

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145434	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024
NAME OF PROVIDER OR SUPPLIER Claridge Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Jenkisson Lake Bluff, IL 60044	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>20042</p> <p>Based on interview and record review the facility failed to ensure residents were not verbally abused by R2 for 3 of 4 residents (R1, R3, R4) reviewed for abuse in the sample of 4.</p> <p>The findings include:</p> <p>The Final Incident Investigation Report dated 3/27/24 for R2 showed the resident that was verbally abused was R1 and the resident accused of abuse was R2. The original allegation showed R2 was in an area of the dining room, repeatedly in an agitated manor calling R1 a black n***** multiple times and this was witnessed by other African American residents. The facts that were determined in the investigation showed R2 was in the dining room and was using derogatory statements towards the African American Resident population.</p> <p>On 4/2/24 at 9:33 AM, V3 ADON (Assistant Director of Nursing) stated R2 was calling R1 a n*****. R1 was upset and said we need to get R2 out of there. V3 stated she told R2 to leave the dining room. V3 stated R2 is alert and oriented but has a lot of psychiatric problems. V3 stated R2 was moved to the third floor.</p> <p>On 4/2/24 at 10:05 AM, R1 stated R2 was calling him a n***** and it made him feel low and bad. R1 stated R3 was at the table with him, and he thought R4 was behind him when this happened.</p> <p>On 4/2/24 at 10:12 AM, R3 stated she was sitting at a table with R1 when this happened. R3 stated R2 has been bothering her for a long time. R2 gets in her face, argues, and says nonsense. R3 stated R2 harasses her. R3 stated R2 called her a n*****. R3 stated when someone uses that word their intent when they use it is to hurt your feelings.</p> <p>On 4/2/24 at 10:38 AM, R4 stated R2 has called him names before and has called him a n*****. R4 stated he has heard her say it but no one else heard her when she said it. R4 stated it makes him angry when someone says n*****. R4 stated R2 always picks on R3. R4 stated R2 has it out for R3 because of R1. R3 and R1 are always together and R2 wants to be around R1 but R3 doesn't like that.</p> <p>On 4/2/24 at 11:03 AM, R2 stated R3 did not like her sitting at the table with R3 and R1 but doesn't know about any argument with them. R2 stated she was trying to be nice to R3. R2 stated V6 CNA (Certified Nursing Assistant) made her mad and told her to go to her room and did not tell her why she had to go to her room. R2 stated V6 was pushing her buttons and she said n***** by accident.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/2/24 at 1:10 PM, V6 CNA (Certified Nursing Assistant) stated, When I came in that morning R1 and R3 were at a table and so was R2. R1 and R3 play cards; they ignore R2 when she says things. R2 was calling R3 big and fat. At breakfast it got worse. I asked R2 to move to another table and she refused. I asked R2 to go to her room and she refused. R2 said I can't tell her what to do you n*****. Then she R2 called R3 a n***** and R1 a n***** that really upset R1. R2 has called me that before but I haven't heard her call a resident that. R2 would call me that in front of other black residents. V2 DON (Director of Nursing) and V3 ADON (Assistant Director of Nursing) know about R2's behavior. R2 was bad on the third floor so they brought her to the second floor, and she continued her behavior. Now R2 is back on the third floor.</p> <p>The Facility's Abuse Prevention Program policy (no date) showed, verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.</p> <p>The Face Sheet dated 4/2/24 for R2 showed diagnoses including epilepsy, schizoaffective disorder, cellulitis, osteoarthritis, depressive episodes, and vertigo.</p> <p>The Behavior Monitor record for March 2024 for R2 showed staff were to monitor for the following behaviors: itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, and refusing care. Staff are to document N if the resident is monitored and none of the behaviors were observed. Staff are to document Y if the resident is monitored and any of the behaviors are observed. On 3/26/24 No is documented for behaviors on the day, evening, and night shift and this was the date of the incident. The record showed R2 had behaviors on 3/3, 3/6, 3/13, 3/17, 3/27, 3/20, 3/24, and 3/27.</p> <p>The Psychiatrist Note dated 3/26/24 for R2 showed she has been exhibiting increased delusional behavior, irrational thinking, and racing thoughts. Her verbal aggression towards other residents in the nursing home has escalated, and she is displaying significant anxiety coupled with irrational thought patterns. Her medication regiment includes risperidone 2 mg taken twice daily, and she has been prescribed seroquel 50 mg in the morning and 100 mg at night. Despite this, the patient has been selectively non-compliant with her seroquel intake, leading to a deterioration in her behavior over the past two-three weeks, likely exacerbated by her inconsistent medication adherence.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>20042</p> <p>Based on interview and record review the facility failed to ensure a thorough investigation of an abuse allegation was conducted for 1 of 3 abuse investigations reviewed involving 2 of 4 residents (R1, R2) in the sample of 4.</p> <p>The findings include:</p> <p>The Final Incident Investigation Report dated 3/27/24 for R2 showed the resident abused was R1 and the resident accused of abuse was R2. The original allegation showed R2 was in an area of the dining room, repeatedly in an agitated manor calling R1 a black n***** multiple times and this was witnessed by other African American residents. The facts that were determined in the investigation showed R2 was in the dining room and was using derogatory statements towards the African American Resident population. The investigation did not have any interviews conducted with R1, R2, or any other residents present (R3). The investigation did not have any interviews of other employees and residents that have contact with R2.</p> <p>On 4/2/24 at 9:33 AM, V3 ADON (Assistant Director of Nursing) stated R2 was calling R1 a n*****. R1 was upset and said we need to get R2 out of there. V3 stated she told R2 to leave the dining room. R2 is alert and oriented but has a lot of psychiatric problems. R2's normal behavior is to get in residents faces and has not called other residents names before that she has heard. R2 may call someone stupid or say she doesn't like them. V3 stated R2 has not said the word n***** before.</p> <p>On 4/2/24 at 10:05 AM, R1 stated R2 was calling him a n***** and it made him feel low and bad. R1 stated R3 was at the table with him, and he thought R4 was behind him. R1 stated no one asked him about the incident.</p> <p>On 4/2/24 at 10:12 AM, R3 stated she was sitting at a table with R1 when this happened. R3 stated R2 has been bothering her for a long time. R2 gets in her face, argues, and says nonsense. R3 stated R2 harasses her. R3 stated R2 called her a n*****. R3 stated when someone uses that word their intent when they use it is to hurt your feelings. R3 stated no one asked her about what happened.</p> <p>On 4/2/24 at 10:38 AM, R4 stated R2 has called him names before and has called him a n*****. R4 stated he has heard her say it but no one else heard her when she said it. R4 stated it makes him angry when someone says n*****. R4 stated R2 always picks on R3. R4 stated R2 has it out for R3 because of R1. R3 and R1 are always together and R2 wants to be around R1 but R3 doesn't like that.</p> <p>On 4/2/24 at 10:45 AM, V4 RN (Registered Nurse) stated she was off when the incident happened and that no one has interviewed her about R2. V4 stated R2 has called residents names and it upsets the other residents.</p> <p>On 4/2/24 at 11:03 AM, R2 stated R3 did not like her sitting at the table with her and R1 but doesn't know about any argument with them. R2 stated she was trying to be nice to R3. R2 stated V6 CNA (Certified Nursing Assistant) made her mad and told her to go to her room and did not tell her why she had to go to her room. R2 stated V6 was pushing her buttons and she said n***** by accident.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/2/24 at 1:35 PM, V3 ADON (Assistant Director of Nursing) stated V1 (Administrator) is the abuse coordinator, but he delegates the investigations to her. V3 stated when she does an investigation, she interviews the staff that were there and saw what happened. V3 stated she tried to interview R1 but at the time R1 was really upset. V3 stated she could have interviewed R1 later. V3 stated she normally interviews the resident involved and other residents present. V3 stated she did not interview any other staff or residents. V3 stated that looking back she probably should have interviewed them. V3 stated R1 and R3 are alert, oriented and interviewable. V3 stated R2 must be approached like a child at times but at other times she is able to talk normally to her.</p> <p>The Facility's Abuse Prevention Program policy (no date) showed, verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Investigation Procedures: An interview with the person(s) reporting the incident. Interviews with any witnesses to the incident. An interview with the resident. Interview with other residents to which the accused individual has regular contact. Interview other employees to determine if they have ever witnessed other incidents of mistreatment involving the accused individual. An interview with the accused individual or individuals (with a witness present).</p>		