STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016216	A. BUILDING: _____ B. WING _____	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIMENSIONS LIVING BURR RIDGE	6801 HIGHGROVE BOULEVARD BURR RIDGE, IL 60521

(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 Annual Sheltered Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 330.780c) 330.710a) 330.1110a) Section 330.780 Incidents and Accidents c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. 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. This REQUIREMENT was not met as evidenced by: Based on interview and record review, the facility failed to report a resident's fall that required hospitalization. This applies to 1 of 2 residents (R200) reviewed for incidents and accidents in the sample of 3. The findings include: R200's face sheet included metabolic encephalopathy, traumatic subdural hemorrhage with loss of consciousness status unknown, orthostatic hypotension, chronic systolic congestive heart failure, unsteadiness on feet,	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 repeated falls, syncope and collapse, restlessness, and agitation, need for assistance with personal care, unspecified Dementia, unspecified severity without behavioral disturbances. R200's Comprehensive assessment dated 4/21/23 showed that R200 is intact in cognition. On 05/15/23 at 11:38 AM, R200 was stated was lying in bed and got up and by holding on to his walker, transferred self to wheelchair. R200 stated that he recently fell while he was outside the facility in the courtyard "with my friends." R200 stated that when he went over the threshold while wheeling self, his fell over backwards and hit his head and there was some bleeding from his head. R200 continued that the staff came and send him out to the hospital where he stayed for four days. On 05/16/23 at 11:39 AM, V2 (Director of Nursing) stated that she did not report this incident to IDPH (Illinois Department of Public Health) as reportable incidents are when residents have bonding, staples, and sutures. V2 remarked "He did not have any of these." V2 stated that R200 went to another floor on return to the facility from the hospital and therefore she did not follow up. V2 stated that she will check the hospital papers and come back with the information. On 05/16/23 at 12:14 PM, V2 stated based on hospital reports, R200 had a hematoma and that she did not report it. Hospital Final Reports dated 04/14/23 included that Computed Tomography of the head and brain showed acute right subdural hemorrhage status post fall.	S9999		

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S9999	Continued From page 2 (C) 330.710a) Section 330.710 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review, the facility failed to follow smoking policy guidance to provide supervision and provision of smoking paraphernalia in a designated smoking area. This applies to 1 of 1 resident (R201) reviewed for policies and procedures in the sample of 3. The findings include: R201's face sheet included diagnoses of nicotine dependence, alcohol use, chronic obstructive pulmonary disorder, abnormal aortic aneurysm without rupture, other seizures. R201's Smoking Safety Assessment (dated 02/15/23) showed that R201 was moderately impaired in cognitive skills for decision making. The same assessment included that R201's right	S9999		

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S9999	Continued From page 3	S9999		

hand is contracted and drops ashes on self. Interventions included Supervised smoking by staff, Facility storage of tobacco products and fire materials only,

R201's revised Service Care Plan dated 09/05/22 for Tobacco Use included: Assistance required for escorts to smoking area, light cigarette.

On 5/15/23 at 4:27 PM, R201 was seen wheeled outside by V9 CNA (Certified Nursing Assistant) through an exit area that had a signage on door "No Smoking." R201 had one unlit cigarette in his mouth and another in his left hand. V9 left R201 outside and came back into the facility and when asked if R201 is allowed to be outside by himself, V9 remarked "He is a grown man. He can smoke by himself. He is in an enclosed enclave. He got the cigarettes from the nurses station." V9 then pulled out a gadget from her pocket and stated that she is going to set the timer for 10 minutes and will be back and then left the area. R201 was seen smoking outside with his left hand as his right hand was contracted and in a brace. The ashes from the cigarettes were noted falling on his pants and his clothes were also covered with white powdery substance. When asked where he got his lighter from, R201 reached into his coat and stated, "I had it all the time."

On 05/15/23 at 4:38 PM, V10 (Registered Nurse) stated "We give him his cigarettes and he can keep his lighter. He gets his cigarettes from the nurse on duty."

On 05/16/23 at 9:40 AM, R201 was wheeled outside to another area by an unknown staff member and placed close to the exit door. The staff member then left the area and R201 was seen lighting up a cigarette.

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S9999	Continued From page 4 On 05/16/23 at 9:48 AM, R201 was still smoking unsupervised and noted to rest his left hand with the lit cigarette on his knee and the ashes were falling unto his pants. When asked R201 remarked "I lit my own cigarette. I have the lighter in my pocket." R201 then proceeded to put a second cigarette in his mouth and took a lighter out of his pocket and lit the cigarette. On 05/16/23 at 9:52 AM, V11 (CNA), came outside and stated "We check on him every five to ten minutes. He likes to sit out here for some time. He is not supposed to be near the doors. He should be in the enclosed area (further down) where there is an ash tray so that the ashes do not fall all over. V11 then wheeled R201 to this area where a cigarette receptacle was seen but no other safety equipment's or signage. On 05/16/23 at 11:38 AM, V2 (Director of Nursing) stated that R201 care plan should be followed to escorts to smoking area, and light cigarette. V2 also stated that since R201 spills ashes on self, he should be wearing an apron. V2 stated that R201 should not have been in an area that had the signage "No smoking." V2 added that the policy for designated smoking area should be followed. On 05/16/23 at 11:53 AM, V4 (Director of Wellness) stated that R201's family requested that facility remove all cigarettes and lighters from R201 and that the staff to provide the same during smoke breaks. Facility policy and procedure titled "Smoking" (revised May 2020) included as follows: 3. If the facility allows smoking there should be designated areas for smoking that are posted.	S9999		

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S9999	Continued From page 5 4. All residents who smoke will be assessed for their safety at time of admission/readmission, quarterly and/or when there is a change in resident's condition. Based on results of the assessment, safety materials may be provided such as apron, cigarette holder, and supervision as needed. 5. Residents who require supervision will be taken to the smoking area at designated times. 6. The designated smoking area(s) will have the following: a. "No Oxygen" signs b. Smoking blankets c. Fire Extinguishers d. Approved cigarette receptacles (B) 330.1110a) Section 330.1110 Medical Care Policies a) The facility shall have a written program of medical services approved in writing by the advisory physician that reflects the philosophy of care provided, the policies relating to this and the procedures for implementation of the services. The written program of medical services shall be followed in the operation of the facility. This REQUIREMENT was not met as evidenced by: Based on interview and record review, the facility failed to follow policy guidance to update care plan with new interventions post fall and follow implementation. This applies to 1 of 2 residents (R200) reviewed for Medical Care Policies in the sample of 3.	S9999		

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S9999	Continued From page 6 The findings include: R200's face sheet included metabolic encephalopathy, traumatic subdural hemorrhage with loss of consciousness status unknown, orthostatic hypotension, chronic systolic congestive heart failure, unsteadiness on feet, repeated falls, syncope and collapse, restlessness, and agitation, need for assistance with personal care, unspecified Dementia, unspecified severity without behavioral disturbances. R200's Comprehensive MDS (Minimum Data Set) assessment dated 4/21/23 showed that R200 is intact in cognition. On 05/15/23 at 11:38 AM, R200 was lying in bed and got up and by holding on to his walker, transferred self to wheelchair. R200 was noted to have multiple personal items around the room including two oxygen canisters with tubing coiled on the floor next to R200's bed. R200 stated that he can get in and out of bed by himself. R200 stated that he has fallen several times in the room recently in the last few months as he was dizzy. R200 stated that he was trying to walk to the bathroom most of the time when he fell. R200 stated that he did not use the call button to ask for help to use the bathroom as the one he had around his neck broke two years ago, and it was never replaced. R200 stated that he pulled the call gadget from the bathroom wall and keeps it in his walker pocket to call for help but staff usually take a long time to respond. R200 then pulled out a call gadget from the walker holder to show the same. R200 also stated that sometimes his walker is not within reach to access the call light gadget. R200 stated he wanted to go to the dining room and asked if he could be wheeled downstairs. R200 was requested to push the call	S9999		

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S9999	Continued From page 7	S9999		

light that was in his walker, and he did so. After waiting for about ten minutes, with no response from staff, V4 (Director of Wellness) was flagged down the hallway outside R200's room. V4 stated that she did not notice any call monitors on. When V4 came into R200's room and asked where his neck call alert pendant is, R200 repeated that it was broken two years ago. When V4 asked R200 if he had told anybody about it, he replied that he told "about ten people" over the course of time. V4 remarked that she was new to the facility and will ensure that R200's call pendant is replaced right away. V4, at a later time clarified that the call button should alert the nursing aides pager and alert her in her office and a monitor on the first floor. V4 added that the bathroom call garget has to be pressed down hard for it to work.

On 05/16/23 at 11:18 AM, R200 was seen in the dining room with a call pendant around his neck. R200 remarked "I finally got it after asking for it for two years. When I fell in the room, I just lay there (about 45 minutes) and called and called until somebody found me."

Facility falls incident logs for falls in room since January 2023 included that R200 fell on 1/22/23, 4/7/23, 4/11/23.

Post fall evaluations for 1/22/23 included as follows: R200 fell in his room and was found in sitting position next to his bed with walker in front of him. R200 was attempting to use the bathroom without assistance. R200's call button was not within reach and resident's room was extremely cluttered. R200's dinner tray was on the floor. This was a huge concern and brought up to management. Educated R200 on having his call light on his person and waiting for assistance.

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S9999	Continued From page 8 Post fall evaluation for 4/7/23 had only check marks on categories specified which included as follows: R200 found in his room, post fall position on back, clutter in surroundings, change in ability to transfer/ambulate for risk factors. No further interventions were specified. Post fall review for 4/11/23 included as follows: R200 fell in his room. R200 observed on floor with kneeling position. Stated that he got out of the bathroom and his pants fell. Tripped and lost balance and fell on knee and hit the floor. Fall interventions prior to fall included : adjust bed at lower position, toilet around schedule, answer call light as soon as possible. New fall interventions: adjust bed at lowest position, toilet around schedule, answer call light as soon as possible. R200's Service Care plan included: At risk for falls due to room being severely cluttered, has hoarding issues. Fall interventions are: clutter free, assistive devises available and in good repair, personal items and call devise within reach (date initiated 08/6/2022, revision on 02/09/23). Facility policy and procedure for accidents/Falls (November 2019) included as follows: Policy: The community strives to promote safety, dignity, and overall quality of life for its residents by providing an environment that is free from any hazards for which the community has control and by providing appropriate supervision and interventions to prevent avoidable accidents. Procedure: 8. A post-fall assessment will be conducted following any fall episode. Once the post fall assessment is completed by the Director of Wellness (DOW), the DOW or designee will seek	S9999		

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S9999	Continued From page 9 additional input from the interdisciplinary team and other staff. 9. The resident's individualized care plan is to be updated with changes or new interventions post fall/incident/accident, communicated to the appropriate staff, and implemented. (B)	S9999		