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	08/06/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920 Based on interview and record review, the facility failed to notify the resident's representative of a resident discharge from the facility, including the reasons for the move in writing, and failed to have a record that the local Ombudsman was notified of the discharge. This failure affected one (R3) of three residents reviewed for discharge. Findings include: R3 is a [AGE] year-old male admitted to the facility on [DATE], past medical history includes: Abdominal aortic aneurysm without rupture, essential primary hypertension, diabetes, other lack of coordination, need for assistance with personal care, alcohol abuse, history of falling, etc. Physician order. dated 6/11/2024. states: Discharge Home with Home Health, RN, Wound Care RN, Ok to Take Medication from facility. Progress note, dated 7/5/2024, states as follows: Resident discharged with belongings and medication. Transferred to community living home. Social service progress note, dated 7/2/2024, reads: (R3) is scheduled to discharge on 7/5/24 at 1PM. Staff from Independent living program will provide transportation. (R3) has a follow-up app (appointment) with his PCP (Primary Care Physician) in the community on 7/10/24 at 11AM, IDT (Interdisciplinary Team) made aware. There is no documentation any family member, POA (Power of Attorney) or Ombudsman was notified of R3's discharge. On 7/31/2024 at 3:56PM, V12 (Social Services) said when R3 was admitted to the facility from the hospital, R3 wanted to leave. The facility sent out referrals and resident was accepted in one community living place. V12 said she was not aware R3 had a State Guardian. V12 said they tried to reach family members of R3, but were unable. The staff from the community living that he went to came to pick him up, and R3 went with all his belongings. The facility has since not followed up with the resident; they don't usually do that. On 8/1/2024 at 12:05PM, V12 said, The place (R3) was discharged to does not provide any medical care. (R3) was appropriate because he does not need any medical care; the wounds he was admitted with were healed before he was discharged . (R3) was going to have a room and access to a kitchen. The facility was supposed to assist him with clothing and other needs in the community. (continued on next page)

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

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/01/2024 at 9:59AM, V17 (Social Service Director) said she recalls R3, but had just started working at the facility before he was discharged . V17 said she had a conversation with V16 (State Guardian), who called and asked about the resident; she told him that the resident discharged . V16 informed her the resident had a State Guardian. V17 looked through resident's documents and did not see any documentation of V16 being a State Guardian. V17 said that she brought it up in the morning meeting and no one was aware; the information may not be uploaded in the EMR (electronic medical record) and V17 does not have access to previous EMR system. On 8/1/2024 at 9:33AM, V16 (State Guardian) said R3 was appointed to Office of State Guardian (OSG) temporarily on 4/29/2024, then on 5/10/2024, the OSG guardianship became permanent. R3 was at the hospital and was transferred to the facility for placement, the hospital communicated to the facility through the social worker that resident was a ward of the State, the information was included in the referral packet. V16 added the resident is now in a different facility; he was discharged to a community setting that provided no medical care; resident cannot make his own decision. V16 added he visited the resident at the facility in May and introduced himself. On 8/3/2024 at 1:26PM, V32 (Hosp Social Worker) said the facility was aware R3 is a ward of the state because it was specified in the referral letter that was sent to the facility. V32 stated she spoke to the facility liaison who confirmed the facility is aware that resident has a state guardian. On 8/5/2024 at 9:00AM, V1 (Administrator) said she spoke to V16 (OSG) and she told the records department to look for any documentation of R3's guardianship when he was at the facility. V1 later presented documentation from the facility stating R3 was a ward of the state. V1 said OSG should have been notified of resident's discharge. Facility transfer and discharge policy, dated September 2016 ,states in its policy, to assure resident transfers and discharges will be conducted in accordance with residents' rights, physician orders, and in such a manner as to maintain continuity of care. Under policy specifications, the policy states in item 2, When the facility transfers or discharges a resident under any circumstance, the resident/authorized legal representative must be notified verbally and in writing at least thirty (30) days prior to the intended discharge.

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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** 40920 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) and failed to ensure two staff were used when providing care for a resident (R7) per the resident's plan of care. These failures affected two (R1, R7) of four residents reviewed for falls and resulted in R1 sustaining a laceration to her head that required treatment for scalp laceration and R7 sustaining a head laceration. Findings include: 1. R1 is a [AGE] year-old female admitted to the facility on [DATE]. 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 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, [AGE] 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 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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. 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. 50519 2. R7 is an [AGE] 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 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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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.