STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (CMS-2567)

Provider/Supplier/CLIA Identification Number:	Multiple Construction:	Date Survey Completed:
145914 (X1)	A. Building: B. Wing: (X2)	8/11/2021 (X3)

Name of Facility Surveyed:	Facility Address (Street, City, State. Zip Code)
SOUTHPOINT NRSG & REHAB CTR	1010 WEST 95TH STREET CHICAGO Illinois 60643

Name of Accrediting Organization Performing Survey (if applicable):

ID Prefix Tag (X4)	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency should be preceded by full regulatory or LSC identifying information)	ID Prefix Tag	PLAN OF CORRECTION (Each corrective action should be cross-referred to the appropriate deficiency)	Completion Date (X5)
F 000	- Complaint Investigation #2185496/IL136635 #2185473/IL136597 #2185235/IL136319 #2185452/IL136576 #2185473/IL136597 #2185439/IL136560 SOUTHPOINT NURSING & REHAB is in compliance with 42 CFR Part 483, Requirements for Long Term Care facilities for this survey.			