Illinois Department of Public Health

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 12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHPOINT NURSING & REHAB CENTER	1010 WEST 95TH STREET CHICAGO, IL 60643

(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 Complaint Investigation: 2288704/IL152837, 2289097/IL153329 Facility Reported Incident of October 12, 2022/IL152725, Facility Reported Incident of October 21, 2022/IL153148 & Facility Reported Incident of October 23, 2022/IL153149. Facility Reported Incident of October 11, 2022/IL152736	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.1210b) 300.1210d)6) 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 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1	S9999		

and assistance to prevent accidents.

These Requirments were NOT MET as evidenced by:

Based on interviews and record reviews, the facility failed to keep residents (R1, R2, R4, R10, and R11) free from abuse for 5 of 9 residents reviewed for abuse. This failure resulted in R3 and R4 having an altercation, resulting in R3 punching R4 in the eye and R4 sustaining a bruised right eye and R4 feeling unsafe around R3. This failure resulted in R4 and R6 living in fear with R6 stating the needs to sleep with one eye open affecting R6's sleep pattern due to fear that R3, who is R6's current roommate, will attack R6.

Findings include:

R3's Face Sheet documents resident is a 61-year-old with diagnoses including but not limited to: EPILEPSY, UNSPECIFIED, NOT INTRACTABLE, WITH STATUS EPILEPTICUS, HYPERLIPIDEMIA, UNSPECIFIED, INSOMNIA, UNSPECIFIED, BIPOLAR DISORDER, UNSPECIFIED, SCHIZOPHRENIA, UNSPECIFIED, SCHIZOAFFECTIVE DISORDER, UNSPECIFIED, TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS, ESSENTIAL (PRIMARY) HYPERTENSION(I10), UNSTEADINESS ON FEET.

Facility's Final Reportable (10/21/22) regarding R3 and R4 documents in part: Based on interviews conducted, review of the resident's record, interview with the housekeeper, Social Service Worker and R4 who alleged that R3 was playing his television too loudly and he asked him to turn it down. R4 stated that they exchanged

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S9999	Continued From page 2 words then R3 came over to his side of the room and knocked over a basin of water used to clean himself, and said 'what you gonna do about it, you're in a wheelchair', "He then balled his fist to hit me, I ducked, but he managed to graze my left eye." Staff intervened immediately but R3 had returned to his side of the room. Nurse assessed R4 for pain and bruises. R4 expressed that he was not in pain and that his eye does not hurt and feels safe in the facility. However, as per protocol, R3 was ordered out to H. P. Hospital for psych evaluation. Both Resident's care plan and assessment will be updated as appropriate. Families, MD made aware of the outcome of this investigation." Behavior Care plan (initiated 07/11/2022) notes R3 demonstrates cognitive impairment and displays behavioral symptoms related to diagnosis of severe mental illness. Behavior Care plan (initiated 10/21/2022) notes R3 has a history of aggressive behavior including verbal/physical aggression. Minimum Data Set Section G (MDS) (dated 11/24/2022) scored R3 as (2) requiring one-person physical assistance for bed mobility. M.D.S (dated 11/24/2022) scored R3 as (2) requiring one-person physical assistance for transfers. R4's Face Sheet documents resident is a 42 year old with diagnoses including but not limited to: PULMONARY HYPERTENSION, UNSPECIFIED, EPILEPSY, UNSPECIFIED, INTRACTABLE, WITH STATUS EPILEPTICUS, METABOLIC ENCEPHALOPATHY, NONTRAUMATIC SUBDURAL HEMORRHAGE, UNSPECIFIED, MUSCLE WASTING AND ATROPHY, NOT ELSEWHERE CLASSIFIED, MULTIPLE SITES, DIFFICULTY IN WALKING, NOT ELSEWHERE	S9999		

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S9999	Continued From page 3 CLASSIFIED, OTHER ABNORMALITIES OF GAIT AND MOBILITY, MUSCLE WASTING AND ATROPHY. Minimum Data Set Section G (MDS) (dated 11/14/2022) scored R4 as (3) extensive assistance requiring 2-person physical assistance for bed mobility. M.D.S (dated 11/14/2022) scored R4 as (3) extensive assistance requiring one-person physical assistance for transfers. On 11/29/2022 at 12:32pm, R3 stated, ""I don't remember anything about that." On 11/29/2022 at 1:02pm, R4 stated, "On 10/21/2022, I remember that day that the incident occurred between me and R3. I came into my room one day and R3 and I were roommates at the time. It was in the afternoon, R3 had his tv up real loud. I asked R3 to please turn the tv down because I had a headache. When I asked R3 to turn the tv down politely, R3 ignored me. I asked R3 to turn the tv down for the second time and R3 said to me, "I used to be a boxer and I will knock you out." I don't know what triggered R3 to get up and come to my wheelchair and R3 got aggressive. R3 swung on me, and I tried to block myself, however, R3 was still able to hit me, and he gave me a black eye. I am wheelchair bound and he came to me aggressively and I tried to block it, but he was able to punch me and give me a black eye. When R3 came to my wheelchair in an aggressive manner, R3 knocked my water over with his hand. The water was standing on my bedside table and R3 knocked my water over on purpose with his hand which resulted in the water spilling on the floor. R3 had an incident on the 3rd floor as well where R3 tossed down nurses to the floor. R3 is very aggressive, and he has a mental problem, and I am wheelchair	S9999		

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S9999	Continued From page 4 bound and I have a physical problem so R3 posed as a direct threat to me. Why is R3 still in this facility. R3 is not appropriate to be in this facility he is very aggressive and dangerous. R3 can be dangerous at times to other residents. With R3 you never know what R3 can do or what he is capable of because R3 has mental problems, and I don't feel safe with R3 at all. They moved R3 out of my room, but he's still in the building and I know for a fact that other residents fear R3 because R3 gets into resident's faces aggressively all the time. I don't feel safe with R3 in this building because he is severely mentally ill, and he is dangerous and aggressive towards others." On 11/30/2022 at 11:04am V8 (social service director) stated, "On 10/21/2022 I was called by my psych tech to inform me that an altercation between R3 and R4 occurred. The nurse was there and performed a skin assessment after the altercation and R3 was not able to be redirected. R3 was aggressive and not accepting direction and loud with everything and we had to put R3 on a 1 to 1 supervision after the altercation occurred. The psychiatrist ordered to send R3 to the hospital for psychiatrist evaluation. R3 and R4 were roommates at the time the altercation occurred. R3 has mental issues and is often loud and aggressive toward staff and other residents. At times R3 cannot hold conversation and exhibits a lot of aggressive behaviors. R3 has had physical contact with another resident prior to the physical altercation with R4. It occurred with a different resident in a dining room, where R3 was aggressive and touched another resident so we had to send R3 out for psychiatric evaluation. R4 is not the only resident that was physically assaulted by R3, there have been another resident. R3 is a resident with severe mental	S9999		

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S9999		S9999		

Continued From page 5

health issues and there have been many instances where R3 verbally assaulted staff and other residents. We sent R3 to the hospital for psychiatric evaluation many times. R3 was on each resident floor, and we keep moving R3 around. R3 had incidents with other residents on each floor so we had to move R3 many times. Based on R3's behaviors, R3 is not suitable for this facility, R3 is not appropriate for this facility. R3 is a threat to other residents. R3 is a threat to the safety of other residents and staff as well. Any times we send a resident out for psych evaluation, we send the resident with a petition and R3 was sent back to this facility and were told by hospital nurse that R3 is stable and good to return. We did indicate that R3 is a danger to self and other residents. R3 is not appropriate to have a roommate because most of the time, the roommates that share a room with R3 complain about R3. At this time, R3 is not appropriate to have a roommate because R3's current roommate (R6) is complaining about R3. One of the staff members complained that R3 aggressively got into their face and was not able to be redirected."

On 12/01/2022 at 10:21am V1 (administrator) stated, "I am the abuse coordinator. The facility policy is that all staff have to report any kind of abuse and all staff have to watch and monitor for any kind of resident abuse. It is mandatory for staff to report any form of abuse to the administrator. If any kind of abuse is reported, we investigate. We have cameras and we do a full investigation into abuse allegations. Any kind of abuse such as resident to resident or staff to resident is investigated and we have to report it to the state agency anything regarding any sort of harm allegation that was reported we have to report it to the state. Depending on the type of

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S9999	Continued From page 6	S9999		

abuse that is reported, we investigate, and we also report it to the resident's physician. If there is an abuse allegation which involves resident to resident, we immediately separate the residents. If the abuse allegation is between 2 roommates, we separate them and move them to different locations and we assess the residents for injuries. The aggressor is sent out and also if there are injuries involved, we send the resident out. If there is an issue between 2 roommates and the 2 roommates are not getting along, we try to accommodate the needs and desires of the existing roommate that was there in that particular room. If we move a new roommate into the room of an existing resident residing in that room and if there is a problem between the 2 roommates, then we accommodate the needs of the existing roommate, unless the existing roommate that was there first is the one that causes the problems and issues. Typically, if the new roommate that was moved into the room of another roommate is the one causing issues, we move that resident out of that room. I started working at this facility on November 8 and I am not familiar with what occurred between R3 and R4. R3 should have been in the room by himself and not placed into a room with any other resident if R3 is constantly aggressive towards other residents and staff, but I was not made aware of this at all. I will move R3 into a private room immediately. I will also look into possibly finding R3 a more suitable facility which can accommodate R3's severe mental health issues."

On 12/01/2022 at 6:48pm, V36 (psychiatrist) stated "The incident between R3 and R4 happened on 10/21/2022 and after the incident, R3 was sent out to the hospital for psychiatric and R3 was admitted. R3 was admitted for a while and then sent back to the facility. I was informed

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S9999	Continued From page 7 from a nurse at the nursing home that when R3 came back to the facility, R3 is more calm and more compliant with medications and more manageable. So far there has been no aggression from R3 toward other resident. At this time R3 is more manageable due to R3's last psych admission. I told the nursing facility that R3 does not get along with his current roommate and has issues with any roommate R3 has and R3 should be in a room by himself. I told the social service director that R3 should be in a room by himself because R3 does not get along with any resident because of R3's severe mental illness. R3 is a man of his own mind and suffers from severe mental illness and R3 should be in a room by himself for safety of other residents." R3's Progress Note (10/21/2022) documents, "Made aware by co-staff of resident in his room with physical aggression towards his roommate. Both immediately separated and placed 1:1 with staff. Remains verbally aggressive and refused writer to assess him. Facial scratches observed refuse writer to cleanse and dress area. Doctor called and made aware. New order to transfer to hospital noted and carried out. Admin and DON made aware. Report given to hospital and states okay to transfer to ED (emergency room) ambulance made aware with ETA (estimated time of arrival) 40 mins. State Guardian office call and made aware. All necessary paperwork completed." R6's Face Sheet documents resident is a 76 year old with diagnoses including but not limited to: DISORDER OF CARTILAGE, UNSPECIFIED, GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS, MUSCLE WASTING AND ATROPHY, NOT ELSEWHERE CLASSIFIED, UNSPECIFIED SITE, OTHER	S9999		

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S9999	Continued From page 8 ABNORMALITIES OF GAIT AND MOBILITY, OTHER LACK OF COORDINATION, UNSPECIFIED LACK OF COORDINATION, UNSPECIFIED ABNORMALITIES OF GAIT AND MOBILITY , UNSTEADINESS ON FEET. R6's Minimum Data Set Section C (MDS) (dated 08/25/2022) documents R6 with a Brief Interview for Mental Statues (BIMS) score of 15. On 11/30/2022 at 11:04am V8 (social service director) stated, R6 is complaining about R3 and asked me to move R3 out of the room. Since R3 has not made any physical contact with R6, I feel that it is ok for R3 and R6 to share a room. Since R3 did not physically attack R6, I feel at this time it is safe for R3 and R6 to share a room. We did not give R3 a private room because a private room is given to a resident on isolation and since R3 is not on isolation precautions, we did not place R3 in a private room. The last time R6 came to me and expressed concern pertaining to R3, R6 stated that R3 watches television really loud and late at night and R6 cannot sleep. R6 also expressed to me that R3 talks to self and R6 expressed some concerns with R3's behavior. R6 requested that we remove R3 from his room. R6 expressed concerns with R3 and requested for R3 to be moved out of R6's room. R6 did express to me that R3 watches television loudly in the late hour. I explained the rules to R6 that if a resident complains about their roommate, then the resident who is complaining is the one who will be moved out. I said to R6 that if he is complaining about R3 that I have to look for a room for R6 and move R6 instead of moving R3. R6 was residing in that room first, before R3. R6 stated that R6 did not want to be moved. R6 wanted us to move R3 out.	S9999		

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S9999	Continued From page 9	S9999		

(B)

2 of 2 Violations

300.610a)
300.1210b)
300.1210d)6

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 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,

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S9999	Continued From page 10	S9999		

seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Requirements were NOT MET as evidenced by:

Based on observation, interview, and record review, facility failed to follow their policy to ensure initial fall risk assessments and fall prevention interventions are completed for 1 (R14) out of 3 residents reviewed for accident and prevention. This failure resulted in R14 sustaining a fall, being transferred for hospital evaluation and requiring stitches to the forehead.

Findings include:

On 11/30/2022 at 2:17 PM, V2 (Director of Nursing) stated she (V2) has been working here 8 weeks. V2 stated, "Upon admission you have to do an initial fall risk assessment. This is important because if you know the resident has an unsteady gait you can aid preventing falls by providing them with the necessary interventions. Once somebody falls, we do initial the fall risk assessment and do the follow up as a team. There were no initial fall risk assessments done for R14. V2 stated, R14 fell on 10/10/2022. R14 fell again on 10/11/2022. When R14 fell on 10/11/2022, he had a laceration on his head". V2 stated, "I am not sure if R14 had any initial fall interventions in place. I don't think they did an initial fall risk assessment. I just started around that time and hadn't gotten my full bearings yet".

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S9999	Continued From page 11	S9999		

V2 stated the purpose of the care plan is to keep up with the patient's treatment plan. V2 also stated that if there is change of status whether the interventions were working or not, the care plan would be updated. The initial fall risk assessment could have helped to appropriately monitor the resident and provide him (R14) with the necessary fall prevention interventions to prevent him from falling and injuring himself.

R14's progress note by LPN (10/10/2022) documents in part: R14 observed on the floor sitting on buttocks with wheelchair near unlocked and no socks on his (R14) feet. R14 stated he (R14) was attempting to go to the bathroom and fell. Head to toe assessment obtained and no abnormal findings noted. No deviation from mental/physical baseline.

R14's progress note by LPN (10/12/2022) documents in part: Nurse assessed R14 since R14 is a re-admission back to facility post fall. R14 is alert and oriented x1. R14 has stitches in middle of forehead, right leg wound and wound on right heel, wound on left heal and wound on right elbow.

R14's Physician progress note (12/24/2022) documents in part: R14 was sent to outside hospital on 10/11/2022 due to fall. R14 hit his head. R14 received stitches to the forehead.

Facility's Reported Incident for R14's fall incident (10/11/2022): On 10/11/2022, R14 sustained fall incident with head injury. 10/11/2022 - Full assessment completed. Ice pack applied. Area cleansed with normal saline solution with pressure dressing applied. Pain assessed. 911 notified. MD notified. Family notified. Transported to emergency department for evaluation and

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHPOINT NURSING & REHAB CENTER	1010 WEST 95TH STREET CHICAGO, IL 60643

(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
S9999	Continued From page 12 treatment. On 10/12/2022 at 7:38 PM, R14 returned to facility. Full assessment completed. Sutures noted to forehead. Pain management in place. Based on a thorough review of R14's medical record, staff, and resident interview, the incident was determined to be contributed by R14 attempting to ambulate out of bed without staff assistance. Sutures to forehead remain intact with follow up appointment scheduled for removal of sutures. Reviewed R14's Electronic Medical Record. No documentation of initial fall risk assessment. Reviewed R14's care plan. No documentation of fall prevention interventions prior to 10/10/2022. Facility's Fall Prevention Protocol documents in part: Fall risk assessment is completed upon admission and readmission. Implement individualized approaches/interventions based on resident's risk. The Fall Prevention Strategies/Interventions list are used to identify appropriate interventions. Interdisciplinary care plan should be implemented for residents at risk and interventions to prevent falls. (B)	S9999		