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 11/09/2020

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SOUTH SUBURBAN REHAB CENTER	19000 SOUTH HALSTED HOMEWOOD, IL 60430

(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2096417/IL125763 2097195/IL126702 2097784/IL127349	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) 300.610a) 300.1010h) 300.1210b) 300.1210d)5) 300.3240a) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. 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)	S9999		

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S9999	Continued From page 2 These Requirements are not met as evidenced by: Based on interview and record review the facility failed to ensure a resident at risk for developing pressure ulcers did not develop pressure injuries from an immobilizing splint and had pressure relieving interventions in place. The facility also failed to assess a resident with an immobilizer in place and failed to get treatment orders for a resident with an immobilizing splint. This failure resulted in R1 developing multiple deep tissue injuries to her right heel and foot. This applies to 1 of 3 residents (R1) reviewed for pressure ulcers in the sample of 25. Findings include: R1's face sheet showed she was admitted on July 13, 2020 with diagnoses including abnormalities of gait and mobility, muscle weakness, orthostatic hypotension, diabetes, chronic kidney disease, pressure ulcer to her buttock and right tibia fracture (on July 17, 2020). The Minimum Data Set assessment dated July 24, 2020 shows R1's cognition is intact. The skin Braden scale assessment dated July 20, 2020 shows R1 is at risk for developing pressure ulcers. The Event Report dated July 17, 2020 at 5:19 PM, V13 (Registered Nurse) documents R1 had an unwitnessed fall in the bathroom and was sent to the local hospital. The nurse's note dated July 18, 2020 documents R1 returned back to the facility with a right tibia fracture and instructed to wear the splint until the	S9999		

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S9999	Continued From page 3 follow up appointment with V27 (Orthopedic Physician). The ER discharge instructions dated July 17, 2020 states to follow up with V27 (Orthopedic Physician) on Monday July 20, 2020 to set up the follow up appointment. Instructions to wear the splint until the follow up appointment and no walking while wearing splint until cleared by orthopedics. The nurse's note dated July 20, 2020 V8 (Licensed Practical Nurse) documents the facility was unable to set up R1's orthopedic follow up appointment. V26 (Assistant Director of Nursing) was notified and the facility scheduler to follow up. The nurse's note dated August 3, 2020, documents (R1) has an appointment scheduled for 8/10/2020 with the orthopedic physician. R1's follow up appointment was not scheduled until 14 days later. The nurse's note dated August 10, 2020 documents when R1 returned from her orthopedic appointment, 25 days later after her initial appointment was not scheduled, R1's long leg splint was removed. The wound nurse assessed R1's right lower extremity and found that R1 had four new pressure ulcers to her right lower extremity. The pressure ulcers are as follow: Right heel deep tissue injury measuring 7.0 cm (centimeters) x 7.0 cm Right medial foot deep tissue injury measuring 3.0cm x3.cm Right lateral foot deep tissue injury measuring 3.0cm x2.0cm	S9999		

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S9999	Continued From page 4 Right dorsal foot deep tissue injury measuring 15.0cm x10.cm The Treatment Administration Record for July 2020 shows orders for daily skin assessments. There is no documentation/assessment for the following days: July 18, July 19, and July 22, 2020 - July 31, 2020, 12 days with no skin assessments. The Treatment Administration Record for August 2020 shows orders for Turn and Reposition every two hours; this is left blank for 31 days. The Care Plan dated through September 2020 shows R1 is at risk for developing pressure ulcers but does not include pressure relieving interventions. The Physician Order Sheets dated through September 2020 shows no additional orders to assess R1's right lower extremity or orders for assessing care/removal of the immobilizing splint. On November 3, 2020 at 9:15 AM, R1 said she had a splint in place after she fell at the facility. R1 said, "I had to stay in bed with the immobilizer on until my follow up appointment. R1 said the staff told her they couldn't do anything with the splint because that's what the Dr. ordered." R1 said, "It hurt so much. The staff didn't care. They said, 'there's nothing I can do.'" R1 said staff did not elevate her leg and would not remove the splint to look at her leg/foot. On November 3, 2020 at 9:00 AM V4 (Wound Nurse) said, "R1 had a fall on July 17, 2020. She went out to the ER for evaluation. She came back to the facility and had a right tibia fracture with an immobilizer on. The ER orders were not to	S9999		

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S9999	Continued From page 5	S9999		

remove the splint until she was seen by the orthopedic physician, so we followed those orders until her orthopedic appointment on August 10, 2020 (25 days later)." V4 said R1's follow up appointment was supposed to be for July 20, 2020 but was rescheduled for August 10, 2020 (25 days later). V4 said when R1 came back to the facility after her orthopedic appointment, R1 had multiple deep pressure ulcers to her right foot. V4 said R1's immobilizer caused the pressure on her right foot. V4 said, "R1 complained of pain to that area, but we were following the orders not to remove the splint until R1 followed up with orthopedic physician." V4 said residents who are at risk for developing pressure should have pressure relieving interventions in place. V4 said they did not call to get additional orders for R1's splint.

On November 4, 2020 at 2:30 PM, V24 (Orthopedic Physician Assistant) said R1 was evaluated on 8/10/20 almost 4 weeks after her fall. R1 had a long leg splint (temporary splint), not a cast. When the splint was removed, she had multiple pressure ulcers to her right lower extremity. R1 had a pressure ulcer to her right heel, right medial and lateral area of the foot, and on the front of her right ankle. V24 said there was delay in R1 having her follow up appointment in a timely manner.

On November 5, 2020 at 9:15 AM, V8 (Licensed Practical Nurse) said she called to make R1's appointment for July 20, 2020 but was unable to make R1's appointment. V8 said she notified V26 (Assistant Director of Nursingo follow up to make R1's appointment.

On November 2, 2020 at 11:50 AM, V2 (Director of Nursing/DON) said staff should follow up with

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S9999	Continued From page 6 the physician and get additional orders for residents with splints. On November 5, 2020 at 10:00 AM V26 (ADON) said normally she would call and make the appointment herself but does not remember if she called to set up R1's appointment. V26 said staff should assess a resident's skin and extremity every shift and follow up with additional orders for care of a resident's splint. The facility's Pressure Ulcer and Wound Prevention/Management Program dated December 2006 states, "To identify residents who are at risk for developing pressure ulcers and skin breakdown. To prevent pressure ulcers and skin breakdown. To provide a guideline for the appropriate nursing management of skin breakdown when it occurs." (B) (Violation 2 of 2) 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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	S9999		

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S9999	Continued From page 7 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 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. 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:	S9999		

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S9999	Continued From page 8 Based on interview and record review the facility to ensure a resident was supervised during toileting. This failure resulted in R1 falling in the bathroom and sustaining a right tibia fracture. This applies to 1 of 7 residents (R1) reviewed for safety in the sample of 25. Findings include: R1's face sheet showed she was admitted on July 13, 2020 with diagnoses including abnormalities of gait and mobility, muscle weakness, orthostatic hypotension, and right tibia fracture (on July 17, 2020). The Physical Therapy Evaluation dated July 14, 2020 shows R1 presents with muscle weakness, has reduced ability to safely ambulate, and requires maximum two person assist with transfers and standing. R1 is at risk for falls and has weakness to her trunk area and lower legs. The Minimum Data Set assessment dated July 24, 2020 shows R1's cognition is intact and requires extensive assist with toileting. The Nurse's note dated July 14, 2020 at 3:25 PM documents R1 was found on her knees next to her bed. The Event Report dated July 17, 2020 at 5:19 PM, V13 (Registered Nurse/RN documents R1 had an unwitnessed fall in the bathroom. V13 documents she was notified of R1's fall in the bathroom. R1 said she was trying to stand. The report documents R1's ambulation status is independent and has no weakness to her extremities. R1 was transferred to the ER for evaluation.	S9999		

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S9999	Continued From page 9 The Nurse's note dated July 18, 2020 at 12:34 AM, documents (R1) returned back to the facility. (R1) has a right tibia fracture. R1's care plan dated through September 2020, showed she was at risk for falls with interventions including to observe frequently and place in supervised area when out of bed. On November 3, 2020 at 9:15 AM, R1 said a Certified Nurse Assistant (CNA) assisted her to the bathroom. R1 said the CNA left her in the bathroom and said when you're done pull the call light string. R1 said she pulled the string and waited and waited and no one came. R1 said then she stood up and fell. On November 3, 2020 at 1:05 PM, V13 (RN) said she was R1's nurse on 7/17/20 when R1 fell. V13 said she was notified that R1 was on the floor in the bathroom. V13 said she does not remember who took R1 to the bathroom and said it was not safe to leave her in the bathroom un-supervised. V13 said during report she was notified R1 had a recent fall. On November 3, 2020 at 10:05 AM, V10 (Physical Therapist) said R1 was a two person assist with transfers, she had weakness and decreased strength in her right leg and could not stand well. R1 was a fall risk and needed assistance with toileting. On November 2, 2020 at 1:50 PM, V3 (Director of Nursing) said fall risk assessments are done on admission and after each fall to determine a resident's fall risk with interventions in place to prevent falls. On November 3, 2020 at 11:35 AM, V2 (Assistant	S9999		

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S9999	Continued From page 10 Administrator) said R1 did not have any fall risk assessments. The Fall Clinical Protocol Policy Revised August 2008, states, "As part of initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falls...the staff will document risk factors for falling in the resident's record and discuss the resident's fall risk...based on preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls..." (B)	S9999		