STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016497	A. BUILDING: _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SUBURBAN REHAB CENTER	19000 SOUTH HALSTED HOMEWOOD, IL 60430

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S 000	Initial Comments Complaint Investigation 1993077/IL111721	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:

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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to implement, communicate and document in care plan, fall risk assessment and interventions for 1 of 3 residents (R1) reviewed for falls in a total sample of 3. This failure resulted in R1 falling out of bed, sustaining a laceration to

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forehead, a fractured nose and separated left shoulder.

Findings include:

R1 was admitted to facility on 4/13/19 at 6:35pm from a local hospital.

Hospital Discharge Summary on 4/13/19 documents R1 is a fall risk.

On 5/6/19 at 4:45pm, V10 (Licensed Practical Nurse/LPN) stated, "I admitted R1 to facility, accompanied by family who made it very clear he was a fall risk. I also received report from local hospital before he came that he was a fall risk as well. With him coming in on the weekend, we would not be able to get floor mats or other proper fall precautions until the next day unless we saw some laying around in another room. I did what I could. Then, V12 (Licensed Practical Nurse/LPN) finished the admission."

V12's Admission Fall risk assessment on 4/13/19 notes R1 is high risk for falls.

V12's progress note on 4/13/19 at 8:07pm notes R1 had multiple falls at home and writer explained to family that staff will put down a floor mat.

On 5/6/19 at 1:30pm, V5 (Certified Nursing Assistant/CNA) stated, "I worked with R1 during the day on 4/14/19 for the first time and I saw his legs sliding off the bed and stiff as a board. I told him he would fall like that so we assisted him up and the floor mat was put against the wall. He was in the dining room the rest of the shift."

On 5/6/19 at 12:50pm, V4 (CNA) stated, "I started

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my shift that afternoon (4/14/19) and was not briefed that R1 was a fall risk or using a floor mat. There was a mat in the room but I thought it was for his roommate. There was not a care card made for him yet that lists if he is a fall risk or the interventions. I laid R1 in bed, then left the room for a minute. When I returned, R1 was on the floor and bleeding from a gash on his forehead."

On 5/6/19 at 4:30 pm V9 (Registered Nurse/RN) stated, "I took care of R1 on 4/14/19, the evening he fell. The family had been there when I started my shift. After the family had left, I asked V4 to get R1 into bed. I heard that the family told V4 to put the floor mat on the floor. R1 was a new admission so V4 and I didn't even know about the floor mats or that he was a fall risk. There was no care card for him yet and R1's name was not on the fall risk list so there were no interventions listed. The restorative nurses make the care card, which states if the resident is a fall risk. There was a laceration on the forehead after he fell. There was no floor mat. He was sent to the emergency room."

On 5/6/19 at 4:46pm, V8 (Restorative Nurse) stated, "When someone is admitted and a fall risk, it is in the admission packet. I am off on the weekends, and when I come in on Monday, myself and the other restorative nurses look at the admissions and go thru to see who is a fall risk. The admitting nurse would add the fall interventions. On weekends, the nurses give verbal report if resident is a fall risk and the interventions in place to the other nurses. The care card is put in place by restorative CNAs, so on the weekends, the staff just give verbal reports about fall risk and interventions."

On 5/7/19 at 10:16am, V3 (Director of

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Nursing/DON) stated, "The restorative aides work 7 days a week and are responsible for seeing the new admissions then creating a care card for the CNAs with the fall risk and interventions listed. If that was not done for some reason, the nurses on the unit are able to create this as well, in addition to verbally informing the CNAs and other nurses of fall interventions. R1 should have had a care card by the next evening (the evening of R1's fall) that lists interventions and fall risk or been given verbal report. There is no policy or protocol for nurses to create, report and document fall interventions when resident is admitted."

V9's progress note dated 4/14/19 at 9:40pm, notes V4 was making rounds and noted R1 laying on his left side on the floor near the bed. R1 had half inch laceration noted to the forehead with small amount of blood noted. Pressure dressing applied. R1 was sent to the local emergency room for evaluation.

Emergency room report dated 4/14/19 states R1 is status post a mechanical fall with a laceration to the right forehead, fracture of the distal tip of the nose and left shoulder separation as an injury. The patient showed signs of intractable pain during the course of the hospital stay and several medication were initiated in an effort to control his pain. Eventually, he was placed on oral morphine and discharged to home on hospice on 4/20/19.

Care plan dated 4/13/19 notes that R1 is at risk for falling related to impaired mobility and does not include floor mat as an intervention as stated in V12's progress note.

Physical Therapy notes dated 4/14/19 (the evening of R1's fall) note R1 is a fall risk and has

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S9999	Continued From page 5 impaired range of motion to upper and lower extremities as well as right hip and knee. R1 is totally dependent with bed mobility. (B)	S9999		