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 04/18/2024

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 2490303/IL168649, 2490336/IL168687, 2490509/IL168912 Facility Reported Incident 02/29/24 IL170677	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3) 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	S9999		

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S9999	Continued From page 1 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 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for	S9999		

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further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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 were not met as evidence by:

Based on interviews and records reviewed the facility failed to develop a plan of care to prevent a resident with a history of suicidal ideation from obtaining items that can cause self-harm. The facility also failed to develop interventions for one resident (R4) with a history of suicide ideation with a plan for skill groups, including suicide prevention group, and failed to provide therapeutic programming. The facility failed to develop a plan for check in to assess daily mood or notify the attending psychiatrist of R4's change in mood which documents feeling down, depressed, or hopeless nearly every day. This failure affected one of three residents (R4) reviewed for safety and supervision in the sample. This failure resulted in R4 being able obtain a belt and was found hanging from a towel rack on the bathroom floor on 02/29/24. R4 was pronounced dead in the hospital on 3/5/24.

The findings include:

R4 with a diagnosis including, but not limited to: Borderline Personality Disorder, Spondylosis with Radiculopathy, Schizoaffect Disorder, Major Depressive Disorder, Anxiety Disorder, Restless Leg Syndrome, Suicidal Ideations, and Bipolar

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S9999	Continued From page 3 Disorder, Current Episode Mixed, Severe without Psychotic Features. R4 was admitted to the facility on 2/15/24. R4 was assessed on 2/22/24 to have a BIMS (Brief Interview of Mental Status) of 15 indicating R4 is cognitively intact. R4's medication administration record dated 2/1 through 2/29/24 includes behavior monitoring every shift with documentation stating the letters "NA" on 2/28/24 on evening and night shifts. (The two shifts prior to R4 being found.) According to the facilities final investigation of incident occurring on 2/29/24, R4 observed lying on the floor unresponsive, staffed observed a belt around R4's neck and Cardio Pulmonary Resuscitation (CPR) was initiated. R4 was transported to the hospital for evaluation. The facility was informed that R4 died from his self-inflicted injuries. On 3/8/24 at 10:25AM, V14, Licensed Practical Nurse (LPN), said "(V15, Certified Nursing Assistant (CNA)), came to get me and said (R4)'s roommate, (R8), could not get in the room. I went down to the room. When I got there the Director of Nursing (DON), V15, and I tried to get in the room so we pushed the door in." V14 explained the bathroom door was open against the room door blocking it from opening. V14 said the first person in the room was the Director of Nursing. V14 said "When we got the room open and I went in, I saw (R4) half out the bathroom, with his feet out the bathroom, half his body in the bathroom and half out, and he was face down. We flipped him over and saw a belt around his neck, it was buckled on his neck. (V15) took the belt off. I didn't see if (R4) had any marks on his neck. I got the pulse ox (Oximeter) device and I took carotid pulse. (R4) was purple, I don't recall if his eyes	S9999		

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were open or closed. (R4) was the only resident in the room and there is no other entrance to the room. It looked like the belt was on one part on the towel rack, the end was tied in a knot." V14 said 911 took R4 to the hospital. V14 said she later found out R4 was on a vent a few days later. V14 said she had seen R4 sitting on his bed talking to R8 and the last time she saw him was around 9:40AM. V14 said regarding her charting in the Medication Administration Record (MAR) she charted "NA" because "NA" and none basically stand for the same thing.

On 3/14/24 at 12:31 V10, Director of Nursing, said "I am not sure what NA means on the MAR." At 12:46PM, V10 said none and nonapplicable are not the same. V10 said "NA means that situation does not apply, we should say none not NA."

On 3/8/24 at 10:49AM, V6, Psychiatric Rehabilitation Services Coordinator (PRSC), said R4 was calm and there was nothing out of the ordinary. V6 said R4 had a history of homelessness. V6 said R4 said he planned to be here short term. V6 said "I did a 1:1 session with (R4) on 2/28/24, the day before the incident because he was in cigarette room and so was I." V6 said R4 was placed in Symptoms and Behavioral Management because of his history with suicide. V6 said "We have a safety contract, I got him to sign it for the suicide and I did the suicide risk assessment. I believe (R4) had been hospitalized before admission for suicide attempt and depression. The information is in the referral packet. I don't recall the method he used."

On 3/8/24 at 12:09PM, V16, Housekeeping, said (in Spanish, with designated Spanish Speaking Surveyor) "The roommate, (R8), called me over

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to him near the door to his room. The bathroom door was blocking the room door from opening. I peeked around the door and I saw (R4) on the floor. I ran to the CNA and she told the nurse. I thought there was a fabric tied from the towel bar to his body, but I didn't stay to see where it was tied. I saw (R4) was face down." V4 said this was around 12:10PM. On 3/14/24 at 11:38AM V16 said the police took the towel bar when they came in.

On 3/8/24 at 12:47 PM, V8, CNA, said "I was not assigned to (R4). I had seen him at breakfast. This happened before lunch."

On 3/8/24 at 1:25 PM. V17, CNA, said "I arrived to work at 7:00AM on 2/29/24. I did my rounds, (R4) was awake." V17 said R4 went to eat breakfast in the dining room. V17 said "I peeked in on (R4) about 11:30 AM, both residents (R4 and R8) were watching television in the room. I then went to break. I was outside and saw the ambulance and police cars. I thought that was crazy, he was just ok, laughing, and making jokes. It's weird that they said he tried to kill himself, I never got that vibe. I'm not sure if he had a history of suicide. If I had known, I may have checked on him more often."

On 3/8/24 at 2:04PM, V18, CNA, said some residents are at more risk for suicide. V18 said no one was on suicide risk watch on 2/29/24 on the second floor.

On 3/8/24 at 2:19PM V10, Director of Nursing, said on 2/29/24, V15 knocked on her office door and told her R4 was on the floor. V10 said "I went to (R4)'s room and I moved the room door a little, his legs were blocking the door. When I got in the room, I saw an object on (R4)'s neck. I

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S9999	Continued From page 6 untied it, a belt, it was around (R4)'s neck and the other end was on the bar." V10 said R4 was bluish/purplish. V10 said the towel bar stayed attached to the wall, there were 2 knots on the towel bar. R4 was face down. R4 was dressed. V10 said there was blood on the floor, it came from the side of R4's head. V10 said there is only one entrance to the room. V10 said "I don't know where R4 got the belt from." V10 said Cardio Pulmonary Resuscitation was initiated. V10 said 911 arrived and took over. V10 said the police took the belt. V10 said the belt was black or blue. On 3/14/24 at 10:04AM V4, Psychiatric Rehabilitation Services Director (PRSD), said Social Services does the Cognitive BIMS assessment, Discharge Potential, Community Assessment, Aggression, Suicide Risk, Trauma, Substance Abuse, Social History and level of function for those with SMI (Serious Mental Illness), and Smoking Assessments. V4 said "We review the admission packet. The purpose of the assessments are to determine what the patient needs are." V4 said the PASRR are done at the hospital before they are admitted to the facility to determine facility placement. V4 said "We use the section of what the patient will benefit from to help determine the type of groups they need. Any abnormal findings on the PHQ9 (Mood assessment) requires updates to the care plan and possibly placement in new groups. We give the, DON, Floor Nurse, and/or the MDS nurse the results if any are abnormal assessment findings. The Care plan should be individualized. If a resident has a plan to use sharp items for self injury, we would remove them and do routine checks. (R4) was on hourly checks from when he first got here." V4 said the forms are filled out by the social worker. V4 said "We complete a belongings inventory. (R4) would not have been	S9999		

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S9999	Continued From page 7 allowed a belt and he would not have been able to keep his phone and laptop chargers. I don't know where (R4) got the belt from. Any group, 1:1's or groups refusals should be documented." At 12:12PM V4 reviewed the handwritten Nursing Observation Sheet presented for hourly monitoring on R4. The observation started on 2/16/24. V4 said "The observation sheets are kept in my office. The Nurse Observations sheets are continued until the resident is stable, then we would stop the nurse observation sheet. We meet twice a day, morning (8:00AM) and afternoon (PM) to discuss if they should continue the observations." The surveyor asked V4 why the observation on 2/28/24 is not completed for night shift (12AM-6AM). V4 replied "I don't know. There is no documentation to say when to stop the hourly monitoring sheets. (R4) was in Symptom and Behavior Management. If any resident has suicide ideation or history they'll be placed in the group. The majority of the time the group topics are not always discussed on 1:1 visit." V4 reviewed R4's Preadmission Screening and Resident Review (PASRR) with the surveyor. V4 read from the PASRR, V4 said R4 should have been placed on 3 group programs. V4 said programs including behavior management, development, maintenance, and consistent implementation across settings of those programs designed to teach daily living skills, grooming, personal hygiene, nutrition, health, and drug therapy. V4 continued reading and said crisis intervention program to keep yourself safe. Individual, group, and family psychotherapy. V4 said R4 could have Psychiatrist and Psychologist services. V4 said the Psychologist comes to the facility every 2 weeks and the psychiatrist comes once a week. V4 said the psychologist had not seen R4 yet. V4 said R4 should have been in Symptom and Behavior management, Traditional	S9999		

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S9999	Continued From page 8 Living, and Self Maintenance groups. The surveyor asked for the documentation of the mentioned programs. V4 said "I didn't bring those copies of programs or 1:1, I misunderstood what you wanted. I only brought the Symptom & Behavior Management Group records." At 1:26PM V4 provided group confirmation form for R4. V4 said R4 should have received more groups. The surveyor reviewed R4's care plan and V4 said it should state the frequency not just "#" for days for programs. On 3/14/24 at 12:28PM, V4 said "The nurse observation sheet is stopped once the patient is stable. We meet twice a day, morning (10:00AM) and afternoon (3:00PM) to discuss if they should continue or are stable." The surveyor asked V4 why the observation dated 2/28/24 is not completed for night shift and evening. V4 said "I don't know." V4 said there is no documentation to say when to stop the observations. V4 said R4 was in Symptom and Behavior Management group. V4 said if the resident has suicide ideation or history of suicide attempts, they will be placed in Suicide Prevention group. V4 said if a resident does not attend group they will get a 1:1 session. V4 said the group topics are not always discussed the same as during a 1:1 session. V4 a reviewed PASRR with the surveyor. V4 said R4 should be in Group for management and monitoring medication. Development, maintenance, and consistent implementation across settings of those programs designed to teach individuals daily living skills necessary to become more independent and self determining including but not limited to grooming personal hygiene, mobility, nutrition, vocational skill, health, drug therapy, mental health education, money management, and maintenance of the living environment. You may benefit from programs to	S9999		

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S9999	Continued From page 9 teach daily living skills to help improve independence. Crisis intervention services or plan. You would benefit from a plan to keep yourself safe. Individual, group, psychotherapy to develop healthy coping skills. Psychiatrist and psychologist services. V4 said the Psychologist comes every 2 weeks and the psychiatrist comes once a week. V4 said the psychologist had not seen R4. V4 said R4 should be in Symptom and Behavior Management, Traditional Living, and Self Maintenance Groups. V4 said R4 should have been on 3 programs. At 1:26 V4 provided group Confirmation Form for R4. V4 said R4 should have received more groups. Reviewed R4's Care plan with V4, V4 said the care plan should state the frequency not just "#" for days to attend groups. On 3/14/24 at 1:30PM, V12, Administrator, was interviewed regarding R4's (State Agency) final report. V12 said a moderate risk is more severe, it does not mean the same as minimal risk. V12 said the Medical team is the medical nurse practitioner and the psychiatrist, V9, and his Nurse Practitioner. V12 said "I wrote the final report based on the progress notes and records I reviewed." V12 Reviewed PASSR and said there is no recommendation for specialized services. V12 said there is a list at each nurse's station of residents with suicide ideation and suicide attempts history. V12 said staff need to make frequent rounds, checking, any signs or symptoms, or if they present with any behaviors staff should notify nurse and social services. V12 said the police took the belt and towel rack. V12 said while hospitalized, R4's plan was to cut himself or walk into traffic. V12 said if staff was supervising R4, then staff should be aware if he had a belt. V12 said V31, Transport CNA, said she saw R4 15 minutes before the code. V12 said	S9999		

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S9999	Continued From page 10 we don't have video. V12 said the nurse said 2 hours was when she last saw R4. On 3/14/24 at 2:35PM V39, MDS (Minimum Data Set) Nurse, said "Social Services does not communicate with me what they do. I don't check their assessments sections, only that is gets done. I just make sure its completed, sections C, D, and E. Each department is responsible for their own assessments and care planning." On 3/14/24 at 3:11PM V31, Transport CNA, said "I was at the nurses station on 2/29/24 and I saw (R4) get off the elevator. I was hanging the appointments list." V31 said R4 had books in his hands. V31 said R4 did not say anything. V31 said R4 may have gotten the books form the library or another resident. V31 said "Then I got on the elevator and 5 minutes later, I heard them call a code blue. Lunch was maybe 30 minutes to 1 hour after the code happened. I probably seen (R4) between 10:30AM- 11:00AM." On 3/15/24 at 11:50AM, V9, Psychiatrist, said the plan for R4 was to monitor him. V9 said R4 had no complaints of depression or anxiety. V9 said regarding R4's symptoms for impulsive and racing thoughts they are part of his diagnosis of Borderline Personality Disorder (BPD). V9 said R4 also had a Bipolar diagnosis. V9 said Bipolar is usually treated with medications and BPD is treated with talking therapy at least monthly. V9 said "We did not write an order for him to be in psychotherapy. Usually the providers (facility) provide supportive psychotherapy by way of a trained Nurse Practitioner or Physician Assistant." V9 said R4 can't be held accountable for what he signed on a behavior contract. V9 said the contracts are only a tool used to help to establish rapport with the patient. V9 said behavior	S9999		

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S9999	Continued From page 11 contracts are not shown to prevent self harm. V9 reviewed R4's PHQ-9 (mood assessment) on his computer. V9 said of the PHQ-9, "I don't know how accurate these are. With a diagnosis of BPD they may have a negative response, maybe they just woke up or are upset about something vs when they are in a good mood all the answers may be positive outlook. I would like to have seen a follow up to this one." V9 said while in the hospital R4 admitted to having chronic Suicide Ideation and racing thoughts but no harming behaviors. V9 said initially what got R4 hospitalized was because he said his plan was to stab himself or walk in front of traffic. V9 said "The facility told me (R4) attempted suicide. I am not sure what method he used." On 3/17/24 at 10:29AM, V25, Assistant Director of Social Services, said the licensed social worker did not see R4 while he was in the facility. R4's Preadmission Screening and Resident Review (PASRR) dated 2/12/24 states: mental health disorders: Bipolar disorder. mental health symptoms: suicidal talk. Pharmacotherapy including administration and monitoring of the effectiveness and side effects of medications which have been prescribed to change inappropriate behavior or to alter manifestations of psychiatric illness. You may benefit from programs to teach daily living skills to help improve independence. Crisis interventions or plan. You would benefit from a plan to keep yourself safe. You may benefit from psychotherapy to decrease mental health symptoms and develop healthy coping skills. You are currently in the hospital because you had thoughts of ending your own life. You appear overly tearful to others. You have anxious thoughts.	S9999		

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S9999	Continued From page 12 R4's Screening Assessment for Evaluation Self Harm/Suicide Risk dated 2/16/24 completed by V6 documents R4 past history of suicidal ideations, history or problems, major depression and personality disorder diagnosis: Significant/Severe problems. Struggling with poor performance, perfectionist personality and/or a negative view of the future: Moderate Problem. Category Score = 11 (6-15) Moderate Risk. Comments: per hospital referral packet, has history of suicide ideation but denies at this time. R4's Belongings Inventory dated 2/16/24 documents nothing for possession of belt, no accessories, 1 pair of shoes but no description of the shoes. 1 cell phone with charger and 1 laptop with charger. Review of Medication Administration Record (MAR) 2/1/24-2/29/24 notes a list from 0-17 of Behaviors. Interventions are listed 0-9. Outcome results. Documentation prompts list Beh (behavior) Int (interventions) and Out (outcome) for every shift. 2/23-2/27/24 on days and evening document 0 (none) behaviors. On 2/28 evening and night shift document NA. Per DON interview indicated Not Applicable. Monitoring of medication side effects on 2/28-2/29 documents NA. Review of Mood Assessment dated 2/22/24 indicates R4 reported he was "feeling down, depressed, or hopeless nearly everyday. R4 reported trouble with sleep nearly everyday. R4 reported feeling tired or little energy half or more of the days assessed. R4 reported feeling bad about self or that he is a failure or have let himself or his family down on several days.	S9999		

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S9999	Continued From page 13 The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual states the intent of Mood Assessment. The items in this section address mood distress and social isolation. Mood distress is a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable. Social isolation refers to an actual or perceived lack of contact with other people and tends to increase with age. It is a risk factor for physical and mental illness, is a predictor of mortality, and is important to assess in order to identify engagement strategies. R4's care plan initiated on 2/16/24 states he has a history of self harm ideation (thoughts) and behaviors related to his mental illness. The care plan Intervention prompts "what occurred, where, circumstances surrounding the events, precipitants and any current plan to harm. The facility did not documented the information mentioned in the prompt. R4's care plan he resist care related to medication compliance. This was not documented in R4's progress notes or MAR. R4's care plan identifies he has a need for specialized rehabilitation, support, counseling secondary to mental illness. R4's care plan identifies he has coping problems. Group and one to one programing are identified interventions but no specification of frequency or identification of programs R4 was assessed to need. All interventions are dated 2/16/2024. Care plan initiated 2/16/2024 states I am in need of specialized rehabilitation, support, counseling and or psychotherapy services secondary to a mental illness diagnosis, depression diagnosis. Care plan includes demonstrates a pattern of	S9999		

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S9999	Continued From page 14 situational and or coping problems in areas such as psychosocial well-being, mood state and or behavior symptoms. This appears related to symptoms are manifested by mood distress, anger, anxiety, sadness, and insomnia. Interventions are dated 2/16/2024. There were no updates or additional interventions added after the completion of the mood assessment completed on 2/22/24. The facility presented two handwritten group therapy progress notes for R4, the first is dated 2/16/2024. Group goals: confronting fears and anxieties. Focus of session: symptom and behavior management. Plan: discuss how to manage stress. There is no discussion of suicide prevention. Group therapy progress note dated 2/20/2024. Discussing techniques on how to manage stress. Plan: enhancing social skills. There is no discussion of suicide prevention. During the survey the facility provided a list of residents that have a history of suicide ideation slash suicide history (SI/SH) dated 3/1/2024. There are 52 residents named on this list. Nursing Observation Sheet for R4 reviewed. Observation initiated on 2/16/24 at 12:00AM for every shift. Observation sheet ends on 2/28/24 includes documentation from 8:00AM- 11:00AM. There is no documentation prior to that. There is no documentation in the progress notes or care plan to explain the discontinuation of the observation. R4's Group Therapy Progress Notes dated 2/16/24 and 2/20/24 for Symptom and Behavior Management reviewed. (skill groups indicated on Group Form are Behavior Management, Suicide Prevention Group, Smoking Safety, and	S9999		

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S9999	Continued From page 15 Symptoms and Behavior Management. A progress note written by V6 dated 2/29/24 states a 1:1 for Symptom and Behavior Management was completed. There is no record R4 participated or was offered a group program or 1:1 for Suicide Prevention. R4's PASRR Summary dated 2/14/24 documents if you are admitted to a Medicaid certified nursing facilities what services and supports are nursing facility staff required to provide for you? You made better you may benefit from programs to teach daily living skills to help improve independence. Crisis intervention services or plan. You would benefit from a plan to keep yourself safe. Individual, group, and family psychotherapy. You may benefit from psychotherapy to decrease mental health symptoms and develop healthy coping skills. R4's Progress note dated 2/15/24 identified as welcome note resident has a BIMS of 15. Per record, resident does have racing thoughts and has sign symptoms of mood distress. Resident has a history of suicide ideation with a plan. Resident was homeless prior to going to the emergency room for suicide ideation with a plan. Per record, resident has auditory hallucinations. Progress note dated 2/28/24 state social service met with R4 to check on his well-being. There is no notation that resident was asked about thoughts of harming himself or if he had a plan to harm himself. A second progress note on 2/28/24 titled skills training participation record states symptoms and behavior management. Willingness motivation to engage in session good compliance progress towards care plan objectives: good. Movement towards positive	S9999		

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stages of change: good. Acquiring enhanced life skills: good. Comments: understanding our diagnosis. No mention of questions related to suicide ideation or suicide plan. This is the only skills training participation record found for R4 from 2/15/24 through 2/28/24.

R4's Progress Notes dated 2/29/24 indicated he observed on the floor face down with an object around his neck.

The facility final State Report dated 3/6/24 states R4 was transported to local hospital for evaluation. The facility was informed R4 passed from his self inflicted injuries.

Fire Department Run sheet dated 2/29/24 documents onset 12:07PM. Run sheet documents intubation attempted but unsuccessful due to airway obstruction and tracheal trauma. R4 transported to closest facility.

Hospital records states admitted 2/29/24 after hanging "D/C 3/5/24."

The death certificate was requested on 3/8/24 and 3/18/24. Cause of Death is pending.

The facility policy and procedure for behavior management dated 1/1/2021 states document evaluation of the presence of behavioral symptoms or the potential for behavioral symptoms in the residence medical record and care plan. Document the initiation of behavioral interventions and mental health professional visits in the residence medical record and care plan. Document education provided to resident and or family responsible party. Document nonpharmacological interventions attempted and resident response. Document notification of

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S9999	Continued From page 17 physician and family member of actions taken to reduce or prevent behaviors The facility Safety and Supervision of residents policy dated September 2022 states safety risk and environmental hazards are identified on an ongoing basis. Our resident oriented approach to safety addresses safety and accident hazards for individual residents. The facility oriented and resident oriented approaches to safety are used together to implement systems approach to safety which considers the hazards identified in the environment and individual risk factors and then adjust interventions accordingly. (AA) 2 of 2 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3) 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.	S9999		

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S9999	Continued From page 18 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 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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:	S9999		

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S9999	Continued From page 19 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 were not met as evidence by: Based on interviews and records reviewed the facility failed to prevent the use of illicit drug in the facility. This affected two of three residents (R10, R11) reviewed for safety and supervision. This failure resulted in R10 with a history of substance abuse being found unresponsive at the bedside without respiration or pulse on 01/10/24 at approximately 8:00am. R10 death certificate documented cause of death as Fentanyl Acetyl Fentanyl and 4-ANPP (Despropionol Fentanyl)) toxicity. Findings Include: 1. R10, age 69, with diagnosis including but not limited to Viral Hepatitis C, Opiod Abuse (3/8/23), and Altered Mental Status. R10 was assessed on 12/5/23 to have a BIMS (Brief Interview of Mental Status) of 6 indicating R10 has severe cognitive impairment. R10 was initially admitted to the facility on 3/8/23 with a history of substance abuse.	S9999		

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S9999	Continued From page 20 Progress Notes dated 12/30/24 states R10 observed unconscious with respiratory distress while in bed. Sternal rub performed; resident difficult to arouse and not responding to stimuli. Writer administered PRN (As Needed) Narcan. The resident became alert and responsive but remained in a mentally altered state. Vitals: T-135/84, P-110, T-98.3F, RR-24, 02 sat (oxygen saturation) 95% via nasal cannula 2 L/min (Liters per minute). Resident sent to Hospital for evaluation via 911. Progress notes dated 12/31/23 document R10 in his bed at 3:05AM. On 3/18/24 at 11:03AM, V34, Registered Nurse, said "On (12/30/23), I stopped at (R10)'s room and (R10) was in the bed. I was checking him for breathing or a sign that he is alive. (R10) had labored breathing. I haven't seen too many patients with overdose or using heroine. I was checking (R10)'s vitals and then thought to check the chart and saw his diagnosis of history of drug use. I saw (R10) had an order for Narcan and I administered it." V34 said after administering the Narcan R10 "came right out." On 3/18/24 at 11:42AM, V41, Licensed practical Nurse (LPN), said "On (1/10/24) between 7:30AM and 7:45AM, not after 8:00AM, I saw (R10) was unresponsive and I called for a code blue. I had not done vitals on him prior to this." V41 said R10 was newly moved to her unit. V41 said "I found him unresponsive about an hour or little over an hour after I last saw him." V41 said R10 was in his bed when she saw him unresponsive. V41 said "I tried calling his name and he was not waking up. I applied the pulse ox (oximeter) device and did not get a reading, I could not feel a pulse and was not able to get a blood pressure. I had heard that (R10) went to the hospital before he came to my unit, but they said his drug test	S9999		

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S9999	Continued From page 21 was clean. I was not aware they had given him Narcan in the past. I am not aware of any resident having had drugs or contraband in the facility." On 3/17/24 at 2:14PM V30, CNA, said "I was here on (12/30/23) and (1/10/24) when (R10) had an unresponsive episodes. I was not assigned to (R10) on (1/10/24), I don't know who had him. At the start of the shift, I saw (R10) in his room and he spoke to me. This was sometime after 7:00AM and breakfast trays had not been passed." On 3/17/24 at 2:25PM, V37, CNA, said "If someone has a drug use history or recent finding the nurses will let us know to keep a close eye on them. I was not here on (1/10/24), I don't know who worked (R10)." On 3/17/24 at 2:56PM, V38, CNA, said she was not assigned to R10 on 1/10/24. V38 said on 12/30/24 she was not aware R10 was being sent to the hospital. V38 said she was retuning from break and saw R10 as the ambulance was taking him out. On 3/18/24 at 10:20PM, V17, CNA, said "I had no interaction with (R10) on (1/10/24)." V17 said V30 was assigned to R10 on 1/10/24. V17 said "I didn't see (R10) before the code blue was called." V17 said the last time she worked with R10 was on 1/8/24 and he was not on hourly rounding. V17 said R10 did not leave the facility or go outside. The surveyor asked V17 if she was made aware that R10 had been to the hospital on 12/30/24 with suspicion of drug use. V17 said "I was not notified." On 3/18/24 at 11:36AM, V6, Psychiatric Rehab Service Counselor, said when she assessed R10	S9999		

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the daughter notified R10 has a history of drug abuse. V6 said R12 has a history of drug use.

On 3/18/24 at 9:54AM, V43, Substance Abuse Coordinator, said R10 was not attending group and he was not on 1:1's. V43 said "When I was introduced to (R10) it was told to me that he was under suspicion. I did assess (R10) to see if he qualified. I asked (R10) if he wants to be on 1:1." V43 said R10 said he did not have a problem and that he did not do drugs. V43 said R10 was alert and able to answer her question. The surveyor asked V43 if the resident has a low cognitive score, would they understand to respond. V43 said they may not be accurate. V43 said "I was told to go assess (R10) for substance abuse program and that he is under suspicious behavior." V43 said from R10's history, "I am not aware of his preferred drug." V43 said Social Service Initial Interview for SMI/Substance Abuse Disorder was done on R10 on 12/8/23. V43 said "I have to do the assessment if the resident has a relapse, has done a substance, to confessed to it."

On 3/18/24 at 1:25PM, V36, Restorative Nurse, said "I am not aware of any residents who have been seen or suspected of drug use. Nurses should know what residents had been seen or suspected of using drugs. I would want to know if a resident I am assigned to has used drugs or been given Narcan in the last 30 days."

On 3/17/24 at 12:58PM, V10, Director of Nursing, said facility contraband is weed (marijuana), cigarettes, any smoking pens, and hard drugs.

R10's Delirium assessment dated 12/5/23 states the resident has inattention and disorganized thinking and behavior continuously present. R10's

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S9999	Continued From page 23 Mood assessment documents he is feeling down, depressed, or hopeless, trouble sleeping, feels tired, poor appetite, and feeling bad about yourself. These symptoms were recorded present several days. Behavior of hallucinations and delusions were present 4-6 days during the assessment period. R10's Social Service Initial Interview for SMI/Substance Abuse Disorder dated 3/9/23 documents R10 has a history of mental illness and history of substance abuse problems. Section C includes "Per hospital paperwork and resident daughter, heroin." R10's care plan initiated on 3/9/23 documents R10 in not capable of an outside pass. Care plan documents R10 had a history of substance abuse/chemical dependency. Interventions include a verbal or written behavior contract. Interventions do not include group or 1:1, nor is it documented that R10 wouldn't not benefit from the groups or 1:1's. A signed Resident Behavior Contract for R10 is dated 3/9/23, however no initials are documented that he agrees or understands the topics. Ambulance Run Sheet dated 12/30/23 Primary Impression: Overdose, Heroin. Staff stated they gave 4mg (milligrams) of Narcan. Staff stated this is not the first time patient has used Heroin. R10's hospital record dated 12/30/23 documents patient was observed for four hours without any relapse of his Opiod overdose. Reason for visits: loss of consciousness and accidental drug overdose.	S9999		

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S9999	Continued From page 24 R10's death certificate documents an autopsy was performed. Cause of Death for R10, only reason documented, is Combined Drug Toxicity. 2. R11 age 40 Seizures, Anxiety Disorder and Major Depressive Disorder. On 3/17/24 at 10:57AM V25, Assistant Director Social Services, said "I searched (R11)'s room. It was reported on Friday (3/15/24), he was smoking weed at night. I found lighters and he said he smoked the weed." V25 said the resident can't use a marijuana pen on property and they can't have in the facility. V25 said the plan for R11 is the group, Moving Forward, for substance abuse group. V25 said "(R11) did not tell me where he got the pen from. I am not sure if he got if from another residents." V25 said Social services will do the searches. V25 said the nurses knew. V25 said "(V24, LPN), notified me and the fire department came to the facility because the smoke alarms were activated." On 3/17/24 at 12:25PM V29, Registered Nurse (RN), said on Friday, 3/15/24 "I was charting on the first floor when the smoke alarms went off. We went to (R11)'s room and saw smoke and there was a smell, it was weed. I didn't go in the room, I left the unit." V29 said V1 was R11's nurse. On 3/17/24 at 12:38PM R11 told the surveyor "I had a blunt in my pocket and lighter. I had them from last Saturday (3/10/24). I had gone out with my brother and forgot I still had it in my pocket. I smoked it all up on Friday." On 3/17/24 at 12:44PM V1, Licensed Practical Nurse, said R11 was smoking in the room bathroom. V1 said "I heard the alarm, I saw	S9999		

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	IL6001697	A. BUILDING: _____ B. WING _____	C 04/18/2024

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
S9999	Continued From page 25 smoke, and I assessed R11. I didn't see (R11) smoking but it smelled like marijuana." V1 said R11 didn't have it anymore. V1 said the smoke cleared it. V1 said R11 had not been out of the facility that day. V1 said R11 said it was a pen, but didn't see it. V1 said "I asked (R11) to give me the pen, he would not give it to me. I wrote a progress note, but it wasn't saved (in the electronic chart)." V1 said R11 had not done anything like that before. On 3/17/24 at 12:58PM V10, DON, said if a resident is found using drugs or it is reported, the nurse needs to assess the resident. Assessment includes vitals, make sure the resident is ok, and do a body assessment. V10 said contraband is weed, cigarettes, smoking pens, and hard drugs. V10 said the nurses should be documenting these things in the chart. V10 said the nurses should not leave the contraband items with the residents. V10 said if the nurse is unable to obtain it, they need to notify social services or call the police. V10 said "We should try to do a room search room and try to get the contraband from the resident. We need to get the contraband from the resident, because it could be dangerous for the facility. If the resident has a lighter, a lighter can be a possible fire danger." V10 said another resident or roommate may get the contraband. V10 said "I was called on Friday, (3/15/24) and told (R11) had a pen." V10 said V1 did not say if she confiscated the pen. V10 said when a resident goes out, I know social services is to search the resident upon return from an outing. V10 said Nursing can search as well. On 3/18/24 at 9:54AM V43, Substance Abuse Coordinator, said R11's drug of choice is marijuana and using a vape with marijuana in it. V43 said R11 had some marijuana, he got it out	S9999		

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S9999	Continued From page 26 west, I don't know when he went out west. R11's Smoking Risk Review dated 3/16/24 documents R11 was seen smoking marijuana in his room and setting the fire alarm off. R11's Initial Interview for Substance Abuse Disorder dated 12/8/23 documents R11 said he used alcohol and drugs, marijuana and vape, often. R11's Initial Interview for Substance Abuse Disorder dated 6/29/23 documents R11 has used alcohol and drugs, not specified by name of drug. On 3/18/24 while in the facility there was not an Initial Interview for Substance Abuse Disorder provided dated 3/15/24-3/18/24 and none was seen during the surveyors record review. R11's care plan initiated on 3/16/23 identifies R11 non compliant with smoking policies and found with paraphernalia in his room. R11's care plan initiated on 3/16/24 documents R11 requires supervisions for outside pass. R11 pass is resumed and R11 pass revoked. All interventions are dated 3/16/24 and nothing to provide interventions for marijuana and vape use as indicated on Initial Interview for Substance Abuse Disorder dated 12/8/23 and 6/29/23. R11 progress notes dated 3/16/24 It was reported to writer (V25, Assistant Director of Social Services) that R11 was smoking marijuana in his room, setting off the fire alarm last night. R11 admitted to smoking marijuana. V25 documented she conducted a room search and "numerous lighters and vapes were found." There was no progress note dated 3/15/24 while the surveyor reviewed the record and not presented to the facility when requested. No smoking or behavior contract was presented	S9999		

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S9999	Continued From page 27 for R11. The facility resident smoking policy dated March 2020 states if assessed to be appropriate for independent smoking, the resident must sign a smoking contract with the facility. Possessing, carrying, or holding materials used to smoke including but not limited to cigarettes cigars loose tobacco pipes lighters and matches by residence is prohibited inside the building. Residents must give smoke and materials to staff when they enter the building, even if the resident has been assessed to be independent in carrying such materials when off the premises. Persons bringing smoke materials into the facility for residence use must leave these items at the front desk. Residents are prohibited from giving smoking materials to other residents. The facility undated policy on contraband materials states this organization reserves the right to conduct inspections if there is reason to suspect/believe that a resident has contraband items/materials in his or her possession these items include but are not limited to alcohol, illicit street, or over the counter drugs, weapons, and smoking materials. In situations where illegal activity appears to have taken place appropriate authorities will be notified. (AA)	S9999		