Illinois Department of Public Health

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 ______	09/21/2023

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 Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.690 a) 300.690 b) 300.690 c) 300.1210 b) 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 that resident. b) The facility shall notify the Department of	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1 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. This requirement is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to adequately supervise a resident (R43) with elopement behaviors for	S9999		

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residents reviewed for elopement. This failure resulted in R43 eloping and being found unresponsive in the community, sustaining a traumatic muscle injury, and being hospitalized.

Findings include:

R43 is a 56-year-old male admitted to the facility on 05/02/2022 with diagnoses including but not limited to Chronic Kidney Disease, Stage 3 unspecified; Schizoaffective Disorder, unspecified; Unspecified Intellectual Disability; Major Depressive Disorder, recurrent, unspecified; and Anxiety Disorder, unspecified.

According to MDS (Minimum Data Set), dated 07/14/2023, under section C, R43 has a BIMS (Brief Interview of Mental Status) score of 15, indicating a high level of cognitive functioning. Section G reads R43 requires supervision and set up across all Activities of Daily Living.

R43's Elopement Risk Review, dated 05/07/2022, reads in part, "Score: 3. A score of 4 or more indicates risk and requires interventions/plan."

R43's Elopement Risk Review, dated 10/14/2022, reads in part, "Score: 5. A score of 4 or more indicates risk and requires interventions/plan."

R43's Elopement care plan, dated 10/14/2022, reads, "(R43) presents with wandering/attempted elopement risky behavior symptoms, wandering with a purpose. On 8/1 (2023) (R43) eloped from the facility. Approach: (R43) is an elopement risk and for safety precautions he wears Wander Guard; social service will assess (R43) for elopement quarterly and as needed; social service will post (R43's) picture in the lobby; staff

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will provide (R43) opportunities for safe wandering throughout the unit; staff will provide redirection when (R43)is observed wandering into unsafe areas or situations."

Per record review, R43 eloped on 10/14/2022, by running out of the facility's front entrance, and on 08/01/2023, by jumping out of the second floor window.

Progress note, dated 10/14/2022 at 7:05 AM written by V19 (Licensed Practical Nurse) reads in part, "(R43) noted running out of the facility, police notified, staff was able to safely return (R43) to the facility."

Progress note, dated 08/01/2023 at 9:45 AM written by V11 (Licensed Practical Nurse), reads in part, "At around 7:20 AM, (R43) was noticed to be missing from his room. The window was seen to have been forced opened. Hospital returned call and stated that (R43) was at their facility. (R43) kept at the hospital for further evaluation."

Police report, dated 08/01/2023 at 7:56 AM, reads in part, "On 08/01/2023 at 7:56 AM, I was dispatched to (the facility) in reference to a missing person. (R43) left from a window roughly 30 minutes ago. At 10:01 AM (dispatch) confirmed that (area) hospital confirmed that (R43) was admitted. The charge nurse (stated) that (R43) was found in the community unconscious, laying in the grass, with his clothing completely soaked. Paramedics administered (narcotic overdose treatment)."

Hospital record, dated 08/01/2023, reads in part, "Arrival date/time 08/01/2023 at 8:12 AM. (R43) presents to emergency department for agitation.

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(R43) was found outside of a woman's house, yelling. She called 911. Upon paramedics arrival, he was not making sense. (R43) had pinpoint pupils, so they gave (narcotic overdose treatment). (R43) on arrival states "I'm not ok". (R43) doesn't know why he's here. Reason for hospitalization: Rhabdomyolysis. Discharge diagnosis: Rhabdomyolysis likely due to hypovolemia with history of extreme physical activity."

Progress note, dated 08/08/2023 at 4:17 PM written by V11 (Licensed Practical Nurse), reads in part, "(R43's) Readmission from the hospital. Hospital diagnosis: rhabdomyolysis."

On 09/19/23 at 3:17 PM, V1 (Administrator) was interviewed regarding R43's elopement on 08/01/2023, V1 stated, "Was this reportable? We found him right away; is this elopement? I did not report it to the Illinois Department of Public Health"; V1 further stated: "Staff was aware that (R43) was missing but we didn't find him, police called and told us that (R43) was found. To clarify, V1 was asked, "Would you consider this an elopement?" V1 stated, "Yes". V1 continued: "(R43) jumped out from the second floor window. (R43) might have been harmed but, because he walked away from the property, that means he wasn't harmed. We called the police as soon as we were aware that (R43) was missing. On 08/01/2023 at 08.30 AM, the floor nurse called me to notify me that (R43) was gone. Code Pink was called, staff initiated search in and outside of the building. That's also when the police, family, and the doctor was called. While all this was being done, around 10:00 AM, the hospital called the facility to notify us that (R43) was found and brought to them. (R43) was admitted to the hospital for a week or so. When he returned, he

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S9999	Continued From page 5 was placed on elopement precautions. (R43's) window was secured with one screw before the elopement. Now, all facility windows have 2 screws and (R43's) window has an alarm." On 09/19/23 at 3:54 PM, V11 (Licensed Practical Nurse) stated: "I worked on day shift the day of (R43's) elopement (08/01/2023). (R43) was in a different room back then. (R43) was placed on precautions since the incident (08/01/2023), so now he is across from the nursing station, his window has an alarm, and we round more frequent on him. (R43) never displayed elopement behaviors before, so we didn't have any precautions for him. On 08/01/2023, I found out about (R43) being gone around 7:15 AM. Night shift nurse said that he was missing at around 7:06 AM. She was notified by (V15, Certified Nursing Assistant) who assisted him about 10 minutes earlier. At around 7:25 AM, we called Code Pink - that's when everyone stops everything they're doing to look for a missing person. We checked the entire building. We then noticed that (R43's) window was slightly opened and that's when we realized he might have eloped through the window, which is located on the second floor. Next, we notified (V1), and he told us to call 911. We also notified family and the doctor. (R43's) family got here right away. They were hysterical. When police arrived, they took (R43's) description, and we provided them with (R43's) picture. At that time, the police received notification through the radio that (R43) was found and is at the hospital. The resident has privilege pass to leave the facility accompanied by the family. (R43) wasn't leaving the facility often; the family was picking him up less and less. When I talked to (R43) after elopement incident, (R43) said that he wanted to see his family. (R43) was admitted to the hospital after	S9999		

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elopement for rhabdomyolysis and came back with ordered antibiotics."

On 09/20/2023 at 1:23 PM, V12 (Social Service Case Manager), stated: "I have known (R43) since he was admitted (on 05/02/2022). (R43) is quiet, he used to keep to himself, but lately he interacts more with other residents and staff. (R43) is close to his family. He has privilege pass to go out with them. Initially, (R43) wasn't going out often at first, but more recently, he was going out every two weeks or so. For safety reasons, (R43) has to be assisted by somebody because of some mental issues and confusion. (R43) has had two elopement incidents during his stay at the facility, one on 10/14/2022 and on 08/01/2023. After incident on 10/14/2022, (R43) was evaluated by psychology and started wearing elopement prevention device. I talked to (R43) after the incident on 08/01/2023. (R43) said he just wanted to leave. (R43) should be always wearing his elopement prevention device. It was placed on his ankle. When (R43) returned from the hospital 8/8/23, his elopement prevention device was gone, so we gave him a new one that he wears on his wrist now. (R43) was able to elope because of the way he exited which was through the window; the elopement prevention device would alarm if (R43) would attempt to exit through the breezeway by the main entrance."

On 09/20/2023 at 2:02 PM, V13 (Medical Doctor/MD), stated: "I'm (R43's) primary physician. Rhabdomyolysis is a breakdown of the muscle. It could be caused by multiple reasons, such as trauma to the muscle."

On 09/20/2023 at 2:45 PM, V14 (Maintenance Director), stated: "I've been a Maintenance Director since May of 2023. The elopement

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incident happened on 08/01/2023. As staff was searching for the resident, we reinforced every window in the facility. Previously, windows had screws that were screwed into window frame, whereas now, there are brackets that wrap around window frame that are secured with two screws. Brackets are installed to allow to open a window by 2-3 inches, same as before. (R43) was so strong that he broke the screw out and was able to open a window completely."

On 09/21/2023 at 2:38 PM, V14 (Maintenance Director) measured the distance of R43's window from the ground; the measurement is 12 feet.

R43's picture was not observed to be posted in the lobby throughout the course of the survey.

On 09/20/2023 at 1:43 PM, R43 was wearing elopement prevention device on left wrist.

"Elopement and Search (Code Pink)" policy, dated February 2014, reads in part, "All personnel are responsible for Knowing the whereabouts of residents for which they are assigned; Employees are instructed in elopement prevention and search protocol during initial orientation and throughout the year. Code Pink drills are conducted by qualified facility staff throughout the year."

(A)