AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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	1L6003453				11/27/2017	
NAME OF I	PRÖVIDER OR SUPPLIER		•	STATE, ZIP CODE		
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S 000	Initial Comments		S 000			
	Complaint Investiga #1786232/97638 N #1786332/97743 F3 #1786423/97848 F2 Incident Report Inve 11/1/17/IL98039 F	lo Def 323 204 F157 estigation to Incident of				
S9999	Final Observations		S9999			
	STATEMENT OF L	ICENSURE VIOLATIONS:				
	300.610a) 300.1210b) 300.1210d)6) 300.2900d)2) 300.3240a)					
	Section 300.610 R	esident Care Policies				
	procedures governifacility. The written be formulated by a Committee consisting administrator, the amedical advisory conformation of nursing and othe policies shall complete the facility and shall accomplete the facility and shall facility.	dvisory physician or the ommittee, and representatives in services in the facility. The y with the Act and this Part. shall be followed in operating the reviewed at least annually documented by written, signed		Attachment	•••	
	Section 300.1210 (Nursing and Persor	General Requirements for nal Care		Statement of Licensure	Violations	
Ilinois Depar	tment of Public Health					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: ___ C B. WING IL6003453 11/27/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6450 NORTH RIDGE BLVD RIDGEVIEW REHAB & NURSING CENTER CHICAGO, IL 60626 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 S9999 Continued From page 1 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. 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 300.2900 General Building Requirements _____ d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee

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or agent of a facility shall not abuse or neglect a

resident. (Section 2-107 of the Act)

PRINTED: 01/18/2018 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING IL6003453 11/27/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6450 NORTH RIDGE BLVD RIDGEVIEW REHAB & NURSING CENTER CHICAGO, IL 60626 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 2 S9999 THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY: Based on interview and record review, the facility failed to supervise two residents, which resulted in one resident (R2) falling from a third floor window, and one resident (R1) eloping from the facility. The facility also failed to follow their elopement policy by not reporting the resident elopement to the Police, the Administrator or the Director of Nursing for over four hours. Four residents (R1, R2, R3 and R5) were reviewed for falls and supervision in a total sample of 12. This failure resulted in one resident (R2) sustaining multiple bone fractures. Findings Include: 1. The medical record documents R2 as a 63 year old admitted to the facility on 9/26/17. R2 has diagnoses of, but not limited to, bipolar disorder, Alzheimer's disease, other schizophrenia, agitation and anxiety. Interview on 11/14/17 at 1:45 PM E3 ADON (Assistant Director of Nursing) stated "I was

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leaving the office at the end of the day, I forgot something so I parked the (car) in front of the building. I saw someone lying on the ground. I noticed it was a new resident. I called for help. The receptionist and the first floor nurse came out to help. We kept R2 immobile. We assessed R2 and called 911. I didn't see any injuries. R2 was able to speak, he/she didn't say what happened, she/he just kept repeating "I'm trying to get to my daughter." The EMT (Emergency Medical Team)

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING:		COMPLETED		
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CALID SUMMARY STATEMENT OF DEFICIENCIES PRETEX EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETEX TAG EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 3 and the police came, and took R2 to the hospital. I then went inside and called the DON (Director of Nursing) and the Administrator. The Final Incident Investigation Report written by E2 DON documents, date and time of incident 9/28/17 at 5:15 PM. The admitting hospital reported upon inquiry that resident (R2) was admitted for extensive injuries due to fractures of some bony prominences. Investigations and reports did not give us any clue of how resident might have sustained such injuries. Resident was last seen in her/his room and within the next two hour rounds resident was noted on the spot in front of the building, where he/she was transferred for evaluation. Interview on 11/14/15 at 2:30 PM E9 LPN (Licensed Practical Nurse) stated that I pass med's (medications) between 4:00 and 6:00 PM. It is a very busy time. I saw R2 around 4:30 in her/his room. Before that R2 was very agilated, going in other residents rooms, the nurse on the previous shift said R2 was trying to get off the floor. R2 was very confused all the time. Her/his roommates are also confused. On 11/9/17 at 12:45 PM E1 Administrator and E2 DON stated in reference to R2, no alarms went off, we checked the videos, R2 did not go out the doors. The window drame in R2's room was picked at. The window and screen was intact. I had the window boarded up. The ADON was going home and saw R2 outside at about 5:30 PM on 9/28/17. R2 was able to speak, but did not say what happened. R2 was found below her/his			NG CENTER 6450 NOF	TH RIDGE			
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out the window. On 11/9/17 at 12:00 PM E5 Maintenance Director		On 11/9/17 at 12:45 DON stated in refer off, we checked the doors. The window picked at. The wind had the window boa going home and say PM on 9/28/17. R2 say what happened room window. We a out the window.	is PM E1 Administrator and E2 rence to R2, no alarms went videos, R2 did not go out the frame in R2's room was ow and screen was intact. I raded up. The ADON was w R2 outside at about 5:30 was able to speak, but did not a R2 was found below her/his are assuming he/she jumped				

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29999 29999	stated they called in R2's room. The win with, the frame was inside the frame, the The window on the glass sandwiched to was missing. The owindow, but only in the top of the frame guard that keeps the high was tampered window frame. The when he got to R2's was still in the wind resting against the window frame as was leaning against. The window frame as was leaning against. The window screen glass pane downstate. On 11/9/17 at 3:00 about the extra pan window it had glass not tell me it was a did not know the screen glass pane downstate. Progress Notes by document Resident control by opening of sitting still, intruding in to their personal easily re-directed.	ne in to check the window in dow frame was tampered apart and the screw at holds the glass was gone. bottom has two panes of ogether. One pane of glass other pane was still in the place by the epoxy seal on e, it was loose. The tamper e window from being raised to with, but still intact in the e Housekeeper, E8 told me is room, the one pane of glass ow, the other pane was wall below the window. PM E8 stated in Spanish, stated that when he got to R2's and one pane of glass still in and the other pane of glass still in and the other pane of glass to the wall under the window. I was pushed up. I took the airs to the maintenance room. PM E1 stated "I did not know e of glass, when I saw the in it. They (E5 and E8) did double paned window, and I reen was pushed up." E2 dated 9/27/17 for R2 to demonstrates poor impulse doors, triggering alarms, not gon other residents by getting space and belongings, not	29999			
		everely impaired cognition.				

IL6003453 B. WING CT 11/27/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6450 NORTH RIDGE BLVD CHICAGO, IL 60626 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG COMPLET TAG CHARACTORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 5 The Elopement Risk Tool for R2 dated 9/28/17 documents the resident is confused at time and place and has the ability to leave the building. Types of Interventions: staff aware of resident on wander/elopement risk, exit and statinvell alarms, frequent monitoring. Comment: Resident is very confused and attempts to leave the floor. Resident resides on the third floor and is supervised at all times. Cat Scan of the lower left extremities results from the local hospital dated 9/28/17 document R2 has a badly comminuted intra articular open fracture of the lateral malleolus, chip fracture off the dorsal anterior aspect of the talus. X-ray of the pelvis dated 9/28/17 for R2 document an acute comminuted fracture of the left femur with a coxa vera deformity. Cat Scan of the pelvis dated 9/28/17 for R2 document acute compression fractures of L1 and L2 (fumbar spine), fractures of L1 and L2 (fumbar spine), fractures of L1 and L2 (fumbar spine), fractures of	AND PLAN OF CORRECTION IDENTIFICATION NUMBER			LE CONSTRUCTION :	(X3) DATE	SURVEY PLETED	
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Cach Deficiency Must be preceded by full reductions PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY S9999 Continued From page 5 S9999 The Elopement Risk Tool for R2 dated 9/28/17 documents the resident is confused at time and place and has the ability to leave the building. Types of Interventions: staff aware of resident on wander/elopement risk, exit and stainwell alarms, frequent monitoring. Comment: Resident is very confused and attempts to leave the floor. Resident resides on the third floor and is supervised at all times. Cat Scan of the lower left extremities results from the local hospital dated 9/28/17 document R2 has a badly comminuted intra articular open fracture of the calcaneus, Minimally displaced fracture of the lateral malleolus, chip fracture off the dorsal anterior aspect of the talus. X-ray of the pelvis dated 9/28/17 for R2 document an acute comminuted fracture of the intertrochanteric area of the left femur with a coxa vera deformity. Cat Scan of the pelvis dated 9/28/17 for R2 document acute compression PREFIX TAG CROSS-REFERNOED TO THE APPROPRIATE CONSTRUCTION	RIDGEV	IEW REHAB & NURSI	NG CENTER				
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L5 transverse processes extending into the vertral body and involving the spinous process, multiple bilateral fractures of the sacrum with spinal canal stenosis, multiple fractures of the pelvis, hematoma and hemorrhage. 2. The medical record documents R1 as a 43 year old admitted to the facility on 7/16/16. R1 has diagnoses of but not limited to schizophrenia, agitation, major depressive disorder, restlessness and generalized anxiety. The Missing Person Incident Report of 9/29/17 written by E2 DON for R1 documents date of incident 9/29/17 at 4:00 AM. Staff immediately search the surrounding area, staff searched the facility, lower level. MD (Medical Doctor) notified	S9999	The Elopement Ris documents the resi place and has the a Types of Intervention wander/elopement frequent monitoring confused and attern Resident resides or supervised at all time. Cat Scan of the low from the local hosp R2 has a badly comfracture of the calcastracture of the calcastracture of the laterative dorsal anterior at the pelvis dated 9/2 acute comminuted intertrochanteric are vera deformity. Cat 9/28/17 for R2 document fractures of L1 and L5 transverse procevertral body and invitable bilateral fraspinal canal stenos pelvis, hematoma at 2. The medical recyear old admitted to has diagnoses of be agitation, major depand generalized and The Missing Persor written by E2 DON incident 9/29/17 at a search the surround	k Tool for R2 dated 9/28/17 dent is confused at time and ability to leave the building. Instantist staff aware of resident or risk, exit and stairwell alarmatic. Comment: Resident is verified to leave the floor. In the third floor and is lest. The referentiates results it al dated 9/28/17 document aminuted intra articular opendated and leaves, Minimally displaced all malleolus, chip fracture of aspect of the talus. X-ray of 18/17 for R2 document an another acute compression L2 (lumbar spine), fractures asses extending into the rolving the spinous process, actures of the sacrum with its, multiple fractures of the and hemorrhage. The facility on 7/16/16. R1 at not limited to schizophrenionessive disorder, restlessnessivety. Incident Report of 9/29/17 for R1 documents date of 4:00 AM. Staff immediately ding area, staff searched the	a of			

AND DIAM OF CORDECTION INCIDENTIFICATION AND ROSE.		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED				
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	9:30 AM, Administra	ator Notified at 9:00 AM.							
	(Licensed Practical at about 3:00 AM (station and asked for his/her room. At 4:10 Nursing Assistant) of floor, we searched for the first floor back door The door alarm new police, or the Adminfrom me. I know the	AM via telephone E6 LPN Nurse) stated, " I did rounds R1) came to the Nurse's or paper, then went back to 00 AM the CNA (Certified noticed (R1) was not on the the floor, around the building, e heard an alarm, they called 1) go out. (R1) went out the . We searched the perimeter. ver went off. I didn't call the nistrator, time just got away e protocol is to call the Police or. This has never happened							
	Nursing) stated the floor. R1 was on the back door alarm we went to the alarm do not go off. The vide the alarm on the thir. They did a head core E6 texted me at aro Around 7:00 AM E6 happened, I told her family. I called E1, be call. The Police arrigone 5 days. The K stated they found R warrants under his/lifer over a year, I do cannot go out alone supervision.	AM E2 DON (Director of alarm went off on the first at third floor. The first floor ent off. The Nurse and CNA cor. The third floor alarm did so shows R1 was picking at rd floor door and disarmed it. unt and found out R1 missing, and 4:30 AM, she did not call. It called and told me what r to call the Police and the cout she did not receive the event around 9:00 AM. R1 was ane County Police called and 1 and R1 was in custody for the name. R1 has been here n't know of any problems. R1 to the police has to have							
		PM E1 stated that I did not aving until I got to work at							

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY
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NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RIDGEV	IEW REHAB & NURSI	NG CENTER	TH RIDGE E , IL 60626	BLVD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
S9999	9:00 AM. The nurse Police and the DON On 1114/17 at 12:00 stated that E6 and the night R1 left. Woutside. The third f Someone on the se door alarm went off around the neighbowe didn't see R1. E On 11/8/17 at 2:00 floor alarm above the exposed wires conwire connected to a asked E5 if you pull would that disarm the Writer was able to r E5 stated he check alarm for the outsid first floor Nurse's Stated he check alarm for the outsid first floor Nurse's Stated he check alarm for the outsid first floor Someone State of the facility policy tit Missing Residents a documents: Should resident prove unsudesignee shall make	e should have called me, the I, that is the protocol. O PM by telephone E7 CNA myself worked the third floor fe looked on all the floors and loor alarm did not go off. Econd floor told me the outside so I went outside. I drove rhood with another CNA but to stayed on the floor. PM with E5 observed third he door. There were two hected to two screws, and a box above the screws. Writer the wires off the screws he alarm and E5 stated yes, each the wires and screws. Is the alarms monthly. The e doors only sounds at the station, not any of the other e codes after R1 got out. Ided Facility Policy Regarding and Elopement ,undated, I a thorough search for the eccessful, the Administrator or e a report of the incident to ement emergency response	\$9999			
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