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 12/01/2023

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 Survey: 2388792/IL165776, FRI of 9/10/23/IL164898, FRI of 9/20/23/IL164902 & FRI of 9/28/23/IL165775	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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 and assistance to prevent accidents.

These Requirements were not met as evidenced by:

Based on interview and record review, the facility failed to prevent a fall by not implementing effective fall interventions for residents (R5, R6) who were at risk for fall and with history of falling and failed to supervise (R16) from smoking while oxygen is in use. The facility failed to ensure that resident (R7) was assessed by nurse before moving / transferring back to bed, facility failed to follow facility policy and procedutes and failed to follow residents care plans. These failures resulted in (R5) sustaining an lumbar compression fracture, (R6) sustaining acute subdural hematoma. These failures affected 4 (R5, R6, R7,R16) out of 4 residents reviewed for resident safety / falls/supervision.

Findings include:

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S9999	Continued From page 2 1. R5 health record documented initial admission date of 4/6/23 with diagnosis not limited to Fracture of nasal bones, End stage renal disease, Unspecified systolic (congestive) heart failure, Weakness, Unspecified abnormalities of gait and mobility, Unspecified dementia, Other lack of coordination, Cerebral infarction, Hypoglycemia, Unspecified atrial fibrillation, Anemia, Essential (primary) hypertension, Low vision left eye, Hyperparathyroidism. On 11/29/23 at 10:35 am Observed R5 sitting up on wheelchair by her bed, appears comfortable, well groomed, alert, and oriented to time, place, person, and situation, verbally responsive. R5 able to recall the fall incident on 10/5/23, stated that she got up from bed to go to the bathroom. Stated that she called the staff using the call light, but nobody was answering and wanted to urinate badly, so she got up and went to the bathroom. Stated that after using the bathroom she walked back to her room but slid and next thing she knew she was sitting on the floor. Stated that she used to ambulate, she was not wearing non-skid footwear and she was barefooted at the time of the fall incident. Stated that in the hospital it was found out that she had a fracture in the lumbar area / tailbone. Stated that she is still having on and off pain especially when she is sitting for a long period of time. On 11/30/23 at 9:41 am V27 (R5's Nurse Practitioner) stated that he recalled R5 fall incident on 10/5/23. Stated that the nurse called him regarding the incident. Stated that R5 had refused to go to the hospital after the fall incident but the next day she agreed to be transferred to the hospital due to severe back pain. Stated that R5 Compression fracture was most likely from	S9999		

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S9999	Continued From page 3 the fall. Stated that R5 is not totally immobile and is able to get out from bed. Stated that R5 was not wearing a non-skid footwear / barefooted at the time of the fall incident can be a contributing factor of the fall. Stated not able to rule out the cause of the fall as it was an unwitnessed incident. At 12:32 pm V31 (LPN, former employee) was interviewed via phone and said that around 1st week of November she left the facility. Stated that she knew R5 and was able to remember the fall incident on 10/5/23. Stated that R5 got up from bed without calling for assistance. Stated that R5 wanted to go to the bathroom. Stated that R5 was identified as a fall risk. Stated that fall could have been prevented if R5 room was closer to the nurse's station, frequent rounding and more number of staff in the facility to closely check or monitor R5 whereabouts and to attend to R5 needs. Stated unable to remember if R5 was wearing a non-skid footwear or barefooted on 10/5/23 fall incident. R5 nursing Progress Note dated 10/5/2023 documented in part: Resident was observed on hallway floor outside of room. R5 Fall Risk Review assessment with signed date of 10/9/23 documented in part: Score: 12 (High Risk for Falls). Assessment showed that R5 had a history of fall in the last 3 months. R5 fall risk assessment dated 8/8/23 indicated a total score of 19 (high risk for falls). R5 Physician Progress Note dated 10/16/2023 documented in part: a long-term resident of the facility was sent to hospital with a fall. The patient was evaluated in the ER. X-ray to lumbar spine showed L1 compression fracture. R5 Care plan dated 10/6/23 documented in part: R5 has had an actual fall related to unsteady gait.	S9999		

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Care plan interventions included but not limited to: Ensure non-skid footwear is in place and available. Monitor whereabouts and provide redirection/education as needed.
MDS (Minimum Data Set) dated 7/14/2023 showed that R5's cognition was moderately impaired. R5 needed extensive assistance with bed mobility, transfer, locomotion on and off unit, dressing, personal hygiene, toilet use; Supervision with eating, walk in room and corridor. MDS showed that R5 used walker. MDS indicated that R5 was frequently incontinent of bowel and bladder.

2. R6 health record documented initial admission date of 7/22/20 with diagnosis not limited to Nontraumatic subdural hemorrhage, Paranoid schizophrenia, Other lack of coordination, Parkinsonism, Depression, Hypoxemia, Primary osteoarthritis, Dysphagia oropharyngeal phase, Acute kidney failure, Metabolic encephalopathy, Unspecified abnormalities of gait and mobility, Insomnia, Weakness, Respiratory failure, Unspecified injury of head, History of falling, Syncope and collapse, Difficulty in walking, not elsewhere classified, Bilateral primary osteoarthritis of first carpometacarpal joints, Muscle weakness (generalized), Dysphagia oral phase, Gastro-esophageal reflux disease without esophagitis, Other secondary, hypertension, Dementia in other diseases classified elsewhere, Schizophrenia.

On 11/28/23 at 11:01am Observed R6 sitting up on wheelchair in the dining / day room, Alert and verbally responsive with confusion. R6 unable to recall / verbalize any fall incident.

At 9:57 am V28 (CNA) said that she remembered R6 fall incident on 9/10/23. Stated that R6 was

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S9999	Continued From page 5 found sitting on the floor in another resident's room. Stated that R6 used to ambulate with walker and roam around the unit or another resident's room. Stated that she was not aware that R6 was a fall risk. Stated no fall preventions implemented prior to R6 fall incident on 9/10/23 because R6 was not a fall risk. Stated that if R6 was identified as a fall risk, closely monitoring and frequent redirection could have been done. Stated that R6 could have a 1:1 but staff is also busy attending with other residents and providing care. R6 Fall Risk Review assessment with signed date of 9/10/23 documented in part: Score: 11 (High Risk for Falls). Fall Risk Review assessment dated 8/28/23 indicated a total score of 10 (High Risk for Falls). R6 Nursing Progress Notes dated 9/10/2023 documented in part: resident was found sitting on the floor in another resident's room. R6 escorted to her room, observed little laceration to upper right eye, bleeding noted. R6 hospital records dated 9/10/23 (Hospitalist History and Physical) documented in part: Patient is a nursing home resident where she tripped and had a fall hitting her head on the ground. Patient has a small laceration on her right eyebrow no active bleeding. CT (computerized tomography) head revealed small acute subdural hematoma overlying the left lobe and left frontal and anterior temporal areas up to 5 mm (millimeter) in thickness. R6 Physician Progress Note dated 9/25/2023 documented in part: long term resident of the facility. The patient was sent to Hospital ER (emergency room) on 09/10/2023 for evaluation due to an unwitnessed fall. CT of head revealed small acute subdural hematoma overlying the left lobe and left frontal and anterior temple area up	S9999		

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to 5 mm in thickness with no evidence of mass effect or midline shift.
R6 Care plan dated 06/28/22 documented in part: At Risk for Falls. Care plan interventions included but not limited to: Frequent rounding on resident for safety. Nursing Staff will complete a Fall Risk Assessment per Facility Fall Protocol. Follow the facility Fall Protocol.
MDS dated 9/5/2023 showed that R6's cognition was severely impaired. R6 needed extensive assistance with bed mobility, transfer, walk in room and corridor, locomotion on unit, dressing, toilet use and personal hygiene; Limited assistance with locomotion off unit, eating. MDS showed that R6 used wheelchair. MDS indicated that R6 was always incontinent of bowel and bladder.

3. R7 health record documented initial admission date of 5/20/14 with diagnosis not limited to Muscle wasting and atrophy, Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, Heart failure, Congestive heart failure, Weakness, Personal history of covid-19, Contracture, Other specified anemias, Vitamin d deficiency, Essential (primary) hypertension, Type 2 diabetes mellitus without complications, Atherosclerotic heart disease of native coronary artery without angina pectoris, Hyperlipidemia, Major depressive disorder, Benign prostatic hyperplasia without lower urinary tract symptoms.

At 12:03 pm V23 (LPN/Licensed Practical Nurse) stated that she was able to remember R7 fall incident on 9/28/23. Stated that when did her rounding, saw 2 CNAs attending R7 in bed. Stated that one of the CNAs said that resident fell on the floor and was transferred back to bed without informing her. Stated that she told the

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S9999	Continued From page 7 CNAs that they are not supposed to move the resident until seen or assessed by the nurse. Stated that she was very upset with the CNAs because R7 was transferred back to bed without informing the nurse to assess R7. Stated that she informed the DON about the incident and CNAs were in serviced or educated to never move a resident until a nurse assesses the resident after a fall incident. At 12:17 pm V24 (CNA/Certified Nursing Assistant) stated that she was the assigned CNA to R7 on 9/28/23 fall incident. Stated that during making rounds, R7 was on the side of the bed in sitting position with another CNA (V29). Stated that they both assisted R7 back to bed x 2 staff assist. Stated that she was not the one who first saw R7 sitting on the floor. Stated that she did not initiate the transfer of the resident. Stated that she was not aware that V29 did not inform the nurse yet about the fall incident. Stated that facility's fall protocol is to leave the resident and call the nurse to check / assess on the resident before moving / transferring the resident. Stated that she was disciplined / written up because of the fall incident. Stated that if resident was moved / transferred after a fall incident without informing the nurse first, the resident could have a broken bone or injury that CNA don't know of, and it could trigger another injury or worsen the injury. Stated that the best thing to do is to call the nurse before touching or moving the resident. At 1:27 pm V29 (CNA) said she was able to recall R7 fall incident on 9/28/23. Stated she saw the resident sitting on the floor. Stated that she went to nurse's station and nurse was doing medication pass. Stated that she went back R7 room and picked up / transferred R7 back to bed with another CNA (V24). Stated that they	S9999		

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transferred R7 to the bed and the nurse was not aware of the fall incident. Stated that staff were instructed not to move the resident without informing the nurse first to assess the resident after a fall incident. Stated "I know it was wrong, but I was trying to help the resident." Stated that after a fall incident, if resident was not assessed first by the nurse and was moved / transferred, resident could have broken bone, can cause more injury or worsen the injury.

At 12:26pm Observed R7 sitting up on wheelchair in the dining room, alert and verbally responsive with forgetfulness. Stated that he fell on the floor after rolling over from bed, unable to recall date and time. Stated he was assisted back to bed by 2 staff.

R7 Nursing Progress Note dated 9/28/2023 documented in part: the resident was noted on the floor in a sitting position with his back was towards the bed. Received resident in bed alert verbally responsive.
R7 Fall Risk Review assessment with signed date of 9/28/23 showed score of 14 (High Risk for Falls).
MDS dated 7/27/2023 showed R7's cognition was severely impaired. R7 needed extensive assistance with bed mobility, transfer dressing, toilet use and personal hygiene; Dependent / total assistance with locomotion on and off unit; Limited assistance with eating. MDS showed that R7 used wheelchair. MDS indicated that R7 was always incontinent of bowel and bladder.

At 1:40pm V3 (Restorative Director, LPN/Licensed Practical Nurse) said that in the event of fall incident, CNA should inform the nurse immediately before moving the resident. Stated that nurse is expected to do full body

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assessment to check for any injury. Stated that if resident was identified as a fall risk, fall prevention interventions should be implemented for resident's safety. Reviewed R6's electronic health record with V3 and stated that if R6 was closely monitored, fall could have been prevented. Stated that R5, R6 and R7 were identified as a fall risk. Stated that Fall risk assessment is done by nurse on duty upon admission, quarterly and every after-fall incident.

Facility's fall prevention program policy dated 1/25/23 documented in part:
- The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary.
- A fall risk assessment will be performed after any fall incident
- Safety interventions will be implemented for each resident identified at risk.
- Nursing personnel will be informed of residents who are at risk of falling.
- Resident at risk of falling will be assisted with toileting needs.
- Footwear will be monitored to ensure the resident has proper fitting shoes and / or footwear is non-skid.

Facility policy and procedures for Resident Supervision / Monitoring dated 7/2023 documented in part:
- All staff are responsible for monitoring residents' locations, to ensure resident safety at all times.
- Staff must immediately provide supervision/monitoring, as deemed appropriate to ensure the safety of the at-risk resident(s), i.e.

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reduced cognition, impaired physical mobility, etc.

4. On 11.29.2023 at 11:40 AM, R14 said he observed R16 in her doorway, smoking marijuana. R14 said he is concerned about the safety of residents residing in the facility as R16 uses oxygen. R14 said he reported his concern to V15 (Social Service Director).

On 11.30.2023 at 10:58 AM, V15 (Social Service Director) said, "what happened with R16, the nurse said she (R16) was smoking. When I talked to her, she denied smoking in her room. I counseled her that she can't smoke with oxygen. She doesn't go out; I don't know how she gets the contraband. We counsel her, call her family to inform of situation, we do random room checks. We found marijuana and marijuana butts. She will not tell how or from whom she got the marijuana. Smoking while using oxygen is a danger to R16, other residents, and staff because an explosion could happen".

11.29.2023 at 12:00 PM, R16 was observed awake, alert, neat, clean, sitting up in bed, watching television. An oxygen concentrator was observed at bedside; the concentrator was on, however, R16 was not using oxygen. R16 said she dons/doffs her oxygen cannula. R16 said she is a former marijuana smoker/smoker; stopped a while ago.

12.1.2023 at 12:58 PM, V53 (Former Licensed Practical Nurse) said via telephone interview, that she never saw R16 smoking marijuana, but did on several occasions smelled an odor of marijuana in R16's room. V53 said R16 did not have a roommate on those occasions. V53 said R16 denied smoking marijuana each time. V53

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said she counselled R16 about the dangers of smoking oxygen while using oxygen, telling R16 it was dangerous and R16 could catch fire, blow herself up, and die. V53 said she did confiscate smoking paraphernalia including a cigarette lighter and what appeared to be marijuana cigarettes; resident was referred to Social Service, paraphernalia was turned over to Social Service.

On 11.30.2023 at 10:58 AM, V15 (Social Service Director) said the nurse said she (R16) was smoking. when I talk to her, she denies smoking in her room. I counseled her, that she can't smoke with oxygen. We do random room checks; we found marijuana and marijuana butts in her room. R16 will not tell us how or from whom she got the marijuana. V15 said it's a danger to R16, other residents, and staff because she's on oxygen an explosion could happen. V15 said R16 was told at the end of Otober, if she continues to smoke in the facility she will be discharged.

9.30.2023 at 3:51 AM, Nursing Progress Note documents: Upon rounds staff smelled marijuana. Writer went into resident room asked resident was she smoking or smoked marijuana resident stated no. Resident currently receiving O2 @ 2L/NC continuously. Resident has history of having contraband materials in/on the facility premises. During the room search, smoking materials was found in resident's room/possession. All contrabands were confiscated from the resident. Resident was re-educated on the facility smoking and substance abuse policy and advised to adhere to them at all times. Resident was also educated on the negative impact of marijuana along with her prescribed medication with the use of oxygen may cause health/bodily harm to her. IDT to be

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made aware of resident's behavior.

10.18.2023 at 6:29 PM Social Service Note documents: Staff conducted a random room search for contrabands with resident's presence. Resident has a history of having contraband materials in the facility premises. During the room search, smoking materials was found in the resident's room/possession. All contrabands were confiscated from the resident. Resident was re-educated on the facility smoking and substance abuse policy and advised to adhere to them at all times. Resident was also educated on the negative impact of marijuana along with her prescribed medication may cause to her health. IDT made aware of resident's behavior. Staff will continue to follow up and document accordingly.

Facility's "Resident Smoking Policy and Procedure (2023) documents: "the Facility will maintain an environment that remains as free from accident hazards as is possible, and the Facility will ensure that each resident receives adequate supervision and assistance to prevent accidents. Residents are not permitted to have any smoking paraphernalia in their room or on their person. Residents with medical oxygen are not permitted to smoke or enter a designated smoking area.

Per "Smoking and Home Oxygen: What You Need to Know" (Montgomery County, MD undated fact sheet): "While oxygen itself is not flammable, an oxygen-rich environment can cause materials to ignite easier and burn quickly. Never smoke inside a home where supplemental oxygen is in use. Smoking while on oxygen increases the risk of fire. Once ignited, fires burn hotter and more rapidly in oxygen-rich surroundings."

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 12/01/2023

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
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