Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING IL6016497 07/17/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 19000 SOUTH HALSTED SOUTH SUBURBAN REHAB CENTER HOMEWOOD, IL 60430 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 000 **Initial Comments** S 000 Facility Reported Incident of May 29, 2023 IL160793 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.3210 t) Section 300.610 Resident Care Policies The facility shall have written policies and a) 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 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 Attachment A plan. Adequate and properly supervised nursing Statement of Licensure Violations care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 08/03/2023 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING IL6016497 07/17/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 19000 SOUTH HALSTED SOUTH SUBURBAN REHAB CENTER HOMEWOOD, IL 60430 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX COMPLETE DATE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 59999 Continued From page 1 S9999 Section 300.3210 General The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements are not met as evidenced by: Based on interview and record review ,the facility failed to protect a resident (R1) from physical abuse by (R2). This failure applied to two (R1 and R2) of five residents reviewed for abuse, and resulted in R1 obtaining a hematoma, facial laceration, laceration of right lower leg, and closed fracture of condyle of right femur. Findings include: R1's Facility Census documents R1 was admitted on 4/2/19, with the following medical diagnoses: Parkinson's Disease, Schizoaffective Disorder. Muscle Weakness, Major Depressive Disorder, Anxiety Disorder, Cognitive Communication Deficit, Personal History of Traumatic Brain Injury and Conversion Disorder with Seizures or Convulsions. R1's Minimum Data Set (MDS), dated 6/5/23, documents R1's Brief Interview for Mental Status (BIMS) score 10, moderately impaired.

and Weakness.

R2's Facility Census documents R2 was admitted on 6/19/19, with the following medical diagnoses: Mild Intermittent Asthma, Major Depressive Disorder, Anxiety Disorder, Other Sleep Disorders not due to a Substance or Known Physiological Condition, Dysphagia Oral Phase

R2's Minimum Data Set (MDS), dated 4/17/23,

PRINTED: 08/03/2023 **FORM APPROVED** Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C IL6016497 07/17/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 19000 SOUTH HALSTED **SOUTH SUBURBAN REHAB CENTER** HOMEWOOD, IL 60430 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 2 S9999 documents R2's Brief Interview for Mental Status (BIMS) score 14, cognitively intact. R1's Nursing Notes, dated 5/29/23 at 7:04pm, documents,"(V3, Licensed Practical Nurse/LPN) was alerted to room by loud screams, observed (R1) sitting in wheelchair screaming and crying, blood coming from the mouth and grabbing (R1's) right knee. (R1) states "that **** hit me (R2)". V3 alerted more staff for assistance. First aid rendered to mouth with blood trickling down the jaw. Vital signs taken. Manger on Duty (MOD) notified, Local Emergency Response Activated." R2's Nursing Progress Notes, dated 5/29/23 at 7:04pm, documents, "(V3) heard screaming coming from bedroom, (V3) observed (R2) sitting in wheelchair on (R2's) side of the room. (V3) asked (R2) what happened? (R2) responded, "(R2) hit that **** (R1), (R2) was verbally and physically aggressive towards roommate and using profanity with staff. (V3) asked (R2) to show (V3) how (R2) hit (R1). (R2)stated, '(R2) hit (R1) with this (pointing at the arm of the wheelchair)'. (V3) called out for more staff assistance. Staff removed (R2) from the bedroom." R1's Nursing Notes, dated 5/29/23 at 7:34pm, documents R1 leaving the building alert and verbal with Local Emergency Response Team.

knee. "
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petition.

R2's Nursing Notes, dated 5/29/23 at 7:47pm, documents R2 leaving the facility with local emergency response going to hospital with

R1's Hospital Report, dated 5/29/23, documents, "Two absorbable sutures placed in the left corner of mouth, and three ethilon sutures in the right

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this." V3 said R1 and R2 were transferred to the emergency room for evaluation and treatment. On 5/30/23 at 8:11am, R1 returned to the facility,

On 7/17/23 at 9:40am, V1, Administrator, said,

alert and quiet, with a hematoma, facial laceration, laceration of right lower leg, and closed fracture of condyle of right femur.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY
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L IL6016497		B. WING		07/17/2023	
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			DEFICIENCY		
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	"On 5/29/23. (V3. Li	icensed Practical Nurse)			
		altercation between (R2) and		·	
	(R1). (V1) immediate	tely started an investigation,		;	
-	and all notification was done, along with notifying			-	
	Illinois Department	of Public Health. (V1)			
	interviewed (V3), wl	no informed (V1) that (V3)	1		
	heard a noise comi	ng from (residents room). (V3)			•
	immediately entered	the room, and (V3) saw (R1)			
	holding (R1's) mout	h. (V3) asked (R1) what			
) informed (V3) that (R2) hit			
		were sent to emergency			
		On 5/30/23, (R1) returned the diagnosis of hematoma.			
		d laceration of the right lower			
	leg."	u laceration of the right lower			
	10g.				
	The Facility's Illinois	Abuse Prevention Policy,			
		uments: "this facility affirms			
	the right of our resid	lents to be free from abuse,			
	neglect, exploitation	, misappropriation of			,
		n of goods and services by			
i		t. This facility therefore			
	prohibits abuse, neg				
	misappropriation of	property, and mistreatment of			
		o do so, the facility has sh a resident sensitive and			
		nt. The purpose of this policy			
		facility is doing all that is			
٠.		prevent occurrences of abuse.			
		, misappropriation of			
		of goods and services by		-	
		ent of residents. Abuse:			
	Abuse means any p	hysical or mental injury or			
	sexual assault inflict	ed upon a resident other than			
	by accidental means	s (210 ILCS 45/1-103). Abuse			
1	is the willful infliction	of injury, unreasonable			
		ation, or punishment with			
·		ırm, pain, mental anguish to a			
		3.5). This also includes the	,	·	
	deprivation by an inc	lividual, including a caretaker,			

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