

Illinois Department of Public Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014781 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 02/17/2022 |
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| NAME OF PROVIDER OR SUPPLIER SOUTHPOINT NURSING & REHAB CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 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) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
| S 000 | Initial Comments | S 000 | | |
| S9999 | <p>Complaint Investigation: 2280448/IL142566 & FRI of 1/4/2022\IL142445</p> <p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.3240b) 300.3240d)</p> <p>Section 300.3240 Abuse and Neglect</p> <p>b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)</p> <p>d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)</p> <p>Based upon record review and interview the facility failed to report accurate information to IDPH (Illinois Department of Public Health) for three of three resident to resident altercations and failed to report abuse to IDPH within regulatory requirements for four of six residents (R5, R6, R9, R10) reviewed for abuse.</p> <p>Findings include:</p> <p>On 1/18/22, IDPH received a complaint which includes (1/16/22) physical altercation between R5 and (unidentified) roommate.</p> <p>On 2/8/22 at 10:13am, surveyor inquired about the facility abuse prevention protocol V1</p> | S9999 | <p style="text-align: center;">Attachment A Statement of Licensure Violations</p> | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | <p>Continued From page 1</p> <p>(Administrator/Abuse Coordinator) stated in part "I fill out an initial reportable and email it to public health. We do the investigation. Send the final reportable within 5 days." Surveyor inquired about the (1/16/22) reportable incident between R5 and (unidentified) roommate (as stated on the 1/18/22 complaint). V1 affirmed that she was unaware of any incidents involving R5 and replied "No, not any allegation of this."</p> <p>The (1/16/22) incident report including physical altercation between R5 and R6 was submitted to IDPH on 2/8/22 however the "Incident Date" states 2/8/22 (which is incorrect).</p> <p>On 2/9/22 at approximately 4:00pm, surveyor inquired about the (2/8/22) resident to resident loud verbal altercation (observed by surveyor and several staff) which occurred in the dining room V1 (Administrator) affirmed that she was unaware of the incident.</p> <p>The (2/8/22) incident report including verbal altercation between R9 and R10 was submitted to IDPH on 2/10/22 however the "Incident Date" states 2/10/22 (which is incorrect).</p> <p>On 2/10/22 at 12:01pm, surveyor inquired why the (1/16/22) incident reported to IDPH on 2/8/22 states "Incident Date: 2/8/22 and why the (2/8/22) incident reported to IDPH on 2/10/22 states "Incident Date: 2/10/22" (which makes it appear as if they were both reported timely) V1 refrained from responding.</p> <p>The (1/4/22) incident report states (R3) made physical contact with (R4). Investigation was conducted to include statements from residents and staff & determined that (R4) wandered into (R3's) room. (R3) attempted to redirect (R4) out</p> | S9999 | | |

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| S9999 | <p>Continued From page 2</p> <p>of his room and (R4) lost her balance. however, upon review of staff statements V18 (CNA/Certified Nursing Assistant) documented that "(R3) said that he pushed resident into wall" which is incongruent with the findings.</p> <p>On 2/15/22 at 10:56am, surveyor inquired about the (1/4/22) incident V18 (CNA) stated "When I went to the room I saw (R4) on the floor. He (R3) said that he pushed her (R4) to the ground and there was a hole in the wall."</p> <p>The abuse prevention program (revised 9/1/16) states in part; the person(s) observing an incident of resident abuse or suspecting resident abuse must immediately report such incidents to the Charge Nurse who will immediately report the allegation to the Administrator. When an alleged or suspected case of abuse is reported the Administrator or Director of Nursing in the Administrators absence, will notify the following persons or agencies of such incident immediately: State Licensing and Certification Agency (ie: IDPH).</p> <p>(C)</p> | S9999 | | |