STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145639	A. BUILDING _____ B. WING _____	C 09/08/2006

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) COMPLETION DATE
F 309	Continued From page 5 5. Starting on 9/2/06, QA rounds will be made daily to ensure that all the NPO residents are identified and meals are served using meal tickets. Nursing Administration will review the Stand-Up Shift Report's documentation daily. QA committee will review quarterly or sooner if necessary. Although the Immediate Jeopardy was removed on 9/2/06, the facility remains out of compliance at a severity level 2 to allow for implementation and review of all the above responses.	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)4) 300.2040b) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:	F9999		

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F9999	Continued From page 6 4) Personal care shall be provided on a 24-hour, seven day a week basis. Section 300.2040 Diet Orders b) Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident. These regulations are not met, as evidenced by the following: Based on record review and staff interview, the facility failed to ensure that 1 resident's (R2) NPO status was maintained as ordered, and failed to ensure that facility practice of not serving food trays to residents without a meal ticket was followed. This failure to maintain R2's NPO status and the failure to follow the facility protocol regarding meal service resulted in a choking incident which resulted in the death of R2. Findings include: During interview with E1 (Administrator) on 9/6/06, E1 stated that R2 was recently re-admitted to the facility with orders to be NPO (nothing by mouth) after having a G-tube (gastrostomy tube) placed at the hospital. Prior to this hospitalization, R2 had been eating at the facility and did not have a G-tube. According to E1, R2 returned to the facility on the evening of	F9999		

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F9999	Continued From page 7 9/1, and on 9/2, E8 (CNA), who was familiar with caring for R2 from his previous admission, gave R2 a food tray, which he ate. E1 stated that the facility practice is that no resident gets a food tray if there is no meal ticket for that resident until the CNA checks with nursing to see if the resident can eat and what diet they are on. E1 stated that because R2 was just re-admitted, there was no meal ticket for R2. E1 also stated that normally, for a new admission or a re-admission, until the pre-printed labels are prepared, dietary would handwrite a meal ticket, but there was no meal ticket for R2. After investigating this incident, E1 stated that she believed that E8 told E6 (dietary aide) that she needed a tray for a resident who was just re-admitted. E1 stated that E8 has been suspended. Review of R2's medical record reflects the following: R2 was re-admitted to the facility from the hospital at 7:00pm on 9/1, with physician's orders to be NPO. R2 had multiple medical diagnoses including Pneumonia, Emphysema, Seizure disorder and Respiratory Failure. Nursing notes from 9/2 reflect that at 12:15pm, R2 was found unresponsive, with no vital signs, CPR was initiated, and 911 was called. Nursing notes also reflect that R2 was transported to the hospital where he was pronounced dead. During telephone interview with E8 (CNA) on 9/6, E8 stated that on 9/2, she was not caring for R2, but did pass trays on his section, and was familiar with caring for him before his hospitalization at which time R2 did receive a food tray. E8 stated that on 9/2, while passing trays, she knew that R2 was back in the facility. E8 stated that she did not have a meal ticket for R2, but that she wanted to make sure he ate, and	F9999		

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F9999	Continued From page 8 so she asked the dietary server for an extra tray for him because he had just been re-admitted. E8 stated that she was aware that residents are not to be served food trays without a meal ticket unless the CNA checks with the nurse to see if they can eat and find out what their diet is. E8 denied having a meal ticket for R2, and denied asking any nurse about R2's diet or whether R2 could even eat. E8 stated that she gave him his breakfast tray and then picked it up later, and that R2 had eaten everything off of it, and that he appeared fine. E8 stated that at lunch she again asked the dietary server for an extra tray for R2 because he was newly re-admitted, and got one. E8 denied the dietary server asked her to see a meal ticket for this tray. E8 stated that she believed E6 (dietary aide) was distracted by talking to someone when she asked for the tray, and he did not ask her to see a meal ticket. E8 denied noticing the tube feeding at R8's bedside either at breakfast or lunch. E8 stated that she served R2 his lunch tray on 9/2, and left him feeding himself. About a half an hour later, at 12:15pm, she returned to pick up his tray, and found R2 sitting up in bed unresponsive and very pale. She stated she immediately went to get the nurse, who went in to check on him, and then a code was called, as well as 911 being called. E8 stated that she noted food around R2's mouth. E8 stated that for breakfast on 9/2, R2 ate oatmeal, scrambled eggs, toast, milk and juice. E8 stated that R2 ate about half of his lunch of lasagna, bread, mixed vegetables, fruit cocktail, juice and milk. Review of the facility's master menu for Week 1- Saturday confirms that for lunch, meat lasagna, mixed vegetables, fruit cocktail, bread and liquids were served. Review of Chicago Ridge Police Department	F9999		

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F9999	Continued From page 9 Incident Report and investigation reflect interviews with the Chicago Ridge Fire Department personnel who attempted to resuscitate R2. This report reflects that large pieces of food were found in R2's mouth, and that once this food was removed, more food was found blocking R2's airway. Review of narrative notes contained in the Chicago Ridge Fire Department report dated 9/2 reflect that when R2 was moved to the fire department backboard, the crew noted solid food smeared on R2's pillow and bed sheets. Additionally, when the crew began to intubate R2, they found ..."large chunks of solid food (possibly fruit cocktail) blocking the pt's airway...". the report indicates that they used forceps to remove the pieces of food, and they were then able to intubate R2. During telephone interview with E12 (RN) on 9/7, E12 stated she was R2's nurse on 9/2, and she stated that he had his tube feeding running, and that she was aware R2 was NPO. E12 stated that E8 did not ask her about R2's diet, or whether he could get a meal tray. E12 stated that when E8 told her to check R2 because he didn't look right, she went into his room right away, found him unresponsive without vital signs, and initiated CPR and instructed staff to call a code and call 911. During telephone interview with E6, E6 confirmed that he was serving trays from the steam table on the 2nd floor on Saturday, 9/2. E6 stated that he is aware of the rule that no resident is to get served a tray without a meal ticket, unless the CNA checks with the nurse about their diet. He denied giving E8 any tray without a meal ticket. (A)	F9999		