

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0050450		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/13/2026	
NAME OF PROVIDER OR SUPPLIER SOUTHPPOINT NURSING & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1010 WEST 95TH STREET , CHICAGO, Illinois, 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) COMPLETION DATE	
S0000	Initial Comments Complaint Investigation: 2682336/2787984		S0000			04/01/2026	
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive		S9999			04/04/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 and assistance to prevent accidents. These regulations were not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents wear appropriate footwear to prevent falls, for one of three residents reviewed for falls (R3) in the sample of 18. This failure resulted in R3 falling and sustaining a subarachnoid hemorrhage and subdural hematoma. Findings include: R3's face sheet documents R3 is an 88-year-old with diagnoses including but not limited to: Other Pulmonary Embolism with Acute Cor Pulmonale, Essential (Primary) Hypertension, Stenosis of Coronary Artery Stent, Sequela and Dementia in Other Diseases Classified Elsewhere. R3's MDS (Minimum Data Set of 1.22.2026) documents a BIMS (Brief Interview for Mental Status) score of "3" indicating severe cognitive impairment. 2.25.2026 facility's final incident report documents, in part: "the facility completed its investigation through medical record review and interviews. It was determined that (R3) was in a supervised area and abruptly stood up to ambulate and lost her balance. Prior to the fall, (R3) was sitting in a chair with her walker. The other staff in the surrounding area provided witness statements that (R3) got up to ambulate and lost her balance and fell before staff		S9999				

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S9999	Continued from page 2 could intervene. (R3) was observed with a raised area to the back of her head. She denied pain or discomfort. Due to the resident being on a blood thinner she was ordered to be sent to the hospital. Received report from the hospital that (R3) had a nontraumatic subarachnoid hemorrhage. 3.5.2026 at 12:19 PM, V12 (Restorative Nurse) said regarding R3's fall of 2.17.2026, that's another fall that occurred when I was not here. My recollection is that staff said she had just got up, that she was coming from her room, walking down hallway near the nurses' station, and she fell somewhere at the nurses' station. The nurse said she was facing away from the resident and did not see R3 fall but heard it and went to help the resident. I was told that R3 may not have been wearing appropriate footwear. So, my intervention probably was to ensure that resident is wearing appropriate footwear. We encourage our residents to wear closed shoes, if issues with swelling, then non-skid socks. 3.5.2026 at 2:53 PM, V4 (LPN-Licensed Practical Nurse) said R3 had a fall. It was dinnertime. R3 was walking with her walker down the hallway to the dining room for dinner. I didn't see her fall; I had my back to her. I heard her walker; I saw her on the floor. R3 was unable to tell what happened but said she did not hit her head. She was wearing slides (Slide shoes (or sliders) are open-toed, backless footwear characterized by a thick strap across the top of the foot for easy, slip-on, and slip-off use.). That was her preferred footwear. When asked if slides were appropriate footwear for resident, V4 said honestly, no, she shouldn't have been wearing slides. She was sent to the hospital for evaluation and treatment for an unwitnessed fall on blood thinners. 3.10.2026 at 9:13 AM via telephone V31 (Nurse Practitioner) said, I received a voice message from the nurse at the facility that R3 was sent to the hospital for a witnessed fall with head strike. Given her history of blood thinners, it was the right thing to do. I always send them out with a hit to the head and on blood thinners because there's a chance that they could have a bleed (brain hemorrhage) and if left untreated they could die. Given her age, she should have proper foot gear, something with a grip, a closed toe/heel shoe or socks with a grip so that they (residents) can ambulate properly and reduce the likelihood of a fall. I'm not sure what a slide is. Surveyor explained what a slide is. V31 said I wasn't there but that form of footwear is not appropriate.		S9999				

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S9999	Continued from page 3 2.17.2026 4:40 PM, Nursing Progress Note (completed by V4) documents, in part: Resident was ambulating with walker. Walked behind the nurses' station to go towards the dining room lost her balance and fell backwards. Resident wearing slides at the time of fall. Appeared to hit her head on the floor. Resident on blood thinners. V31 (NP) called and gave orders for resident to go to (local hospital). 2. 218.2026 at 3:49 PM, Nursing Progress Note documents, in part: Called (local hospital) to check status of resident and was told by ER resident had been transferred to (receiving hospital). This writer called (receiving hospital) and was told resident was not in their possession. 2.19.2026 7:28 AM, Nursing Progress Note documents, in part: Writer called (receiving hospital) to follow up on the resident. Spoke with (RN), he states the resident has been admitted to Neuro ICU admitting diagnoses subarachnoid hemorrhage. 2.17.2026 at 7:43 PM, Hospital Progress Note documents, in part: History obtained from patient's daughters at the bedside. 88-year-old female history of dementia, on Eliquis who presents to the emergency department for evaluation after fall. Daughters were told patient had a mechanical fall in the nursing home, landed on her head. Reports headache, neck pain as well as bruising around her left wrist. 2.17.2026 at 10:16 PM, CT (Computed Tomography) of head impression documents, in part: focal left parafalcine (lesion refers to a distinct, localized abnormality (such as a tumor, meningioma, or other mass) situated on the left side of the falx cerebri, which is the dural membrane separating the two hemispheres of the brain) hyperdensity favoring meningioma over acute subdural hemorrhage. 2.18.2026 at 1:56 PM, MRI Brain with/without contrast impression documents, in part: 1. Tiny left frontal, parietal temporal and occipital subdural hematoma (a thin, widespread collection of blood between the brain surface and its outer covering, a serious condition that can potentially require surgical drainage (burr holes) or close observation). 2. Small focus of subarachnoid hemorrhage within a sulcus left parafalcine posterior front lobe (a small focus of subarachnoid hemorrhage (SAH) within a sulcus of the left posterior frontal lobe is a localized brain bleed. Head trauma is the most common cause of focal subarachnoid head trauma).		S9999				

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S9999	Continued from page 4 2.18.2026 at 10:42 AM, Hospital Progress Note documents, in part: Patient signed out pending CT. Patient CT head negative on preliminary read. Patient was subsequently discharged. I received a call from radiology after patient had already left the emergency department that there could be a potential small subarachnoid versus meningioma. The patient was brought back from (ambulance) within 10 minutes. MRI (Magnetic Resonance Imaging -scan is a noninvasive medical imaging test that uses powerful magnets and radio waves) was obtained. MRI revealed subarachnoid as well as subdural. Patient started on nicardipine (medication used to treat high blood pressure and chest pain) per recommendation of neurosurgery specialist and was expeditiously transferred to (receiving hospital). 2.18.2026 at 1:48 PM, Hospital Progress Note documents, in part: Patient with bleed on MRI. 2.18.2026 at 5:31 PM, CT Brain without contrast impression documents, in part: No acute intracranial hemorrhage, herniation (abnormal protrusion or displacement of an organ, tissue, or structure through a weakened wall, muscle, or opening) or hydrocephalus (abnormal accumulation of cerebrospinal fluid within the brain's ventricles, causing increased pressure on brain tissue). Surveyor requested facility's fall policy/protocol and received Guidelines for Incidents/Accidents/Falls (dated 6.23.2023). These guidelines document, in part: Policy: It is the policy of the facility to ensure that any incident/accident to include falls is reported immediately to the nurse or appropriate person designated to be in charge. After the resident has had immediate attention and their safety is established, a written report will be entered into Risk Management (usually Risk Management section of PCC). The facility will ensure that incidents and accidents that occur involving residents are identified, reported, investigated and resolved. The facility will create a database related to incidents/accidents as part of the QAPI process to enable trending and tracking. This information will be used to implement corrective actions to include any needed training to prevent reoccurrences when possible. 3.5.2026 at 1:43 PM, V2 (DON-Director of Nursing) said, the policy I gave you yesterday (Guidelines for Incidents/Accidents/Falls-undated) is the only fall policy we have. R3's care plan I am at risk for falls related to the following potential/present contributing risk factors:	S9999					

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S9999	Continued from page 5 generalized weakness, changes in environment, and adjustment to facility, P. E. (Pulmonary Embolus), HTN (Hypertension), Coronary artery disease, Dementia, Psychosis, anxiety. Date Initiated: 01/22/2026, Revision on: 01/29/2026 documents the following interventions: Ensure that I am wearing appropriate footwear that provide stability and good traction when ambulating or mobilizing in their w/c and during transfers Date Initiated: 01/22/2026 and Upon return from hospital: Ensure that I am wearing appropriate footwear that provide stability and good traction when ambulating or mobilizing in their w/c (wheelchair) and during transfers. Date Initiated: 02/17/2026 Revision on: 02/18/2026 (A)		S9999				