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 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 Investigations 2494473/IL174062 and 2494342/IL173897	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.690 a) 300.690 b) 300.690 c) 300.1210 b) 300.1210 c) 300.1210 d)6) 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of	S9999		

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 08/06/2024

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S9999	Continued From page 1	S9999		

that resident.
b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.
c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

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.
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

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	IL6016497	A. BUILDING: ______ B. WING ______	C 08/06/2024

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S9999	Continued From page 2	S9999		

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.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to adequately supervise a resident in the locked unit who was assessed as high fall risk (R1); failed to ensure two staff were used when providing care for a resident (R7) per the resident's plan of care; and failed to report a fall incident that resulted in a serious injury to the State Agency for a resident within 24 hours of the incident (R5). These failures resulted in R1 sustaining a laceration to her head that required treatment for scalp laceration, R7 sustaining a head laceration, and R5 being admitted to Neuro Intensive Care Unit.

Findings include:

1. R1 is a 60-year-old female admitted to the facility on 8/30/2023. Past medical history includes, but not limited to: unspecified dementia, major depressive disorder, anxiety disorder, vitamin D deficiency, unspecified psychosis not due to a substance or known psychological condition, vitamin B deficiency, and cognitive communication deficit.

Fall care plan, dated 9/1/1023, stated R1 is at risk for falls d/t (due to) use of antipsychotic

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	IL6016497	A. BUILDING: ______ B. WING ______	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 3	S9999		

medications and weakness. Interventions include, provide proper, well-maintained footwear, provide resident an environment free of clutter, Observe frequently and place in supervised area when out of bed.

Minimum Data Set (MDS) assessment, dated 5/16/2024 section GG (functional abilities and goals), coded R1 as requiring partial/moderate assist to supervision /touching assist for all ADL cares, including waling 10 to 50 feet.

Facility reported incident, dated 6/01/2024 at 6:41PM, documented R1 expressed discomfort during shower when her hair was being washed. CNA noticed bleeding on resident's hair and called the nurse. R1 was noted with an open area and moderate amount of bleeding from the crown on the right side. R1 was sent to the local hospital emergency room for further evaluation.

Hospital emergency room record, dated 6/1/2024, states the chief complaint as head injury with unknown LOC (level of consciousness). The same record states, "60-year-old female. Patient unable to provide history, called facility and they said that the aid noticed a head laceration, unsure where the laceration came from, unsure if patient fell." R1 underwent a repair for a laceration measuring 2cm x1cm with five staples.

On 7/30/2024 at 12:10PM, R1 was observed in the dining room walking around with a staff trying to redirect R1. She was noted wearing a pair of socks only, no shoes.

On 7/31/2024 at 1:10PM, R1 was observed again walking around in the dining room. About 20 residents were in the dining room, not engaged in any activities. One CNA (Certified Nursing

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 08/06/2024

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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S9999	Continued From page 4	S9999		

Assistant) was in the room at this time. R1 was observed with a sock on one foot and one shoe that looked too big for her on the other foot. Four residents were observed walking up and down the hallway with no staff in sight; one of the residents was entering different rooms and coming out. There were no activities going on in the unit.

On 7/31/2024 at 1:15PM, V10 (CNA) said there are three CNA's assigned to the locked unit; she is the only one in the dining room now because one CNA is picking trays in the hallway and the other CNA is assisting a resident. V10 said the nurses were supposed to be monitoring the hallways. All the residents in the unit are fall risk and all require constant supervision.

On 7/31/2024 at 1:25PM, V11 (LPN) said she is the only nurse assigned to the locked unit, and all the residents require constant monitoring and supervision. "We do the best we can with the number of staff we have, I think the unit needs more staff but was told that one nurse and three CNA's is enough." V11 added sometimes she does not take a break, but when she does, she makes sure all the three CNA's are around, "or sometimes someone from activities will be in the unit. I am working with what I am provided." V11 added R1's injury was not witnessed. It was discovered during ADL (activities of daily living) care and R1 requires constant monitoring and supervision. V11 was not sure how R1 sustained the injury.

On 7/31/2024 at 4:06PM, V13 (CNA), said, "(R1) walks around all the time and requires constant supervision. She is a fall risk and wears nonskid socks. She doesn't usually wear a shoe because she removes them."

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 08/06/2024

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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S9999	Continued From page 5	S9999		

On 8/4/2024 at 12:16PM, V2 (Director of Nursing/DON) said, "(R1) is a fall risk and requires constant supervision. Someone should have known the source of her injury."

2. R7 is an 84 year old female admitted to the facility 1/11/24, with diagnoses including but not limited to Hypertension, ipolar, respiratory failure, Rhabdomyolysis, hypothyroidism, celiac artery compression syndrome, and diverticulitis. R7 was admitted to hospice on 05/10/24.

On 07/26/24, R7 had a fall requiring transfer to local hospital emergency room to repair laceration requiring 16 sutures. Report reads R7 slid off side of bed during Activity of Daily living. on 07/27/24 report sent to the Illinois Department of Health.

On the (MDS) Minimum Data Set assessment of 06/19/24 section C the BIMS (Brief Interviewed Mental Status) score was 14/15. On MDS of 07/29/24 GG section R7 is dependent except for eating. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity.

On 07/30/24 at 11:32 AM, R7 was in a recliner in the dining room, with right side of the face yellowish/bluish bruises, and a dressing on forehead. R7 was watching television. R7 said, "I fell a couple days ago. The Certified Nursing Assistant was assisting me to change, and I was a too far at the edge of the mattress and I rolled out bed. Usually, I get two Certified Nursing Assistants, but I only had one the day of my fall. I was on the floor, and I bleed a lot. I went to the hospital and needed around 16-20 stitches. I was

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 08/06/2024

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SOUTH SUBURBAN REHAB CENTER	**19000 SOUTH HALSTED HOMEWOOD, IL 60430**

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S9999	Continued From page 6	S9999		

Continued From page 6

told that it is a V shape."

On 07/31/2024 at 12:45 PM, V9 (Unit Manager) said, "(R7) requires two staff assist for ADL's (Activity of daily living) and getting up from bed using a lift. Residents have a care card inside their closet door with information for Certified Nursing Assistants to use to obtain information about ADL's and how to get out of bed. Certified Nursing Assistants can also look up under EMR (electronic medical record) under the resident information index."

On 08/1/24 at 2:05 PM, V27 (Certified Nursing assistant) said, "I was helping (R7) to change on 07/26/24. During the fall, (R7) had a bowel movement. (R7) was at the edge of the bed and (R7) rolled out bed with the head down first. (R7) is extensive assist and requires two nursing assistants during brief changing and repositioning. Because (R7) has an air mattress, I was supposed to have assistance to help (R7), but I didn't have it. I looked for assistance but everyone was busy and my nurse was passing her medications."

On 08/05/2024 at 9:55AM, V28 (Licensed Practical Nurse) said, "I came in at 7:00 PM to work and the Nursing Assistants start at 3:00PM. I completed my rounds at 7:25PM. (V27) came back from her break and went down to provide care to (R7). (V27) called me and notified me (R7) rolled out of bed during care. I expected (V27) to call for assistance when providing care to (R7). (R7) is on the air mattress and the air can fluctuate and the resident can go all to one side and fall out of the bed."

On 08/05/24 at 12:11 V2 (Director of Nursing) said, "I expect the Nursing Assistants to use the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 7	S9999		

care cards or resident information system in the EMR to look up how much assistance each resident requires. (R7) requires two person staff assists when receiving care and she is on an air mattress."

Facility presented policy titled, Fall Protocol (undated), includes:
Assessment and Recognition.
As part of the initial assessment the physician will help identify individuals with a history of falls and risk factors for Subsequent falls
Treatment and management.
Based on previous assessment, the staff and physician will identify pertinent intervention to try to prevent subsequent falls and to address risk of serious falls.

Facility presented policy titled, Activities of Daily Living (ADL) (dated 02/2023), includes:
Our collaborative professional team, together with the resident and or resident representative:
1. Will recognize and evaluate an inability to perform ADL's or risk for decline any ability to perform ADLs.
2. Develop and implement in the accordance of with resident's evaluated needs, goals and care, and preferences and will address the identified limitations in ability to perform ADLs.

3. R5 is a 76-year-old male with diagnoses including but not limited to osteoarthritis, colon cancer, congestive heart failure, diabetes mellitus, gallstone, gout, hypertension, dyslipidemia, pancreatitis, endoscopic retrograde cholangiopancreatography, sphincterotomy, hip surgery, prostate cancer, Subdural Hemorrhaging post Burr hole surgery and subdural drain 1/2/24 and Right Middle Meningeal Artery embolization

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 8	S9999		

1/10/24 and seizure.

R5 was admitted to the facility 12/11/2023 to 02/28/24. R5 expired 03/25/24 the cause of death was Aspiration Pneumonia Non-Traumatic.

R5's (MDS) Minimal Data Set assessment of 12/28/23 section C the BIMS (Brief Interview of Mental Status), R5 refused to complete it. On MDS of 12/28/23 GG section, R5 is dependent for sit to stand, chair/bed-to chair transfer. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.

R5's Fall score on admission 12/11/23 is 11, and 1/24/24 is 12 and 2/26/24 is 17.

Care Plan review for the fall of 12/27/23 with intervention in place for floor mats and for 12/28/23 to send to the Emergency room for evaluation.

R5 had two falls while in the facility, first fall on 12/27/23 and another 12/28/23. R5 was seen by in house Nurse Practitioner for 12/27/23 fall, and for 12/28/23 fall R5 was sent to the hospital for evaluation. R5's Computerized tomography scan date 12/29/23 of the head showed with Right Acute on Chronic Subdural Hematoma measuring up to 13mm. R5 was admitted to Neuro Intensive Care Unit. Subdural Hemorrhaging post Burr hole surgery and subdural drain 1/2/24 and Right Middle Meningeal Artery embolization 1/10/24.

Facility Report completed on 07/31/24 for Fall with injury; there was no documentation of any previous reports submitted to the State Agency for this fall.

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 08/06/2024

NAME OF PROVIDER OR SUPPLIER: **SOUTH SUBURBAN REHAB CENTER**

STREET ADDRESS, CITY, STATE, ZIP CODE: **19000 SOUTH HALSTED HOMEWOOD, IL 60430**

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S9999	Continued From page 9	S9999		

R5 fall on 12/27/23 at 03:00 PM and last seen at 2:50 PM. R5 fall on 12/28/23 at 01:54 PM and was last seen 1:45PM at during rounds.

On 08/1/24 at 10:39 AM, V22 (Certified Nursing assistant) said, "I was assigned to provide care to (R5) the day of 12/28/23 fall. I don't work for the facility since March of 2024, and I do not remember taking care of this resident; that was a long time ago."

On 08/1/24 at 11:01 AM, V25 (Registered Nurse) said, "I sent (R5) to the hospital after fall. (R5) was observed on the floor. I called the Nurse practitioner per family request and sent (R5) to the Hospital."

On 08/5/24 at 12:11PM, V2 (Director of Nursing) said, "I will call the Administrator and notify of any injury and report immediately. The report for the Illinois Department of Public Health needs to be completed within two hours. This fall with injury should have been reported and investigated, but it was not reported until 07/31/24."

On 07/31/2024 at 3:00PM, V1 (Administrator) presented facility Policy Titled, Abuse Prevention Policy, undated. It reads: "Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health Immediately, but not more than two hours of the allegation of abuse. Any incident that does not involve abuse and does not result in serious injury shall be reported with reported within 24 hours."

(B)