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	06/30/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observations, interviews, and record reviews, the facility failed to do a complete skin assessment and monitor a resident's (R1) skin issue, failed to have treatment orders in place, failed to have the wound physician evaluate R1's wound, and failed to identify a new skin issue for 1 (R1) out of 6 residents reviewed for Quality of Care. Findings include: R1's admission Record documents in part diagnoses of aphasia (communication impairment) following a stroke, right side weakness and paralysis, heart failure, chronic obstructive pulmonary disease, hypertension (high blood pressure), hyperlipidemia (high cholesterol, and epilepsy. R1's 4/6/2026 MDS (Minimum Data Set) assessment documents in part that R1 is severely cognitively impaired. R1 is dependent on staff for toileting, bed mobility, and grooming/hygiene. R1's 6/9/2026 lower extremity scans document in part significant arterial stenosis. On 6/23/2026 at 12:44 PM, survey team along with V9 (2nd Floor Unit Manager) observed R1 lying in bed. There was a gauze dressing wrapped from R1's right knee down to the foot. R1's left ankle also had gauze dressing wrap. V9 was not familiar with all of R1's wounds. On 6/24/2026 at 11:42 AM, V8 (Wound Care Coordinator) performed R1's wound care with assist from V24 (Wound Care Tech). During wound care, red drainage noted coming from behind R1's right knee. V8 stated it was a new skin issue. Per R1's wound assessments, V8 measured it to be 1.5cm (centimeter) (length) x 1.20cm (width). The left ankle had multiple skin issues. Left medial (inside) ankle with two skin issues. The central (top) wound was scabbed, but the distal (bottom) wound was draining. Per R1's wound assessments, V8 measured it to be 8.5cm x 2.0cm. V8 stated the left outer/lateral ankle wound was new. Per R1's wound assessments, V8 assessed it to be a full thickness wound with slough measuring 3.8cm x 2.0cm. V8 and V24 completed wound treatment to wound behind right knee and left ankle wounds. Did not observe V8 perform wound care treatment to R1's right heel which surveyor observed a dark, circular skin issue. V8 and V24 placed foam heel protectors and sheet over R1. Surveyor asked V8 if there were any wound treatments to R1's right heel or if facility leaves it open to air. V8 was confused and thought surveyor meant to ask about R1's left ankle wounds. Surveyor reiterated question regarding R1's right heel. V8 removed R1's sheet and right foam boot. V8 stated did not notice the right heel skin issue. V8 stated skin issue is new. V8 tried to rub it off but it remained. Per R1's wound assessments, V8 assessed it to be a full-thickness wound measuring 2.0cm x 1.0cm. V8 stated last seeing R1 and doing R1's wound care on Monday (6/22/2026). V8 stated did not do a full skin assessment at that time and did not notice the skin issues behind R1's right knee, right heel, or left lateral ankle. V8 stated V28 (Wound Doctor) has not seen R1's lower extremity wounds but was scheduled to see them on 6/26/2026. V8 stated that typically V8 will inform the primary doctor about any new issues. Depending on the type of skin issue, V8 will recommend referral to V28 (Wound Doctor) to see the resident. Facility's Daily Floor Assignment sheets documents in part that R1 was due for a bath on 6/22/2026. During a telephone call on 6/25/2026 at 1:07 PM, V12 (CNA, Certified Nurse Assistant) stated V12 provided R1 with a bed bath on 6/22/2026 and caring for R1 on 6/23/2026. V12 stated V12 did skin assessment during bed bath but could not note any new wounds to R1's lower extremities because they had wound dressings. On 6/25/2026 at 2:45 PM, V2 (Director of Nursing) stated staff should perform body/skin checks during showers/baths. V2 stated the wound care team should be taking care of and assessing (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	whatever is wrapped up when they unwrap the dressings. During a telephone interview with V27 (R1's Primary Physician) on 6/30/2026 at 10:02 AM, V27 stated R1 is very high risk for skin wounds related to vascular insufficiency. V27 stated V27 could not recall if facility informed [V27] of every wound for R1. V27 stated that V28 (Wound Doctor) was part of R1's care team. V27 stated the expectation was for the wound care team to communicate to V28 and to have V28 treat R1's wounds. During a telephone interview with V28 on 6/30/2026 at 11:30 AM, V28 stated V28 conducted initial assessment of R1 (6/5/2026) for a post-surgical wound to abdomen. V28 stated did not know about R1's lower extremity wounds until surveyor called on 6/25/2026. V28 stated typically facilities will notify V28 of new skin issues during rounds with the wound nurse at the facility. V28 stated wound care team did not bring up any other issues for R1 during 6/19/2026 rounds. V28 stated expectation is for wound care team to address wounds until V28 can assess them in person and make recommendations. V28 stated V28 did not reassess R1 until 6/26/2026. V28 stated R1's wounds were unavoidable due to vascular insufficiency and is prone to additional wounds until vascular insufficiency is fixed. Regarding skin assessments, V28 stated that whoever unwraps R1's leg dressings are responsible for observing any new skin areas prior to replacing the bandages. R1's progress note dated 6/9/2026 5:42 AM and 8:25 AM, documents in part that V42 (Nurse) observed intact blisters to R1's left inner lateral lower leg and open skin to outer lateral left ankle. Progress notes read that V42 notified V27 and the wound care team. R1's progress notes or wound assessments do not contain a complete assessment (wound measurements/appearance) or updated weekly assessments regarding the open skin to R1's outer lateral left ankle. R1's Order Summary Report also did not contain any wound care orders to the left lateral leg/ankle until 6/24/2026 (time of survey). On 6/24/2026, R1's left lateral ankle had a full thickness wound with slough measuring 3.8cm x 2.0cm. R1's wound summary of the left lower medial ankle documents, in part, that the facility identified it on 6/8/2026 measuring 8.5cm x 2.8cm. 6/09/2026 picture of left medial ankle shows a reddened top area. The bottom area is larger with blistering. On 6/17/2026, facility described it as a partial thickness wound measuring 8.5cm x 4.0cm. No documentation that this wound was referred to V28 during 6/19/2026 rounds. R1's Care Plan Report documents, in part, that R1 has potential for skin integrity impairment related to multiple comorbidities (initiated 3/31/2026). Interventions initiated 3/31/2026 include to observe skin during routine care and report alteration to the nurse, skin check on shower days and [as needed], and assessed by wound [Medical Doctor] as needed. R1's Care Plan Report also reads that R1 has potential/actual impairment to skin integrity (initiated 3/30/2026 and revised 6/24/2026). Intervention initiated on 3/30/2026 reads weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Requested facility's skin care program, skin assessment policy, or wound care policy from V1 (Administrator) and V2 (Director of Nursing). Facility provided Prevention of Pressure Wounds policy. Although R1's wounds were characterized as arterial wounds, policy documents in part: The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family, and addressed. Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown.