STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145977	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Shore Rehabilitation	2425 East 71st Street Chicago, IL 60649

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to assess, monitor, identify and intervene promptly for one resident (R2) who was responsive but became unresponsive. This failure resulted in R2 being sent to the hospital and led the R2's death.Based on interview and record review the facility failed to assess, monitor, identify and intervene promptly for one resident (R2) who was responsive but became unresponsive. This failure resulted in R2 being sent to the hospital and led the R2's death.Findings include:The immediate jeopardy began on [DATE], when R2 had a change of condition was not immediately addressed. The administrator, Director of Nursing, and Regional Nurse Consultant were notified of the immediate jeopardy on [DATE] at 2:08pm.An abatement plan was provided on [DATE] at 4:23pm. This plan was sent back for corrections.An abatement plan was provided on [DATE] at 11:56am. This plan was sent back for corrections. An abatement plan was provided on [DATE] at 3:10pm. This plan was accepted on [DATE] at 4:28pm.Based on observation, interview, and record review, the immediacy was removed on [DATE]. Although the immediacy was removed, the facility remains out of compliance at severity level II until the facility can evaluate the effectiveness of the removal plan and maintain substantial compliance with this regulation.R2's diagnoses heart failure, paroxysmal atrial fibrillation, hyperlipidemia, hemiplegia, shortness of breath, acute embolism and thrombosis of deep veins of right upper extremity, type 2 diabetes, schizophrenia, epilepsy. R2's Minimum Data Set (MDS) dated [DATE]) has R2's Cognitive Skills for Daily Decision Making scored as Severely Impaired.On [DATE] at 1:29pm V8 (Certified Nursing Assistant/CNA) stated V5 (Licensed Practical Nurse/LPN) instructed V8 to sit in the dining area with R2 and to keep calling R2's name to try to keep R2 awake. V8 stated R2 had previously been responsive and talking but the day R2 was sent out ([DATE]), R2 was unresponsive. V8 stated she informed V5 R2's breathing was labored and V5 told her R2's breathing was normal and to just stay there and keep calling R2's name.On [DATE] at 2:08pm V5 (LPN) stated she noticed a change in R2's condition on [DATE] late afternoon. V5 stated R2 was sweating while being under the fan. V5 stated she informed V10 (Wound care coordinator/Manager on duty) she feels R2 had a change of condition and asked V10 what should she do. V5 stated V10 instructed her to just monitor R2. V5 stated she was told by V9 (Wound care nurse) V10 was waiting on the doctor.On [DATE] at 2:52 pm V9 (Wound Care Nurse), V9 reviewed text messages and calls between V9 and V10 (Wound care coordinator/Manager on duty) and verified communication regarding R2's change of condition happened at noon on [DATE].On [DATE] at 2:52pm V9 (Wound care nurse) stated on [DATE] at approximately noon, V9 noticed R2 did not look good. V9 stated R2 was not responsive and R2's eyes were rolling. V9 stated before [DATE], R2 was able to talk and verbalize his needs. V9 stated she informed V5 (LPN) to let the doctor know of R2's change of condition. V9 stated she informed V10 (Wound care coordinator/Manager on duty) R2 was not responding and looked like R2 needed to be sent out to the hospital. V9 stated V10 stated she was waiting to hear back from R2's doctor.On [DATE] at 3:17pm V10 (Wound care coordinator/Manager on Duty) stated on the morning of [DATE], R2's nurse informed her R2's room was warm. V10 stated she went to check R2's room and it was hot, so she provided R2 with a fan. V10 stated R2 had heavy breathing and was asleep. V10 stated she was informed by V9 in the afternoon R2 was lethargic. V10 stated she told V9 to get R2's vital signs and inform the doctor. V10 stated she never told V5 nor V9 she would call to inform R2's doctor of his change in condition. V10 stated she did not call the doctor regarding R2's change of condition. V10 stated she never went to see R2 after she was informed of R2's change of condition.On [DATE] at 10:05am V11 (LPN) stated she was informed at the beginning of her shift (7pm) R2 did not look good. V11 stated she assessed R2, called the doctor and received orders to transfer R2 out to the hospital.On [DATE] at 12:44pm V2 (Director of Nursing/DON) stated a change in level of consciousness would be considered a change of condition. V2 stated after a true change of condition is identified, the doctor should be called immediately. V2 stated if there is a problem with a resident, the manager on duty should go look at the resident. V2 stated V5 (LPN) telling V8 (CNA) to continuously call R2's name was not an appropriate intervention. V2 stated the physician should have been made aware at the time R2's altered mental status was discovered.On [DATE] at 5:36pm V15 (Medical Doctor/MD) stated she was on call until 5pm on [DATE]. V15 stated she was never made aware of R2's change of condition. V15 stated if she would have been made aware, she would have had the nurse to triage R2 and depending on R2's vital signs and symptoms, gave orders.R2's progress note dated [DATE] at 8:05am documents in part, Resident is alert and oriented, able to make needs known R2's