

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 08/13/2024
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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35174</p> <p>Based on observation, interview, and record review the facility failed to protect the resident's right to be free from physical abuse by another resident which applies to 5 of 5 residents (R1, R2, R3, R4, R5) reviewed for abuse in a sample of 7. This failure resulted in R1 sustaining a right hip fracture.</p> <p>The findings include:</p> <p>1. R1's Facesheet printed on 8/12/24 showed R1 to be a [AGE] year-old male admitted to the facility with diagnoses which include: metabolic encephalopathy, hemiplegia (right sided), vascular dementia, cerebral infarction.</p> <p>R2's Facesheet printed on 8/12/24 showed R2 to be an [AGE] year-old male admitted to the facility with diagnoses which include: dementia and Alzheimer's disease.</p> <p>The facility's Final Incident Report dated 8/4/24 showed R1 and another male (R2) had an altercation on 7/31/24. It is noted R1 and R2 have dementia and cognitive deficits. R1 approached R2 who was sitting in a chair. R1 attempted to get R2 to move from the chair. R2 stood up and struck R1 in the face. R1 then fell back onto the floor.</p> <p>On 8/12/24 at 1:00 PM, R6 stated, A few of us (residents) were in the dining room area before breakfast time. (R2) was sitting in (R1's) spot. (R1) gets upset when other residents are sitting in his chair. (R1) nudged (R2), waved his hands to (R2) to get away. (R2) stood up and punched (R1) in the face. (R1) fell back on the floor.</p> <p>On 8/12/24 at 2:00 PM, R7 stated, When (R1) walked into the dining room (R1) got upset. We (residents) do not have assigned seats, but (R1) has his chair he sits in all the time. (R1) walked up to (R2), (R1) tapped (R2) on the arm, and (R2) punched (R1) in the face. (R1) fell back on the floor and landed on his butt.</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/13/24 at 11:00 AM, V3 (Assistant Director of Nursing) stated R1 initially had no signs of injury. After the incident R1 was placed in a wheelchair at the table for breakfast. At the end of breakfast V10 (Certified Nursing Assistant/CNA) came and asked me to look at R1. V3 stated R1 usually ambulates by himself with no assistance. At that time R1 was having difficulty standing up and bearing weight on his right leg. V3 stated when R1's leg was moved R1 winced in pain. V3 stated R1 was sent out to the hospital.</p> <p>R1's Hospital Records showed he was admitted on [DATE] with a right hip fracture after having an altercation with another resident. These records showed R1 needed to have hip surgery to repair the fracture.</p> <p>On 8/12/24 at 9:20 AM, V2 (Director of Nursing/DON) showed this writer R1's right hip which had a dressing covering a surgical site.</p> <p>2. The Facility's Final Incident report dated showed R3 was waiting for bingo to start in the 3rd floor dining room. R3 asked a male resident (R2) if he could move because he was sitting in her chair. This report showed R2 got upset and struck R3 in the face and arm. The Report was filled out and completed by V3.</p> <p>On 8/12/24 at 11:45 AM, R3 stated she was in the dining room to play bingo. 'The Chinese guy' (R2) was sitting in my chair. I leaned over to ask him if he could move. (R2) swung at me and hit me in my face and arm. R3 stated she immediately went to V7 (Registered Nurse/RN) about it. R3 stated she was upset at the time but is fine now.</p> <p>On 8/12/24 at 12:35 PM, V7 (RN) stated R3 came out of the dining room yelling the Chinese guy hit her in the face and arm. V7 stated she went to check the dining room. (R6) and (R7) told me (R2) hit (R1).</p> <p>On 8/12/24 at 2:00 PM, R7 stated, A while ago we were waiting to start bingo. (R2) was sitting in a chair by the wall. (R3) came in and started yelling at (R2). (R2) started swinging at (R3). R7 stated she was not sure where R2 hit R3. R3's back was to her. R3 then left the dining room yelling for V7.</p> <p>On 8/12/24 at 9:20 AM, attempted to interview R2 with V2 (DON) as a translator. R2 only speaks Korean. R2 stated he does not remember hitting anyone.</p> <p>3. R5's Facesheet printed on 8/12/24 showed R5 to be a [AGE] year-old male resident admitted to the facility with diagnoses which include: dementia, traumatic subdural hemorrhage, and unspecified psychosis.</p> <p>R4's Facesheet printed on 8/12/24 showed R4 to be a [AGE] year-old male with diagnoses which include: dementia, unspecific psychosis, and major depressive disorder.</p> <p>The facility's Incident Report dated 7/10/24 showed R5 was found sitting on the floor outside another resident's room (R4). R5 had a laceration above his left eye. This Report showed R4 stated R5 tried to come into his room. R4 stated he pushed R5 out of his room, R5 stumbled, and hit the doorway as he fell . This report showed R5 sustained a laceration to his left eyebrow approximately 2 centimeters long.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R4's emergency room report dated 7/16/24 showed R4 was treated for a laceration repair.</p> <p>On 8/13/24 at 9:30 AM R5 was sitting in the dining room. R5 had a reddish scar above his left eyebrow.</p> <p>The facility's Abuse Policy dated 7/3/12 showed the facility affirms the rights of the residents to be free from abuse.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35174</p> <p>Based on interview and record review the facility failed to notify law enforcement when an allegation of physical abuse occurred which applies to 4 of 4 residents (R1, R2, R4, R5) reviewed for abuse notification in a sample of 7.</p> <p>The finding include:</p> <p>1. The facility's Final Incident Report dated 8/4/24 showed R1 and another male (R2) had an altercation on 7/31/24. It is noted R1 and R2 have dementia and cognitive deficits. R1 approached R2 who was sitting in a chair. R1 attempted to get R2 to move from the chair. R2 stood up and struck R1 in the face. R1 then fell back onto the floor. This report showed the police were not contacted after both residents' families declined to contact them.</p> <p>R1's Hospital Records showed he was admitted on [DATE] with a right hip fracture after having an altercation with another resident. These records showed R1 needed to have hip surgery to repair the fracture.</p> <p>2. The facility's Incident Report dated 7/10/24 showed R5 was found sitting on the floor outside another resident's room (R4). R5 had a laceration above his left eye. This Report showed R4 stated R5 tried to come into his room. R4 stated he pushed R5 out of his room, R5 stumbled, and hit the doorway as he fell. This report showed R5 sustained a laceration to his left eyebrow approximately 2 centimeters long. This report showed R5's family declined to have the police called.</p> <p>R4's emergency room report dated 7/16/24 showed R4 was treated for a laceration repair.</p> <p>On 8/13/24 at 11:30 AM, V3 (Assistant Director of Nursing) stated she believed the police did not have to be called if the families did not want to contact them (press charges). V3 stated a resident hitting another resident and causing a fracture is considered a serious injury. The police should have been contacted.</p> <p>R1 and R5's medical record showed no indication law enforcement was notified after receiving an injury from being struck or pushed physically by another resident.</p>		