STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006571	A. BUILDING: _____ B. WING _____	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIDGE GARDENS	7001 WEST CULLOM NORRIDGE, IL 60634

(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 #2470154/IL168462	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.1640a)1)2) 300.1650a) 300.1650b) Section 300.610 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 by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006571	A. BUILDING: _____ B. WING _____	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIDGE GARDENS	7001 WEST CULLOM NORRIDGE, IL 60634

(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
S9999	Continued From page 1	S9999		

includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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 300.1640 Labeling and Storage of Medications

a) All medications for all residents shall be properly labeled and stored at, or near, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006571	A. BUILDING: _____ B. WING _____	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIDGE GARDENS	7001 WEST CULLOM NORRIDGE, IL 60634

(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
S9999	Continued From page 2	S9999		

nurses' station, in a locked cabinet, a locked medication room, or one or more locked mobile medication carts of satisfactory design for such storage. (See subsections (f) and (g) of this Section.)

1) These cabinets, rooms, and carts shall be well lighted and of sufficient size to permit storage without crowding.

2) All mobile medication carts shall be under the visual control of the responsible nurse at all times when not stored safely and securely.

Section 300.1650 Control of Medications

a) The facility shall comply with all federal and State laws and State regulations relating to the procurement, storage, dispensing, administration, and disposal of medications.

b) All Schedule II controlled substances shall be stored so that two separate locks, using two different keys, must be unlocked to obtain these substances. This may be accomplished by several methods, such as locked cabinets within locked medicine rooms; separately locked, securely fastened boxes (or drawers) within a locked medicine cabinet; locked portable medication carts that are stored in locked medicine rooms when not in use; or portable medication carts containing a separate locked area within the locked medication cart, when such cart is made immobile.

These requirements were not met as evidenced by:

Based on observations, interviews and record reviews, the facility failed to safeguard a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006571	A. BUILDING: _____ B. WING _____	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIDGE GARDENS	7001 WEST CULLOM NORRIDGE, IL 60634

(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
S9999	Continued From page 3	S9999		

medication that led to a confused resident (R1) ingesting that medication. The facility failed also failed to supervise R1 to prevent R1 from ingesting another resident's medication. This failure resulted in R1 being hospitalized for drug overdose, fast heartbeat, and altered mental status.

This applies to one out of seven residents (R1) reviewed for supervision with medication.

Findings include:

On 1/9/2024 at 12:50 PM, V4 (ADON-Assistant Director of Nursing) said an incident occurred between the hours of 4:30 AM to 5:00 AM. He said V19 (RN-Registered Nurse) received a delivery from pharmacy on 12/17/2023 at 1:13 AM. Soon after delivery, V19 left the medication on top of V20's (RN) medication cart which was inside a locked unit. V19 did not inform V20 of the delivery. Around 4:30 AM, V21 (CNA-Certified Nurse Assistant) saw R1 walking around the unit and holding a bingo card of medication (Chlorpromazine 25 mg (Milligrams), 30 tablets). The medication she was holding was for another resident. V21 noticed that 18 tablets were popped. V21 found 8 tablets on the floor. Ten tablets were not found. R1 was noted to have a whitish substance on her mouth. R1 was brought to her room and was assessed. R1's heart rate was 116 beats per minute. R1 became lethargic and she was sent to a local hospital where admitting diagnoses were drug overdose, tachycardia and altered mental status.

R1's Admission Records showed her original admit date was on 11/10/2022. R1 was discharged to a local hospital on 12/17/2023 and was readmitted on 12/20/2023. Diagnoses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006571	A. BUILDING: _____ B. WING _____	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIDGE GARDENS	7001 WEST CULLOM NORRIDGE, IL 60634

(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
S9999	Continued From page 4	S9999		

include accidental poisoning by unspecified drugs, medications and biological substances and dementia. R1's MDS (Minimum Data Sheet) dated 11/10/2023 documented R1's cognition as moderately impaired and needed supervision or touching assistance with ambulation. R1's MDS dated 12/28/2023 documented R1's cognition as severely impaired and needed supervision or touching assistance with ambulation.

On 1/9/2024 at 10:12 AM, V7 (RN) said the incident could have been avoided if the medications were secured and if staff were aware that R1 was walking around the unit at that time.

On 1/9/2024 at 12:19 PM, V17 (NP-Nurse Practitioner) said R1 accidentally ingested unknown amounts of Chlorpromazine 25 mg and became lethargic that is why she was sent to a local hospital for further evaluation. She said Chlorpromazine is very sedating and caused R1 to be lethargic. She said if medications were properly stored and if staff saw R1 walking around, the incident would not have happened.

On 1/9/2024 at 12:30 PM, V4 (ADON) said R1 would not have accidentally ingested 10 tablets of Chlorpromazine 25 mg if the medication was properly stored and if R1 was supervised while walking around the unit.

On 1/9/2024 at 12:50 PM, V3 (DON-Director of Nursing) said the incident would have been avoided if the medications were secured in the medication cart or the medication room as she expects the nurses to do. She said she expects the nurses to store all medications in the medication cart or the medication room for safety and security reasons and so nobody, including residents, staff, or visitors, could get access to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006571	A. BUILDING: _____ B. WING _____	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIDGE GARDENS	7001 WEST CULLOM NORRIDGE, IL 60634

(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
S9999	Continued From page 5	S9999		

the medications.

On 1/9/2024 at 1:21 PM, V18 (Psychiatric NP) said side effects of Chlorpromazine includes lethargy and dizziness, EPS (Extra Pyramidal Symptoms). She said Chlorpromazine causes tachycardia. She said R1 was sent to the hospital so she can be closely monitored after accidentally ingesting Chlorpromazine.

On 1/11/2024 at 9:18 AM, V3 (DON-Director of Nursing) said R1 would not have accidentally ingested Chlorpromazine if she was being supervised while walking around the unit.

R1's Hospital Records dated 12/18/2023 at 7:30 AM documented R1 came to ER (Emergency Room) due to altered mental status and drug overdose. Upon arrival to ER, R1 was very somnolent and arousable only to painful stimuli. Diagnosis was altered mental status and drug overdose.

Facility's Storage Medication Policy revised on March 2020 states the following: ..." Policy Statement: The facility shall store all drugs and biologicals safely, securely, and orderly. ...Locked Compartments...7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others."

Facility's Policy titled Safety and Supervision of Residents revised in March 2020 stated the following: ..." Policy Statement: The facility strives to make the environment as free from accident hazards as possible. Resident safety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006571	A. BUILDING: _____ B. WING _____	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORRIDGE GARDENS	7001 WEST CULLOM NORRIDGE, IL 60634

(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
S9999	Continued From page 6 supervision and assistance to prevent accident is a priority. ... 7. Resident supervision is a core component of the system's approach to safety." (A)	S9999		