STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

A. BUILDING
B. WING

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

08/08/2013

(X4) ID PREFIX TAG

(X5) COMPLETION DATE

NAME OF PROVIDER OR SUPPLIER

SOUTHPoint NURSING & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1010 WEST 95TH STREET
CHICAGO, IL  60643

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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will provide labor and/or materials to perform the following-Main Aluminum Entry System to furnish and install one dark bronze continuous surface mounted gear hinge.

This document did not link any evidence that the facility automated door locking system was not operating properly.

On 5/16/2013 during morning status meeting and on 6/11/2013 E1 (administrator) expressed prior to the survey, he was aware there was a problem with the door properly closing when someone leaves out. It was this condition that did not permit the door to lock.

F9999 FINAL OBSERVATIONS

LICENSURE VIOLATIONS:

300.610a)
300.1040
300.1210a)
300.1210b)
300.1220b(2)(3)(7)
300.3240a)
300.3240d)
300.3240f)

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.
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<td>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.</td>
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<td>Section 300.1040 Care and Treatment of Sexual Assault Survivors</td>
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<td>a) For the purposes of this Section, the following definitions shall apply:</td>
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<td>b) The facility shall adhere to the following protocol for the care and treatment of residents who are suspected of having been sexually assaulted in a long term care facility or elsewhere (Section 3-808 of the Act):</td>
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<td>c) The facility shall take all reasonable steps to preserve evidence of the alleged sexual assault, and not to launder or dispose of the resident's clothing or bed linens until local law enforcement can determine whether they have evidentiary</td>
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<td>1) Notify local law enforcement pursuant to the requirements of Section 300.695;</td>
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<td>2) Call an ambulance provider if medical care is needed;</td>
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<td>3) Move the survivor, as quickly as reasonably possible, to a closed environment to ensure privacy while waiting for emergency or law enforcement personnel to arrive. The facility shall ensure the welfare and privacy of the survivor, including the use of incident code to avoid embarrassment; and</td>
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<td>4) Offer to call a friend or family member and a sexual assault crisis advocate, when available, to accompany the survivor.</td>
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<td>Continued From page 29 value, including encouraging the survivor not to change clothes or bathe, if he or she has not done so since the sexual assault. d) The facility shall notify the Department and draft a descriptive summary of the alleged sexual assault pursuant to the requirements of Section 300.690.</td>
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b) The DON shall supervise and oversee the nursing services of the facility, including:
   2) Overseeing the comprehensive assessment of the residents’ needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
   3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.
   7) Coordinating the care and services provided to residents in the nursing facility.

Section 300.3240 Abuse and Neglect
   a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
   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.
   f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**SOUTHPOINT NURSING & REHAB CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1010 WEST 95TH STREET
CHICAGO, IL  60643

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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Condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility.

These requirements are not met as evidenced by:

Based on observation, record review and interview, the facility failed to protect 1 resident (R11) from being sexually assaulted, failed to report the assault to the appropriate authorities in a timely manner, failed to seek treatment for R11, and failed to protect other residents on the unit from the perpetrator (R10) for 1 of 14 residents reviewed for abuse.

Findings Include:

The medical record date 06/07/13 indicates R11 diagnoses include: Dementia, Late Affect Cerebral Vascular Accident and Gait Abnormality.

R11’s Minimum Data Sets (MDS) dated 06/12/13 indicates C0500 Summary Score was 00 (resident unable to complete the interview). C1300 (A), Inattention and Disorganized thinking was scored 1 (Behavior continuously present does not fluctuate).

R11 was observed on 07/03/13 at 9:00am, sitting in her room in a wheelchair with chair alarm in place. Resident was alert and oriented X 2. Surveyor asked R11 was she found in bed with a male resident (R10). R11 stated, "No, I was not in his room or bed. No, I was not in his room Saturday and I don't know what you are talking about."

R11 was very confused and unable to tell what happened on 06/29/13 with R10.
### SUMMARY STATEMENT OF DEFICIENCIES

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On 07/03/13 at 9:10am, E1 (Administrator) stated, "There were two residents found in bed. It happened on a Saturday. It was the Certified Nurse Aide (CNA) that found them in bed. They were in the male's room (R10). It was reported on Sunday (06/30/12). We didn't call the police or send her out to the hospital. The physician didn't give any orders. She was checked by the nurse. I cannot determine if the female resident (R11) gave her permission. She is confused at times. R10 is on every 15 minutes monitoring."  
On 07/03/13 at 2:50pm, E17 (CNA) per telephone stated, "It was around 2:30pm. I was going to answer a call light. I heard the alarm going off. It was approximately 3 - 4 minutes when alarm went off. Upon stepping in the room, I saw the wheelchair to the right of the bed in (R10's room). I noticed (R10) on top of (R11). I asked (R10) to get off (R11) and he didn't get off of her. I tried to get him off but was unable to get (R10) off her. He was moving up and down on (R11). (R11) was undressed from the waist down. (R10's) pants were pulled down where you could see the buttocks. I noted a housekeeper coming down the hall. I told her to get the nurse and the nurse came to the room. (R10) was still on top (R11) when the nurse came down. (R11) bottom clothes were off. Her diaper and pants were on the floor. (R10) pants were pushed down to his middle thigh. You could see the back and top part of the buttocks. E19 (nurse) and I got (R10) off (R11). His pants were down and he pulled the pants up. E19 escorted (R10) out of the room. She asked him to go to the nurses' station. (R11) is confused and does not understand when told do something. (R10) is on every 15 minutes monitoring."  
E18 (Housekeeping) on 07/03/13 at 2:36pm, stated "I was leaving out of the dining room. I..." | F9999 |
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looked down the long hall, E17 said to get the nurse. So, I waved to E19 and told her E17 needed her. I was waving at her and she came running. She asked what was wrong. I said I don't know why they needed you right away."

E19 (Nurse) on 07/03/13 at 10:00am, stated, "I was on the phone getting report for a resident coming back to the facility. When I stood up I saw the housekeeper down hall and she was gesturing me to come down the hall. I went down the hall. I asked the housekeeper to call another nurse (E22). When I enter (R10's) room. I saw (R10) and (R11) lying in bed. (R10) was lying behind (R11). I immediately told him to get up. He was fully dressed. There was nothing exposed on (R10). She (R11) was undressed from the waist down. The other nurse and I walked him to the Nurses' station and placed him on 1:1. I had CNA (E17) take (R11) to her room. I went to (R11's) room and did body assessment. Afterwards E22 (Nurse) and I called the manager on duty (E20). He (E20) came up and he called the administrator (E1). He interviewed both residents. The nurse (E22) and I (E19) called the physician. I was given an order from the Nurse Practitioner (Z10) to get lab work for Sexually Transmitted Diseases (STD) for (R10). No, I didn't send (R11) out to the hospital or call the police department. E20 said that the policy and procedure is to call the administrator and physician. I did a body assessment on (R11). She was taken to the shower room and washed up. I notified E20 and went by his leadership. The Nurse Practitioner (Z10) didn't give an order to send (R11) out to the hospital. (R11) is alert and oriented X 1. (R10) is on every 15 minutes monitoring."

When asked did R11 understand what happened to her? E19 stated, "No, she does not
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understand what happened to her. The CNA said she just heard the alarm going off."
On 07/03/13 at 10:50am, E20 (MDS Coordinator/Manager on Duty) stated, "I was the manager on duty. I was doing rounds on the 1st floor. When I came up there, a nurse (E22) made me aware that a couple of residents (R10 and R11) were found in the room lying in bed. They were separate when I got up on the floor. He (R10) was at the nurse's station. I was told they were lying in bed together. (R11) was taken to the dining room. I told them to take her (R11) to her room and do body observation. She was taken to the bath/shower room and cleaned up. I didn't call the police or send her out to the hospital. I called the administrator."
On 07/03/13 at 2:10pm, Z10 (nurse practitioner) stated, "I received a call about (R11) from one of the nurses. She informed me that (R11) was found in the room with a male resident (R10). The nurse informed me that they were possibly having sexual intercourse. There was no evidence of sexual assault."
Surveyor asked Z10 if she came to facility to assess the R11 for vaginal trauma or injury. E10 stated, "No, I didn't check her. The nurses informed me what happened, I ordered a STD panel."
On 07/09/13 at 2:00pm, Z12 (family member) per telephone stated, "The facility said it was consensual sex. She (R11) has dementia. I don't know if she can make decisions for herself. The male had taken advantage of her. My husband has the Power Of Attorney for his mother. She cannot make decisions for herself."
The resident was not sent out to the hospital to be assessed nor were the police notified. The care plan was not updated or revised on how
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(R11) will be monitored, supervised or protected from R10.

The medical record date 3/6/13 for R10’s diagnoses include: Schizo-Affective Disorder, Bipolar, Dementia and Altered Mental Status.

The incident report dated 06/29/13 at 4:00pm, indicates "(R10) is alert and oriented with periods of confusion. Allegedly R10 was observed lying on another resident (R11) in an inappropriate manner. R10 and R11 were immediately separated and provided one to one supervision". On 07/03/13 at 9:15am, R10 was observed sitting in the dining room during breakfast. R10 was alert and oriented with some confusion (dates and time). R10 was observed ambulating throughout 3rd floor unit.

On 07/03/13 at 9:30am, surveyor asked R10 if a lady was found in his bed. R10 stated, "Yes, I don't know her name. She was in my bed. I had intercourse with a lady." During the interview R10 asked, "Could I touch your thigh?"

R10 left the dining room at 11:40am and went into his room. At approximately 1:00pm, R10 came out of his room and continued to walk the unit, and at one point looked into a room which a female resident resided. From 11:40am to 1pm there were no staff monitoring or supervising of R10.

The Screening Assessment for indicators of aggressive and/or harmful behavior for R10 dated 07/01/13 indicates A. Risk Assessment (6). History of abuse/neglect either as a recipient or perpetrator including abusive and/or inappropriate sexual behavior score 1 and 2 (moderate problem and substantial or significant). B. Recommendation and Outcome (3). In need of structure, medication management, supervision. In addition, the resident may benefit from evaluation and on-going intervention from
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<td>Continued From page 36 licensed mental health professional. R10's total score was 11. Comments were that a total score 11 will be referred for psychiatric evaluation. No evidence of a psychiatric evaluation being conducted on R10 was found. The social services progress notes indicates on 06/04/13 &quot;staff reported to writer that resident was making inappropriate comments towards staff. Writer met with resident regarding report on sexually inappropriate behavior. Writer educated resident (R10) to refrain from making sexually inappropriate comments or threats to staff&quot;. 06/08/13 &quot;staff reported to writer that resident (R10) was swearing and threatening staff&quot;. 06/25/13 &quot;Staff reported that resident (R10) was swearing at peers&quot;. 07/1/13 at 8:45am, &quot;met with resident (R10) name below to provide education on safe sex practices. Resident (R10) is encouraged to communicate with staff if he has any interest in pursuing sexual relationships with other peers&quot;. 07/04/13 &quot;staff reported to writer that resident (R10) was making sexually inappropriate comments and threatening staff. Writer meet with resident (R10) regarding report on sexually inappropriate behavior. Writer educated resident (R10) to refrain from making sexually inappropriate comments or threats to staff&quot;. The nurses notes dated 06/29/13 does not indicate that R10 was sent out to the hospital for evaluation. On 07/08/13 at 10:00am, Surveyor asked E23 (nurse), where R10 was located. E23 (nurse) stated, &quot;R10 was sent out to the hospital for aggressive and inappropriate sexual behavior.&quot; The nurses note dated 07/06/13 indicates R10 had inappropriate sexual behavior and was sent</td>
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out to the hospital.

E23 (Nurse) on 07/08/13 at 10:30am, stated, "I worked on Saturday (7am to 3pm) shift. I was doing my last round at the end of the shift. I walked into (R10's) room and I said Hi. He asked me do you want to be my friend? I told him, I am your nurse. When I was walking pass he was trying to hug me. He grabbed me so tight, I was unable to get away from him. He asked me could he kiss me in my mouth. I said "No". I was trying to redirect his behavior while he was holding me. I was trying to break away from him. He asked me if I was married. I said yes, he loosened up and I broke away and got a male certified nurse aide (CNA). He was alright with the male CNA. He was placed on a 1:1 monitoring. I called the physician and was given an order to send R10 out to the hospital.

On 07/08/13 at 3:30pm, E21 (Memory Care Director) stated, "We were monitoring him every 15 minutes and 1:1. He was not sent out for evaluation until after the incident of 07/06/13 with the staff."

The care plan (physical and psychosocial needs) dated 01/14/13 indicates R10 has a history of inappropriate sexual behavior, of touching staff that provide activity of daily living care. There was no assessment or revised/updated intervention on care plan for inappropriate sexual behavior for R10.

The Abuse Prevention Program dated 03/02/13 indicates:

A completed copy of the incident and written statements from the witnesses, if any, will be provided to the administrator with in 24 hour of the occurrence of such incident. Residents who allegedly mistreated another resident will be immediately removed from contact with that resident during course of the investigation. The accused resident's
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condition shall be immediately evaluated to determine the most suitably therapy, care approaches and placement, considering his or her safety, as well of the other residents and employees of the facility.

Upon receiving reports of physical or sexual abuse, the charge nurse will immediately examine the resident. Findings of the examination must be recorded in a separate incident report and the resident's medical record. Any incident that involves crimes to a resident is to be reported within 2 hour of the incident. The Law Enforcement Officials will be informed in a sexual abuse of a resident by another resident.

Upon receiving information concerning a report of abuse, the Administrator or Director of Nursing will request that a representative of the social services department monitor resident's feeling concerning the incident as well as the resident's reaction to his/her involvement in the investigation. Unless otherwise requested by the resident, the social service representative will provide the administrator and the Director of nursing with a written report of his/her findings in the medical record.

(A)