

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6016497	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2020
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NAME OF PROVIDER OR SUPPLIER SOUTH SUBURBAN REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 19000 SOUTH HALSTED HOMewood, IL 60430
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S 000	Initial Comments Complaint Investigation 2096427/IL125777	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	<p>Attachment A Statement of Licensure Violations</p>	

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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 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: 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. 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 protect and prevent a resident (R2) from being abused by another resident (R1). The facility also failed to prevent R1 for possessing a firearm while residing in the facility. As a result, R1 fatally shot R2 with a firearm he possessed while in the facility. R2 later died from multiple gunshot wounds to the chest, arms, and legs. These failures affect one (R2) of seven residents reviewed for supervision. Findings include: 1. According to the face sheet R1 a 32-year-old male resident admitted to the facility on 7/28/2020 due to open wound of right buttock. R1's diagnoses included but were not limited to unspecified open wounds of right buttock, lower	S9999		

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S9999	<p>Continued From page 2</p> <p>back and pelvis; sleep apnea and paraplegia.</p> <p>A Brief Interview for Mental Status (BIMS) assessment dated 7/31/2020 indicated his cognitive function was intact.</p> <p>According to a R1's criminal background data, R1 had convictions for possession of controlled substance, domestic battery with bodily harm, aggravated battery of officials and the unlawful possession of a weapon.</p> <p>2. According to the face sheet R2 was 77-year-old male resident with diagnoses including but were not limited to unspecified mood disorder and Alzheimer's disease. R2 was admitted to the facility on 6/12/2020. The last re-admission was on 7/28/2020.</p> <p>R2's progress note dated 7/13/2020 indicated R2 was being petitioned out to a local hospital due to recent behaviors. On 08/10/2020, at 11:43AM, V20 (Registered Nurse) stated, "R2 needed increased supervision due to his verbal and physical aggression. R2's agitation would come out of nowhere; it was very sporadic."</p> <p>3. The State Agency was notified about a shooting involving two residents, but no reported incident was received from the facility. The surveyor conducted interviews regarding the incident that occurred on 8/08/2020 involving R1 and R2; the following was indicated:</p> <p>On 08/08/2020, at 10:00AM, R3 stated, "I was asleep, and the noise woke me up. I heard the gunshot. I could not see who it was; it was a man. The door was open. R2 was lying on the floor when I left the room after the police came. There was a lot of blood."</p>	S9999		

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S9999	Continued From page 3 On 08/08/2020, at 10:15AM, R4 stated, "On 08/08/2020 at 3:01AM, I heard three-gun shots. It sounded like it was right at the door, but it was behind me in the other room. R1 was in and out of the room all night. I heard the three-gun shots and then R1 returned to the room. R1 told me he shot someone. Then R1 said it was someone else who had shot someone. I have never seen R1 or R2 talk to each other. I know staff heard the shots and no one did anything. I never saw R1 with a gun. I keep to myself. R1 was always on the go, like he was on drugs, everyday all day." On 08/08/2020, at 10:20AM, R5 stated he heard two pops because his door was wide open. On 08/08/2020, at 10:30AM, R6 stated, "I heard 3 gun shots early this morning. I heard that the police found a gun on R1. I used to tell R4 that R1 acted like he was on drugs. I thought something was wrong with him because of how he acted." On 08/09/2020, at 10:22AM, V3 (Licensed Practical Nurse/LPN) stated, "On 08/08/2020, around 3:00AM, I heard 2 gun shots. V2 (LPN) and I went and looked for help. R1 would be roaming the halls going to visit other residents all the time. I did not notice that he left the floor on 08/08/2020, because I was working on the other unit. V2 and another certified nursing assistant (CNA) worked the entire floor. There are usually two CNAs, but one CNA had to be pulled to another floor. There is no type of security. The receptionist is there until 11:30pm. After that, there is no one. The facility is always short staffed. I believe that R1 got the firearm when he eloped because he was determined to get outside	S9999		

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S9999	<p>Continued From page 4 of the facility."</p> <p>On 08/09/2020, at 10:49AM, R7 stated, "On 08/06/2020, R1 came to my room flashing a gun around the room. R1 would not tell me where or how he got the gun. I told R1 that he could be locked up for having a gun. R1 said that he didn't care about being locked up or being in jail. R1 stated that my roommate was bothering him (R2), and they had gotten into it. I am not sure what they had gotten into it about. R1 told me that 'he was taking care of business like he always does. R1 has gotten aggressive with me before. I was scared to death when R1 showed me the gun. I was not sure if he was going to pull the trigger on me or what he was going to do. Immediately, I told V12 (CNA). V12 told me not to worry about it; he would take care of it. On 08/07/2020 in the morning, I told V11 (LPN). Staff do not always pay attention to us or care to get involved. I do not feel safe in the facility because something like this happened once and it could happen again."</p> <p>On 08/09/2020, at 11:14AM, V11 (Unit Supervisor/LPN) stated, "No one ever came to me and said that a resident had a gun. No one has ever reported anything like that to me."</p> <p>On 08/09/2020, at 11:27AM, V12 (CNA) stated, "No resident has ever told me that another resident had a gun."</p> <p>On 08/08/2020, at 2:04PM, V7 (LPN) stated, "On 08/07/2020 at 11:15PM. the alarms on the first floor were going off on my unit. I thought the receptionist was there, but she is only there until 11:30PM. R1 was always roaming the building due to his insomnia. R1 was like this every night. I asked R1 why the alarms were going off. R1 stated he wanted to get some fresh air. I took R1</p>	S9999		
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S9999	Continued From page 5 back upstairs to his unit. A few minutes later, the alarm went off again. When I went out by the outside doors of the facility, I saw R1 was outside of the building hiding. I called staff upstairs. R1 saw me and came to the door. I told R1 that he is not allowed out of the building. I took R1 back upstairs and re-educated him that residents cannot be outside. A few minutes later, the alarm goes off for a third time. This time, V2 (LPN) was with R1. R1 was wandering the building and kept on going right through the front doors. I don't recall if V2 tried to stop R1. V2 took R1 back to the unit. About 3:00AM, V3 (LPN) came down from the second floor of the unit. She asked if I heard a noise. She wasn't sure if it was gunshots. We went upstairs; all the lights were off. R1 told me that two women had been shot on the first floor. The police were called. The police arrived and told us that R2 had been shot. Chest compressions were being performed on R2 as his body was being taken out of the facility." On 08/09/2020, at 2:52PM, V2 stated, "V3 (LPN) and I heard gunshots. We took off running from the gun shots to a secure unit downstairs and called 911. I told 911 that there were gunshots and an active shooter. I told police that we were not comfortable returning to the unit until they arrived. R1's behavior was never like this before. The police told us that R1 had shot another resident. Police took over everything after that." 4. Ambulance records dated 08/08/2020 documented the following: R2 found unresponsive and not breathing. Ambulance crew found multiple gunshot wounds on the resident. Medical records from the local hospital emergency room dated 08/08/2020 documented R2 expired from multiple gunshot wounds and cardiac trauma.	S9999		

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S9999	<p>Continued From page 6</p> <p>On 08/08/2020, at 11:56AM, V6 (Detective) stated, "The firearm was located in the back of R1's personal wheelchair. When paramedics arrived at the scene, R2's body was on the ground. They stated that there were no signs of life. R2 was transported to a local hospital. R2 was pronounced dead at 4:11AM."</p> <p>On 08/09/2020, at 12:54PM, V16 (R2's family member) stated, "I talked to the doctor that treated R2. The doctor said that R2 had been shot six times: twice in the arm; twice in the chest; twice in the leg. The physician told me R2 did not survive."</p> <p>Facility policy titled Abuse Prevention Policy documents "The facility is committed to protecting our residents from abuse by anyone including, other residents. The facility affirms the right of our residents to be free from abuse."</p> <p>(A)</p>	S9999		