STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058396	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE REHABILITATION	2425 EAST 71ST STREET , CHICAGO, Illinois, 60649

(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) COMPLETION DATE
S0000	Initial Comments Complaint Investigations:2585951/IL195517 Based on interview and record review the facility failed to assess, monitor, identify and intervene promptly for one resident (R2) who was responsive but became unresponsive. This failure resulted in R2 being sent to	S0000		07/10/2025
S9999	the hospital and led the R2's death. Final Observations Statement of Licensure Findings: 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)3) 300.3240a) 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. 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	S9999		08/05/2025

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

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S9999	Continued from page 1 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 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on interview and record review the facility failed to assess, monitor, identify and intervene	S9999		

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S9999	Continued from page 2 promptly for one resident (R2) who was responsive but became unresponsive. This failure resulted in R2 being sent to the hospital and led the R2's death. Findings include: R2's diagnoses heart failure, paroxysmal atrial fibrillation, hyperlipidemia, hemiplegia, shortness of breath, acute embolism and thrombosis of deep veins of right upper extremity, type 2 diabetes, schizophrenia, epilepsy. R2's Minimum Data Set (MDS) dated 06/22/25) has R2's Cognitive Skills for Daily Decision Making scored as Severely Impaired. On 07/01/25 at 1:29pm V8 (Certified Nursing Assistant/CNA) stated V5 (Licensed Practical Nurse/LPN) instructed V8 to sit in the dining area with R2 and to keep calling R2's name to try to keep R2 awake. V8 stated R2 had previously been responsive and talking but the day R2 was sent out (06/22/25), R2 was unresponsive. V8 stated she informed V5 R2's breathing was labored and V5 told her R2's breathing was normal and to just stay there and keep calling R2's name. On 07/01/25 at 2:08pm V5 (LPN) stated she noticed a change in R2's condition on 06/22/25 late afternoon. V5 stated R2 was sweating while being under the fan. V5 stated she informed V10 (Wound care coordinator/Manager on duty) she feels R2 had a change of condition and asked V10 what should she do. V5 stated V10 instructed her to just monitor R2. V5 stated she was told by V9 (Wound care nurse) V10 was waiting on the doctor. On 07/01/25 at 2:52 pm V9 (Wound Care Nurse), V9 reviewed text messages and calls between V9 and V10 (Wound care coordinator/Manager on duty) and verified communication regarding R2's change of condition happened at noon on 06/22/25. On 07/01/25 at 2:52pm V9 (Wound care nurse) stated on 06/22/25 at approximately noon, V9 noticed R2 did not look good. V9 stated R2 was not responsive and R2's eyes were rolling. V9 stated before 06/22/25, R2 was able to talk and verbalize his needs. V9 stated she informed V5 (LPN) to let the doctor know of R2's change	S9999		

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S9999	Continued from page 3 of condition. V9 stated she informed V10 (Wound care coordinator/Manager on duty) R2 was not responding and looked like R2 needed to be sent out to the hospital. V9 stated V10 stated she was waiting to hear back from R2's doctor. On 07/01/25 at 3:17pm V10 (Wound care coordinator/Manager on Duty) stated on the morning of 06/22/25, R2's nurse informed her R2's room was warm. V10 stated she went to check R2's room and it was hot, so she provided R2 with a fan. V10 stated R2 had heavy breathing and was asleep. V10 stated she was informed by V9 in the afternoon R2 was lethargic. V10 stated she told V9 to get R2's vital signs and inform the doctor. V10 stated she never told V5 nor V9 she would call to inform R2's doctor of his change in condition. V10 stated she did not call the doctor regarding R2's change of condition. V10 stated she never went to see R2 after she was informed of R2's change of condition. On 07/02/25 at 10:05am V11 (LPN) stated she was informed at the beginning of her shift (7pm) R2 did not look good. V11 stated she assessed R2, called the doctor and received orders to transfer R2 out to the hospital. On 07/02/25 at 12:44pm V2 (Director of Nursing/DON) stated a change in level of consciousness would be considered a change of condition. V2 stated after a true change of condition is identified, the doctor should be called immediately. V2 stated if there is a problem with a resident, the manager on duty should go look at the resident. V2 stated V5 (LPN) telling V8 (CNA) to continuously call R2's name was not an appropriate intervention. V2 stated the physician should have been made aware at the time R2's altered mental status was discovered. On 07/03/25 at 5:36pm V15 (Medical Doctor/MD) stated she was on call until 5pm on 06/22/25. V15 stated she was never made aware of R2's change of condition. V15 stated if she would have been made aware, she would have had the nurse to triage R2 and depending on R2's vital signs and symptoms, gave orders. R2's progress note dated 06/21/25 at 8:05am documents in part, "Resident is alert and oriented, able to make needs known."	S9999		

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S9999	Continued from page 4 R2's progress note dated 06/22/25 at 7:54pm documents in part, "Shortness of breath, unresponsiveness, seems different than usual ...weak, confused, or drowsy at the time of evaluation." Review of R2's record shows no entry before the change of condition note dated 06/22/25 at 7:54pm for R2's change of condition. Review of R2's records show no indication R2's physician was notified before the change of condition note entered on 06/22/25 at 7:54pm. R2's hospital record dated 06/22/25 documents in part, "Nursing home patient presents by the paramedics in cardiac arrest. Paramedics called the nursing home for mental status changes and found the patient lethargic, hypoxic and agonal breathing. Patient lost heart rate and respirations at the nursing home. Patient intubated en route ... Present asystole with no pulse ... Disposition: Expired." R2"s care plan dated 06/18/25 documents in part, "Resident has the following advance directives: Living Will, POLST (Physician Orders for Life Sustaining Treatment) CPR (Cardiopulmonary Resuscitation) ... Resident is a FULL CODE - if resident becomes unresponsive, call for help immediately and begin Basic Life Support sequence." Facility's policy titled "Resident Rights Guideline" dated 11/2024 documents in part, Purpose: It is the practice of this facility to provide for an environment in which residents may exercise their rights, each day. Our residents have certain rights and protections under Federal law. Our facility meets and provides these rights through care and related services at all times ...Our facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility protects and promotes the resident of the residents ...All residents have the right to equal access to quality care regardless of a diagnosis, severity of condition, or payment source." Facility's policy titled "Acute Condition Changes - Clinical Protocol" dated 08/2008 documents in part, "Assessment and Recognition ...1. As part of the	S9999		

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S9999	Continued from page 5 initial assessment, the Physician will help identify individuals with a significant risk for having acute changes of condition during their stay; the Nurse shall assess and document/report the following: a. Vital signs b. Neurological assessment c. Change in level of consciousness, memory, or mood ... f. Onset, duration, severity ...5. The nursing staff will contact the Physician based on the urgency of the situation. For emergencies, they will call or page the Physician and request a prompt response". Facility's job description titled "Licensed Practical Nurse (LPN)" undated, documents in part, Summary: The LPN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations govern our facility, and as may be required by the Director of Nursing to ensure the highest degree of quality care is always maintained." (AA)	S9999		