STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145970	A. BUILDING _____ B. WING _____	C 10/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE NUR & REHAB CENTER	2649 EAST 75TH ST CHICAGO, IL 60649

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F 328	Continued From page 30 The surveyor reviewed R2's medical record and found R2 has a diagnosis of bilateral neck cancer and receives radiation therapy. R2's current physician's order sheet indicated suctioning of R2 as needed. R2's care plan with a start date of 9/02/2008 and goal date of 12/02/2008 indicated R2 had swallowing difficulties and aspiration precaution and the goal was not to choke or aspirate on food/liquids. On 9/30/2008 at 5pm during the daily status meeting, the surveyor presented the observation of R2's difficulty to cough up sputum and the delay in staff interventions. The surveyor questioned why one nurse left R2 without giving R2 suctioning to relieve the resident's distress and possible aspiration. No answer was given.	F 328		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1010h) 300.1210a) 300.1210b)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 which 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. These policies shall be in compliance	F9999		

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F9999	Continued From page 31 with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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 accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. 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. b) 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	F9999		

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F9999	Continued From page 32 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 regulations are not met, as evidenced by the following: Based on interviews, record review and review of facility policy the facility failed to ensure that 1 sampled resident (R5) was free from neglect as evidenced by the facility's failure to: -Comprehensively assess a resident with complaint of pain. - Provide on-going monitoring of this pain. - Notify the physician in a timely manner of a medical change in a resident's condition. - Provide/assist with transport of this resident to the hospital. These failures resulted in R5 being sent to the hospital with a suspected Ruptured Abdominal Aneurysm requiring emergency surgery. Findings include: R5 is an 86 year old resident with diagnoses including A-fibrillation, Dementia, Diabetes Mellitus and GERD (gastro esophageal reflux disease). R5, who is identified as alert and	F9999		

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F9999	Continued From page 33 oriented. was admitted to the facility on 08/09/07. During telephone interview on 09/30/08 at approximately 12:15Pm, Z8 (daughter of R5) stated to surveyor, "On 09/08/08 I spoke with Z3 (ex-employee) about my mom's (R5) complaint of stomach pain. My mom's abdomen was hard and swollen. Z3 said she would call the doctor for an order for an Ultrasound, so I left that day." Z8 continued, "When I came (to the facility) the next day (09/09/08) my mom was still in a lot of pain and her stomach was really hard and swollen even more. I knew something was wrong. Z8 continued, "I found out that Z3 hadn't even called the Doctor so I spoke with E11 (Social Service Director) about helping me get my mother to the hospital. E11 told me E10 (evening nurse supervisor) would have to call the doctor before he could call an ambulance. I told E11 I wasn't sure I could wait because I had waited since yesterday and nothing was done, I also told E11 how much pain my mother was in and how swollen her stomach was." Upon further interview Z8 stated to surveyor, "I then talked with E10 who told me I would have to pay for my own ambulance, so I put my mother in my car and took her to the closest hospital. She had to have surgery the next morning." During survey at the facility on 10/01/08 E11 was interviewed regarding Z8's complaint of asking for help to transfer R5 to a local hospital on 09/09/08. E11 confirmed that Z8 came to his office around 4:00pm on the day R5 transferred (09/09/08). E11 elaborated how Z8 talked about R5's abdomen distended, complaint of pain and declining condition. Upon further interview E11 stated, "When I left at 4:30 Z8 and R5 was still in the building, I thought E10 would call the Doctor	F9999		

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F9999	Continued From page 34 and take care of it". E11 added, "Z8 was in a state of panic but she agreed to wait until E10 called R5's Doctor. However, while Z8 was waiting for E10 to call the Doctor, Z8 said something about this is the third day she had waited for nursing staff to obtain an order to send R5 to the hospital." There was a 30 minutes lapse in time from the time Z8 came to E11's office seeking help at 4:00pm and the time E11 left at 4:30Pm. On 10/01/08 at approximately 4:32pm, E10 was interviewed regarding Z8's concern of R5's abdomen and transfer to hospital on 09/09/08. E10 confirmed that she was aware of R5's complaint of pain when coming on duty on 09/08/08. E10 added, "Throughout the shift R5 never complained of pain to me, I never gave R5 anything for pain." Upon further interview E10 added, "I never did a physical assessment of R5's abdomen." E10 continued, "On the next day (09/09/08) when I came on duty R5's daughter met me at the door and told me she was going to take R5 to an urgi-care because she (Z8) wanted an ultrasound. I tried to call Z2 (attending physician of R5) but when she called back Z8 had already taken R5 out." Upon further interview E10 stated, "I knew Z8 took R5 to the hospital and they did a procedure, but I really don't know what they did. Z2 called back about 5 minutes after I called her." E10 continued, "I told E3 (Director of nurses) about all of this while Z8 was still here in the facility." Documentation by E10 on 09/08/08 at 3:45pm reads as follows: "Z2 on page regarding complaint of stomach pain. Awaiting MD call back." From 3:45pm until 11:30pm on this day when E10 left duty there was no documentation	F9999		

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F9999	Continued From page 35 by E10 regarding attempts to call Z2, as well as no comprehensive assessment of R5's abdomen. There were no attempts by facility staff to reach Z2 until 4:15PM the next day (26 hours later) when Z8 removed R5 to hospital in her automobile. E3 and E7 (Assistant Director of Nurses) were interviewed regarding R5's complaint of pain and staff's intervention. E3 stated, "I don't know nothing about R5's pain." Upon interview E7 confirmed being aware of R5's complaint of pain for 2 days prior to Z8 taking R5 to the hospital. Upon further interview E7 stated, "Z2 told Z3 to monitor the resident." E7 added that all this was information given to her through another staff. This interview is in conflict with interview with Z2 and documentation of staff being unable to reach Z2. Clinical record review indicated that on 09/08/08 at 2:30pm, documentation was as follows: "R5 had a complaint of pain at a 7 on a 10 (10 = worst pain) point scale upon palpation of abdomen. Pain medication provided. MD on page and awaiting response. Endorsing over to 3-11 shift." Surveyor reviewed the facility's MAR (medication administration record) for R5 for the month of September and found no documentation of R5 ever being medicated for pain even though R5 had an existing PRN (as necessary) pain medication ordered. Surveyor also noted minimal documentation regarding R5's pain, as well, there was no comprehensive assessment of the pain including condition of R5's abdomen (for example soft versus hard, tenderness, bowel sounds etc). There were also no other accompanying assessments to this complaint of pain including no vital signs.	F9999		

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F9999	Continued From page 36 On 10/01/08 at approximately 2:50pm Z2 (attending physician of R5) was interviewed by surveyor per phone regarding facility's notification of change in condition, complaint of abdominal pain for R5. Z2 stated, "I never got a call from the nursing home regarding R5's abdominal discomfort on the day before her transfer, I never got one call, no matter what they document." Z2 continued, "When the nursing home called me on the next day, Z8 had transferred R5 to the hospital." Z2 continued, "I later got a call this same day from the Emergency room of the hospital saying my resident was there with a Ruptured Abdominal Aneurysm requiring emergency surgery." Z2 said "If they (the facility staff) could not reach me they should have called E9 (Medical Director). However, no one tried to call me." Later this day at approximately 4:10pm, Z2 contacted surveyor per telephone and added, "I just reviewed R5's hospital record/CT scan." Z2 at this time gave a diagnosis from the hospital records to surveyor and added, "It's the same thing" (as Ruptured aneurysm with same signs and symptoms). The facility has a policy that staff is to call the Medical director if there is a significant change in a resident's condition and staff is unable to reach an attending physician of a resident. The facility had no evidence that E9 was ever called. E9 was interviewed on 10/01/08 at 3:30pm regarding notification of a change in condition of R5 on 09/08/08 or 09/09/08. E9 stated, "I don't recall getting a call related to R5 having abdominal pain." Upon further interview E9 stated, "If staff is unable to reach the	F9999		