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 03/10/2022

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

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S 000	Initial Comments Complaint Investigation 2291576/IL144014	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. Section 300.1210 General Requirements for Nursing and Personal Care 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. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to provide appropriate and sufficient supervision, and failed to provide adequate interventions for a resident to prevent him from falling and sustaining injuries. This failure affected one resident (R7) who had two falls within one week with injuries requiring hospital evaluation. Findings include: R7 is an 80-year-old man who has resided in the facility since 2018 with the following past medical history: Hypertensive heart disease without heart failure, Sepsis Unspecified organism, Cerebrovascular disease, Hemiplegia unspecified affecting right dominant side, Dementia, Essential primary hypertension, Dysphagia oral phase, unsteadiness on feet, need for assistance with personal care, Senile entropion of unspecified eye etc.	S9999		

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S9999	Continued From page 2 On 2/28/2022 11:55AM, R7 was noted in bed alert, and awake, states that he is doing okay. He does not remember how long he has been in the facility. Bed in low position, wheel- chair noted at bedside, no floor mats. On 2/28/2022 at 2:13PM, V7 (Restorative Nurse) said that when there is a fall, the care plan is updated, she is not sure of the time period, they will do investigation and update as necessary. Fall is considered an incident, sometimes, the intervention may have been there and becomes a repetition, but care plan should reflect a revision date. On 2/28/22 at 2:39PM, V4 (Wound Care Nurse) said that she is familiar with R7, he is a total care and a fall risk. R7 had a fall on 1/14/2022, she was working on the floor when the C.N.A notified her, resident was on the floor, when she got to the room, he was sitting in his wheelchair in his room before the fall, he may have tried to get up. Resident sustained an injury in the same site he had one after the last fall, he was sent to the hospital. On 2/28/22 at 4:00PM, V20 (RN) said that R7 is a very high fall risk, he requires staff assistance for transfer and eating, resident is also disoriented and incontinent of bowel and bladder. V20 added that R7 should not be in his room by himself. He should always be at the nursing station when not in bed. Review of R7's care plan initiated 11/01/2016 and revised 10/16/2018, 5/4/2020, 5/12/2020 and 2/08/2022 states: I am at risk for falls r/t Use of Cardiovascular medications, Cerebrovascular Accident (CVA), Hemiplegia, Arthritis, and Visual	S9999		

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S9999	Continued From page 3	S9999		

impairment; I had a fall with injury and sutures to head on 5/4/2020. Interventions include to encourage resident to sit back in wheelchair, frequent observation to assist resident in sitting back in w/c.

Facility Minimum Data Set (MDS) assessment dated 12/28/2021 section C coded R7 scored a BIMs of 00, section B coded R7's vision as moderately impaired, and section G coded him as 4/2, indicating extensive with one-person physical assist for transfer, eating and toilet use. Facility fall incident presented by V1 (Administrator) showed that R7 had an unwitnessed fall in his room on 1/09/2022 and sustained a laceration on right side of forehead; and was sent to hospital for evaluation. R7 had another unwitnessed fall in his room 5 days later, on 1/14/2022, sustained an injury at the same site and was also sent to the hospital for evaluation. Resident's care plan was not revised or updated after both fall incidents.

Progress note dated 1/09/2022 at 21:40 states; Called to resident's room by roommate after he states he heard a loud noise in the next bed. Writer and nursing staff observed resident laying on his right side in a fetal position with blood on the floor surrounding the resident's head. Another progress note dated 1/14/2022 at 22:06 states: Roommate call for help, went to attend the call noticed resident on the floor with face down.

Hospital record dated 1/14/2022 states that resident was brought for treatment after falling face forward out of his wheelchair, similarly, this happened about 5 days ago, he was in the same emergency room with laceration and was admitted for COVID-19. The same hospital record listed clinical impression as intraparenchymal hematoma of right side of brain due to trauma

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S9999	Continued From page 4 without loss of consciousness, facial laceration and COVID-19. On 3/01/2022 at 10:34AM, V1 said that if someone falls out of bed, they can lower the bed and put down a floor mat. R7 was falling out of his wheelchair, not from bed. He is very particular about the time he wants to go to bed and if staff put him in the room, he might try to get out of the chair by himself. He is usually in the nursing station or dining room; he is not supposed to be in his room by himself. V1 also said that the facility has used alarms in the past for fall prevention, but they just make annoying noise every time the resident moves. It was not helping so she got rid of them. A document presented by V1 (Administrator) tilted fall prevention policy (Undated) states its purpose as to ensure safety to all residents within their functional abilities, maximizing their independence and minimizing their risk for falls and associated injuries. Some of the interventions that could be used to prevent falls include placing a pad, mat or mattress next to the bed on the floor, chair/bed alarms to alert staff of resident movement, keeping resident at the nursing station for supervision. Another document also presented by V1 titled Care Plan (Undated) states that all residents will have a comprehensive assessment and an individualized plan of care developed to assist them in achieving and maintaining their optimal status. Under item 8, the document states in part that care conferences for review and revision of resident's care plan are scheduled at a conducive time...when a change occurs in a resident's condition...the care plan is then reviewed and updated.	S9999		

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S9999	Continued From page 5 (A)	S9999		