STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016497	A. BUILDING: _____ B. WING _____	C 10/18/2023

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 Facility Reported Incident of September 25, 2023 IL165290	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)6) 300.3240 a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 are not met as evidenced by: Based on interview and record review, the facility failed to prevent or determine how an injury of unknown origin occurred for one (R1) of three residents reviewed for resident injuries in a total sample of three. This failure resulted in R1 suffering a right hip fracture after being sent to the hospital for right thigh swelling and not being able to stand. Findings Include: R1 is a 79 year old with the following diagnosis: fractured neck of the right femur, urinary tract infection, myocardial infarction, dementia, and history of falling. R1's Minimum Data Set (MDS), dated 8/15/23, documents a Brief Interview for Mental Status score is a six (severe cognitive impairment).	S9999		

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S9999	Continued From page 2 A Nursing note, dated 9/19/23, documents it was brought to the nurse's attention by other staff, R1 could not stand or sit on the edge of the bed. Upon assessment, R1's right thigh was swollen. No bruises or redness were noted. R1 verbalized pain on the affected side. The physician was notified and ordered to send R1 to the hospital for an evaluation. The Hospital Records, dated 9/19/23, documents R1 presented to the hospital for the chief complaint of right hip fracture. R1 was also diagnosed with a myocardial infarction, acute kidney injury, and urinary tract infection. An x-ray of the right hip shows a comminuted (bone broken in two places) intertrochanteric involving the right proximal (closer to the body) femur. The lesser trochanter is displaced medially. A CT (computerized tomography) of the chest showed a moderate T10 compression fracture that is possibly acute, but the exact age of the fracture could not be determined. R1 received hip surgery, with a nail being placed in the fractured bone to provide support. R1 was sent back to the facility on 9/25/23 after medically cleared. The Facility Incident Report Form, dated 9/25/23, documents R1 returned from the hospital with a diagnosis of urinary tract infection in right hip fracture. The CT scan revealed a moderate T10 compression fracture that is possibly acute but exact age is unable to be determined. R1 was sent out to the hospital on 9/19/23 due to not being able to sit or stand from the bed around the morning hours. Swelling was observed to R1's right side. R1 also complained of pain to the affected area during the assessment. Staff were interviewed and no one witnessed R1 fall or be injured. Care was provided at baseline with no	S9999		

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S9999	Continued From page 3	S9999		

injuries or falls noted. R1 normally ambulates on the unit without staff assistance. R1 is capable of getting up independently. R1 is unable to say what happened due to a diagnosis of dementia.

A Nursing note, dated 9/25/23, documents R1 readmitted to the facility from the hospital, with a diagnosis of right hip fracture and urinary tract infection. R1 is alert to name. The right thigh was swollen. There's a total of three surgical incisions.

On 10/12/23 at 12:45PM, R1 was sitting in the dining room. R1 is alert to self only. R1 can only answer questions with one or two words. R1 did not remember fracturing R1's right hip or vertebrae. R1 was not able to state how the fractures occurred.

On 10/12/23 at 1:17PM, V3 (Nurse) stated V3 was the nurse the day before R1 went to the hospital on 9/19. V3 denied R1 complaining of any pain, and denied R1 having any falls/accidents that were brought to V3's attention. V3 denied completing a full body assessment during this shift on R1, because there was "no need." V3 stated R1 is confused at baseline and can only answer simple questions. V3 reported R1 went to the hospital and returned with a right hip fracture. V3 endorsed since R1 was not able to say what happened and staff did not witness any accidents/falls, then this type of injury is considered an injury of unknown origin.

On 10/12/23 at , V4 (Certified Nursing Assistant/CNA) stated R1 laid in bed all day on 9/18, and did not want to get out of bed. V4 endorsed telling the nurse, but denied R1 having any other change in condition that needed to be reported to the nurse. V4 reported getting R1 ready for breakfast on 9/19, and R1 kept saying

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S9999	Continued From page 4 "ouch" when being changed. V4 stated R1 said R1's leg was hurting, but could not say what happened. V4 reported R1 is normally able to stand and ambulate in the halls without assistance, but that day, R1 was not able to stand from the bed. V4 denied knowing R1 had any falls or other incidents before 9/19 that would have caused pain to the right leg. On 10/12/23, V6 (Nurse) stated V4 told V6 R1 was not able to stand after getting R1 ready for day. V6 went and did a full body assessment and noticed R1's right thigh was swollen. V6 was only able to verbalize being in pain on the right leg but could not state what happened . V6 denied R1 being able to stand that morning. V6 sent R1 out to the hospital per physician orders. V6 stated R1 was readmitted to the facility later with a right hip fracture. V6 denied being aware of any accidents or falls that would cause a hip fracture. V6 stated if an injury is unwitnessed and a resident is unable to say what happened, then the injury is an injury of unknown origin. On 10/13/23, V7 (CNA) stated V7 took care of R1 the day before R1 went to the hospital. V7 reported R1 spent the both shifts (3PM-11PM and 11PM-7AM) in the bed. V7 denied R1 having any complaints. V7 denied R1 showing any signs of pain when care was provided. V7 denied R1 having any falls or accidents that would cause a fracture. On 10/13/23, V8 (Nurse) stated R1 stayed in the bed the entire night shift before going out to the hospital the next day. V8 denied R1 complaining of any pain when assessed. V8 denied being aware of any accidents or falls that would cause a hip fracture. V8 stated getting in report R1 spent the entire day in bed. V8 stated R1's fracture	S9999		

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S9999	Continued From page 5 would be considered an injury of unknown origin. On 10/17/23, V2 (Director of Nursing/DON) stated R1 returned to the facility on 9/25 with a fractured right femur and T10 compression fracture. V2 reported interviewing staff that cared for R1, and all staff denied R1 having any falls or accidents that would cause a fracture. V2 reported when a resident has an injury, then an investigation needs to be completed to see how the injury occurred. V2 denied R1 being able to tell V2 how the fractures occurred because of R1's mental status. V2 denied being able to find the source of the injury during the investigation. V2 endorsed this would be considered an injury of unknown origin. On 10/17/23 at 5:17PM, V9 (Medical Director) stated, "Staff notified me (R1) had a right hip fracture and T10 compression fracture. The T10 fracture's age could not be determined but was possible acute. A compression fracture in this area of the spine would be from osteoporosis, but other causes would be a hard fall directly near that area, or a motor vehicle accident. She had an intertrochanter fracture that was comminuted. These type of fracture is usually occur due to a fall." V9 endorsed fractures caused by osteoporosis are more in the bone shaft and this fracture was closer to the hip joint. V9 denied R1 having a diagnosis or being on medication that could weaken bones or cause a spontaneous fracture. V9 endorsed these type of fractures are "more likely from a fall." The Abuse Prevention Policy, undated, documents, " ...3. For resident injuries, not involving an allegation of abuse or neglect, the administrator will appoint a person together,	S9999		

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S9999	Continued From page 6 further facts to make a determination as to whether the injury should be classified as an "injury of unknown source." Any injuries should be classified as an "injury of unknown source" when both of the following conditions are met: the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and the injury is suspicious, because of the extent of the injury or the location of the injury (e.g., the injury is located in an area, not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidents of injuries overtime." (A)	S9999		