STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145914	A. BUILDING _____ B. WING _____	**07/28/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medication documentation was completed to substantiate administration for one resident(R1) of 3 reviewed for medication administration. Findings include: On 7/22/20 at 2:40pm, V10 (R1's Physician) was interviewed. V10 stated that it is important that a resident takes his [MEDICAL CONDITION] medications as ordered to ensure that the therapeutic level of the medication is maintained; and that if a resident does not take his [MEDICAL CONDITION] medications, that resident will have [MEDICAL CONDITION] and it could result in being sent to the hospital. On 7/22/20 at 10:50am on the first floor, V6 (Licensed Practical Nurse, LPN) stated (R1) usually comes to the nurse to ask for his medications, he does not refuse his medications for me. When I give any medication, I sign it on the MAR (Medication Administration Record). On 7/22/20 at 2:55pm, V9 (LPN) stated (R1) takes his medicine without any problems, very cooperative, he usually comes to meet me at the medication cart and ask if it's time to take his medications. He is alert and oriented, and has never refused his medications for me. He knows and understands that he will have a [MEDICAL CONDITION] if he doesn't take his [MEDICAL CONDITION] medications. On 7/22/20 at 2:15pm, V2 (Director of Nursing) was asked why all the missing entries on the MAR for all three months and there were no records that R1 refused his [MEDICAL CONDITION] medications. V2 stated If the resident refused a medication, or if resident is out on a pass, there are chart codes to put in the box, and if the nurse did not put their initials in the box, they should put the chart codes to show why the medication was not given. The MAR (Medication Administration Record) should not be blank; there should be the nurse's initial or the code that shows why the medication was not given. At this time, V2 presented R1's laboratory reports for [MEDICATION NAME] Acid Levels dated 6/25/20 and 7/6/20. Both reports show very low blood levels of [MEDICATION NAME] Acid at 12.5 and 19.5 micrograms per milliliters respectively. A review of R1's Medication Administration Records(MAR) and Physician order [REDACTED]. [MEDICATION NAME] Acid 500mg daily had 6 missing entries. [MEDICATION NAME] Tablet 750mg had 6 missing entries for 9am dose, and 11 missing entries for 5pm dose for the month. JUNE 2020 MAR: [MEDICATION NAME] 400mg, 9am dose missed 10 times, 5pm dose missed 8 times. [MEDICATION NAME] Acid 500mg at 9am daily was missed 10 times. [MEDICATION NAME] 750mg 9am dose was missed 10 times, while the 5pm dose was missed 8 times during the month. JULY 2020 MAR: Up till 7/21/20 that R1 was discharged , R1 missed his medications as follows: [MEDICATION NAME] 200mg 9am dose missed 2 times while the 5pm dose was missed 7 times. A review of R1's progress notes shows that R1 had [MEDICAL CONDITION] on the following dates: 4/28/20; 6/2/20(sent to the hospital); and 7/7/20(sent to the hospital). R1's nurses' notes dated 6/2/20 at 3:45am written by V11 (LPN) stated that 911 emergency ambulance was called to take R1 to the hospital for [MEDICAL CONDITION]. Another progress note dated 7/7/20 at 12:51am written by V8(LPN) shows that V8 observed R1 having [MEDICAL CONDITION] that lasted 3 to 5 minutes intervals and R1 was in and out of consciousness. V8 received orders to send R1 to the hospital by calling 911 emergency ambulance. On 7/7/20 at 8:05am, another nurse V9 (LPN) documented in the progress notes that she spoke with the emergency room nurse at the hospital and was told that R1's Admission [DIAGNOSES REDACTED]. R1's care plan dated 1/20/20 and reviewed on 4/10/20 and 7/10/20 states that R1 is at risk for [MEDICAL CONDITION] activity related to a [DIAGNOSES REDACTED]. Facility's policy on Following Physician order [REDACTED]. Another policy titled Medication Administration dated 02/2012 states under Purpose: To ensure that resident medications are administered in a timely manner and documentation is completed to substantiate administration. #4 states: Medication Administration Record [REDACTED]. Medications that are refused by the resident or are not administered for other reasons will be circled on the particular day of no administration. The reason for not administering the medication will be documented on the back of the medication administration record. The facility nurses did not follow these policies.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.