STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001697	A. BUILDING: _____ B. WING _____	C 09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHICAGO RIDGE SNF	10602 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415

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S 000	Initial Comments Complaint Investigations: 2196348/IL137670 2196372/IL137700 2195915/IL137133 2196288/IL137594 2196260/IL137562 2196286/IL137591 2196095/IL137357 2196663/IL138067	S 000		
S9999	Final Observations 300.690a) 300.690b) 300.690bc 300.1210b) 300.1210c) 300.1210 d)3) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. 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 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. 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	S9999		

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S9999	Continued From page 2 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing 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. A. Based on interview and record review the facility failed to assess and monitor a resident at risk for elopement and failed to implement interventions to prevent the resident from leaving the facility through a first floor window for 1 of 3 residents (R1) reviewed for accidents and incidents in a total sample of 10. This failure resulted in R1 leaving the facility and walking towards a 4 lane intersection. R1 was found sitting on the ground the next day at a nearby gas station. R1 requires continuous oxygen and did not have oxygen available after elopement. R1 was noted in respiratory distress and transferred to the hospital where the resident was diagnosed with Pneumonia requiring intubation. Findings Include: The Face Sheet documents that R1 was admitted to the facility on 8/17/21 with a diagnosis of COPD, heart failure, Bipolar Disorder and Schizophrenia. R1's hospital record dated 8/8/21 prior to admission to the facility documents that the resident was seen in the emergency room for respiratory distress. R1 was requesting to leave, and a psychiatric evaluation was done. R1 presented with poor judgment and insight and was placed on elopement precautions with 1:1	S9999		

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S9999	Continued From page 3 monitoring and a sitter prior to being discharged. Nurse's Notes dated 8/18/21 documents that R1's vitals were stable, and the resident was on oxygen and being monitored. Resident on inhalers prescribed during hospital admission. Nurse's Notes documents that R1 was not in the his room on 8/19/21 at 10:40pm. A search of the building was done, and the resident was not located. A chair was noted up against the resident's window with the screen pushed out. The Police were called, and a missing person report filed. R1's family notified. Nurse's Notes dated 8/20/21 at 7:03am documents that R1 was found walking outside of the building. R1 was short of breath. The paramedics called and R1 transferred to the local hospital for evaluation. On 9/2/21 at 1:45pm V3 (Nurse) stated "Doing rounds when I got there, I noticed R1 wasn't in the room. This was around 10:30-10:40pm and we started a search of the building. I went back to the room when the resident wasn't found in the building. I noticed a chair against the window and 2 latches snapped on the window so the window would be able to open wide. The window screen was missing. I went outside and the screen was on the ground. R1 jumped out of the window. I notified the Physician and the family. I couldn't find the resident outside at all. I called the Police and filed a missing person report. Staff found the resident walking back to the facility around 6am. The oncoming nurses saw R1 and got a wheelchair to bring the resident back into the building. I asked the resident what happened and R1 said 'I wanted to get out of here, I wanted to have a good time.' I checked the resident's vitals	S9999		

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and R1 was short of breath. I gave the resident oxygen, I called 911, within 5 minutes the paramedics were here and R1 was transferred to the hospital."

On 9/2/21 at 1:55pm V4 (DON) stated "When I came in that morning, I was told by the nurse that R1 was absent from the resident's room during rounds. On second shift the resident was in bed and was last seen around 10:20pm. When the oncoming Nurse did rounds for third shift around 10:30pm the resident was gone. Staff did search the building and could not find the resident. Staff called the Physician and the family. R1 had been telling staff 'I want to go home.' The day shift staff saw the resident by the gas station and the nurses went to get the resident. R1 continued to say, 'I want to go home.' The Physician was notified and R1 was sent to the hospital. R1 did not come back to the facility. The family came in and picked up the resident's belongings. Social Service does the Elopement Risk Assessment but the nurse's complete the initial assessment on admission. They look for things like the resident saying they want to leave, behaviors of hanging around doors or exits and stairwells, and residents asking guests about getting out of the facility. If the resident is alert and oriented staff will talk with them and have social service talk with them to find out the reason for wanting to leave. Staff will increase monitoring and get family involved. I'm not sure if R1 ever talked with Social Services."

On 9/2/21 at 2:20pm V6 (Social Service Director) stated "R1 was not assessed for elopement by Social Services. Social Service met with the resident for MDS assessment and got a BIMS Score of 14 out of 15. R1 was also monitored for being depressed. I was not aware of any exit

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seeking behaviors. No one told me that R1 was requesting to leave the facility. If notified we would chart the behaviors, notify the Administrator, and create a care plan with interventions. We would also update the care plan quarterly. We meet with the residents within 2 weeks of admission for elopement risks unless there's behaviors present. I wasn't aware of any behaviors."

On 9/2/21 at 2:35pm V7 (Nurse) stated "R1 was supposed to be on 5 liters of continuous oxygen but the resident was constantly taking it off. I kept redirecting and educating the resident. R1 was also on isolation and the resident was non-compliant and kept leaving the room asking for cigarettes, getting cigarettes, and going outside to smoke. Sometimes I would go in to check the resident's oxygen levels and R1 would not be in the room, R1 would be out smoking. I called R1's family and I heard the resident on the phone saying, 'I want to leave, I want to go home, and I don't want to be here.' The family said they would come and bring the resident some things from home. R1 understood but was still non-compliant, leaving the room and not wearing the oxygen. I last saw the resident around 10:30pm and R1 was in the room. I told the Nurse that R1 was non-compliant, the resident was smoking, leaving the room and wouldn't listen. I notified the family, and I notified Social Services but I'm not sure which social service person I spoke to. I always tell social services if I notice elopement behaviors."

Hospital records reviewed and documents that on 8/20/21 at 7:50am R1 was brought to the emergency room after escaping the nursing facility overnight and being found wandering the streets. R1 was wrapped in blankets and

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presented with chills. R1 had an increased heart rate and had an increase in oxygen needs. R1 was diagnosed with pneumonia and psychosis. R1 had increased respiratory distress and increased carbon dioxide levels. R1 was intubated and placed on the ventilator. R1 did not return to the facility.

On 9/3/21 at 12:05pm V9 (CNA) stated "I was going to the gas station before my shift started and I saw someone sitting on the sidewalk. R1 was having trouble breathing. R1 hollered to me 'I need help, have staff at the nursing home bring a wheelchair.' I had never seen R1 before. I went back to the facility and let the staff know that the resident was at the gas station. The staff came and brought the resident back to the facility and R1 was sent out."

R1's Community Survival Skills Assessment dated 8/18/21 documents that R1 did not appear capable of unsupervised outside pass privileges and staff will continue to monitor.

R1's Elopement Assessment dated 8/18/21 documents that R1 did not have a history of elopement, R1 did not have any behaviors and staff will continue to monitor.

R1's care plan on admission documents that R1 presents with altered respiratory function requiring oxygen therapy due to a diagnosis of COPD. R1 presented with movement behaviors that may be interpreted as wandering, pacing, or roaming due to a diagnosis of Bipolar Disorder and problems understanding the immediate environment. Staff is to implement preventative intervention strategies: assess for potential elopement or unauthorized departure risk and make rounds or room checks per facility protocol

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S9999	Continued From page 7 to minimize the chance of unauthorized leave. B. Based on interview and record review the facility failed to report an elopement to the Regional Office where a resident climbed out of a window and was later hospitalized for 1 of 3 residents (R1) reviewed for accidents and incidents in a total sample of 10. Findings Include: The Face Sheet documents that R1 was admitted to the facility on 8/17/21 with a diagnosis of COPD, heart failure, Bipolar Disorder and Schizophrenia. Nurse's Notes documents that R1 was not in the resident's room on 8/19/21 at 10:40pm. A search of the building was done and the resident was not located. A chair was noted up against the resident's window with the screen pushed out. The Police were called and a missing person report filed. R1's family notified. Nurse's Notes dated 8/20/21 at 7:03am documents that R1 was found walking outside of the building. R1 was short of breath. The paramedics called and R1 transferred to the local hospital for evaluation and did not return to the facility. All reportable accidents and incidents were reviewed and there was no documentation that IDPH was notified. On 9/2/21 at 1:05pm V2 (Assistant Administrator) stated "The incident with R1 was an unauthorized exit, not an elopement because the resident was alert and oriented. There was no investigation or	S9999		

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S9999	Continued From page 8 reportable sent over to IDPH to my knowledge." (A)	S9999		