Illinois Department of Public Health

			(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
IL6014781		B. WING		06 /	06/11/2015						
NAME OF PROVIDER OR SUPPLIER SOUTHPOINT NURSING & REHAB CENTER 1010 WEST 95TH STREET CHICAGO, IL 60643											
PREFIX (EAC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE				
Section Screenir History F e) In add 2-201.5(shall, wir resident check pr Informat admissid check w Hospital be base and other Departm of the Ad These F by: Based or failed to backgro admissid supplem R55, R5 resident Findings On 5/9/1 resident Admissid R50 was	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Final Observations STATEMENT OF LICENSURE VIOLATIONS: Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) These Requirements Were Not Met as evidenced				DEFICIENT						

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

06/29/15

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED								
			A. BUILDING.										
		IL6014781	B. WING		06/11/2015								
NAME OF	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	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON SHOULD BE COMPLETE HE APPROPRIATE DATE								
S9999	R52 was admitted initiated on 5/12/15 R53 was admitted initiated on 5/12/15 R54 was admitted initiated on 5/12/15 R55 was admitted initiated on 6/8/15 R56 was admitted initiated on 5/18/15 R57 was admitted initiated on 5/18/15 R58 was admitted initiated on 6/8/15 R59 was admitted initiated on 6/8/15 R59 was admitted initiated on 6/8/15 E25 stated in an initiated on 6/8/15. E25 stated in an initiated on 6/8/15 E25 stated in an initiated on 6/8/15 E25 stated in an initiated on 6/8/15.	on 5/5/15 and the check on 5/6/15 and the check on 5/6/15 and the check on 5/12/15 and the check on 5/15/15 and the check	S9999										

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Illinois Department of Public Health STATE FORM

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