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
	IL6001697	A. BUILDING: ____ B. WING ____	C 06/14/2022

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 2294242/IL147469	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.690c) Section 300.690 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 a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. 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. These requirements are not met as evidenced by: Based on interviews, and records reviewed the facility failed to report a missing resident (R11) to the required state agency. This failure affected one resident (R11) who left the facility in the middle of the night on 5/20/2022 and has not been located since.	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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S9999	Continued From page 1 Findings include: R11's was admitted to the facility on 7/29/2021. Page one of the Nursing Facility Placement Assessment Summary information dated 8/2/2021 (PASSAR) and faxed to the facility per cover sheet documents R11's mental health history as follows: History of multiple psych hospitalizations, chronic homelessness, eloping from NF's (nursing facilities). On 6/1/2022 at 1:35 PM V32 (Nurse) states on the evening of 5/20/22 she got report at 10:30 and made rounds at 10:45pm. At 10:45 pm R11 was sleeping. V32 states she then did her nursing work. V32 states about 12:00am R11 was still in bed. At around 2:00 PM V32 states she heard a door alarm from the north side of the hallway. V32 states she was giving medication to a patient in their room. I heard the door alarming and immediately ran and to check everyone. While I was running towards the door, I was checking rooms. V32 states she opened R11's door and didn't see anyone, and she and another nurse went outside to check the street and bushes. We checked all around the building and round where cars are also, and we did not see R11. CNA started checking residents. When we went back inside the nurse and the CNA did a head count and said R11 was not there. We checked other floors, bathrooms and all doors and anywhere he may be. V32 states they did not find R11. V32 states she called the DON and Administrator and they advised her to call the police. On 6/1/2022 at 2:26 PM V1 (Administrator) states R11 left the facility in the middle of the night on 5/20/2022. At 3:23 PM V1 states R11 had a	S9999		

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S9999	Continued From page 2 history of leaving AMA from facilities. He was listed as an elopement risk on PASSAR. Elopement is a resident unfit to leave facility themselves. If a resident is unfit to leave, then we notify IDPH. V1 states the facility stopped looking for the resident 3 days later. V1 states he has no knowledge where R11 is. On 5/31/2022 at 3:02 PM V5 PRSC states "It's the administration's responsibility to report to IDPH an elopement." V5 states she does not know where R5 is. "Anyone who has a history of elopement, I would consider them at risk." Showed V5 a copy of PASSAR dated 8/2/22. V5 stated, "I should have been aware of his history. If I'd known he had a history of elopement, I would have noted it on the assessment, care plan, and documented it in his notes." On 6/1/2022 at 2:20 PM V2 (DON) states, "I don't believe one was done," when asked for the community survival skill assessment for R11. On 6/2/22 at 9:37 V7 (Social Worker) states he had never seen PASSAR before today. V5 states, "I have never seen it before today. I'm seeing that he is a risk for elopement. Had I seen that previously, I would have done the elopement-risk-protocol. V5 states, an "elopement is a situation whereby a resident leaves the facility unauthorized." V5 states, "This is an elopement because with an AMA (Against Medical Advise) there is documentation. The whole facility knows this is an elopement. I called all my team members. They were aware." On 5/31/2022, Review of IDPH reportable incidents for the facility is absent for any report for R11's elopement.	S9999		

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S9999	Continued From page 3 R11's care plan is absent of any plan for elopement risk. The facility's Missing Resident policy documents the following: Policy: It is the policy of this facility to report and investigate all reports of missing residents. (C)	S9999		