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 10/27/2021

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SOUTH SUBURBAN REHAB CENTER	19000 SOUTH HALSTED HOMEWOOD, IL 60430

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S 000	Initial Comments Investigatiaon of Facility Reported Incident of 9-19-21/IL138705 Complaint Investigation 2197461/IL139032 2197574/IL139171	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) 300.1210b) 300.1210d)4) 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: 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 These requirements were not met as evidenced by: Based on observation and interview the facility failed to provide washcloths and towels to clean 1 (R1) of 3 residents reviewed for dignity after R1 had been incontinent in his brief. This failure resulted in R1 stating feeling humiliated and angry because staff used a sheet to wash and dry him. Findings include: R1 is a 55 year old with diagnoses including but not limited to diabetes, post right below the knee amputation, weakness, and depressive disorder. R1's Cognitive Assessment dated 7/9/21 notes he is cognitively intact. On 10/20/21 at 12:21PM R1 said he was left in stool this morning. R1 said no changed him because there were no towels. R1 said, "I pulled my call light at 5:30AM. The Certified Nursing Assistant (CNA) came in and said she had to find towels to clean me so she left. The CNA then returned and said she can't find towels." R1 then said V4 (Restorative Nurse) checked on him and R1 reported to him he was waiting to be changed. R1 said V8 (CNA) came in and used a bath sheet to clean him because she told him there were no towels or washcloths. R1 said this made him feel humiliated and angry. R1 said, "The worst part is the way the staff look at me; they make me feel like it's my fault." On 10/20/21 at 12:39PM surveyor observed a linen cart on R1's unit with 1 washcloth and 4 bath towels. A second linen cart adjacent to R1's unit was observed to have no towels or washcloths.	S9999		

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S9999	Continued From page 2 On 10/20/21 at 12:42PM V9 (CNA) looked in the large linen cart on the floor and said there are only 2 washcloths on this cart. On 10/20/21 at 12:50PM V8 (CNA) said, "I told R1 there were no linens this morning." V8 said she went to laundry in the morning and there were no clean towels or washcloths. V8 said washcloths and towels are used to clean incontinent residents. V8 said she washed R1 using a bath blanket to wash and dry him. V8 said R1 was angry but not at her. V8 said the towels came to the unit on the cart later in the morning. On 10/20/21 at 1:19PM V7 (CNA) said, "There are no towels or wash cloths on my linen cart. We have not had any towels delivered." V7 said she has not had any towels since the morning. V7 said she brings her own wipes to clean her residents. On 10/20/21 at 1:25PM surveyor observed 2 stacks of towels and washcloths on folding table in laundry room and being stacked onto 2 large linen carts. V5 (Housekeeping Manager) showed surveyor closet with bags of new towels and linens on 2 shelves. V5 said, "We have enough and extra towels." V6 (Housekeeping) said, "No one has come to the laundry room to ask for towels today." Surveyor attempted to contact V26 (CNA) who worked on 10/20/21 at 5:30AM with R1. Surveyor was unable to reach V26 on 10/22/21 at 10:06AM and 4:42PM. (B)	S9999		

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S9999	Continued From page 3 (Violation 2 of 2) 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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 300.1210 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,	S9999		

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S9999	Continued From page 4 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 300.1220 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. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to monitor a resident (R3) while sitting at the nurses' station in a wheelchair and failed to develop fall interventions for 2 resident's (R3 and R4) that address their risk for falls while in a chair or transferring. These failures resulting in R3 sustaining a nondisplaced left subcapital femoral neck fracture and a traumatic subarachnoid	S9999		

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S9999	Continued From page 5 hemorrhage and R4 sustaining a skin tear. Findings include: 1. Review of R3's facesheet documents an 89 year old male admitted to the facility on 9/8/2021 and was discharged on 10/4/2021. Minimum Data Sheet (MDS) dated 9/15/2021 section GG documents R3 requires substantial/maximal assistance with transfers and sit to stand. Review of admission fall assessment dated 9/8/2021 documents R3's fall risk score as a 10 and fall risk level as High. Review of fall report dated 9/9/2021 documents resident had an unwitnessed fall and was found on the floor by staff not on floor mats. On 10/21/2021 at 12:27 PM during interview V24 (Licensed Practical Nurse/LPN) stated she remembered R3. V24 stated she did not remember any fall precautions that R3 was on. Regarding R3's fall on 9/9/2021, V24 stated R3 "did not have a floor mat on the floor when we found him on the floor as I charted." Review of R3's care plan did not mention R3's 9/9/2021 fall. The only intervention on R3's care plan for risk for falls was dated 9/9/2021 and stated: "keep bed in low position with breaks locked." Facility Reported Incident dated 9/19/2021 documents: the nurse noted R3 stood up out of his wheelchair by the nursing station and nurse could not reach him before he lost his balance and fell on his left side hitting his head on the floor.	S9999		

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S9999	Continued From page 6 On 10/21/21 at 12:58 PM V30 (Certified Nursing Assistant/CNA) stated R3 was sleeping in his wheelchair at the nurses' station. V30 stated, "I was coming from the bathroom from the 100 side and walking towards the nurse's station. V27 (LPN) came out of a room and was walking with me towards R3. The other CNA was coming down the hall of 200 unit from doing patient care. We all were walking towards the nurses' station. All of a sudden R3 stood up and we all started running towards him and he fell." Surveyor asked was there anyone at the nurses' station with R3. V30 responded, "No. There was not anyone at the nurses' station with him. The night shift said R3 kept getting out of the bed overnight. He was already at the nurses' station when I got here. I knew he was a fall risk." On 10/22/2021 at 10:20 AM V18 (CNA) stated in regard to R3's fall on 9/19/2021, "It was right after breakfast; he (R3) was sitting at the nurses' station. I was coming from the 200 side giving patient care and doing rounds. As soon as I saw R3, he stood up and fell forward. V27 (LPN) was coming out of room right next to him. V30 (CNA) was coming from the other hallway. We all saw him at the same time. It was a hard fall. He was responding verbally. R3 was saying, 'I fell. I fell.' I didn't see anyone at the nurses' station with him before he fell. " On 10/26/2021 10:50 AM V27 (LPN) stated the following regarding R3's fall on 9/19/2021: "I was down the hall passing medications. I came to fill a water pitcher and when I turned around, he (R3) was standing in front of his wheelchair. I ran to try to catch him and couldn't get there in time and he fell." Progress note written by V27 (LPN) dated 9/19/2021 documents the following: "Writer observed resident stand up from sitting position in	S9999		

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S9999	Continued From page 7 wheelchair, lose balance, fall to left and hit his head on the floor." Review of staff interviews post incident document the following: V30 (CNA) was coming from patient care when she saw R3 fall V18 (CNA) was coming from break when she saw R3 fall V28 (CNA) was on break and did not witness the fall. R3's hospital discharge instructions document the following: Discharge diagnoses: 1. Status post fall, at the nursing facility, resulting in nondisplaced left subcapital femoral neck fracture and traumatic subarachnoid hemorrhage. R3's care plan does not document any interventions for falls that address risk for falls while in a chair or transferring. 2. Review of admission fall assessment dated 7/7/2021 documents R4's fall risk score as a 15 and fall risk level as High. Minimum Data Sheet (MDS) dated 9/15/2021 section GG documents R4's chair to bed transfer as dependent. Post Fall report for R4 dated 8/1/2021 documents: CNA informed nurse she observed resident on the floor. V29's (Nurse) progress note dated 8/1/2021 documents the following regarding R4: Resident was observed sitting on the floor next to his bed. Resident stated he was trying to walk from his wheelchair to his table and lost his balance and slid to the floor. (R4) has a skin tear to the right elbow.	S9999		

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S9999	Continued From page 8 On 10/22/2021 at 11:06 AM R4 was in his room sitting in a wheelchair. R4 stated, "I get dizzy all the time and fall." Regarding R4's recent fall on 8/1/2021, R4 stated, "I got out of the wheelchair to get in bed and fell. What was I supposed to do? These people are busy. I don't have time to sit around all day. I slid under the bed. I injured my arm. I was on the floor for 2 hours. They couldn't see me. I couldn't get out for a whole 2 hours." R4's fall care plan dated 7/13/2021 documents the following intervention: keep bed in low position with breaks locked. V24 (LPN) stated she didn't know R4 was on any fall precautions. V24 stated, "Mostly we are told in report who is a fall risk. We don't keep fall risk posted anywhere in the room or on the door. Fall precautions should be in care cards, the ones that the CNAs use. I have seen a few behind the beds on the wall." V24 stated she is not sure if care plans are in the computer. On 10/22/21 at 12:29 PM V18 (CNA) stated, "R4 transfers himself all the time. We tell him to call us when he needs to go to the restroom or if he needs to get up. You can hook the light straight on him and he will not pull it." V18 stated she will put him in the chair and walk down the hall and he puts himself back in the bed. Review of R4's care card that was hanging in his room is absent of documentation of fall precautions. R4's Care plan does not document any interventions for falls that address risk for falls while in a chair before 8/1/2021 fall.	S9999		

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S9999	Continued From page 9 Facility "Falls and Fall Risk, Managing" policy dated 2001 documents the following: Policy statement: based on previous evaluations and current data, staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. 6. Staff will identify and implement relevant interventions to try to minimize serious consequences of falling. (A)	S9999		