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 10/20/2022

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

(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 2297402/IL151254 2298118/IL152142	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.690(b) Section 300.690 Incidents and Accidents 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. This requirement is not met as evidenced by: Based on interview and record review the facility failed to follow its incident reporting policy for one resident (R3) out four residents reviewed for accidents and supervision. This failure resulted in the facility not reporting to the state agency that R3 cut his wrist with a razor, made a suicide attempt and that R3 had to be sent out to the hospital to be evaluated. Findings Include: Facility's incident/accident report denotes the incident/accident report is completed for all accidents or incidents where there is injury or the potential to result injury and resident-to-resident physical altercations. An "accident" is defined as any happening, unexpected, unintended event not consistent with the routine operation of the facility that can result in bodily injury other than	S9999	**Attachment A** Statement of **Licensure Violations**	

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S9999	Continued From page 1 abuse. An incident/accident report will be completed for all unexpected events that occur, that cause actual or potential harm to a resident or employee. Any serious condition resulting from an accident requiring first aid, physician visit, or transfer to another health care facility. Suicide or attempted suicide. The Administrator, Director of Nursing or Nursing Supervisor must notify the Illinois Department of Public Health, by fax, as soon as possible within twenty-four (24) hours of the occurrence. 9/10/2022 16:47 R3 Nursing Progress Note reads: Observe superficial cut marks on resident right wrist blood noted near cut. Bleeding controlled, area cleaned with normal saline solution and covered with a dry dressing. No bleeding observed through the bandage. resident was provided a 1:1 for observation. When nurse asked resident what happened he said, "I cut my wrist with a razor because I didn't get my anxiety medication." Nurse also asked Where he got the razor from, the resident refused to answer. The nurse had administer 0.5 mg of clonazepam at 4 PM. A room search was perform by the nurse with resident present do to 1:1 observation. NP, family, DON, and administrator notified. Received order from NP to send resident out to hospital. Resident remains on 1:1 observation until ambulance came and transferred resident to Hospital. Resident refused vitals. No evidence of bleeding to the bandage, bandage was CID. R3 stated on 10/13/22 at 6:10 pm he got the razor from the nurse to shave. R3 stated he cut himself to get attention. R3 stated, he would go to the nurse's station to get the razor that his mother brought him. R3 stated had used the razor and the nurse never came back to get it.	S9999		

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S9999	Continued From page 2	S9999		

V5 (Certified Nurse Aide) stated on 10/14/22 at 3:40pm she has worked at the facility for 26 years and taken care of R3. V5 stated R3's mother would purchase him razors and the razors would be at the nurse's station for him when he needed to shave. V5 stated R3 knew how to go to the nurse's station and ask for the razor and was supposed to bring it back to his nurse when he was done. V5 stated she was working on the day (9/10/22) getting residents ready for dinner when the nurse (V3) called for assistance. V5 stated she went to R3's room and noticed he was bleeding from his wrist. V5 stated, the razor had been removed and they monitored 1:1 until the ambulance came and picked R3 up. V5 stated whenever anyone gives a razor to a resident, that person is responsible for getting that razor from the resident. V5 stated they should never leave the razor with a resident for any long length of time.

V3 (Registered Nurse) stated on 10/13/22 at 6:00 pm, that R3 had cut his wrist with a razor. V3 stated the razor that R3 had in his room was not one that the facility purchases for the residents. V3 stated residents are not to have razors in their room or in their possession. V3 stated R3 was given first aide care then sent to the hospital for evaluation.

V1 (Administrator) stated on 10/19/22 at 4:40 pm, R3 obtained a razor and cut his wrist. V1 stated the facility does report and record incidents however the facility did not report to IDPH that incident regarding R3 cutting himself. V1 stated, they did not report the incident since R3 sustained only a minor cut to his wrist.

V8 (Director of Nursing) stated on 10/19/22 at 5:00 pm, the facility did record the incident of R3

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S9999	Continued From page 3 cutting himself but not sure if a report was sent to IDPH. (C)	S9999		