

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001697	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/25/2022
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NAME OF PROVIDER OR SUPPLIER CHICAGO RIDGE SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 10602 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415
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(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 Investigation: 2292180/IL144815	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.690a) 300.690b) 300.690c) 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 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	S9999	Attachment A Statement of Licensure Violations	

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

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>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.</p> <p>These requirement were NOT met as evidenced by:</p> <p>Based on interview and record review, the facility failed to report an elopement of a resident (R1) to IDPH and failed to follow their elopement policy for one of three residents reviewed for elopement in a total sample of seven.</p> <p>Findings Include:</p> <p>R1 is a 63 year old with the following diagnosis: encephalopathy and unspecified mood disorder. R1 admitted to the facility on 11/26/21.</p> <p>A Nursing note dated 2/27/22 at 10:08PM documents R1 was in an altercation with another resident and caused damage to the wall in the room. The doctor was notified and an order was placed to send R1 to the hospital. R1's guardian also notified.</p> <p>A Nursing note dated 2/27/22 at 11:23 PM documents R1 left the building against medical advice because R1 did not want to go to the hospital.</p> <p>On 03/17/22 at 3:06PM, V7 (Nurse) stated, "it was charted as against medical advice because he's alert and oriented times four and V1 told me</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>to chart it that way. R1 did not sign any AMA paperwork. No, R1 wasn't explained any risks or given any of his belongings before he left. Usually when someone elopes we will try to run after them if we see them leave and call 911 and give a description of them so they can look out for the person. No, I never called police."</p> <p>On 03/22/22 at 1:34PM. V1 (Administrator) stated, "We charted it as AMA because he was alert and oriented. Once he found out he was going, he got upset and left. Normally for elopements we call the police, search the area, and notify public health. I will even get in my car and go around to the surrounding buildings and ask people if they saw anyone."</p> <p>The policy titled, "Discharge Against Medical Advice (AMA)," dated 2/4/20, "It is the policy of the facility to acknowledge the right of a resident to sign him/her self out of the facility without consent of an order from the attending physician providing that the resident has the decisional capacity to do so. It has been determined that the resident is able to make his/her own decisions and chooses to exercise this right, he/she will be discharged from the facility against medical advice. 1. Prior to leaving the facility, the resident and/or guardian will be provided with an explanation of the potential risks of such a discharge and alternatives to the same. 2. Prior to leaving the facility, the nurse on duty will provide the resident and/or legal guardian of information regarding the residence current treatment and medication regiment. 3. In the event that it is questionable as to whether the resident and/or legal guardian has a decisional capacity to make an informed decision about an AMA discharge, professional and administrative staff are to be consulted in collaboration with the residents</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>psychiatrist/physician ... 5. Any resident or legal representative choosing to discharge or be discharged without the consent of an order from the attending physician is expected to sign the AMA form. 6. If a resident or legal guardian refuses to sign the AMA form, the form will be signed by two staff members witnessing the resident or guardians refusal to sign. Notation of the refusal and description of the discharge will be recorded in the resident's clinical record. 7. In the event the resident assigning him/herself out AMA, his/her legal representative and/or family member will be notified by facility personnel.</p> <p>The policy titled, "Elopement Policy," that is undated document, "In the event if a resident cannot be located and is believed to have eloped from the facility the following protocol will be followed: 1. The nurse assigned to the unit where the resident resides will initiate a search of the assigned unit. 2. Concurrently with #1 above, the unit nurse will inform the charge nurse of the other units of the possible elopement and the unit search will be conducted on all nursing units. 3. Concurrently with #1 and #2 above, the unit nurse will inform the staff on the main floor of the possible elopement and a search of that area will be conducted. 4. Concurrently with #1, #2, and #3 above, a staff member will be instructed to check all agree egress doors for a possible exit and then search the surrounding areas of the facility. 5. If the resident cannot be located pursuant to the above procedures, the charge nurse assigned will notify the administrator, DON, attending physician, residence emergency contact/family for/guardian/representative, and Police Department."</p> <p>(B)</p>	S9999		

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