are the Tylenol 650 mg every 6 hours via G.T. as needed for pain. V7 was not available for interview after several attempts. V14 (nurse practitioner) did a telehealth visit on 10/18/20, with staff and documents multiple gun shot wounds, mandible fracture, right temporal bone fracture, bilateral nasal bone fracture, right middle cerebral artery stroke and right carotid dissection. V14 failed to address the pain level and the medications for the pain. On 11/21/20 at 11:15 AM, V14 stated he never saw the resident (via telehealth because of the pandemic), but relied on the staff nurses to give him an accurate account on R3. V14 stated he was never informed of R3's pain, and if he had been alerted he could of ordered non-narcotic medication for the pain. V14 stated when a person comes in with pain medication orders, it usually means they are in pain. V14 stated that V15 (Attending Physician) would be best to talk on R3's pain and medications ordered. On 11/21/20 at 11:49 AM, V15 stated he has never seen the patient and this patient was assigned to him when he was admitted to the facility. V15 stated that no staff member ever called him about R3's pain and medications. V15	S9999		

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S9999	Continued From page 5 stated that the order for oxycodone was from the hospital, but the hospital did not send a signed, written order. V15 stated if the nurses would have reached out to the hospital physician, he may have sent a signed order. In any case, V15 stated that it is unacceptable, not appropriate, and not good care when staff fail to provide the medications and treatment as ordered. V15 stated that the nursing staff should have followed up with R3's pain by referring him to a pain clinic. Review of the hospital documentation documents that R3 was receiving 5 mg of oxycodone with 2 Tylenol (650 mg) for pain as needed every 6 hours. Hospital also documents that R3 sustained 7 gun shot wounds to the face, upper extremities and back, right carotid artery dissection and bullet retained from abdomen. Review of the October 2020 and November 2020 medication administration record (MAR) documents no Tylenol or oxycodone was given from 10/16/20 to to 11/10/20 (3.5 weeks) nor was there a daily accurate pain assessment. R3 did receive Tylenol on 11/11/20 at 0144 and again on 11/14/20 at 0128 for pain levels at 9 and 7 because he went to the nurses station to complain of pain. It documents the Tylenol is effective, but R3 stated the Tylenol helps a little and is better than no medication. The location of the pain is not documented. R3's vitals were not documented from 10/16/20 to 10/23/20 per the MAR. On 11/20/20 at 11:30 AM, V10 (Nurse Consultant) was asked if there is any nurse who can explain R3's MAR and medications. V10 stated she would send someone down. V2 (Director of Nursing) was not available or in facility.	S9999		

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S9999	Continued From page 6 On 11/20/20 at 12:50 PM, V13 (Corporate Nurse) stated she will do her best to explain anything she can since no one else is available but stated she is not assigned to this facility. V13 stated that the blanks in the MAR means the medication was not given. V13 was not able to say why an accurate comprehensive pain assessment was not done by staff, nor why the oxycodone was not followed up on or why the Tylenol was not given for 3.5 weeks. On 11/19/20 between 9:40 AM to 11:15 AM, residents R3, R4, R5 and R6 stated that many vulnerable residents are ignored by nursing. Nurses are not distributing medications as ordered or on time. Nursing staff act impatient when asked for something or when help is needed. They say they will be back but never come back. R5 stated that V3 is the restorative nurse but has been working the first floor as a floor nurse. The residents say the nurses and aides are scarce and hard to find on the floors. The facility's policy labeled Management of Pain documents the facility's policy is promote resident comfort and preserve their dignity and provide effective pain management. This will be achieved through prompt and accurate assessing and diagnosing the pain. Encouraging residents to self report pain. Optimizing the resident's ability to perform activities of daily living. Monitoring treatment efficacy and side effects. Preventing and minimizing anticipated pain. Using pain medication judiciously to balance the resident's desired level of pain relief. Pain will be assessed and managed in a timely fashion, especially if it is of recent onset. The physician will be notified of resident's complaint of pain when not relieved by medication as ordered by physician. The pain assessment will be done upon admission and it	S9999		

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S9999	Continued From page 7 will measures the impact of pain on the resident's function, assessing the resident's physical condition, history, mental status and ADLs. The assessment will cover intensity, location, onset, type and frequency, description, change, treatment, effect and what makes it worse or better. Pain monitoring should be documented on the back of the MAR/pain flow sheet the effectiveness of pain medication and the effectiveness should be assessed 1 to 2 hours after pain medication administration. (B)	S9999		