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 _____	C 11/14/2024

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 Complaint Investigation 2498946/IL180188	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b) 300.1210 d)3) 300.3240 a) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such	S9999		

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 _____	C 11/14/2024

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
S9999	Continued From page 1	S9999		

accident, injury or change in condition at the time of notification.

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.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to immediately notify the physician and obtain an order to transport a resident with an acute change in mental status and respiratory status to the hospital. This affected one of three

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 _____	C 11/14/2024

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
S9999	Continued From page 2	S9999		

residents (R1) reviewed for acute change in condition. This failure resulted in R1 experiencing an acute change in condition at on 10.13.24 at approximately 7:00am, and the facility staff not notifying the physician or calling EMS until 10:44am. R1 was admitted to the hospital with a diagnosis of aspiration pneumonia and sepsis secondary to pneumonia.

Findings include:

R1's EMS (Emergency Medical Services) run sheet, dated 10/13/24, notes EMS 911 was notified at 10:44AM for an unresponsive resident. Emergency crew was dispatched and arrived at R1's bedside at 10:54AM. R1 remained unresponsive to verbal and painful stimuli throughout transport to the hospital. R1's heart rhythm showed atrial fibrillation with rapid ventricular response. R1's lung sounds with rhonchi (gurgling) throughout right and left lungs.

R1's hospital medical record, dated 10/13/24, notes per facility staff, R1 was eating at 8:30AM and was alert and oriented x 2, R1's baseline. R1 wears oxygen at 2 liters per nasal cannula, oxygen saturation was 85% on oxygen. R1 only responded to painful stimuli. R1 presented to the emergency room with a chief complaint of unresponsiveness and respiratory distress. EMS crew reports that they found R1 with vomit on clothes and mouth, unresponsive, and in respiratory distress. Initial work up in the emergency room revealed opacification throughout the entire right lung with some opacification in the left lung most concerning for aspiration. On initial assessment by the intensive care team, R1 is minimally responsive with audible gurgling with breathing. Per heart monitor, R1 in atrial fibrillation with rapid

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 _____	C 11/14/2024

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
S9999	Continued From page 3	S9999		

ventricular response, heart rate 120s-130s. R1 with elevated troponin level (protein found in the heart muscle which leaks into the bloodstream when the heart muscle is damaged resulting in increased level) due to demand ischemia (when the heart's need for oxygen is greater the body's ability to supply it. Initially R1's troponin level was 202 (normal range is less than 52); worsened to 240. CT (computed tomography) scan noted anasarca (severe buildup of fluid in the tissues of several parts of the body). On re-evaluation, R1's gurgling significantly worse, R1 even less responsive than previous with minimal movement to painful stimuli and evident respiratory distress. The intensive care physician expressed concern to R1's family that R1 is unlikely to survive this event and that antibiotics are likely futile given the severity of R1's illness and current medical condition. R1's code status was changed to DNR (Do Not Resuscitate) and R1 was placed in hospice on comfort measures only. R1 expired on 10/14/24.

R1's medical record, dated 10/13/24 at 10:55am, V4, RN, noted V14 alerted by staff that R1 was experiencing a change in condition. Further assessment revealed R1 was lethargic unresponsive to verbal and tactile stimuli. Adventitious (abnormal) lung sounds noted. Head of bed elevated to promote effective breathing. Physician made aware. R1 sent to hospital for further evaluation.

R1's SBAR (situation, background, appearance, and review and notify) form, dated 10/13/24, notes the change in condition, symptoms, or signs observed and evaluated is/are: altered mental status, tired, weak, confused, or drowsy, and shortness of breath. The vital signs documented, temperature 97.1 degrees

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 _____	C 11/14/2024

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
S9999	Continued From page 4	S9999		

Fahrenheit, pulse 80 beats/minute, respirations 18/minute, blood pressure 128/72, and oxygen saturation level 98%. It notes R1's physician was not notified. R1's family was not notified until 11:00AM.

R1's e-Interact form, dated 10/13/24, notes R1's most recent vital signs were obtained at 6:57AM: temperature 97.1, pulse 80, respirations 18, blood pressure 128/72, and oxygen saturation level 98% on room air.

There is no documentation found in R1's medical record noting R1's vital signs were obtained at the time of this event.

On 11/7/24 at 2:00PM, V4, CNA (Certified Nurse Aide) stated R1 did not feel well on 10/13/24. V4 stated R1 did not eat breakfast due to not feeling well. V4 stated R1 was short of breath. V4 stated R1 had oxygen on, but was still trying to catch her breath. V4 stated R1 looked different, not usual self, at the start of V4's shift that day; V4 works 7:00AM-3:00PM. V4 stated she let nurse/unit manager know right away of R1's condition.

On 11/8/24 at 9:25AM, V6, CNA, stated she was working on 10/13/24 on day shift. V6 stated she was not assigned to R1 that day, but is familiar with R1. V6 stated breakfast is served on the 500 and 600 nursing units between 8:00AM and 8:30AM. V6 stated V6 was charting at the nurses' station shortly after breakfast time, when V4 asked V6 to come look at R1, because R1 did not look good. V6 stated V6 observed R1's eyes closed, not responding to verbal stimuli, and heard rattling noises in R1's chest. V6 stated V6 left R1's room and sat at the nurses' station while V4 went to find a nurse. V6 stated there were no

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 _____	C 11/14/2024

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
S9999	Continued From page 5	S9999		

nurses present on the 500 and 600 nursing units at the time of this event. V6 stated V4 went to get V14 (nurse), who was working on the 800 nursing unit. V6 stated V10 (non-clinical manager on duty) was called. V6 stated when V10 saw what was going on with R1, V10 immediately called for V14.

On 11/8/24 at 9:40AM, V7, CNA, stated she was at the nurses' station after breakfast when V4 CNA told her to look at R1. V7 stated V7 observed R1's eyes were closed, R1 was not talking, non-responsive to verbal stimuli, and with rapid breathing. V7 stated V7 left R1's room after seeing R1.

On 11/8/24 at 9:50AM, V8, RN (Registered Nurse) stated this facility's change in condition protocol is to perform a head-to-toe assessment, obtain vital signs, and call the physician or nurse practitioner and get orders to treat the resident in this facility or send resident out to the hospital.

On 11/8/24 at 10:50AM, V9, ADON (Assistant Director of Nursing) stated she was the clinical MOD (manager on duty) on 10/13. V9 stated V9 was notified after breakfast by V14, RN (Registered Nurse). V9 stated V14 informed her R1 did not look well, had vomited, and was not responding like R1 normally does, only responding to sternal rub. V9 stated V14 performed a head-to-toe assessment and obtained vital signs prior to calling V9. V9 stated she was en route to the facility, but not close enough to assess R1 herself, and instructed V14 to send R1 out to the hospital. V9 stated breakfast is served on the 500 and 600 nursing units at 8:45AM or 9:00AM. V9 stated V9 believes it was 9:30AM or 9:45AM when V14 called her. V9 stated V9 arrived at this facility at

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 _____	C 11/14/2024

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
S9999	Continued From page 6	S9999		

10:15AM or 10:30AM. V9 stated R1 was transported to the hospital prior to V9's arrival to facility.

On 11/8/24 at 11:00AM, V10 (non-clinical manager on duty) stated the CNAs, V4 and V7, told her R1 did not look well. V10 stated V10 went to the 800 nursing unit and got V14, RN, to come assess R1. V10 stated V10 went in with V14 to see R1. V10 stated V10 observed R1 still breathing, V14 checked her and then immediately called EMS 911 to transport R1 to the hospital.

On 11/12/24 at 9:50AM, V14, RN (Registered Nurse), stated staff got her about 10:30AM on 10/13/24. V14 stated she was informed by V10 (non-clinical MOD) that R1 was experiencing a change in condition, and was asked if she would go assess R1. V14 stated V14 observed R1 to be non-responsive to verbal and tactile stimuli and with adventitious lungs sounds. V14 stated V14 obtained R1's vital signs and checked R1's blood sugar just in case non-responsiveness was due to hypoglycemia (low blood sugar). V14 stated V14 does not recall what R1's vital signs or blood sugar results; would have to defer to her charting from 10/13/24. V14 stated V14 elevated R1's head of bed to promote effective breathing and then called EMS 911. V14 stated V14 did not call the physician because it is a medical emergency when a resident is non-responsive. V14 stated V14 did not ask where R1's nurse was, just did what she was asked to do.

On 11/12/24 at 11:46pm, V15, LPN (Licensed Practical Nurse), stated V15 stayed over from the night shift to work on the 500 nursing unit due to a nurse calling off. V15 stated she worked until a replacement nurse took over her assignment. When questioned where V15 was when V4, CNA,

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 _____	C 11/14/2024

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
S9999	Continued From page 7	S9999		

was looking for her after breakfast regarding R1, V15 stated she was passing medications to residents in the dining room. When questioned reason V4 did not find V15 in the dining room, V15 stated she was in residents' rooms. V15 stated she last saw R1 at 9:30AM, and R1 was fine and was talking. V15 stated she left the facility at 10:00AM after giving verbal report to V9, ADON, who was taking over her assignment.

On 11/13/24 at 9:15AM, V9, ADON, stated V15 left this facility prior to her arrival. V9 stated V15 did not provide a verbal report on residents, nor R1's change in condition. V9 stated V9 called V15 for a couple of days, without success. V9 stated V9 was trying to interview her regarding the event that took place on 10/13 with R1. V9 stated when she finally spoke with V15, V15 informed her R1 did not look good, and she reported R1's condition to V19 prior to leaving facility. V9 stated the off-going nurse is expected to stay on the nursing unit until the on-coming nurse arrives and takes over the assignment. V9 stated the nurse is expected to assess the resident, obtain vital signs, and notify the physician immediately when there is a change in resident's condition. V9 acknowledged R1 was not fine at 9:30AM, based on staff interviews.

This facility's notification of change policy, dated 10/1/21, notes the requirement for notification of resident, resident representative, and the physician is when there is a significant change in the resident's physical, mental, or psychological status. A significant change includes deterioration in health in either life-threatening conditions or clinical complications.

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 _____	C 11/14/2024

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
S9999	Continued From page 8 (A)	S9999		