

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6016216	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/01/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIMENSIONS LIVING BURR RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 Licensure Post Visit to the Annual Licensure Survey of 05/18/2023. 330.710a) written	S 000		
S9999	Final Observations Statement of Licensure Violations 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 facilities 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 observations, interviews and record reviews the facility failed to follow smoking policy guidance to provide supervision and provision of smoking paraphernalia in a designated smoking area. The facility also failed to update R201's Service Plan with smoking interventions after reassessment of R201's smoking safety. This applies to 1 of 1 residents (R201) reviewed for smoking in a sample of 6. The findings include:	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6016216	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/01/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIMENSIONS LIVING BURR RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 1</p> <p>Service Plan, initiated 10/29/23, shows R201's diagnoses included alcohol use, nicotine dependence, seizures, depressive episodes, chronic obstructive pulmonary disease, and hypertension.</p> <p>On 10/26/23 at 1:15 PM with V4 (Registered Nurse), there were 17 black, round holes the size of the diameter of a cigarette in front of R201's sofa in his room. At 2:46 PM, V4 stated she could not think of anything else the black holes in the carpet could be other than cigarette burns.</p> <p>Progress note, dated 10/7/23, shows, "After writer brought resident outside to smoke 2 cigarettes this [morning] RA (Resident Assistant) then assisted him back to his apartment. Writer smelled smoke in the hallway and then entered his apartment and observed smoke in the room and resident was dying his cigarette butt out on his carpet. Resident didn't end up smoking both cigarettes outside and took one back to his room without RA being aware. Writer explained the importance AGAIN of not smoking in community and especially putting cigarettes out on the floor. Resident states he understands and unsure of why his did this. Manager on duty made aware. Daughter notified. All staff on duty made aware of resident not being able to have any lighter on him or in his room. All lighter and cigarettes to be kept in nurses office or front desk. Staff will need to light cigarette for resident and he is to only have 1 at time. Work order put in due to burnt carpet."</p> <p>Smoking Observation Tool, effective 10/10/23, shows R201 had a history of unsafe tobacco use, had burns or holes in clothing or furniture, had a history of non-compliance in other settings, required staff to store matches or cigarettes at the wellness station for safety, can not dispose of</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6016216	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/01/2023
NAME OF PROVIDER OR SUPPLIER DIMENSIONS LIVING BURR RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
S9999	<p>Continued From page 2</p> <p>ashes/cigarette butts in a safe manner, has a hand injury and wears a brace on the right hand. The smoking observation tool evaluation results concludes R201 is safe to smoke, does not need to be supervised while smoking, nurses will give only one cigarette and will light the cigarette when smoking, and nurses will not leave lighters with residents.</p> <p>R201's Service Plan for Tobacco Use (initiated 9/2/23 and provided on 10/26/23 prior to 12:00 PM for review) shows interventions for R201 include, "Assistance required for: escorts to smoking area, light cigarette." The service plan fails to include R201's interventions of nursing storing R201's cigarettes/lighter, offering only one cigarette at a time, or providing R201 a smoking apron while smoking.</p> <p>On 10/26/23 at 3:00 PM, V8 (Resident Assistant) stated she worked with R201 and took him to smoke cigarettes since March 2023. V8 stated she was not aware of a limit as to how many cigarettes he was supposed to have at one time.</p> <p>On 10/26/23 at 12:12 PM, V6 (Service Coordinator) stated she created R201's service plan. V6 reviewed R201's service plan and stated R201's safe smoking interventions were not listed in his service plan. V6 stated the facility nurses were required to store R201's cigarettes and lighter and staff were to go to the reception desk for R201's smoking apron when he requested to smoke. V6 stated, "All nurses should know he needs a smoking apron." V6 also stated all staff should be aware that R 201 was limited to one cigarette at a time when smoking.</p> <p>On 10/26/23 at 12:01 PM, V4 (Registered Nurse)</p>	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6016216	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/01/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIMENSIONS LIVING BURR RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 3</p> <p>stated the nurses keep R201's cigarettes and lighters in the nursing office drawer and she was instructed to provide R201 only one cigarette at a time when he wanted to smoke. V4 stated she was instructed that she must light R201's cigarette when she provided his cigarette and could provide him another cigarette if he finished his first and requested a second. V4 stated R201 did not need to be provided a smoking apron when he smoked.</p> <p>On 10/26/23 at 11:30 AM, V3 (Activities Director) stated R201 was the only smoking resident in the building. V3 stated she completes the smoking assessments for resident and stated R201's safe smoking interventions included the nurses storing his cigarettes and lighter and only providing R201 one cigarette at a time. V3 stated R201's interventions also included wearing a smoking apron while smoking and staff to "keep an eye on him" while he is smoking. V3 stated he is allowed to smoke alone outside if he has his apron on, but is not allowed to light his own cigarettes. V3 reviewed R201's service plan and stated the service plan interventions should include nurses to store his cigarettes/lighter, nurses to light his cigarette, nurses to only allow R201 to have one cigarette at a time, and R201 to be wearing a smoking apron while smoking. V3 stated R201's intervention of only being provided one cigarette at a time was in place before her 10/7/23 smoking assessment and should have also been included on the 6/2023 smoking assessment. V3 stated she was uncertain why the interventions of offering one cigarette at a time, nurses to hold R201's cigarette/lighter, and R201 to wear a smoking apron while smoking, were not listed in R201's service plan. V3 stated staff do not have to sit with R201 to watch him smoke, but just watch to see when R201 needed to return into the</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6016216	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/01/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER DIMENSIONS LIVING BURR RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 4 building.</p> <p>On 10/26/23 at 1:24 PM with V7 (Skilled Care Plan Coordinator), V2 (Director of Nursing) stated the facility was not specific in R201's care plan with his safe smoking interventions. V2 stated a previous version of R201's care plan contained his interventions but, when reviewed, his current care plan did not include R201's safe smoking interventions including his cigarettes ad lighter to be stored with nursing or that R201 should only be given one cigarette at a time.</p> <p>On 10/26/23 at 10:20 AM, V1 (Administrator) stated R1 was supposed to be "supervised by staff most of the time, but sometimes refuses to have staff stand with him" and monitor his smoking. V1 stated, "He is alert and oriented and can make his own decisions."</p> <p>Facility Smoking Policy/Procedure, revised 5/2020, shows, "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 upon results of the assessment, safety materials may be provide such as apron, cigarette holder, and supervision as needed."</p> <p>Facility Plan of Correction, dated 8/2023, shows, "Corrections for the example(s) cited: R201- Update to R201 service plan for smoking....4. The facility will monitor the corrective actions put into place to prevent reoccurrences: ...Update to any care plans and provide audit to QAPI (Quality Assurance Performance Improvement) by accomplished date or until IDT (Interdisciplinary Team) determination...."</p> <p>(B)</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6016216	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/01/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER DIMENSIONS LIVING BURR RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 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