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 11/17/2022

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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 Investigations 2299069/IL153297 and 2299068/IL153295	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1220 b)3) 300.3210 t) 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	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements are not met as evidenced by: Based on interviews and record reviews, the facility failed to keep a resident free from sexual abuse by not having effective interventions in place including monitoring and supervision, for a resident with known wandering behaviors and	S9999		

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S9999	Continued From page 2 who was exhibiting an increase in behaviors related to dementia diagnoses. This failure applied to one (R2) of one resident reviewed for abuse, and resulted in R2 wandering into another residents room and being sexually assaulted. Findings include: R2 is a 65-year-old female, with diagnoses of Vascular Dementia Severe with other Behavioral Disturbance, COVID 19, Schizoaffective Disorder, Delusional Disorders, Major Depressive Disorder - Recurrent, Protein Calorie Malnutrition, and weakness. R2 was admitted to the facility 09/27/2022. R2's admission abuse risk review 09/28/2022 documents she is at risk of abuse due to her exhibited history of elopement and her exhibited lack of safety awareness; risk factors include serious mental illness, wandering, and impulse control issues. R2's current care plan documents: R2 is at risk of abuse due to her severe mental illness, impulse control issues, minimalizing circumstance, exhibited history of elopement and exhibited lack of safety awareness. R2's progress note, dated 10/10/2022 at 07:29 PM, documents R2 was observed in other resident's rooms three times and was returned to her room by the nurse during night shift. CNA (Certified Nursing Assistant) also reported that resident wanders the halls during 1st shift and often found on a different unit. Will continue to monitor; at 07:32 PM, R2 was found in other resident's room during the writer's first round and day shift CNA reported that resident again was near elevator, and also on a different unit	S9999		

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S9999	Continued From page 3 frequently. R2's progress note, dated 10/30/2022 at 11:49 AM, documents R2 noted with odd behavior. Walking on unit and standing in one spot falling asleep. R2 redirected to room and will rest but gets up again and walks through out unit. Physician called and made aware of behavior. Antipsychotic 5mg twice daily decreased to at bedtime only and monitor behavior. Will continue to observe resident for any changes. R2's progress note, dated 11/05/2022 at 10:00 AM, [Recorded as Late Entry on 11/06/2022 04:15 PM] documents R2 incoherent and unable to follow simple commands. Generalized weakness noted. Physician made aware at 07:15AM and new orders to send R2 to nearest hospital emergency room for evaluation; at 10:35 PM [Recorded as Late Entry on 11/06/2022 10:49 PM] Received R2 from local hospital via stretcher accompanied by 2 emergency transportation personnel, discharge diagnosis of Delirium. R2's progress note, dated 11/06/2022 at 10:30 PM, documents R2 was observed in bed with a blood clot to her left forehead, painful to touch when asked what happened resident stated she did not fall she bumped her head on the wall a couple of days ago, placed call to physician to give update; at 10:45 PM Placed call to ambulance service was informed there were no transportation available at this time. Place call to 911 for transportation. On 11/11/22, R2's interventions included: Staff will provide redirection to R2 to ensure her safety and well-being needs are being met daily and as needed; social service will assess R2 for abuse risk quarterly and as needed; staff will observe	S9999		

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S9999	Continued From page 4 R2 for signs and symptoms of abuse daily and as needed to ensure her safety; abuse care plan initiated 11/12/2022. R2 presents with exhibited history of elopement risky behavioral symptoms with interventions including: Staff will provide opportunities for R2 safe wandering throughout the unit daily; Staff will provide redirection when R2 is observed exhibiting wandering into unsafe areas or situations and/or elopement risky behavioral symptoms as needed. R2's progress note, dated 11/11/2022 at 4:58 PM, documents R2 was eating supper in room and appetite good; at 09:14 PM, R2 noted in male resident's room while CNA (Certified Nursing Assistant) was completing scheduled rounds. R2 noted in the bed with male resident on top of her. Staff members interceded and notified appropriate parties. Message left for Physician on answering service line. R2 transported via 911 to local hospital for examination. R2's Incident Investigation Report, dated 11/11/2022, documents: CNA Witnessed R2 in R3's room, observed both residents in the bed undressed, police were called. Physician and families notified. R2 was sent to the hospital for evaluation. R3 was petitioned out to the hospital for Psych evaluation. Police Report, dated 11/11/2022, documents R3 was observed by staff engaging in sexual intercourse with R2 against her will. On 11/11/22 at 8:43PM, police responded to the facility in reference to a criminal sexual assault. Upon arrival, the responding officer spoke with floor nurse who informed that staff were conducting room checks when they noticed R2 was not in her room and began to look for her. V7 (Certified Nursing Assistant) and V6 (Certified Nursing	S9999		

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S9999	Continued From page 5 Assistant) then told the nurse they found R2 in the bed of R3 engaged in sexual intercourse with vaginal penetration. R2 could be heard telling R3 to stop, and both V7 and V6 told R3 to stop also. R3 refused to stop, forcing the staff to pull R2 from underneath R3. R3 then admitted he pulled R2's leggings off of her. The nurse advised all patients housed in the unit suffer from dementia, and both R3 and R2 suffer from various forms of dementia and other mental and physical health conditions. Both V7 and V6 agreed with the nurses statements. The responding officer spoke with R2 who advised she was watching a movie with R3 when she willingly walked to the rear of the room where R3's bed was. R2 could not give any more information of what else occurred except she told R3 to stop multiple times. The responding officer spoke with R5 who reported R2 was in the room watching a movie when she went towards the rear of the room with R3. R5 then heard R2 telling R3 to stop multiple times but he did not see what was happening. R2's Hospital Record, dated 11/11/2022, documents R2 is a 65-year-old female with a past medical history of schizophrenia, dementia, and delusional disorders who presented to the hospital emergency room from the facility for evaluation after a witnessed sexual assault. R2 reports last night she wandered into a male resident's room voluntarily and went to sleep. R2 reported the next thing she knew the CNA's (Certified Nursing Assistants) at the facility were pulling the male patient off of her after he forced himself onto her without her consent. Alleged sexual assault was witnessed by two Certified Nursing Assistants from facility. Emergency Medical Services reports that the patient wandered into another patients room voluntarily, but he forced himself onto her without consent.	S9999		

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S9999	Continued From page 6 R2's progress notes, dated 11/12/2022 7:38 AM, documents: Resident returned from hospital alert and oriented to self. No pain or distress noted at this time. New order for two HIV antivirals to be started to be taken until November 15. R2's physician progress note, dated 11/12/2022 at 1:33 PM, documents: R2 is a 65-year-old African American female who presented to a hospital for bizarre behavior. She was diagnosed with paranoia and schizoaffective disorder with paranoid exacerbation. R2 was admitted to the facility on 9/27/22 to the secure unit. R2 was seen today for follow up to emergency hospital room visit on 11/11 due to alleged sexual assault. Per nursing and notes, R2 was found in male room pinned under him. R2 was sent to emergency hospital room for assessment and sent back this morning with new orders for two HIV antivirals until 12/13. She appears calm and is confused. She does not want to discuss feelings today. On 11/14/2022 from 1:03PM - 1:27PM, a large bump was on the left side of R2's forehead. R2 stated she bumped her head up against the frame of the wall in front of her bathroom. Observed the frame of R2's bathroom while she showed the surveyor where she bumped her head. R2 stated it happened early one morning when she was on her way to the bathroom and still half asleep. R2 stated the nurse did examine her and she was sent out to the hospital. R2 stated she was watching a movie with R3, and he climbed on top of her. R2 stated she asked R3 multiple times to stop and get up, but he would not get off of her. R2 stated when R3 climbed on top of her she was confused about what he was trying to do. R2 stated she was sent to the hospital after this incident.	S9999		

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S9999	Continued From page 7 On 11/14/2022 from 2:04PM - 2:09PM, V3 (Registered Nurse/Nurse Manager) stated she wasn't in the building during R2's alleged sexual assault, but was the manager on duty. V3 stated on 11/11/2022, she received a call the CNA (Certified Nursing Assistant) found R2 in another residents room and was partially unclothed, and didn't know what to do. V3 stated since R2 can't consent to having sex, they sent her out via 911 to be evaluated for potential abuse. V3 stated R3 was monitored by a police officer who sat in the hallway, until it was determined what to do with him. V3 stated the CNA explained to her during rounds around 6:30PM, she observed R2 in her bed in her room appearing to be settled in for the night then continued rounds. V3 stated when the CNA began the next round around 8-8:30PM, she noticed R2 wasn't in her room, and found her in R3's room next door. V3 stated R2 was living in a room directly next door to R3 at the time of the incident. V3 stated she had R2 sent to hospital to be evaluated. On 11/14/2022 at 4:34PM, V6 (Certified Nursing Assistant) stated she has worked for the facility for seven years. V6 stated she has worked with R2 and R3 often. V6 stated on 11/11/2022, she observed R2 in her room at 5:30PM while collecting dinner trays. V6 stated she and V7 (Certified Nursing Assistant) were conducting rounds on 11/11/2022 at approximately 6PM, and observed R2 was not in her room. V6 stated she and V7 checked all rooms and bathrooms on the locked unit, and when she entered R3's room at 6:30PM or close to 7PM, she looked around the curtain and saw R2 and R3 in R3's bed having sex. V6 stated R2 and R3 were having full intercourse. V6 stated she and V7 instructed R3 to get off of R2 and he refused. V6 stated R3 just	S9999		

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gave her and V7 a mean look and continued. V6 stated she stayed in the room while V7 went to go get other CNA's and Nurses to assist getting R3 off of R2. V6 stated she, a nurse, and two agency CNA's all redirected R3 to get off of R2, and after numerous requests he finally complied. V6 stated R2 was taken to her room, her pants, and a clean pull up were placed on her, and they had her sit at the nurses station. V6 stated R3 remained in his room, and 5 minutes later came out into the hall and asked where R2 was. V6 stated after that, R3 went back in his room and remained until the police arrived. V6 stated the police stayed with R3 once they arrived. V6 stated the police asked staff and R2 what happened. V6 stated when R2 was asked what happened, she reported she wandered into R3's room, sat on his bed, they began talking, he then pushed her back onto his bed, pulled down her pull up and pants, and began having intercourse with her. V6 stated R2 reported when she told R3 to stop he wouldn't stop. V6 stated R2 reported she told R3 to stop, and he just kept going. V6 stated R2 typically roamed sometimes, but in the last couple of weeks had been roaming around a lot in and out of people's rooms. V6 stated the nurses and V2 (Registered Nurse/Assistant Director of Nursing) were aware of R2's behavior. V6 stated the facility's instructions on interventions for R2's wandering is to redirect her, have her come to the dining room, and provide her with a snack or coloring material or something like that. V6 stated R2 and R3 did not interact much prior to this incident. V6 stated R2 sometimes hallucinates and is sometimes confused. V6 stated R2 has not engaged in any other sexual activity prior to this incident. V6 stated R3's roommate R5 was in the room when the incident took place. V6 stated R2 and R3's rooms were right next to each other during this incident.

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S9999	Continued From page 9 On 11/15/2022 from 3:17PM - 4:45PM, V2 (RN/Assistant Director of Nursing) stated most of the memory care residents sit in the dining room for supervision, and this is also where they participate in activities and watch television. V2 stated if R2 was noted to be going in and out of residents rooms, and if it was observed to be an ongoing behavior, it should be reported to social services and the supervisors. V2 stated the nurse and the staff should be informed of this behavior so R2 can be supervised and redirected by the nursing staff. V2 stated if this behavior is ongoing, R2 should be in a supervised area or constantly or frequently supervised by the staff. V2 stated the CNA (Certified Nursing Assistant) would be instructed to monitor R2 and make sure they know her whereabouts. V2 stated she would try not to have a resident with the behavior of wandering into other resident's rooms out of sight. V2 stated at all times the nursing staff should be aware of where residents who are wandering are located. On 11/16/2022 from 12:10PM - 12:48PM, V1 (Administrator) stated abuse risk assessments are completed through social services on admission and as needed. V1 stated the abuse care plan interventions would be implemented based on the admissions policy, abuse policy, care policy, and results of standard assessments. V1 stated the residents abuse care plan should be personalized based on their specific needs. V1 stated increased safety concerns for R2 should have been reevaluated each time she returned from the hospital after a change in her condition. V1 stated determination of a dementia residents decision making ability would be completed with the interdisciplinary team including the physician and she is not certain how this assessment would	S9999		

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S9999	Continued From page 10 be completed. V1 stated she would refer to social services on how this assessment would be completed. On 11/16/2022 from 4:56PM - 5:26PM, V5 (Social Services Director) stated she is aware R2 wanders the unit, however, she had not received any information R2 had been wandering into resident's rooms. V5 stated if R2 was wandering into residents rooms, there would be increased location monitoring and frequent rounds to make sure she is safe and secure. Review of medical record does not show there was any change to R2's plan of care or increased monitoring based on increasing behaviors demonstrated by R2. The facility's abuse prevention policy (October 2022) reviewed 11/16/2022 states: "The facility affirms the right of our residents to be free from abuse. This facility therefore prohibits abuse. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse; "This will be done by: establishing an environment that promotes resident security and prevention of mistreatment." "Sexual abuse includes but is not limited to sexual assault including non-consensual or non-competent to consent sexual activity." "As part of the resident's life history on the admission assessment, comprehensive care plan, and MDS (Minimum Data Set) assessments, staff will identify residents with increased vulnerability for abuse. Through the care planning process, staff will identify any	S9999		

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problems, goals, and approaches, which would reduce the chances of abuse. Staff will continue to monitor the goals and approaches on a regular basis and update as necessary."
"Supervisors will monitor the ability of the staff to meet the needs of residents, including that assigned staff have knowledge of individual resident care needs."

The facility's Resident Rights Policy reviewed 11/16/2022 states:
"The resident has the right to be free from sexual abuse."
"Residents will be cared for in a manner and in an environment that promotes maintenance or enhancement of each residents quality of life, dignity, and aspect in full recognition of his or her individuality."

The facility's Dementia Care policy reviewed 11/16/2022 states:
"Many individuals with a recent hospitalization will still have delirium for some time after discharge. Delirium may be especially problematic in individuals with underlying dementia."
"The staff and physician will jointly define the decision-making capacity of someone with dementia, including the extent to which the individual can participate in making everyday decisions."
"Individuals with dementia can also have a personality disorder, mental illness, psychosis, delirium, or other conditions causing or contributing to impaired cognition and problematic behavior."

The facility's Care Plan Policy reviewed 11/16/2022 states:
"Each resident's comprehensive care plan has been designed to:

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S9999	Continued From page 12 Incorporate identified problem areas. Reflect treatment goals and objectives in measurable outcomes. Collaborate with the resident, family and friends of the resident to identify and implement individualized interventions." "Care plans are revised as changes in the resident's condition dictates." (A)	S9999		