STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145634	A. BUILDING _____ B. WING _____	C 06/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST RIDGE REHABILITATION CENTER	**6300 NORTH CALIFORNIA AVENUE CHICAGO, IL 60659**

(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
F9999	Continued From page 8 d)2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to supervise and monitor 1 resident (R3) in the sample of 3, who has multiple histories of suicidal attempts. R3 has documented multiple suicidal attempts and ideation, and prior to initial admission to the facility, was in the hospital for suicidal ideation. A week after admission, R3 again verbalized suicidal ideation, which led to his hospitalization on 3/27/09. On 5/20/09 at 3:30 PM, R3 managed to go unnoticed to the 2nd floor patio from the 3rd floor, when R3 was witnessed by a passerby fall from the patio to the concrete ground resulting in injury. R3 was sent to the hospital and expired at 4:02 PM that same day. Findings include : R3 was initially admitted to the facility on 3/20/09 with diagnoses of Severe Depression, Hypertension, Dementia, Benign Prostatic hypertrophy, Mild Hydronephrosis, and history of	F9999		

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F9999	Continued From page 9 Suicide. R3 lived on the 3rd floor of the facility in room 300. Per hospital record, R3 was admitted to the hospital on 3/12/09 with a diagnosis of Depression with Suicidal Ideation. Per hospital Admission and Progress notes dated 3/16/09, R3's Psychology Consult indicated that R3 admitted that he tried to commit suicide as one of the navy men in the nursing home where he previously resided questioned R3 as to why he is occupying space for people who really need it while he is healthy, and also after his daughter kidnapped and drugged him. R3 also said in the hospital record that the second time he tried to kill himself was when he felt slighted after he was placed in a room for 4 people instead of a room for 2 people as he was promised. R3's hospital Admission Note dated 3/12/09 at 9:30 PM indicated that, per R3's son-in- law, R3 had 3 serious suicide attempts in the past 2 years. The 1st attempt was an overdose of sleeping pills that R3 saved for several months. R3 was unconscious for 24 hours as a result of this attempt. According to this note, in the 2nd attempt, R3 attempted to electrocute himself by putting his finger in an electrical socket causing him to lose a part of his 3rd finger on his right hand. In his 3rd attempt, R3 cut his wrist and hand. Furthermore, according to his admission note, R3's son-in-law said that R3 continues to talk about killing himself, but will attempt to deny suicidal ideation when in the presence of medical staff. Per R3's 3/12/09 hospital Consultation Report, R3 wants a pill and wants to die. This consultation report indicated that R3 is Suicidal	F9999		

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F9999	Continued From page 10 and with Severe Depression. A week after his initial admission to the facility, R3 was also sent to the hospital for psych evaluation on 3/27/09. Review of R3's Nurses Notes dated 3/27/09 at 2:10 PM indicated that R3 spoke with E10 (Russian Coordinator) and told her of his desire to burn the facility and to put himself off. R3 was sent out to the hospital and was readmitted on 3/31/09. During 6/1/09 interview at 3:28 PM, E10 said that on 3/27/09, R3 told E10 that since no one would give him a doctor who would provide him pills or injection to end his life, he was going to do whatever it takes to put himself out, including him burning the facility. E10 also added that R3 told her of his life story and his attempts to end his life because his daughter stole his money and put him in the nursing home. Review of R3's care plans signed on 4/14/09 indicated that R3's suicidal attempts and the risk of recurrence had been identified and that one of the interventions to prevent further suicide attempts was to "Check resident's activities when in the room and out of the room." Another intervention listed in R3's care plan was to " Monitor for s/s of suicidal ideation, e.g. talk of death, feeling of worthlessness, feeling of having lived too long." During interview on 6/1/09 at 3:05 PM, E6 (Certified Nurse Assistant/CNA assigned to R3 on 5/20/09 at 7-3 shift) said that she was never told that R3 had a history of suicidal attempts in the past. E6 added that if she knew, she would have been more aware of his whereabouts. Similarly, interviews with E12 (3-11 CNA) and	F9999		

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F9999	Continued From page 11 E13 (3-11 CNA) on 6/1/09 indicated that E12 and E13 were also never told by the facility that R3 has a history of suicide attempts. Added to this, E14 (7-3 CNA), E15 (7-3 CNA), E16 (7-3 CNA), E17 (11-7 / 7-3 CNA), and E18 (CNA) all said that they too were never informed that R3 had previous suicidal attempts during interviews on 6/3/09. Added to this, per E9 (3rd floor nurse assigned to R3 on 5/20/09) during interview on 6/1/09 at 2:38 PM, there really was no instruction from anyone in the facility to supervise R3 at all times, nor was there any restriction for him to go to other areas of the facility without staff supervision. E6, E11 (3-11 nurse), E12, E13, E14, and E15 all indicated that there was no formal supervision of R3 and that there was no instruction to supervise him at all times, and not to leave him without any staff supervision in another area of the facility. Per E9 during interview on 6/1/09, she last saw R3 on 5/20/09 between 1:30 and 2:00 PM. E9 said that she saw R3 on the 3rd floor when R3 passed by the nurses station. E5 (2nd floor nurse) said during 6/1/09 interview, that on 5/20/09, she last saw R3 at 3:00 PM going toward the 2nd floor patio. According to E7 and E8 (Activity staff) during 6/1/09 separate interviews which started at 2:22 PM on 5/2/09, both of them initiated bowling with 8 to 12 residents and 1 family member on the 2nd floor patio. E7 said that the activity started between 2:00 and 2:05 PM and ended at around 3:05 PM. Both E7 and E8 also said that after the activity, they both took the residents out of the patio to their floors. Both staff also said that R3 was not a part of that group, nor did E7 or E8 see R3 in the 2nd floor patio during that period of	F9999		

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F9999	Continued From page 12 time. During a 6/1/09 2:15 PM interview, E6 said that after E7 and E8 wheeled all the residents out from the 2nd floor patio after the activity, she glanced at the patio and did not see any resident left in the patio area. E6 explained that she was supervising the 2nd floor Dayroom/Dining area which is directly connected to the 2nd floor patio. E6 further explained that she never saw R3 in the patio nor did she see him pass through the 2nd floor Dayroom. During tour on 6/1/09 at 1:48 PM with E2 (Director of Nursing), it was noted that the 2nd floor patio can only be accessed by passing directly through the 2nd floor Dayroom/Dining area. There is a working alarm on the transparent door to the patio, although according to E5, the patio door alarm was only added after 5/20/09. Per interview on 6/1/09 at 1:38 PM, E3 (Admissions Director) said that on 5/20/09 at around 3:30 PM, she overheard a male teenager tell the 1st floor front desk receptionist that someone fainted outside of the facility. E3 said she went outside followed by E4 (Human Resource Coordinator). E3 continued that she saw R3 laying face down on the ground and bleeding from the upper body, just around the corner of the facility. Per E3, a man outside said that he saw R3 fall. E4 on the otherhand showed the surveyor on 6/1/09 at 1:42 PM, that R3's head was laying on the concrete directly below the 2nd floor patio railing. Per observation, the only way R3 could have fallen from above is if he was at the 2nd floor patio, as all of the facility's windows are far	F9999		

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F9999	Continued From page 13 away from the ground where R3 was found. Per facility's incident report dated 5/21/09, according to an unidentified passerby, R3 was observed "going over the railing from the 2nd floor patio." Furthermore, per this report, R3 expired at the hospital at 4:02 PM on 5/20/09. R3 left a suicide note handwritten in Russian and dated 5/20/09. Per E10 who interpreted the letter in English, R3 said he cannot live anymore, and because no one would give him a shot or tablet to take his life, he has no choice but to end it. According to Z1 during 6/3/09 phone interview at 11:40 AM, R3 had a very intense suicidal thought that would not just go away. Z1 added that R3 was very familiar to her and that he had numerous attempts to end his life prior to this. Z1 also explained that since R3 was sent to the hospital before when he talked openly about his desire to kill himself, this time he kept it to himself so he could carry it out. Interviews on 6/1/09 and 6/3/09 of E6, E13, E14, E15, E16, and E17 indicated that they all received inservices on Depression and the signs and symptoms that need to be reported to the nurse after 5/20/09, but not on how to take care of residents with history of suicidal ideation and attempts. Per facility's determination, there is one more resident (R2) with an identified history of suicidal ideation in the facility at this time. (A)	F9999		