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 _____	C 09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SUBURBAN REHAB CENTER	19000 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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #1192039/IL53568 - No deficiency Complaint #1191810/IL53322 - F329 Complaint #1191741/IL53224 - F323 Incident of 3/21/2011/IL53303 - No deficiency	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews, observation and record review the facility failed to prevent an accident for 1 of 4 residents (R2) reviewed for accidents/incidents in a sample of 4. This failure resulted in R2 rolling out of bed and sustaining a laceration to her right upper brow requiring 8 sutures. The findings include: R2 is a female resident with diagnoses to include: Cerebral Vascular Accident, Head Injury Not Otherwise Specified, Aphasia, Dysphagia, History of Tracheostomy, and Left Hemiparesis per current physicians order sheet. R2 is dependent on staff for all activities of daily living to include turning and re-positioning in bed	F 323		10/20/11

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

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 _____	C 09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SUBURBAN REHAB CENTER	19000 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) COMPLETION DATE
F 323	Continued From page 1	F 323		

per MDS (Minimum Data Set) dated 7/19/11. Incident report dated 5/27/11 documents that R2 fell out of her bed at 8:18 PM sustaining a laceration to her right upper brow. R2 was sent to the hospital and received 8 sutures to close the laceration.

Interview with E2, DON (Director of Nursing) on 8/12/11 at 2:30 PM stated that R2 had been transferred to bed by E5, CNA (Certified Nurse Aide) and a new employee also a CNA. According to E2, R2 had been transferred into her bed properly but had been positioned to close to the edge of the bed which in turn led to her fall. E2 states that E5 was terminated from the facility as a result of this incident. E2 further states that E5 had left the nursing floor without notifying the nurse in charge, leaving only a new employee in training to monitor the residents of that unit.

Interview with E3, LPN (Licensed Practical Nurse) on 8/12/11 at 2:10 AM states that R2 cannot move on her own.

Interview with E4, CNA on 8/12/11 at 2:15 PM states that R2 cannot turn side to side but if she gets hot she has been known to throw her good leg over the side of the bed to remove her covers. E4 stated that is probably how she fell out of bed. E4 stated that it happened on second shift a few months ago when she was not working. E4 also added that if R2 was positioned to close to the edge of the bed it could happen (fall).

Observation of R2 on 8/12/11 at 12:10 PM noted her up in her wheel chair wearing a splint to her left arm and tube feeding running. R2 was unable to speak but nodded her head "yes" that

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 _____	C 09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SUBURBAN REHAB CENTER	19000 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) COMPLETION DATE
F 323	Continued From page 2 she was doing ok.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to monitor psychotropic medications for 1 of 4 sampled residents (R3) reviewed for unnecessary drugs in a sample of 4. The findings include:	F 329		10/20/11

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 _____	C 09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SUBURBAN REHAB CENTER	19000 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) COMPLETION DATE
F 329	Continued From page 3	F 329		

R3 is an 81 year old female resident with diagnoses to include Dementia with Depression, Anemia, Chronic Kidney Disease Stage IV, Muscle Weakness, and Hypertension per (POS) Physicians Order Sheet dated November 2010.

Interview with E2, DON (Director of Nursing) on 9/20/11 at 1:40 PM regarding R3's psychotropic medications. E2 stated that 2 medications were ordered on 10/27/2010 (Risperdal and Seroquel) to address R3's increased behaviors (agitation and hitting out at staff during cares). When questioned whether or not staff attempted other interventions to address these behaviors versus starting new medications E2 stated, "No, the progress notes don't say that anything was done, and that was long before I was employed here."

Nursing notes reviewed from 8/24/2010 (date of admission) through 11/21/2010 (date of transfer to hospital) document only 2 entries (10/27/10 and 10/28/10) that describe R3 as being agitated or striking out at staff. These two entries do not include any documentation that describe other interventions to address R3's behaviors.

Physician order dated 10/27/10 documents the following 2 medications that were added to R3's medication regime: "Risperdal 0.25 mg (milligram) 1 tablet once a day, Seroquel 25 mg 1 tablet at bedtime." These medications are in addition to an already scheduled Ativan 0.5 mg three times a day that R3 had been receiving since her admission.

Nursing notes from 11/2/10 through 11/21/10 document 13 separate entries by nursing staff

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 _____	C 09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SUBURBAN REHAB CENTER	19000 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) COMPLETION DATE
F 329	Continued From page 4 describing R3 as "lethargic", "drowsy", "dozing", or "tired". Nursing notes dated 11/16/10 and 11/09/10 describe R3 as lethargic and her ordered Ativan being held. These nursing notes also describe a decrease in R3's appetite/meal intake. Telephone interview with E2 on 9/21/11 at 1 PM stated that she has no additional information that specifically addresses what other interventions were implemented before adding more medications to R3's medication regime. E2 also stated that she understands the concern that these medications were not monitored/addressed by the facility when R3 became lethargic and drowsy on a daily basis.	F 329		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS Section 300.1210 General Requirements for Nursing and Personal Care 300.1210b)6) 300.3240a) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. 300.1210b)6) b)6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. THIS REQUIREMENT IS NOT MET AS EVIDENCED BY;	F9999		

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 _____	C 09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SUBURBAN REHAB CENTER	19000 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) COMPLETION DATE
F9999	Continued From page 5	F9999		

Based on interviews, observation and record review the facility failed to prevent an accident for 1 of 4 residents (R2) reviewed for accidents/incidents in a sample of 4. This failure resulted in R2 rolling out of bed and sustaining a laceration to her right upper brow requiring 8 sutures.

The findings include:

R2 is a female resident with diagnoses to include: Cerebral Vascular Accident, Head Injury Not Otherwise Specified, Aphasia, Dysphagia, History of Tracheostomy, and Left Hemiparesis per current physicians order sheet.

R2 is dependent on staff for all activities of daily living to include turning and re-positioning in bed per MDS (Minimum Data Set) dated 7/19/11. Incident report dated 5/27/11 documents that R2 fell out of her bed at 8:18 PM sustaining a laceration to her right upper brow. R2 was sent to the hospital and received 8 sutures to close the laceration.

Interview with E2, DON (Director of Nursing) on 8/12/11 at 2:30 PM stated that R2 had been transferred to bed by E5, CNA (Certified Nurse Aide) and a new employee also a CNA. According to E2, R2 had been transferred into her bed properly but had been positioned to close to the edge of the bed which in turn led to her fall. E2 states that E5 was terminated from the facility as a result of this incident. E2 further states that E5 had left the nursing floor without notifying the nurse in charge, leaving only a new employee in training to monitor the residents of that unit.

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 _____	C 09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SUBURBAN REHAB CENTER	19000 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) COMPLETION DATE
F9999	Continued From page 6 Interview with E3, LPN (Licensed Practical Nurse) on 8/12/11 at 2:10 AM states that R2 cannot move on her own. Interview with E4, CNA on 8/12/11 at 2:15 PM states that R2 cannot turn side to side but if she gets hot she has been known to throw her good leg over the side of the bed to remove her covers. E4 stated that is probably how she fell out of bed. E4 stated that it happened on second shift a few months ago when she was not working. E4 also added that if R2 was positioned to close to the edge of the bed it could happen (fall). Observation of R2 on 8/12/11 at 12:10 PM noted her up in her wheel chair wearing a splint to her left arm and tube feeding running. R2 was unable to speak but nodded her head "yes" that she was doing ok. (B)	F9999		