STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146132	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Suburban Rehab Center	19000 South Halsted Homewood, IL 60430

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38796 Based on observation, interview, and record review, the facility failed to prevent an avoidable fall for high fall risk resident with poor sitting balance by not providing 2 persons assist during a shower. This affected one of three residents (R1) reviewed for safety and falls. This failure resulted in R1 falling out of the shower chair on 1/24/24, being transported to the local hospital for treatment, and recieving 7 sutures to the left eyebrow area. Findings include: R1's face sheet shows diagnosis of other lack of coordination, need for assistance with personal care, abnormal posture, muscle wasting and atrophy multiple sites, weakness, cognitive communication deficit, other abnormalities of gait and mobility, hemiplegia and hemiparesis following cerebral infarction affecting unspecified side, and muscle weakness (generalized). R1's care card, dated 10/23, denotes at risk for falls, extensive assist with grooming, mobility wheelchair/ broda, transfer x 2, additional information denotes fall precautions, dysem to broad chair, two persons assist during bathing, bed at lowest position, call light in reach. R1's ADL (activity of daily living) functional analysis, dated 11/10/2023 completed by V5 (Restorative Manager) denotes bathing, totally dependent, staff support provided 2 plus person. R1's Minimum Data Set/MDS, dated [DATE], section C for cognitive patterns denotes score 99; the resident was not able to complete the interview. R1's MDS (Minimum Data Set), dated 2/7/24, 11/12/23 denotes 01 (dependent) for showers. (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility final accident/incident report to the department, dated 1/30/24, denotes event occurred on 1/24/24 at 8:16am, resident involved-R1 name, date of birth, HTN (hypertension) chronic kidney disease, UTI (urinary tract infection), muscle wasting and atrophy, weakness, cognitive deficit, dysphagia, dementia, and generalized weakness. Family and physician notified. Description of occurrence denotes R1 had fall, upon nurse assessment noted with a laceration to left eyebrow. Ice and pressure applied until bleeding stopped. MD (Medical Doctor) notified with order to send out to hospital. Family was made aware. Hospital reported sutures to left eyebrow. Investigation initiated. Final report to follow. Occurrence resolution denotes investigation completed. R1 was sitting in the chair after her shower. CNA (Certified Nursing Assistant) was bending down drying her legs and feet, when suddenly R1 jerked forward falling to her left side before CNA could stop the fall. The nurse immediately went to assess. Upon assessment noted resident lying on left side in front of the shower chair with bleeding from the left eyebrow. Pressure and ice applied until bleeding stopped, resident remained alert with no other injuries noted. Sent to ER (emergency room) for further evaluation. R1 returned from ER accompanied by family with 7 sutures to left side of eyebrow, CT (computed tomography) scan negative. MD (Medical doctor) and family made aware and were satisfied with outcome of investigation. Care plan updated, medicate for pain as needed. R1's fall risk observation, dated 1/24/24, denotes score 15, high risk. R1 progress notes, dated 1/24/24, denotes at 8:00am, the writer was called to the resident's shower room to assist a resident that had an injury and needed to be assessed. Staff was giving resident a shower and was drying the resident off. Staff stated as she was performing ADLs (activities of daily living) resident suddenly fell and the staff member couldn't prevent the fall. The writer and co-worker noticed blood and immediately apply pressure with ice to resident's L (left) side of head, assessed ROM (range of motion) and no bruising at this time noted. The writer called 911 while co-worker stayed and applied pressure and bandage on injury. R1 progress notes, dated 1/24/24, denotes, Resident left facility at 8:25 via stretcher w/ (with) 911 alert and verbal. VS (vital signs) stable and within normal limits. Family, DON (Director of nursing) and NP (nurse practitioner) have been notified. R1 progress notes, dated 1/25/24 at 11:51am, denotes, resident received in bed watching TV (television) The resident has stitches on the left eye by eyebrow and a bruise on the right pinky finger due to a fall earlier. Vital WNR (within normal range) no complaints of pain/discomfort. Resident bed is at the lowest position for safety measure call-light in place. On 2/24/24 at 9:07am, R1 was observed resting in bed, alert, speaks simple words. R1 denied pain. On 2/24/24 at 12:24pm, V1 (CNA) said she was the aide working with R1 when R1 had a fall from the shower chair on 1/24/24. V1 said she had given R1 a shower. R1 was sitting in the shower chair, she was bent down drying R1's legs and R1 suddenly fell out the chair landing on her side. V1 said she saw blood on R1's face. V1 said an aide was passing by and assisted her with getting R1 up from the floor. V1 said no one assisted her with giving R1 a shower. V1 said the nurse came right away when she was yelling for help. V1 said she did not look at R1's care card prior to giving R1 a shower. V1 said she doesn't know if R1 was a one or two person assist with showers. V1 said R1 always fidgets. V1 said she doesn't know if R1 has poor /abnormal posture. V1 explained she has been caring for R1 a long time, and she knows what R1 needs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/24/24 at 2:05pm, V4 (Director of Nursing) said residents should not fall from the shower chairs during showers. V4 said, (R1's) root cause of the fall was because she has jerky movements and (R1) fell from shower chair when the aide was kneeling to dry (R1's) legs. V4 said R1 had jerky movements well before she fell from the shower chair. V4 said R1 should have had an assessment to determine how much assistance she needs during showers. V4 said R1 needs one -person assist with showers due to R1 having jerky movements, and the staff don't know when R1 may lean forward in the shower chair. V4 said the restorative person needs to address when the assessments are done because she doesn't know. V4 was asked if R1 is known for having jerky movements, who is responsible for visibly monitoring R1 for this movements while the CNA bends down to dry R1 legs during/ after a shower, to prevent R1 from falling from the shower chair? V4 said I understand what you are saying. R1's current care plan reviewed with V4. V4 said she does not see a care plan developed for activity of daily living for showers, nor she does she see a care plan developed for how much assistance R1 needs during a shower. V4 said her expectation is that the aides look at the care card prior to providing care. V4 said she updated R1's care plan for falls today (2/24/24), denoting R1 needs two persons assist with showers, and it should have been updated on 1/24/24 after the fall. V4 said R1 is a fall risk. R1 needs two persons assist during bathing. V4 confirmed the care card last update was 10/2023. On 2/29/24 at 1:41pm, V5(Restorative Manager) said she does the activity of daily living assessments. V5 said R1 is dependent for showers, and R2 requires two persons assist with bathing/showers. V5 said she completed R1's functional assessment for ADL, and R1 needs 2 person assist. V5 aid R1 needs two person assist for safety reasons. V5 said two persons assist with help prevent R5 from falling from the shower chair. V5 said the staff should provide the level of assistance the resident is assessed to need. V5 said the aide should look at the care card because they do not have access to the care plan. On 2/25/24 at 12:10pm, V7 (Therapy Director) said R1 has poor sitting balance and cognitive deficits. V7 said she recommends R1 have 2 persons assist during showers for safety reasons. V7 said during the recent therapy evaluation, R1 was not able to maintain a sitting position, and she could not follow directives during the treatment. Facility policy titled managing falls and fall risk, revised 2008, denotes, based on previous evaluations and current data, the staff will identify interventions related to the residents' specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling.