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 07/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHICAGO RIDGE NURSING CENTER	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	Final Observations Statement of Licensure Violations Section 300.1810 Resident Record Requirements a) Each facility shall have a medical record system that retrieves information regarding individual residents. b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives. This requirement was not met as evidenced: Based on interview and record review, the facility failed to have a medical records system which allows resident medical records to be available at all times for one (R1) of three residents reviewed for medical records. Findings Include: 7/28/2015 at 1:30pm, E3 (LPN) was interviewed. E3 was the the 3rd shift nurse who sent R1 to the emergency room. E3 stated, 7/14/2105 at 10:30pm, R1 was having an 'Anxiety Attack'. R1 was SOB and was oxygen (PRN order dated 7/1/2015). R1's breathing improved until 3:30am, when R1 went into full distress. 911 were called. No paperwork accompanied R1 to the hospital, because the 2 copiers the 3rd shift had access to were broken. R1 went to the hospital without paperwork. E3 was not at R1's bedside when the	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 paramedics came because she was trying to copy the paperwork. E6 (RN) was assisting E3 with R1's 'Anxiety Attack'. E6 was not in the room, when the paramedics arrived, because she had to unlock the doors for the paramedics to enter the building. 7/28/2015 at 3:05pm, E5 (LPN) was interviewed. 7/15/2015 at 7am, the hospital called and said R1 was admitted to the hospital with a diagnosis of respiratory distress. Hospital staff asked for a next-of-kin or Guardian because no paperwork accompanied R1 to the emergency room. The hospital staff was given the Guardian's (Z2) and telephone number. 7/28/2015 at 3:13pm, E4 (RN/Evening Supervisor) was interviewed. E4 works 4pm to 11pm. E4 does not remember the exact date, but couple of days after R1 was admitted to the hospital, two representatives from the Public Guardian's office (R1's Case Manager & the Guardian's office's Attorney) visited the facility. They asked to see R1's clinical record. E4 told them that the record was locked up in the front office and she did not have access. Hospital Emergency room records dated 7/15/2015 at 0356 hours stated that R1 arrived at the Emergency room in respiratory distress. R1's blood pressure was 290 systolic and blood glucose level was 315. R1 was awake, but could only nod when asked questions. R1 was not able to provide any history of respiratory failure. R1 underwent Intubation to relieve the respiratory distress. The emergency staff were unaware of R1's DNR (Do-Not-Resuscitate Advance Directive) status or guardianship because the facility failed to send pertinent information with R1 to the hospital emergency room.	S9999		

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S9999	Continued From page 2 (B)	S9999		

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: CHICAGO RIDGE NURSING CENTER COMPLAINT #: 0078781
LIC. ID #: 0045815
DATE COMPLAINT RECEIVED: 07/21/15 09:00:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1
409	POLICY AND PROCEDURES	1

X The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.