Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003453	A. BUILDING: ______ B. WING ______	C 11/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW REHAB & NURSING CENTER	6450 NORTH RIDGE BLVD CHICAGO, IL 60626

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S 000	Initial Comments Complaint Investigation #1786232/97638 No Def #1786332/97743 F323 #1786423/97848 F204 F157 Incident Report Investigation to Incident of 11/1/17/IL98039 F323	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)6) 300.2900d)2) 300.3240a) 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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 300.2900 General Building Requirements

d) Doors and Windows
2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

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THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:

Based on interview and record review, the facility failed to supervise two residents, which resulted in one resident (R2) falling from a third floor window, and one resident (R1) eloping from the facility. The facility also failed to follow their elopement policy by not reporting the resident elopement to the Police, the Administrator or the Director of Nursing for over four hours. Four residents (R1, R2, R3 and R5) were reviewed for falls and supervision in a total sample of 12.

This failure resulted in one resident (R2) sustaining multiple bone fractures.

Findings Include:

1. The medical record documents R2 as a 63 year old admitted to the facility on 9/26/17. R2 has diagnoses of, but not limited to, bipolar disorder, Alzheimer's disease, other schizophrenia, agitation and anxiety.

Interview on 11/14/17 at 1:45 PM E3 ADON (Assistant Director of Nursing) stated " I was leaving the office at the end of the day, I forgot something so I parked the (car) in front of the building. I saw someone lying on the ground. I noticed it was a new resident. I called for help. The receptionist and the first floor nurse came out to help. We kept R2 immobile. We assessed R2 and called 911. I didn't see any injuries. R2 was able to speak, he/she didn't say what happened, she/he just kept repeating "I'm trying to get to my daughter." The EMT (Emergency Medical Team)

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S9999	Continued From page 3 and the police came, and took R2 to the hospital. I then went inside and called the DON (Director of Nursing) and the Administrator. The Final Incident Investigation Report written by E2 DON documents, date and time of incident 9/28/17 at 5:15 PM. The admitting hospital reported upon inquiry that resident (R2) was admitted for extensive injuries due to fractures of some bony prominences. Investigations and reports did not give us any clue of how resident might have sustained such injuries. Resident was last seen in her/his room and within the next two hour rounds resident was noted on the spot in front of the building, where he/she was transferred for evaluation. Interview on 11/14/15 at 2:30 PM E9 LPN (Licensed Practical Nurse) stated that I pass med's (medications) between 4:00 and 6:00 PM. It is a very busy time. I saw R2 around 4:30 in her/his room. Before that R2 was very agitated, going in other residents rooms, the nurse on the previous shift said R2 was trying to get off the floor. R2 was very confused all the time. Her/his roommates are also confused. On 11/9/17 at 12:45 PM E1 Administrator and E2 DON stated in reference to R2, no alarms went off, we checked the videos, R2 did not go out the doors. The window frame in R2's room was picked at. The window and screen was intact. I had the window boarded up. The ADON was going home and saw R2 outside at about 5:30 PM on 9/28/17. R2 was able to speak, but did not say what happened. R2 was found below her/his room window. We are assuming he/she jumped out the window. On 11/9/17 at 12:00 PM E5 Maintenance Director	S9999		

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stated they called me in to check the window in R2's room. The window frame was tampered with, the frame was pried apart and the screw inside the frame, that holds the glass was gone. The window on the bottom has two panes of glass sandwiched together. One pane of glass was missing. The other pane was still in the window, but only in place by the epoxy seal on the top of the frame, it was loose. The tamper guard that keeps the window from being raised to high was tampered with, but still intact in the window frame. The Housekeeper, E8 told me when he got to R2's room, the one pane of glass was still in the window, the other pane was resting against the wall below the window.

On 11/9/17 at 1:20 PM E8 stated in Spanish, interpreted by E5, stated that when he got to R2's room, the window had one pane of glass still in the window frame and the other pane of glass was leaning against the wall under the window. The window screen was pushed up. I took the glass pane downstairs to the maintenance room.

On 11/9/17 at 3:00 PM E1 stated " I did not know about the extra pane of glass, when I saw the window it had glass in it. They (E5 and E8) did not tell me it was a double paned window, and I did not know the screen was pushed up."

Progress Notes by E2 dated 9/27/17 for R2 document Resident demonstrates poor impulse control by opening doors, triggering alarms, not sitting still, intruding on other residents by getting in to their personal space and belongings, not easily re-directed.

The MDS (Minimum Data Set) dated 9/28/17 documents R2 as severely impaired cognition.

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S9999	Continued From page 5 The Elopement Risk Tool for R2 dated 9/28/17 documents the resident is confused at time and place and has the ability to leave the building. Types of Interventions: staff aware of resident on wander/elopement risk, exit and stairwell alarms, frequent monitoring. Comment: Resident is very confused and attempts to leave the floor. Resident resides on the third floor and is supervised at all times. Cat Scan of the lower left extremities results from the local hospital dated 9/28/17 document R2 has a badly comminuted intra articular open fracture of the calcaneus, Minimally displaced fracture of the lateral malleolus, chip fracture off the dorsal anterior aspect of the talus. X-ray of the pelvis dated 9/28/17 for R2 document an acute comminuted fracture of the intertrochanteric area of the left femur with a coxa vera deformity. Cat Scan of the pelvis dated 9/28/17 for R2 document acute compression fractures of L1 and L2 (lumbar spine), fractures of L5 transverse processes extending into the vertral body and involving the spinous process, multiple bilateral fractures of the sacrum with spinal canal stenosis, multiple fractures of the pelvis, hematoma and hemorrhage. 2. The medical record documents R1 as a 43 year old admitted to the facility on 7/16/16. R1 has diagnoses of but not limited to schizophrenia, agitation, major depressive disorder, restlessness and generalized anxiety. The Missing Person Incident Report of 9/29/17 written by E2 DON for R1 documents date of incident 9/29/17 at 4:00 AM. Staff immediately search the surrounding area, staff searched the facility, lower level. MD (Medical Doctor) notified at 9:00 AM, Family notified at 9:00 AM, Police	S9999		

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S9999	Continued From page 6 9:30 AM, Administrator Notified at 9:00 AM. On 11/9/17 at 9:00 AM via telephone E6 LPN (Licensed Practical Nurse) stated, " I did rounds at about 3:00 AM (R1) came to the Nurse's station and asked for paper, then went back to his/her room. At 4:00 AM the CNA (Certified Nursing Assistant) noticed (R1) was not on the floor, we searched the floor, around the building. The first floor Nurse heard an alarm, they called me. No one saw (R1) go out. (R1) went out the first floor back door. We searched the perimeter. The door alarm never went off. I didn't call the police, or the Administrator, time just got away from me. I know the protocol is to call the Police and the Administrator. This has never happened to me before." On 11/8/17 at 1:30 AM E2 DON (Director of Nursing) stated the alarm went off on the first floor. R1 was on the third floor. The first floor back door alarm went off. The Nurse and CNA went to the alarm door. The third floor alarm did not go off. The video shows R1 was picking at the alarm on the third floor door and disarmed it. They did a head count and found out R1 missing. E6 texted me at around 4:30 AM, she did not call. Around 7:00 AM E6 called and told me what happened, I told her to call the Police and the family. I called E1, but she did not receive the call. The Police arrived around 9:00 AM. R1 was gone 5 days. The Kane County Police called and stated they found R1 and R1 was in custody for warrants under his/her name. R1 has been here for over a year, I don't know of any problems. R1 cannot go out alone, he/she has to have supervision. On 11/8/17 at 4:15 PM E1 stated that I did not find out about R1 leaving until I got to work at	S9999		

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S9999	Continued From page 7 9:00 AM. The nurse should have called me, the Police and the DON, that is the protocol. On 1114/17 at 12:00 PM by telephone E7 CNA stated that E6 and myself worked the third floor the night R1 left. We looked on all the floors and outside. The third floor alarm did not go off. Someone on the second floor told me the outside door alarm went off so I went outside. I drove around the neighborhood with another CNA but we didn't see R1. E6 stayed on the floor. On 11/8/17 at 2:00 PM with E5 observed third floor alarm above the door. There were two exposed wires connected to two screws, and a wire connected to a box above the screws. Writer asked E5 if you pull the wires off the screws would that disarm the alarm and E5 stated yes. Writer was able to reach the wires and screws. E5 stated he checks the alarms monthly. The alarm for the outside doors only sounds at the first floor Nurse's Station, not any of the other floors. I changed the codes after R1 got out. The facility policy titled Facility Policy Regarding Missing Residents and Elopement ,undated, documents : Should a thorough search for the resident prove unsuccessful, the Administrator or designee shall make a report of the incident to the local law enforcement emergency response system within 2 hours. (A)	S9999		