

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  06/06/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47552</b></p> <p>Based on observation, interview, and record review the facility failed to ensure a resident, dependent upon staff for cares, had a call light system in place to meet the needs of the resident. This applies to 1 of 20 residents (R4) reviewed for accommodation of needs in the sample of 20.</p> <p>The findings include:</p> <p>R4's Minimum Data Set (MDS) dated [DATE] shows R4 is dependent upon staff for oral hygiene, toileting hygiene, showering/bathing, lower body dressing, personal hygiene, putting on/taking off footwear, rolling left to right in bed, and for all transfers.</p> <p>On 6/2/24 at 10:51 AM, R4 was lying in bed watching television. R4's call light rope was hanging from a switch above R45's (R4's roommate) bed. R4, although nonverbal, was able to say yes when asked if she had a difficult time asking for help from staff.</p> <p>On 6/3/24, direct observations from the third-floor nurse's station were made from 12:07 PM until 12:24 PM. During that time, R4 was making intermittent audible verbal sounds at 12:07 PM, 12:10 PM, 12:13 PM, 12:14 PM, 12:17 PM. R4's audible noises became louder and R4 would continue with the noises for roughly 15 seconds at a time. At 12:18 PM, R45 (R4's roommate) returned to the room and stated that R4 makes those noises when she needs help. R45 proceeded to communicate with R4 to determine the level of help she required. During this time, R4's call light was still not within reach.</p> <p>On 6/3/24 at 12:20 PM, R45 left the room to go alert staff that R4 required assistance.</p> <p>On 6/3/24 at 12:22 PM, R4's audible noises turned into what sounded like a painful howl. V16 Registered Nurse (RN) entered R4's room at 12:24 PM with another staff member to address R4's needs.</p> <p>On 6/4/24 at 1:42 PM, V16 RN stated that R4 is nonverbal but will make audible noises when she requires assistance. There are no other ways for R4 to request assistance from staff. V16 stated they have tried using the call light rope and that it should always be within reach but does not know if R4 can use it. V16 is not aware of any other methods for R4 to alert staff when she requires assistance. V16 stated staff would be responsible for checking on R4 more frequently to make sure R4's needs are met.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility Call Light, Use of policy dated 7/10 states, . 7. When providing care to residents be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light.</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>34314</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident was provided privacy during wound dressing changes. This applies to 1 of 20 residents (R6) reviewed for privacy in the sample of 20.</p> <p>The findings include:</p> <p>On June 2, 2024, at 11:39 AM, R6 was sitting in his reclining wheelchair in the dining room. V15 Registered Nurse (RN) changed R6's right heel dressing while he was sitting in the dining room. There were approximately 20 residents in the dining room. They could see/watch V15 change his dressing.</p> <p>On June 2, 2024, at 12:48 PM, R6 was lying in bed. V15 RN was changing the dressing to R6's buttocks. The bedside curtain and door to his room was open. R6 is the first bed in the room. You could see R6 from the hallway.</p> <p>One June 5, 2024, at 12:36 PM, V3 Assistant Director of Nursing stated, staff should not be doing dressing changes in the dining room, and they need to provide privacy for the residents.</p> <p>The facility's residents right to personal privacy dated September 1, 2011, shows, Policy: Facility staff must examine and treat residents in a manner that maintains the privacy of their bodies. A resident must be granted privacy when treatments are given. Staff should pull privacy curtains, close doors, or otherwise remove residents from public view and provide clothing or draping to prevent unnecessary exposure of body parts during the provision of personal care and services.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40085</b></p> <p>Based on observation, interview, and record review the facility failed to ensure staff-dependent residents were bathed, their nails were cut, and facial hair was groomed for 3 of 20 residents (R1, R24, R64) reviewed for activities of daily living (ADL's) in the sample of 20.</p> <p>The findings include:</p> <p>1. On 6/2/24 at 11:39 AM, R24, who is nonverbal, was lying in bed. His nails, on both hands, were approximately 1/2-1 inch in length, with some curling back. R24's shower schedule shows he should receive showers/baths on Monday and Thursday. The facility shower sheets for R24 showed he had a bed bath on 5/6/24 and not again until 6/3/24. R24's active care plan shows he has diagnoses of dementia, communication deficit, and requires extensive to total staff assistance with his Activities of Daily Living.</p> <p>On 6/2/24 at 11:57 AM, V24 (Certified Nursing Assistant/CNA) stated residents should be given showers or baths 2 times a week, nails should be cut, and facial hair shaved during that time.</p> <p>On 6/3/24 at 10:10 AM V3 (Assistant Director of Nursing/ADON) was in the room providing cares to R24 with V24. V24 said I thought the nail doctor cuts nails (R24's) nails? V3 ADON replied, No the doctor comes for toenails.</p> <p>On 6/5/24 at 9:00 AM, R24 was observed to still have long nails.</p> <p>2. On 6/2/24 at 11:40 AM, R1 was sitting up in a chair in his room. R1 had long stubbly facial hair, and very long nails with a visible black thick substance under the nail beds. R1 said, Yes these nails are very long. I need them cut. The facility shower schedule showed R1 should be given showers on Mondays and Thursdays.</p> <p>On 6/5/24 at 9:01 AM, R1 was observed to still have long dirty nails and facial stubble.</p> <p>R1's active care plan shows he has a self-care deficit and requires extensive staff assistance with his ADL's.</p> <p>3. On 6/2/24 at 10:10 AM, R64 stated she has only gotten one shower since she was admitted about a month ago, and she only got that because her mom came to the facility and threw a fit. The facility shower schedule showed R64 should receive a shower on Mondays and a second shower was not listed for R64. Facility shower sheets indicate that R64 refused a shower on 5/6/24, and 5/13/24 but was given one on 5/20/24, which was her last documented shower.</p> <p>On 6/5/24 at 9:55 AM, R64 stated she does not and did not refuse to take showers at the facility, she wants showers.</p> <p>On 6/5/24 10:07 AM, V27 (CNA) stated residents are supposed to receive showers two times a week. V27 stated usually they can get to them on his shift, but he cannot speak for the evening shift.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R64's face sheet shows she was admitted to the facility on [DATE]. R64's active care plan shows she has a self-care deficit and requires staff assistance with ADL's.</p> <p>The facility provided policy on Nail Care dated July 2010, shows that nails should be kept clean, trimmed and smooth and be completed at bath time or shortly after. The facility's Shower for the Resident policy (undated) does not address a time frame that showers should be given.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34314</p> <p>Based observation, interview, and record review the facility failed to ensure the residents were provided activities. This applies to 3 of 20 residents (R48, R65, R74) reviewed for activities in the sample of 20.</p> <p>The findings include:</p> <p>On June 2, 2024, at 10:11 AM, 11:26 AM, 11:39 AM, 11:46 AM, 12:03 PM and 12:58 PM, R48 and R65 were sitting in the dining room in reclining wheelchairs. There were no activities going on. The television was the only thing on.</p> <p>On June 2, 2024, at 10:30 AM, R74, the facility's resident council president stated, there isn't any activities. They have to entertain themselves.</p> <p>On June 3, 2024, at 10:03 AM, R48 and R65 were sitting in the dining room in their reclining wheelchairs. There were no activities going on. The television was the only thing on. At 10:21 AM, V22 Certified Nursing Assistant (CNA) started playing BINGO with the residents that could play (5 residents). R48 and R65 did not play bingo but remained in the dining room watching everyone else play.</p> <p>On June 4, 2024, at 12:25 PM, V3 Assistant Director of Nursing (ADON) stated, there is no activity director and only 1 activity assistant.</p> <p>On June 4, 2024, at 1:58 AM, V22 CNA stated, only on certain days they do stuff with the residents. It's too much for one person. She stated, she is trying to watch the residents that stand up and do activities and she can't by herself.</p> <p>R48's activities quarterly/annual participation review dated March 18, 2024, shows, The resident is alert but not oriented and likes to sit with her peers in the group. She is interested to do building blocks .</p> <p>R48's activities care plan dated November 30, 2021, shows, Focus: Resident is alert/oriented but confused/forgetful at times with impaired cognition due to Dementia Has interest in religious r/t (related to) programs. Interventions: 2. Encourage to attend/participate in interim activity program as tolerated and increase socialization. 3. Inform the resident when programs of interest occur. Orient to the activity calendar. 5. Offer the resident independent leisure materials with options addressing areas she might like to pursue. 14. Do daily round/short pop-up visit.</p> <p>R65's care plan dated May 4, 2023, shows, Interventions .The resident needs a variety of activity types and locations to maintain interests.</p> <p>R74's Minimum Data Set, dated dated dated [DATE], shows, he is cognitively intact.</p> <p>The facility's activity calendar for June 2024 shows, June 2nd: 10:00 AM- Documentary, 1:30 PM Classic Music. June 3rd: 10:00 AM- Exercise, 1:30 PM Rock &amp; Roll. None of these activities were done during the survey.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility did not provide an activity policy.</p>

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<p>F 0680</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure the activities program is directed by a qualified professional.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34314</p> <p>Based on observation, interview, and record review the facility failed to employ a qualified, full time activity director. This failure applies to all 84 residents residing in the facility.</p> <p>The findings include:</p> <p>The CMS-671 form dated June 2, 2024, shows, there was 84 residents residing in the facility.</p> <p>On June 2nd and 3rd, 2024, no activities were observed.</p> <p>On June 2, 2024, at 10:30 AM, R74, the facility's resident council president stated, there isn't any activities. They have to entertain themselves.</p> <p>R74's Minimum Data Set, dated dated dated [DATE], shows, he is cognitively intact.</p> <p>On June 4, 2024, at 12:25 PM, V3 Assistant Director of Nursing stated, there is no activity director and one activity assistant.</p> <p>On June 5, 2024, at 9:14 AM, V2 Director of Nursing stated, she does not have a activity director. She has been gone since March 2024. There is only 1 activity assistant for the entire building. She does not have the qualifications of an activity director.</p> <p>The facility's job description and performance standards for the activity director shows, Purpose of this position: The purpose of this position is to develop and implement an activity program in compliance with requirements to meet residents' needs.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>40085</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident with a skin rash was assessed and failed to ensure a skin treatment was applied according to standards of practice, for 1 of 20 residents (R17) reviewed for quality of care in the sample of 20.</p> <p>The findings include:</p> <p>On 6/2/24 at 11:06 AM, R17 stated she has a terrible rash, that has been there for over 2 weeks, on her back and in her groin. R17 proceeded to pull down her pants and show this surveyor the rash, that was bright red in color, between her legs and spreading down both thighs. R17 also pulled up her shirt and showed this surveyor a spotty pinpoint rash on her back with some scabbed areas from itching. In R17's shirt pocket was a bottle of Nystatin powder. R17 stated she has told the nurses about the rashes, but no doctor has seen her. The nurses gave her the powder and told her to put it on herself. R17 stated she told the nurse again today (V16 Registered Nurse) who stated she would come and take a look at it.</p> <p>On 6/3/24 at 12:32 PM, V16 RN stated she had not been in to see R17's rash yet but she would look at it today and have the wound physician see it as well. V16 said she was not aware of a rash to R17's back. V16 was asked about the Nystatin that was left in R17's room for her to apply herself and V16 stated that should not have happened, the nurses need to apply the powder and assess the rash.</p> <p>On 6/3/24 at 12:40 PM, R17 stated no one had been in to see her yet, the Nystatin powder was still in R17's shirt pocket.</p> <p>R17's Treatment Administration Record shows an active order, with a start date of 5/24/24, for Nystatin powder to her groin two times a day. There was no order for an ointment for the rash to R17's back.</p> <p>The only documented assessment prior to 6/3/24, provided by the facility for R17's rashes, was a nursing note completed by V16 RN on 5/28/24 that states skin check every Tuesday for skin monitoring, redness to groin.</p> <p>On 6/3/24 at 1:25 PM, V35 (Wound Nurse Practitioner) stated he was not aware of the rashes to R17 until today. V35 believes the rash on R17's back is a form of an allergic reaction, and the rash in her groin is a fungal infection.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>34314</p> <p>Based on observation, interview, and record review the facility failed to ensure a sacral pressure injury was assessed, reported to the physician, and a treatment for the injury was in place. The facility also failed to follow physician orders for pressure injuries. This applies to 1 of 3 residents (R6) reviewed for pressure injuries in the sample of 20.</p> <p>The findings include:</p> <p>On June 2, 2024, at 11:39 AM, V15 Registered Nurse (RN) was changing R6's right heel dressing. R6 had an approximate 1-inch abrasion to his left knee. V15 RN stated, they are leaving it open to air and then put betadine on it.</p> <p>On June 2, 2024, at 12:48 PM, V15 RN was changing R6's sacral wound dressing. R6 had a large, ping pong ball size, purple/red open area on his right buttock. He (R6) had the same size/color wound on his left buttock that was connected to the right buttock. V15 RN stated, she first saw the wound on Wednesday of that week. She was waiting for the wound doctor to come in and evaluate the wound. He was supposed to come that day (June 2, 2024) but wasn't coming now. She (V15) stated, the wound was worse than what she saw on Wednesday. There were no physician orders/treatments in place for the wound. She was just putting betadine on it and covering it with a foam dressing.</p> <p>R6's medical record does not show any assessments of the sacral wound by V15 RN or other nursing staff.</p> <p>R6's progress notes dated April 28, 2024, shows, Resident readmitted from local hospital . Has skin issues on left knee, right heel, both bottom with form dressings on them .</p> <p>R6's progress notes dated June 2, 2024, shows, .Wound dr/doctor supposed to come and evaluate the wound today, but he didn't make it. DON/ADON (Director of Nursing/Assistant Director of Nursing) made aware the sacral wound.</p> <p>R6's Treatment Administration Record (TAR) for the month of June 2024 shows, Left knee, every day shift every Tue, Thu, Sat for treatment, cleanse with normal saline, apply adaptic and foam island (dressing).</p> <p>R6's TAR for the month of June 2024 shows, Cleanse sacral wound with normal saline and put medi-honey with dry-foam dressing on it every shift until healed . The start date for this physician order is June 3, 2024.</p> <p>R6's wound doctor evaluation dated June 3, 2024, shows, sacral pressure wound measuring 6 x 6 x 0.3 (6 cm (centimeters) X 6 cm X 0.3 cm) with 50% purple ecchymosis. Date treatment initiated: 6/3/2024.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R6's care plan dated February 25, 2024, shows, The resident may be at risk for skin breakdown related to the following factors which have a causal relationship or complicate the condition: lack of mobility, bowel and/or bladder incontinence, presence of one or more risk factors but no current ulcers, skin problems or lesions. Approaches/Interventions: .Administer prescribed medications and treatments per doctor's orders.</p> <p>R6's care plan does not address his current pressure injuries.</p> <p>The facility's management/treatment of pressure ulcer(s) dated November 1, 2012, shows, Purpose: The facility will have protocols in place in the even a newly identified pressure ulcer is noted the direct care staff will initiate an appropriate treatment to the wound until that time it is further assessed by the wound care nurse. Any newly identified pressure ulcer must have treatment initiated at the time of discovery.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>40085</p> <p>Based on interview and record review the facility failed to provide restorative services to 2 of 5 residents (R24, R64) reviewed for restorative cares in the sample of 20.</p> <p>The findings include:</p> <p>1.) On 6/2/24 at 11:37 AM, R24 who is nonverbal, was lying in bed with contractures noted to both hands. R24's active care plan shows he has diagnoses including dementia and right sided weakness due to a cerebral vascular accident with contractures to his upper body. R24's Restorative Care Plan shows he requires extensive staff assistance with his Activities of Daily Living and should receive PROM (passive range of motion) to his affected extremities for 15 minutes a day. R24's restorative documentation for the last 30 days showed he was provided range of motion for 15 minutes on 8 out of 30 days 5/9/24, 5/10/24, 5/11/24, 5/16/24, 5/20/24, 5/24/24, 5/29/24 and 6/1/24.</p> <p>On 6/3/24 at 1:42 PM V3 (Assistant Director of Nursing) stated they have a restorative CNA (Certified Nursing Assistant) who should be doing range of motion, and working with residents but he gets pulled to work the floor a lot and then restorative is left up to the CNAs on the floor to complete.</p> <p>On 6/5/24 at 9:13 AM, V32 (Restorative CNA) stated he just covered another CNA's vacation and was pulled to the floor to work for the last 8 days. V32 stated when he is pulled to the floor, he cannot get his restorative job done and the CNA's have to do their own restorative and that may not always be done.</p> <p>On 6/5/24 at 9:20 AM, V24 (CNA) stated she tries to do range of motion for R24 but cannot always get to it when she is the only CNA on that hall.</p> <p>2.) On 6/2/24 at 10:11 AM, R64 stated she was receiving physical therapy however the therapist (V30 Physical Therapist) went out of the country so she was supposed to be walked by the nursing staff but that has not been getting done. R64 additionally stated they are claiming that I always refuse to walk, and I don't. If someone wakes me up, I will go walk with them.</p> <p>On 6/5/24 at 9:25 AM, R64 stated she was walked by her mom yesterday and when her son comes in, he will also walk her. R64 stated one day last week she was too tired to walk because a medication she was on was making her sleepy and did refuse to go but that was the only time that has happened.</p> <p>On 6/5/24 at 9:13 AM, V32 (Restorative CNA) stated R64 is supposed to be walked to the bathroom and back, with a walker, and she can do that with stops to rest, but he is not sure if that is being done when he is pulled to work the floor.</p> <p>On 6/5/24 at 9:35 AM, V27 (CNA) stated he cannot always get time to walk residents when V32 (Restorative CNA) is not there.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R64's Physical Therapy Plan of Treatment shows she was discharged from skilled physical therapy on 5/10/24 but there was no indication on the treatment plan to indicate how often R64 should be walked by the restorative department.</p> <p>R64's ADL (Activity of Daily Living) record for the month of May shows she was not walked at all.</p> <p>A restorative care plan was requested for R64, and what was provided by the facility was a self-care deficit care plan which lists range of motion to be done but no mention in that care plan of walking her.</p> <p>The facility provided Restorative Nursing Program policy (undated) shows that restorative care should be done to prevent a resident from declining. Restorative programs include range of motion, bed mobility and ambulating residents which should be documented daily.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>34314</p> <p>Based on observation, interview, and record review the facility failed to ensure residents at risk for falls were supervised and interventions were in place to prevent falls. The facility also failed to ensure residents were transferred in a safe manner. These failures apply to 2 of 20 residents (R21, R65) reviewed for safety/supervision in the sample of 20.</p> <p>The findings include:</p> <p>1. On June 2, 2024, at 10:08 AM, R21 was sitting in her wheelchair in the dining room. Her (R21) left eye was yellow/green with sutures to her eyebrow.</p> <p>R21's incident/occurrence report dated May 26, 2024, shows, Resident fell forward in the bed after night CNA (certified nursing assistant) put her back to bed after falling. Noted bleeding on her left forehead d/t (due to) laceration.</p> <p>R21's hospital records dated May 26, 2024, shows, she had a fall with a cut on her face. [NAME] and left eyebrow laceration, stitches or tape. The same records continue to show, Pt (patient) arrives via EMS (emergency medical services) with c/o (complained of) mechanical fall and facial lacerations. Pt resides at the facility assisted living facility with hx (history) of dementia . Per staff at the facility, pt was wheeling herself around in her wheelchair when she struck a corner and fell out of the chair, lacerating her chin and forehead. This occurred at 0700 (7:00 AM) and was unwitnessed but staff heard the fall and assisted the patient up and called EMS.</p> <p>R21's progress notes dated May 26, 2024, shows, Resident sent out to local hosp.(hospital) for fall and hit her head with bleeding d/t forehead laceration via 911 .</p> <p>She was diagnosed as below at local hospital; 1. CHIN LACERATION 2. MILD TRAUMATIC BRAIN INJURY</p> <p>3. PELVIC FRACTURE. She came back from local hosp. after having been 9 stitches done on left forehead without dressings on it.</p> <p>On June 2, 2023, at 12:58 PM, R21 wandered out of the dining room in her wheelchair and was sitting in another resident's room down the hall. No one was watching her. At 1:29 PM, she tried opening the exit door and set off the alarm. No one was watching her.</p> <p>On June 3, 2024, at 10:32 AM, R21 was sitting in her wheelchair in the dining room. She was standing up and sitting down. Her wheelchair was not locked. V22 Certified Nursing Assistant (CNA) was in the dining room but attending to another resident. R21 stood up again and realized she couldn't stand well and tried to sit back down but her wheelchair was unlocked so it moved away from her, and she fell on her right side. V22 CNA was on the other side of the dining room. V22 CNA stated, this is why you can't take your eyes off anyone and do games. She also stated, you cannot take your eyes off R21. It is too much for one person. She will stand up and fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R21's incident report dated June 3, 2024, shows, Resident was trying to get up from w/c (wheelchair) when she fell and landed on her left side . wheelchair was unlocked.</p> <p>R21's care plan date-initiated April 9, 2024 shows, The resident is high, risk for falls r/ t (related to) confusion, gait/balance problems, incontinence, psychoactive drug use, unaware of safety needs. Interventions: Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT (interdisciplinary team) as to causes. The care plan has not updated since April 9, 2024.</p> <p>On June 4, 2024, at 12:25 PM, V4 Assistant Director of Nursing (ADON) stated, she reviews the falls. She reviews them and puts an intervention in place but does not put that information anywhere except her office. She has not added any new interventions for R21. R21 has to be watched. She is everywhere and will stand up and fall.</p> <p>The facility's falls and fall risk, managing policy dated 2001 shows, Policy Statement: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Policy Interpretation and Implementation: Prioritizing Approaches to Managing Falls and Fall Risk: 1. The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff my choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once) .</p> <p>The facility's falls-clinical protocol policy dated 2001 shows, Cause Identification: 1. For an individual who has fallen, staff will attempt to define a possible cause within 24 hours of the fall . Treatment/Management: 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling .</p> <p>2. On June 3, 2024, at 10:47 AM, V21 CNA transferred R65 from one reclining wheelchair to another reclining wheelchair. R65 did not have a gait belt on. R65 tried to sit down before he got to the chair and almost fell .</p> <p>R65's care plan last updated December 31, 2023, shows, July 30, 2023, Staff to use gait belt during transfers.</p> <p>On June 6, 2024, at 12:36 PM, V4 Assistant Director of Nursing stated, staff should be transferring R65 with a gait belt.</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>40085</p> <p>Based on interview and record review the facility failed to ensure the Registered Dietician was immediately notified of a significant weight loss for a resident receiving enteral feedings. This failure resulted in a delay in a resident (R24) being assessed by the dietician to implement interventions to prevent further weight loss. The facility failed to ensure weekly weights were completed for a resident (R1) on enteral feedings with insidious weight loss. This applies to 2 of 3 residents (R24, R1) reviewed for enteral feedings in the sample of 20.</p> <p>The findings include:</p> <p>1. R24's active care plan shows he requires enteral feedings through a Gastrostomy tube (G tube). Hospital records from a local community hospital show he was hospitalized from 2/28/24 through 3/12/24 for placement of a gastrostomy tube.</p> <p>R24's nutritional assessment completed by V7 (Registered Dietician/RD) on 3/25/24 show he was readmitted from the hospital with tube feeding orders for a continuous tube feeding of Glucerna 1.2 at 60 (ml) milliliters per hour. These orders were changed by V7, at the request of the facility, to bolus feedings QID (four times a day).</p> <p>R24's weight summary shows on 4/1/24, R24's weight was 101.0 lbs. (pounds). On 4/4/24 R24's weight was 91 pounds, a 10 lb., 9.9% weight loss in 4 days. On 4/15/24, R24's weight had dropped from 91 lbs. to 87.8 lbs, another 3.2 lbs in 11 days. R1's nursing progress notes do not show that V7(RD) or V29 (R24's Physician and Medical Director) were notified of R24's significant weight loss.</p> <p>A Nutrition/Dietary note completed by V7 (RD) on 4/29/24 shows, Patient with significant weight loss noted, 10% in 1 month, Discussed with RN will change to a continuous tube feeding to meet the needs of the patient. A physician's order dated 4/29/24 shows R24's tube feeding was changed from bolus to a continuous feeding of Glucerna 1.2 at 50 ml. per hour.</p> <p>On 6/4/24 at 10:32 AM, V7 (RD) stated she is only at the facility 16 hours per month. V7 stated she is not immediately notified of weight loss as she finds out by notes left in her mailbox when she comes to the facility. V7 stated she could not recall exactly when she was told of R24's weight loss but she did not see him until 4/29/24 so she assumes it was that day. R24 stated she made immediate changes to the tube feeding orders to be a continuous feeding to try to prevent further weight loss.</p> <p>On 6/5/24 at 7:50 AM, V2 (Director of Nursing) stated she was aware of R24's weight loss and she expects the nurses to call the Dietician and Physician right away for significant weight loss and to chart that in the resident's medical record. V2 stated she was not aware that V7 (RD) was only contracted to come to the facility 2 times per month.</p> <p>On 6/5/24 at 10:35 AM, V29 (R24's Physician) stated he was notified of R24's weight loss but not sure of the date. V29 stated he was also unaware that the nursing staff were only leaving notes in the mailbox for V7 (RD) and not calling her to notify her of significant weight loss. V29 state they will have to fix that process because the Registered Dietician should be notified immediately.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/5/24 at 11:41 AM, V16 (Registered Nurse/RN) stated they do not call the Dietician directly they let V3 (Assistant Director of Nursing) know and then put a note in the Dieticians mailbox. V16 stated they should call the residents physician who usually tells them to notify the Dietician.</p> <p>The facility provided Weight Monitoring policy dated 2017 describes significant weight loss as 5% in one month, 7.5% in 3 months, and 10% in 6 months. The policy shows that the physician and dietician should be notified but fails to indicate a time frame.</p> <p>2. R1's Medication Administration Record shows he receives enteral feedings via a G-tube of Jevity 1.2, 300 ml at breakfast and lunch, and 600 ml. at dinner.</p> <p>R1's 2/12/24 Nutrition note completed by V7 (RD) shows the resident has had a significant weight loss of 8% in 6 months and she recommended weekly weights for 4 weeks to monitor his weight.</p> <p>R1's Weight Summary report shows on 2/5/24 he weighed 132.0 lbs. but, no further weight is documented until 3/12/24. One month after V7 ordered weekly weights for R24.</p> <p>On 6/4/24 at 10:32 AM, V7 (RD) stated R1 has a history of refusing the bolus feedings so he can consume his regular diet order. V7 stated she ordered the weekly weights to keep track of his weight and she expects the facility to do the weights when it is ordered.</p> <p>The facility provided Weight Monitoring policy dated 2017 describes significant weight loss as 5% in one month, 7.5% in 3 months, and 10% in 6 months. The policy shows that the physician and dietician should be notified but fails to indicate a time frame. The policy additional shows that a client's body weight is monitored to maintain acceptable parameters of nutritional status.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>40085</p> <p>Based on observation, interview, and record review the facility failed to ensure oxygen tubing was dated and failed to change humidifier containers on the oxygen concentrator for 2 of 4 residents (R23, R61) reviewed for oxygen administration in the sample of 20.</p> <p>The findings include:</p> <p>On 6/2/24 at 10:42 AM, R23 was in bed with a portable oxygen concentrator next to the bed. R23 stated I am not using it right now because they don't change the filter on the back of the machine or the water container. R23's nasal cannula tubing was not dated, and the humidifier container was dated 4/18/24.</p> <p>On 6/2/24 at 11:10 AM, R61 was in her room with her portable oxygen concentrator running. The nasal cannula tubing was also not dated, and the humidifier container was dated 4/18/24.</p> <p>Both R23 and R61's May 2024 Treatment Administration Record (TAR) shows their oxygen tubing and humidifier container are to be changed every week on Sundays. R23 and R61's TAR is initialed as the oxygen tubing and humidifiers being changed however the date on the humidifier for both residents was 4/18/24, and the tubing was not dated.</p> <p>On 6/3/24 at 8:30 AM, V3 (Assistant Director of Nursing) stated the oxygen tubing and humidifiers should be dated and changed weekly.</p> <p>The facility Oxygen Administration policy dated 2018 shows that humidifiers should be dated and initialed when changed and should be changed according to facility protocol.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35541</p> <p>Based on observation, interview, and record review the facility failed to provide sufficient nursing staff to meet the needs of the residents. This failure has the potential to affect all 84 residents in the facility.</p> <p>The findings include:</p> <p>The facility's Long-Term Care Facility Application for Medicare and Medicaid form dated 6/2/2024 showed a resident census of 84.</p> <p>1. R4's Minimum Data Set (MDS) dated [DATE] shows R4 is dependent upon staff for oral hygiene, toileting hygiene, showering/bathing, lower body dressing, personal hygiene, putting on/taking off footwear, rolling left to right in bed, and for all transfers.</p> <p>On 6/2/24 at 10:51 AM, R4 was lying in bed watching television. R4's call light rope was hanging from a switch above R45's (R4's roommate) bed. R4, although nonverbal, was able to say yes when asked if she had a difficult time asking for help from staff.</p> <p>On 6/3/24, direct observations from the third-floor nurse's station were made from 12:07 PM until 12:24 PM. During that time, R4 was making intermittent audible verbal sounds at 12:07 PM, 12:10 PM, 12:13 PM, 12:14 PM, 12:17 PM. R4's audible noises became louder and R4 would continue with the noises for roughly 15 seconds at a time. At 12:18 PM, R45 (R4's roommate) returned to the room and stated that R4 makes those noises when she needs help. R45 proceeded to communicate with R4 to determine the level of help she required.</p> <p>On 6/3/24 at 12:20 PM, R45 left the room to go alert staff that R4 required assistance.</p> <p>On 6/3/24 at 12:22 PM, R4's audible noises turned into what sounded like a painful howl. V16 Registered Nurse (RN) entered R4's room at 12:24 PM with another staff member to address R4's needs.</p> <p>2. On 6/2/24 at 11:39 AM, R24, who is nonverbal, was lying in bed. His nails, on both hands, were approximately 1/2-1 inch in length, with some curling back.</p> <p>R24's shower schedule shows he should receive showers/baths on Monday and Thursday. The facility shower sheets for R24 showed he had a bed bath on 5/6/24 and not again until 6/3/24.</p> <p>R24's active care plan shows he has a diagnosis of dementia, communication deficit, and requires extensive to total staff assistance with his Activities of Daily Living.</p> <p>On 6/5/24 at 9:00 AM, R24 was observed to still have long nails.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>3. On 6/2/24 at 11:40 AM, R1 was sitting up in a chair in his room. R1 had long stubbly facial hair, and very long nails with a visible black thick substance under the nail beds. R1 said, Yes these nails are very long. I need them cut. The facility shower schedule showed R1 should be given showers on Mondays and Thursdays.</p> <p>On 6/5/24 at 9:01 AM, R1 was observed to still have long dirty nails and facial stubble.</p> <p>R1's active care plan shows he has a self-care deficit and requires extensive staff assistance with his ADL's.</p> <p>4. On 6/2/24 at 10:10 AM, R64 stated she has only gotten one shower since she was admitted about a month ago, and she only got that because her mom came to the facility and threw a fit. The facility shower schedule showed R64 should receive a shower on Mondays and a second shower was not listed for R64. Facility shower sheets indicate that R64 refused a shower on 5/6/24, and 5/13/24 but was given one on 5/20/24, which was her last documented shower.</p> <p>5. On 6/2/24 at 11:37 AM, R24 who is nonverbal, was lying in bed with contractures noted to both hands. R24's active care plan shows he has diagnoses including dementia and right sided weakness due to a cerebral vascular accident with contractures to his upper body.</p> <p>R24's Restorative Care Plan shows he requires extensive staff assistance with his Activities of Daily Living and should receive PROM (passive range of motion) to his affected extremities for 15 minutes a day. R24's restorative documentation for the last 30 days showed he was provided range of motion for 15 minutes on 8 out of 30 days 5/9/24, 5/10/24, 5/11/24, 5/16/24, 5/20/24, 5/24/24, 5/29/24 and 6/1/24.</p> <p>On 6/3/24 at 1:42 PM V3 (Assistant Director of Nursing) stated they have a restorative CNA (Certified Nursing Assistant) who should be doing range of motion, and working with residents but he gets pulled to work the floor a lot and then restorative is left up to the CNAs on the floor to complete.</p> <p>On 6/5/24 at 9:13 AM, V32 (Restorative CNA) stated he just covered another CNA's vacation and was pulled to the floor to work for the last 8 days. V32 stated when he is pulled to the floor, he cannot get his restorative job done and the CNA's have to do their own restorative and that may not always be done.</p> <p>On 6/5/24 at 9:20 AM, V24 (CNA) stated she tries to do range of motion for R24 but cannot always get to it when she is the only CNA on that hall.</p> <p>6. On 6/2/24 at 10:11 AM, R64 said she was receiving physical therapy however the therapist (V30 Physical Therapist) went out of the country so she was supposed to be walked by the nursing staff but that has not been getting done. R64 additionally stated they are claiming that I always refuse to walk, and I don't. If someone wakes me up, I will go walk with them.</p> <p>On 6/5/24 at 9:25 AM, R64 stated she was walked by her mom yesterday and when her son comes in, he will also walk her. R64 said one day last week she was too tired to walk because a medication she was on was making her sleepy and did refuse to go but that was the only time that has happened.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 6/5/24 at 9:13 AM, V32 (Restorative CNA) stated R64 is supposed to be walked to the bathroom and back, with a walker, and she can do that with stops to rest, but he is not sure if that is being done when he is pulled to work the floor.</p> <p>On 6/5/24 at 9:35 AM, V27 (CNA) stated he cannot always get time to walk residents when V32 (Restorative CNA) is not there.</p> <p>On 6/3/24, during the resident meeting, R11 and R40 each stated there was not always a nurse assigned to the third floor on the night shift (11 PM-7 AM). R11 stated, There are nights we don't have a nurse. I get scared because what if I choke and no one is there to help me? When we don't have a nurse at night, my 6 AM meds (medications) are late. They aren't given until after 7 AM when the day nurse arrives.</p> <p>On 6/4/24 at 10:00 AM, R28 stated, There has been nights when we haven't had a nurse on the floor. One night I needed a pain pill but there was no one to tell.</p> <p>On 6/3/24 at 2:00 PM, the facility's nursing schedules dated 5/19/24-6/2/24 were reviewed and showed the following:</p> <p>a. On 5/19/24 (Sunday), V34 Registered Nurse (RN) was assigned to both the second and third floors of the facility from 11 PM-7 AM. A daily census form dated 5/19/24 showed 1 Nurse (V34) was responsible for 87 residents from 11 PM-7 AM.</p> <p>b. On 5/20/24 (Monday), No nurse was assigned to the second floor of the facility from 11 PM-7 AM. V2 Director of Nursing (DON) was assigned to the third floor from 11 PM-7 AM. A daily census form dated 5/20/24 showed 1 Nurse (V2 DON) was responsible for 87 residents from 11 PM- 7 AM.</p> <p>c. On 5/27/24 (Monday), V34 RN was assigned to both the second and third floors of the facility from 11 PM-7 AM. A daily census form dated 5/27/24 showed 1 Nurse (V34) was responsible for 85 residents from 11 PM-7 AM.</p> <p>d. On 5/28/24 (Monday), V34 RN was assigned to both the second and third floors of the facility from 11 PM-7 AM. A daily census form dated 5/28/24 showed 1 Nurse (V34) was responsible for 86 residents from 11 PM-7 AM.</p> <p>e. On 6/2/24 (Sunday), No nurse was assigned to the second floor of the facility from 11 PM-7 AM. V34 RN was assigned to the third floor from 11 PM-7 AM. A daily census form dated 6/2/24 showed 1 Nurse (V34) was responsible for 85 residents from 11 PM-7 AM.</p> <p>On 6/4/24 at 7:43 AM, V19 RN stated, I always work the second floor. We are sometimes short-staffed. There have been nights when I am the only nurse for the whole building . If I work both floors, I don't pass 6 AM meds on the third floor. I don't have time. I will pass PRN (as needed) meds to residents on the third floor if they need them .I tell the CNAs on the third floor to call me if there is an emergency.</p> <p>On 6/4/24 at 10:07 AM, V16 RN stated, Yes, there have been days that I have come in for day shift and there has not been a night nurse. Sometimes residents haven't gotten their 6 AM meds.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 6/4/24 at 11:56 AM, V2 DON stated she was responsible for completing the nursing schedule and ensure sufficient staffing. V2 stated she was aware the facility was short-staffed, specifically on nights (11 PM-7 AM). V2 stated, We are supposed to have one nurse assigned to the second floor and one nurse assigned to the third floor on nights. There are nights we only have one nurse for both floors, but I sleep here in case they need anything.</p> <p>The facility's Facility Assessment Tools revised 7/31/23 showed the second floor and third floors were to each have their own nurse assigned from 11 PM- 7 AM as part of the facility resources needed to provide competent support and care for resident population every day and during emergencies.</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>34314</p> <p>Based on observation, interview, and record review the facility failed to monitor behaviors and provide stimulation for residents with a diagnosis of dementia. This applies to 3 of 3 residents (R21, R53, R138) reviewed for dementia in the sample of 20.</p> <p>The findings include:</p> <p>1. R21's face sheet list diagnoses to include dementia.</p> <p>On June 2, 2024, at 10:08 AM, R21 was sitting in the dining room in her wheelchair. There were no activities going on and she was just sitting there. At 11:15 AM, she was trying to leave the dining room. V22 Certified Nursing Assistant (CNA) brought her back into the dining room and put her at the table. At 12:03 PM, she was standing up and down in her wheelchair trying to take food off other resident's trays. She wheeled herself over to the lunch cart and was trying to take food off the cart. At 12:58 PM, she wandered out of the dining room in her wheelchair and was sitting in another resident's room down the hall. No one was watching her. At 1:29 PM, she tried opening the exit door and set off the alarm. No one was watching her.</p> <p>On June 3, 2024, at 9:17 AM, R21 was sitting in the dining room doing nothing. At 10:21 V22 CNA started playing bingo with other residents. R21 was not offered to play bingo or played bingo. At 10:32 AM, she kept standing up and down. She ended up falling out of her wheelchair, on her right side.</p> <p>R21's care plan dated August 8, 2023, shows, The resident has impaired cognitive function/dementia or impaired thought processes r/t Dementia, difficulty making decisions, impaired decision-making, long-term memory loss, neurological symptoms.</p> <p>R21's care plan does not address her behaviors.</p> <p>2. R53's face sheet list diagnoses to include dementia.</p> <p>On June 2, 2024, at 10:20 AM, R53 was sitting in a reclining wheelchair in the dining room doing nothing. There were no activities going on and she was just sitting there. She was fidgeting with a blanket and trying to get out of her wheelchair. At 10:59 AM, she was still sitting in the dining room doing nothing trying to get out of her wheelchair. At 12:58 PM and 1:29 PM, she was still sitting in her reclining wheelchair doing nothing. There was staff in the dining room, but they were not engaging with the resident.</p> <p>On June 3, 2024, at 9:17 AM, R53 was sitting in the dining room in her reclining wheelchair. There were no activities going on and she was just sitting there. At 10:21 AM, V22 CNA started playing bingo with other residents. R53 was not offered to play bingo or played bingo. She continued just sitting in her wheelchair fidgeting with her shoes and trying to get out of her wheelchair.</p> <p>R53's care plan does not address her dementia or behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. R138's face sheet lists his diagnoses to include dementia. His face sheet also shows R138 is a Korean speaking resident.</p> <p>On June 2, 2024, at 10:08 AM, 10:20 AM, 10:59 AM, 11:38 AM and 12:58 PM, R138 was sitting in a chair in the dining room. He keeps standing up. V22 CNA would tell him to sit back down. There were no activities going on and he was just sitting there doing nothing.</p> <p>On June 3, 2024, at 9:17 AM, R138 was sitting in a chair in the dining room. There were no activities going on and he was just sitting there. At 10:21 AM, V22 CNA started playing bingo with other residents. R138 was not offered to play bingo or played bingo. He continued just sitting in the chair doing nothing.</p> <p>R138's medical record does not have a care plan or address his dementia or behaviors.</p> <p>On June 4, 2024, at 1:58 PM, V22 Certified Nursing Assistant stated, on certain days she tries to do stuff with the residents but it is too much for one person to do. She is trying to watch the residents that are standing up. She has asked for help because it is too much for one person to do.</p> <p>The facility's dementia-clinical protocol dated 2001 shows, Treatment/Management: 1. For the individual with confirmed dementia, the IDT (Interdisciplinary team) will identify a resident-centered care plan to maximize remaining function and quality of life 4. Direct care staff will support the resident in initiating and completing activities and tasks of daily living. a. Bathing dressing, mealtimes, and therapeutic and recreational activities will be supervised and supported throughout the day as needed</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>35541</p> <p>Based on observation, interview, and record review the facility failed to provide medically related social services to meet the needs of the residents. This failure has the potential to affect all 84 residents in the facility.</p> <p>The findings include:</p> <p>The facility's Long-Term Care Facility Application for Medicare and Medicaid form dated 6/2/2024 showed a resident census of 84.</p> <p>1. R21's face sheet list diagnoses to include dementia.</p> <p>On June 2, 2024, at 10:08 AM, R21 was sitting in the dining room in her wheelchair. At 11:15 AM, she was trying to leave the dining room. V22 Certified Nursing Assistant (CNA) brought her back into the dining room and put her at the table. At 12:03 PM, she was standing up and down in her wheelchair trying to take food off other resident's trays. She wheeled herself over to the lunch cart and was trying to take food off the cart. At 12:58 PM, she wandered out of the dining room in her wheelchair and was sitting in another resident's room down the hall. No one was watching her. At 1:29 PM, she tried opening the exit door and set off the alarm. No one was watching her.</p> <p>On June 3, 2024 at 9:17 AM, R21 was sitting in the dining room doing nothing. At 10:21 V22 CNA started playing bingo with other residents. R21 was not offered to play bingo or played bingo. At 10:32 AM, she kept standing up and down. She ended up falling out of her wheelchair, on her right side.</p> <p>R21's care plan dated August 8, 2023, shows, The resident has impaired cognitive function/dementia or impaired thought processes r/t Dementia, difficulty making decisions, impaired decision-making, long-term memory loss, neurological symptoms.</p> <p>R21's care plan does not address her behaviors.</p> <p>2. R53's face sheet list diagnoses to include dementia.</p> <p>On June 2, 2024, at 10:20 AM, R53 was sitting in a reclining wheelchair in the dining room doing nothing. She was fidgeting with a blanket and trying to get out of her wheelchair. At 10:59 AM, she was still sitting in the dining room doing nothing trying to get out of her wheelchair. At 12:58 PM and 1:29 PM, she was still sitting in her reclining wheelchair doing nothing. There was staff in the dining room, but they were not engaging with the resident.</p> <p>R53's care plan does not address her dementia or behaviors.</p> <p>3. R138's face sheet lists his diagnoses to include dementia. His face sheet also shows R138 is a Korean speaking resident.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On June 2, 2024, at 10:08 AM, 10:20 AM, 10:59 AM, 11:38 AM and 12:58 PM, R138 was sitting in a chair in the dining room. He keeps standing up. V22 CNA would tell him to sit back down. There were no activities going on and he was just sitting there doing nothing.</p> <p>R138's medical record does not have a care plan or address his dementia or behaviors.</p> <p>4. On 6/3/24, during the resident meeting, R11, R55, and F74 each stated the facility did not have a full-time social worker. R55 stated, They have a part-time woman that comes a couple of hours in the evening a few days a week, but we hardly ever see her. R55 stated she had an ongoing conflict with her new roommate with no resolution due to no one here to deal with it. R55 stated she needed someone's assistance to help her work with my insurance so I can find a dentist but there's no one to help do that either. R11 stated, I see my counselor (contracted psychiatric social worker) once a week when she comes in but, I have no one to talk to if I am upset and need to talk to someone when she isn't here.</p> <p>5. R28's Social Service note dated 4/17/24 showed R28 was seen upon admission to the facility by social services. The note showed R28 was admitted to the facility for subacute rehab after a flare-up of her Multiple Sclerosis. R28's medical records dated 4/18/24-6/3/24 showed no other social services notes for R28.</p> <p>On 6/4/24 at 10:00 AM, R28 stated, I was admitted here for rehab. I have a MS (Multiple Sclerosis) flare-up and broke a rib. The plan was never for me to stay here long term. I have a cat and my own apartment. I need to go home. No one has talked to me about my discharge. I haven't talked to anyone in social services in months.</p> <p>On 6/3/24 at 8:44 AM, V3 Assistant Director of Nursing (ADON) stated, We have not had a full-time social worker in a long time. We have (V18 part-time Social Services) that comes in a few hours during the evenings, but she is part-time.</p> <p>On 6/3/24 at 12:12 PM, V18 (part-time Social Services) stated, I work very part-time there. I am under social services, but I am just helping out. I come in for 3-4 hours during the evening; 3-4 days a week. I help do care plans and MDS's (Minimum Data Set), but I am a little behind on the care plans. V18 stated, I don't do any discharge planning. I don't handle grievances unless someone complains to me. I don't do anything with resident council. I don't help set up appointments or counsel residents unless someone stops me when I'm there. I don't do any behavior management counseling unless I see behaviors happening when I'm there. V18 stated R55 did ask her to help R55 find another dentist but told R55 that she does not help with medical referrals. V18 stated, I told her to tell nursing about it.</p> <p>On 6/3/24 at 11:44 AM, V1 Administrator of the facility stated they had not had a full-time social worker in a while.</p> <p>On 6/3/24 at 11:47 AM, V2 Director of Nursing stated, We haven't had someone in full-time in Social Services for a long time. V2 stated social services is responsible for handling resident problems, problems with roommates, resident's grievances, help with behavior management, helping schedule and set-up monthly resident council meetings, and doing discharge planning for residents.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 6/3/24 at 12:15 PM, V17 Human Resources stated the last time the facility had a full-time social services employee was last year. V17 stated, We have never had a Social Service Director that I am aware of. We used to have a consultant for social services but that hasn't been since last year.</p> <p>On 6/4/24 at 11:05 AM, V17 Human Resources stated, I am responsible for providing the yearly abuse, harassment, and privacy education to our nursing staff. Social services usually does the staff dementia training every year but we don't have anyone in social services to do it.</p> <p>On 6/4/24 at 8:31 AM, V3 ADON was asked for the facility's grievance logs from 3/1/24-6/4/24. V3 stated, I don't think we have any. We don't have anyone to complete the logs and always follow up on them. That would be done by social services.</p> <p>A facility form dated 6/4/24 showed no documented grievances from March 2024-June 2024.</p> <p>The facility's Social Service Director (Designee) job description (undated) showed, The purpose of this position is to provide social services to meet the social and/or emotional needs that affect the residents' ability to achieve their highest level of function; participate in the development of residents' comprehensive care plans; develop policies and procedures to provide social services to residents in compliance with federal, state and local regulations The job description showed the Social Service Director was responsible for developing and coordinating family and resident activities designed to promote social interaction . develop one-to-one professional relationships with residents and families as needed for counseling . assess, plan, and document residents' discharge needs . document the social service component of the Comprehensive Care Plan for each resident in a timely manner . refer residents to social, health and community resources and complete accurate documentation in residents' records concerning the results of such referrals .</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>40085</p> <p>Based on observation, interview, and record review the facility failed to ensure medications were dispensed according to standards of practice for 1 of 20 residents (R26) reviewed for pharmacy services in the sample of 20.</p> <p>The findings include:</p> <p>On 6/2/24 at 11:52 AM, on R26's bedside table was a pill cup containing 1 blue pill. R26 stated sometimes when he is in the bathroom, they just leave his medication for him to take. R26 was not able to indicate what pill was in the cup or what time it was left for him. R26 took the pill while this surveyor was in the room.</p> <p>On 6/2/24 at 12:22 PM, V16 (Registered Nurse/RN) stated residents should be supervised taking their medication and R26 does not have an order that he can self-administer his own medication. V16 also stated if the pill was blue, she believes it was probably his Levothyroxine.</p> <p>On 6/3/24 at 8:30 AM, V3 (Assistant Director of Nursing/ADON) stated medications should not just be left for residents to take they should be supervised.</p> <p>R26's Physician Order Summary (POS) shows an order for Levothyroxine to be given one time a day and shows no order for him to self-administer his own medications. R26's Medication Administration Summary shows the Levothyroxine is scheduled to be given at 6:00 AM.</p> <p>The facility provided pharmacy policy titled Medication Administration (undated) shows that residents can only administer their own medication with a physician order and all residents should be observed during medication administration to ensure a resident takes the medication.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>35541</p> <p>Based on observation, interview, and record review the facility failed to ensure opened, multi-dose bottles of medication, inhalers, and insulin pens were labeled with expiration dates for 4 of 4 residents (R64, R20, R45, R82) reviewed for medication storage in the sample of 20.</p> <p>The findings include:</p> <p>1. R64's June 2024 (physician) Order Summary report showed R64 received Advair Diskus (powder) inhaler, 100-50 mcg (micrograms), one puff, twice a day. The order showed R64 received 30 units of Glargine insulin, subcutaneous (SQ), daily.</p> <p>R20's June 2024 (physician) Order Summary report showed R20 received Lispro insulin, as per sliding scale instructions, SQ (subcutaneous), four times a day.</p> <p>R45's June 2024 (physician) Order Summary report showed R45 received Lantus insulin, 25 units, SQ, daily.</p> <p>On 6/2/2024 at 10:50 AM, the third-floor medication (med) cart was reviewed by this surveyor and V16 Registered Nurse (RN). Upon inspection of the cart, the following medications were found opened and not dated with an opened or expiration date:</p> <p>a) A Lantus insulin pen and Advair Diskus inhaler for R64.</p> <p>b) A vial of Lispro insulin for R20.</p> <p>c) A Lantus insulin pen for R45.</p> <p>On 6/2/24 at 11:00 AM, V17 RN stated all medication vials/bottles are to be dated when opened so staff know when the medication expires.</p> <p>2. R82's June 2024 (physician) Order Summary report showed R82 received Latanoprost 0.005% eye drops, one drop to both eyes as needed.</p> <p>On 6/2/24 at 10:35 AM, the second-floor med cart was reviewed by this surveyor and V15 RN. A medicine cup, containing 6 pills of different sizes and colors was noted in the top drawer of the med cart. When asked about the cup of pills, V15 stated, They have been there since yesterday. I don't know who they are for. They should be labeled with a name, so we know who they are for. One opened/not dated bottle of Latanoprost eye drops for R82 was noted in the cart. When V15 was asked why medications should be dated when opened, V15 stated, I know they should be dated but I'm not sure why.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's Storage of Medications policy dated 10/25/2014 showed, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of supplier . When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The nurse shall place a date opened sticker on the medication and enter the date opened and the new expiration date . The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guideline require different dating .</p>

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<p>F 0801</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47552</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure dietary staff were supervised and trained by a qualified dietary manager resulting in R6, R53, R21, and R65 receiving incorrect physician prescribed diets and resulted in R6 choking, requiring the Heimlich maneuver. R6 required hospitalization for aspiration pneumonia and remains at risk for further episodes of choking and aspiration due to continuing receiving the incorrect diet.</p> <p>This failure applies to 4 of 4 residents (R6, R53, R21, and R65) reviewed for mechanical soft diets in the sample of 20.</p> <p>This failure resulted in an Immediate Jeopardy.</p> <p>The Immediate Jeopardy began on [DATE], when the facility failed to ensure residents were served a mechanically soft diet as prescribed by their physician. V1 (Administrator) was notified of the Immediate Jeopardy on [DATE] at 2:30 PM. This surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on [DATE]; however, noncompliance remains at a Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.</p> <p>The findings include:</p> <p>On [DATE] at 2:05 PM, V4 (Food Service Manager/FSM) stated he has been in his role as food service manager for about three years. V4 only has a food protection manager certification that has expired. V4 is not a certified dietary manager. V4 has not begun the process of signing up to take the certified dietary manager coursework as of [DATE]. V4 stated that he doesn't always know exactly what to do in his position. There isn't someone on site at all times for him to refer to when he has questions.</p> <p>V4's provided food protection manager certification shows an expiration date of [DATE].</p> <p>On [DATE] at 10:37 AM, V7 (Registered Dietitian/RD) stated that she is contracted to provide 16 hours at the facility per month which mainly includes conducting resident nutrition assessments. V7 has never attended a face-to-face staff meeting with all of the dietary staff but has provided printed information for the staff to review.</p> <p>On [DATE] at 8:44 AM, V9 (Cook) stated she has worked here for about eight years. V9 was trained by V4 (FSM) and former cooks on the job. V9 has a current food protection manager certification. V9 stated that a mechanical soft diet is prepared using a knife and cutting the item into bite-size pieces, roughly the size of the fingernail on a pinky finger. V9 does not use any type of machine or device to prepare the mechanical soft diet. V9 stated chopped meats, cooked vegetables, canned fruit, and fresh fruit are allowed on a mechanical soft diet. V9 stated V7 (RD) does not come to the kitchen and V9 has not received training from V7. Per V9, the most recent in-service provided by V4 was a few months ago and covered being careful to send the correct foods for each resident.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Claridge Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  700 Jenkisson Lake Bluff, IL 60044	
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<p>F 0801</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 9:03 AM, V8 (Dietary Aide) stated he reads all of the diet cards during service and notifies the chef as to what to put on each plate. A mechanical soft diet is signified by a green sticker on the diet card. Mechanical soft diets are to receive soft and chopped foods, roughly the size of the fingernail on a pinky finger. V8 stated that residents receiving a mechanical soft diet can receive a lettuce salad as long as the contents of the salad are chopped finely, similar in size to the chopped meats. If tomatoes are a part of the salad, those need to be chopped up as well; they cannot be large pieces.</p> <p>Facility provided dietary staff certificates indicate that V10 (Dietary Aide), V11 (Dietary Aide), V13 (Dietary Aide), and V14 (Dietary Aide) do not have current food handler's certifications.</p> <p>V12's (Cook) Food Protection Manager's certificate has an expiration date of [DATE] and is not currently active.</p> <p>R6's current diet card shows R6 should receive a mechanical soft diet.</p> <p>R6's progress note dated [DATE] shows, Writer was called to R6's room, resident was choking. 911 was called. Heimlich maneuver was performed, a piece of tomato was expelled.</p> <p>On [DATE] at 1:02 PM, V5 (LPN) stated that at the time of the choking event, R6 was lying in bed. V5 was called into R6's room by V6 (Certified Nursing Assistant (CNA)). When V5 entered R6's room, R6 was purple and could not speak. V5 initiated the Heimlich maneuver on R6 and a tomato piece, approximately the size of a quarter, came flying out. V5 stated R6 was receiving a mechanical soft diet on [DATE] and is still on a mechanical soft diet.</p> <p>R6's progress note dated [DATE] shows, Resident readmitted from local hospital via local paramedics. He was on IV (intravenous) antibiotics to treat aspirated pneumonia while at local hospital . On minced moist diet with thin liquid .</p> <p>Facility served menu for [DATE] shows the meal served for the day includes a tomato wedge, pesto chicken salad, potato chips, marinated cucumber and onion salad, pudding with whipped topping, and a dinner roll.</p> <p>Facility diet spreadsheet for [DATE] shows that a mechanical soft diet should have received a diced tomato rather than a full tomato wedge.</p> <p>On [DATE] at the noon meal, R6 received ham cut into cubes, a baked potato with the skin, spinach, and fresh cantaloupe cut into chunks.</p> <p>On [DATE] at the noon meal, R6 received meat lasagna, California blend vegetables, garlic bread, and apple slices.</p> <p>R53's physician order sheet dated [DATE] shows R53 is on a general diet with mechanical soft texture.</p> <p>On [DATE] at the noon meal, R53 received a whole hot dog on a bun, spinach, and fresh cantaloupe cut into chunks.</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 1:43 PM, V7 stated that a hot dog is absolutely not appropriate for a resident on a mechanical soft diet.</p> <p>R21's current diet card reads, mech soft (mechanical soft).</p> <p>On [DATE] at the noon meal, R21 received ham cut into cubes, a baked potato with skin, spinach, and fresh cantaloupe cut into chunks.</p> <p>On [DATE] at the noon meal, R21 received meat lasagna, California blend vegetables, garlic bread, and apple slices.</p> <p>R65's physician order sheet dated [DATE] shows R65 is on a general diet with mechanical soft texture.</p> <p>R65's current diet card reads, Regular diet (with no texture modifications).</p> <p>On [DATE] at the noon meal, R65 received a slice of ham, a baked potato with skin, spinach, and fresh cantaloupe.</p> <p>On [DATE] at the noon meal, R65 received meat lasagna, California blend vegetables, garlic bread, and apple slices.</p> <p>On [DATE] at 1:43 PM, V7 (RD) stated that ham would not be the best option for a resident on a mechanical soft diet. The cut-up squares could be a choking problem. She would also recommend they not serve fresh fruit unless they could guarantee it is soft enough for them to eat.</p> <p>Facility diet spreadsheet for [DATE] shows mechanical soft residents should have received ground ham and a chopped baked potato without the skin.</p> <p>On [DATE] at 1:20 PM, V4 (FSM) said the staff should follow the diet spread sheet for altered diets.</p> <p>On [DATE] at 1:13 PM, V29 (Medical Director) stated, They definitely should be serving what is ordered for the resident's diets.</p> <p>Facility Food and Nutrition Services Diets and Diet Orders, Mechanical Soft Diet policy dated 2017 states, . Procedure: The texture may be altered by one of the following methods: Unless otherwise indicated, meat and meat substitutes will be mechanically ground</p> <p>On [DATE] at 10:40 AM, V29 (Medical Director) stated that he was not familiar with what qualifications a dietary manager requires and he also did not know that V4 (FSM) did not possess the proper qualifications.</p> <p>Facility provided job description for Director of Food and Nutrition Services dated 2018 states, Qualifications: Certified in food safety through an American National Standards Institute (ANSI) accredited course and has one of the following qualifications: Registered Dietitian, Licensed or Certified Dietitian, Certified Dietary Manager .</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The facility presented an abatement plan to remove the immediacy on [DATE]. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented a second revised abatement plan on [DATE] and the survey team accepted the abatement plan on [DATE].</p> <p>The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy:</p> <ol style="list-style-type: none"> <li>1. Immediate Recruitment Efforts: We have placed a Certified Dietary Manager (V31) in this position as of [DATE]. The current Supervisor (V4) will attend a class dated [DATE], to renew his Food Safety Manager Certificate. All other dietary staff files will be audited for compliance with the current Food Handler's Certification by Human Resources (V17) by [DATE]. The Certified Dietary Manager (CDM) (V31) has started the training for dietary staff on [DATE]. The Registered Dietitian (V7) will continue with the training for proper production and serving of mechanical soft diets on [DATE]. This process will be completed by [DATE]. The CDM (V31) will supervise food service production.</li> <li>2. Enhanced Training Programs: As of [DATE] In-servicing and training have begun for dietary staff by the CDM (V31) on providing diet as ordered, communication protocol, review diet, and update orders, in-servicing will continue until all dietary staff is trained before starting their next shift. The ADON (V3) started in-servicing nursing staff on [DATE] on monitoring dietary cards to ensure correct food consistency is being served; in-servicing will continue until all nursing staff is trained by [DATE]. We are enhancing our current training programs to ensure all dietary staff receive continuous education on a yearly basis for food safety, nutritional guidelines, and regulatory compliance. These programs will be provided by our contracted Registered Dietitian (V7) or her designee.</li> <li>3. Policy Review and Updates: A review of our Dietary Policies and Procedures Manual will be reviewed by the CDM (V31) and our contracted Registered Dietitian (V7) this process will be started on [DATE] and continued yearly to ensure they align with State and Federal Regulations. Any necessary updates will be implemented by in servicing the Dietary and Nursing Staff to reinforce our commitment to compliance and high-quality care, this procedure will be given by our contracted Registered Dietitian or her designee.</li> <li>4. Regular Audits and Monitoring: To prevent future occurrences, we will establish a random weekly audit of 3 meals a week for 90 days done by the CDM (V31); this audit will be focused on food consistency matching the dietary card. This procedure will help us monitor for compliance, identify potential issues early, and take corrective actions promptly.</li> </ol> <p>Results will be reported at QA meeting to ensure ongoing compliance.</p>		

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<p>F 0803</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34314</p> <p>I. Based on observation, interview, and record review the facility failed to ensure residents with a history for choking and at risk for choking were served the correct physician prescribed diets. This failure resulted in R6 choking, requiring the Heimlich maneuver, going to the hospital, and being treated for aspiration pneumonia. R6 returned to the facility and continued to be served the incorrect diet putting him at risk to choke again. The facility also failed to ensure R21, R53, and R65 were served the correct physician prescribed diets putting them at risk to choke. This applies to 4 of 20 residents (R6, R21, R53, R65) reviewed for menus in the sample of 20.</p> <p>These failures resulted in an Immediate Jeopardy.</p> <p>The Immediate Jeopardy began on 4/22/24 when the facility failed to ensure residents were served a mechanically soft diet as prescribed by their physician. V1 Administrator was notified of the Immediate Jeopardy on 6/4/24. This surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 6/6/24 however, noncompliance remains at a Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training and staffing levels.</p> <p>The findings include:</p> <p>1. R6's progress notes dated 4/22/24 shows, Writer was called to R6's room, resident was choking. 911 was called. Heimlich maneuver was performed, a piece of tomato was expelled.</p> <p>R6's local hospital records dated 4/22/24 shows, Medical Screening Exam: s/p (status post) reported witnessed choking [SIC (statement is correct)] event earlier today at 1846 (6:46 PM). Local fire department called by SNF (skilled nursing facility) for witnessed event, Heimlich maneuver perform and fully resolved/signed off at the scene.</p> <p>R6's progress notes dated 4/28/24 shows, Resident readmitted from local hospital via local paramedics. He was on iv antibiotics to treat aspirated pneumonia while at local hospital . On minced moist diet with thin liquid .</p> <p>On 6/3/24 at 1:02 PM, V5 Licensed Practical Nurse (LPN) stated, R6 was lying in bed when he choked. It was dinner time, and the CNA (certified nursing assistant/V6) called her into R6's room. R6 was purple and couldn't speak when V5 LPN got into the room. She did the Heimlich maneuver on him and a quarter size tomato came flying out. She couldn't remember what was for dinner that night only that he choked on a tomato. She also stated, his diet has not changed and was on a mechanical soft diet at the time when he choked.</p> <p>The dinner menu for 4/22/24 (the day R6 choked) shows, tomato wedge, pesto chicken salad, potato chips, marinated cucumber and onion salad, pudding with whipped topping and a dinner roll. The spreadsheet for mechanical soft diet shows, tomato wedge (diced (garnish)) .</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 6/3/24 at 1:43 PM, V7 Dietitian stated, ham would not be the best option for a resident on a mechanical soft diet. The cut-up squares could be a choking problem. She would also recommend they steer away from fresh fruit unless they could guarantee it is soft enough for them to eat.</p> <p>On 6/4/24 at 9:03 AM, V8 Dietary Aide stated, residents on a mechanical soft diet can receive a salad if it is chopped fine and the tomato is cut small. They should not receive large pieces of tomato. Mechanical soft diets should be soft and chopped up to about the size of a pinky nail.</p> <p>On 6/2/24, at the noon meal, R6 was served a slice of ham cut into cubes, a baked potato with skin, spinach and fresh cantaloupe cut into chunks. R6 has no teeth.</p> <p>On 6/3/24, at the noon meal, R6 was served meat lasagna, California blend vegetables, garlic bread and apple slices.</p> <p>R6's physician order sheet dated 4/28/24 shows, Regular diet, soft &amp; bite sized texture, regular/thin consistency minced and moist diet/thin liquid for dysphagia.</p> <p>The menu for 6/2/24, at the noon meal shows, orange glazed ham, baked potatoes with sour cream, seasoned spinach, fresh fruit mix and dinner roll. The spreadsheet for mechanical soft diet shows, orange glazed ham: grnd (ground), baked potato: no skin/chopped/add [NAME] (margarine (butter)). The spreadsheet does not show what mixed fruit should be for a mechanical soft diet.</p> <p>The menu for 6/3/24, at the noon meal shows, home style meat lasagna, Italian blend vegetables, fresh fruit and garlic bread. The spreadsheet for mechanical soft diet shows, they can have what is on the menu however it shows they were to get pineapple with the noon meal instead of fresh fruit. The spreadsheet does not show what a mechanical soft diet should get instead of sliced apples.</p> <p>R6's diet card shows, mechanical soft diet.</p> <p>On 6/4/24 at 1:13 PM, V29 (R6's physician/Medical Director) stated, he was aware of him choking during dinner. They definitely should be serving what is ordered for the resident's diets.</p> <p>R6's medical record does not show any evaluations by a speech therapist for diet recommendations.</p> <p>2. On 6/2/24, at the noon meal, R53 was served a whole hot dog on a bun, spinach and fresh cantaloupe cut into chunks. R53 also has no teeth and was having a hard time eating the hot dog and cantaloupe.</p> <p>On 6/3/24, at the noon meal, R53 was served meat lasagna, California blend vegetables, garlic bread and apple slices. R53 was having a hard time eating the apple slices.</p> <p>R53's physician order sheet dated October 1, 2023, shows, General diet, Mechanical Soft texture, Regular/Thin consistency.</p> <p>On 6/3/24 at 1:43 PM, V7 Dietitian stated, A hot dog was absolutely not appropriate for a resident on a mechanical soft diet.</p> <p>R53's current diet card shows, regular diet (not the prescribed diet).</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>3. On 6/2/24, at the noon meal, R21 was served a slice of ham cut into cubes, a baked potato with skin, spinach and fresh cantaloupe cut into chunks.</p> <p>On 6/3/24, at the noon meal, R21 was served meat lasagna, California blend vegetables, garlic bread and apple slices.</p> <p>R21's physician order sheet dated October 1, 2023, shows, NAS (no added salt) diet, Mechanical Soft texture.</p> <p>R21's current diet card shows, mech soft (mechanical soft).</p> <p>4. On 6/2/24, at the noon meal, R65 was served a slice of ham, a baked potato with skin, spinach, and fresh cantaloupe.</p> <p>On 6/3/24, at the noon meal, R65 was served meat lasagna, California blend vegetables, garlic bread and apple slices.</p> <p>R65's physician order sheet dated October 1, 2024, shows, General diet, Mechanical Soft texture, Regular/Thin consistency.</p> <p>R65's current diet card shows, Regular diet (not the prescribed diet).</p> <p>On 6/3/24 at 1:20 PM, V4 Dietary Manager stated, they follow the spreadsheet for altered diets (mechanically soft diets).</p> <p>The facility's food and nutrition services diets and diet orders policy dated 2017 shows, Diet Standardization: Policy: Food and nutrition services will serve standard diets which correspond to the diet columns on the menu spreadsheet and are based on the nutrition manual for healthcare communities . Procedure: Examples of standard diet orders may include: Mechanical soft: The texture and consistency of the general/regular or therapeutic diet is modified. Food maybe served as ground or chopped. Whole food may only be served if it is soft in consistency.</p> <p>The facility's food and nutrition services diets and diet orders, mechanical soft diet policy dated 2017 shows, Policy: Food will be provided in a form designed to meet individual needs. The highest practicable level of eating will be provided. The texture of the food may be altered to mechanical soft consistency. Procedure: The texture may be altered by one of the following methods: Unless otherwise indicated, meat and meat substitutes will be mechanically ground. Plain fish fillet may be flaked. Meat loaf without hard crust and soft casseroles may be served intact. Foods commonly avoided are fibrous raw vegetables (such as celery, radishes, cauliflower, broccoli, etc.), whole kernel corn and nuts. If individual tolerance allows, meat and meat substitutes can by chopped by hand. This will be indicated on the tray card.</p> <p>The facility presented an abatement plan to remove the immediacy on June 5, 2024. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility for revisions. The facility presented a second revised abatement plan on June 5, 2023, and the survey team accepted the abatement plan on June 6, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The Immediate Jeopardy that began on April 22, 2024, was removed on June 6, 2024, when the facility took the following actions to remove the immediacy:</p> <ol style="list-style-type: none"> <li>1. Immediate Recruitment Efforts: We have placed a Certified Dietary Manager (V31) in this position as of 06/04/24. The current Supervisor (V4) will attend a class dated 08/19/24, to renew his Food Safety Manager Certificate. All other dietary staff files will be audited for compliance with the current Food Handler's Certification by Human Resources (V17) by June 5, 2024. The CDM (V31) has started the training for dietary staff on 06/05/24. The Registered Dietitian (V7) will continue with the training for proper production and serving of mechanical soft diets on 06/06/24. This process will be completed by 06/06/24. The CDM (V31) will supervise food service production.</li> <li>2. Enhanced Training Programs: As of 6/5/24 In-servicing and training have begun for dietary staff by the CDM (V31) on providing diet as ordered, communication protocol, review diet, and update orders, in servicing will continue until all dietary staff is trained before starting their next shift. The ADON (V3) started in-servicing nursing staff on 06/05/24 on monitoring dietary cards to ensure correct food consistency is being served, in servicing will continue until all nursing staff is trained by 6/13/24. We are enhancing our current training programs to ensure all dietary staff receive continuous education on a yearly basis for food safety, nutritional guidelines, and regulatory compliance. These programs will be provided by our contracted Registered Dietitian (V7) or her designee.</li> <li>3. Policy Review and Updates: A review of our Dietary Policies and Procedures Manual will be reviewed by the CDM (V31) and our contracted Registered Dietitian (V7) this process will be started on 6/6/24 and continued yearly to ensure they align with State and Federal Regulations. Any necessary updates will be implemented by in servicing the Dietary and Nursing Staff to reinforce our commitment to compliance and high-quality care, this procedure will be given by our contracted Registered Dietitian or her designee.</li> <li>4. Regular Audits and Monitoring: To prevent future occurrences, we will establish a Random weekly audit of 3 meals a week for 90 days done by the CDM (V31), this audit will be focused on food consistency matching the dietary card. This procedure will help us monitor for compliance, identify potential issues early, and take corrective actions promptly.</li> </ol> <p>Results will be reported at QA meeting to ensure ongoing compliance.</p> <p>47552</p> <p>II. Based on observation, interview, and record review the facility failed to ensure residents receiving a regular texture diet received a 3-ounce (oz) portion of sliced ham for the noon meal on 6/2/24. This applies to 4 of 4 residents (R44, R75, R84, R45) reviewed for menus in the sample of 20.</p> <p>The findings include:</p> <p>Facility provided Dietary Type Report shows that R44, R75, R84, and R45 all receive a regular texture diet.</p> <p>On 6/2/24 at 11:27 AM, V12 (Cook) was placing a single slice of sliced ham on each plate receiving a regular texture diet. The slices of ham appeared small. The slices were approximately one quarter inch thick and the size of a three inch by five-inch index card or smaller.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 6/2/24 at 12:10 PM, V12 finished plating all meals and none of the residents received additional ham during normal meal service.</p> <p>On 6/2/24 at 12:37 PM, facility provided test tray was received and the portion of ham was similar to the sizes served during lunch.</p> <p>On 6/2/24 at 12:54 PM, V4 (Dietary Manager) used a calibrated food scale to weigh the ham slice provided on the test tray. The ham slice weighed 1.75 ozs (ounces), providing approximately 88 calories and 11 grams (g) protein. V4 stated the residents were to receive a 3 oz portion of ham, which would provide approximately 150 calories and 20g protein. Residents received approximately 60 calories and 9g less protein than the written menu.</p> <p>On 6/2/24 at 12:55 PM, V9 (Cook) confirmed that V12 cut the ham into slices to serve for lunch on 6/2/24.</p> <p>Facility Diet Spreadsheet shows the portion size for the regular texture diet is to receive a 3 oz portion of ham.</p> <p>On 6/2/24 1:47 PM, R44 said there are sometimes he receives enough food, but he stated the ham received on 6/2/24 was small and he was still hungry after lunch.</p> <p>On 6/2/24 at 1:58 PM, R84 state that he believes the portion sizes served are small.</p> <p>On 6/3/24 at 9:05 AM, R75 stated that she does not believe the food portions served are always large enough. R75 was unable to eat the ham on 6/2/24 and was still hungry after the end of the meal. R75 stated there have been other times that she was still hungry after meals and this was not the first time.</p>		

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NAME OF PROVIDER OR SUPPLIER  Claridge Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  700 Jenkisson Lake Bluff, IL 60044	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47552</p> <p>Based on observation, interview, and record review the facility failed to ensure a serving spoon was sanitized and air dried to prevent foodborne illness. This has the potential to affect all 82 residents in the facility receiving food from the kitchen.</p> <p>The findings include:</p> <p>The CMS 671 dated 6/2/24 shows there are 84 residents residing in the facility.</p> <p>On 6/2/24 at 11:53 AM, V12 (Cook) handed V10 (Dietary Aide) a serving spoon that became soiled during service. V10 took the serving spoon to the three-compartment sink, and quickly dipped the spoon through each individual sink. At the sanitizer sink, V10 dipped the spoon a few times, removed the spoon from the sink, and proceeded to dry the spoon with brown disposable paper towels. V10 returned the spoon to V12 and V12 continued to use the spoon for the remainder of service.</p> <p>On 6/2/24 at 10:01 AM, V4 stated that all dishes are currently being done using the three-compartment sink. The dish machine has been broken for a few years and is not currently in use. When using the three-compartment sink, dishes need to be fully submerged for one full minute in order to sanitize the items. The items then need to be air dried.</p> <p>Facility Manual Sanitizing in Three-Compartment Sink policy dated 2017 states, A sink with three compartments is used for manually washing, rinsing, and sanitizing utensils and equipment that can be submerged . After washing and rinsing utensils or equipment are sanitized in the third sink by immersion in either: Hot water (at least 171 Fahrenheit (F) for thirty seconds) or chemical sanitizing solution used according to manufacturer's instructions. The most common chemical sanitizers are chlorine, iodine, and quaternary ammonia. The manufacturer's label is referenced for the appropriate concentration of the sanitizing solution and for length of submersion time.</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47552</b></p> <p>Based on interview and record review, the facility failed to ensure a resident admitted for therapy services received therapy services. This applies to 1 of 4 residents (R84) reviewed for therapy services in the sample of 20.</p> <p>The findings include:</p> <p>R84's Face sheet shows that R84 was admitted to the facility on [DATE] with a primary admitting diagnosis of a right femur fracture.</p> <p>R84's Care Plan shows the resident has a right hip fracture related to a fall from a car accident.</p> <p>On 6/2/24 at 2:12 PM, R84 stated he was admitted to the facility following surgery after a car accident. He did not believe he was receiving therapy services. He said that V30 (Physical Therapist) was working with him to exercise his leg before V30 went on vacation. R84 stated that V32 (Restorative Certified Nursing Assistant (CNA)) currently works with him on transfers but does not help him walk. On 6/5/24 at 11:08 AM, R84 stated his goal with therapy is to be able to stand and walk again and discharge back home.</p> <p>On 6/2/24 at 2:40 PM, V32 (Restorative CNA) confirmed he is only doing transfers with the resident at this time and not walking with the resident. He believed that the resident has been discharged from therapy.</p> <p>On 6/5/24 at 2:18 PM, V33 (Physical Therapist) stated that she has been filling in for V30 while he is on vacation. V33 has not seen R84 during her time at the facility.</p> <p>R84's Plan of Treatment for Outpatient Rehabilitation form from 5/10/24 states, Pt (patient) is DC (discharged ) from skilled PT (Physical Therapy) services due to no progress and poor motivation. Pt has been referred to restorative program at this time. Long term goals states, Pt will safely ambulate using RW (rolling walker) x 10 feet .</p> <p>On 6/6/24 at 8:43 AM, R84 stated that V30 never informed him that he was discharged from therapy services and believed he was still making progress. R84 said that he has not reached his goal of being able to walk.</p> <p>A physical therapy policy was requested from the facility but was not received prior to the exit date of 6/6/24.</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35541</p> <p>Based on observation, interview and record review facility administration failed to manage the facility in manner to effectively meet the needs of the residents.</p> <p>This failure has the potential to affect all 84 residents in the facility.</p> <p>The findings include:</p> <p>The facility's Long-Term Care Facility Application for Medicare and Medicaid form dated [DATE] showed a resident census of 84.</p> <p>1. On [DATE], at 10:11 AM, 11:26 AM, 11:39 AM, 11:46 AM, 12:03 PM and 12:58 PM, R48 and R65 were sitting in the dining room in reclining wheelchairs. There were no activities going on. The television was the only thing on.</p> <p>On [DATE], at 10:30 AM, R74 the resident council president stated, there isn't any activities. They have to entertain themselves.</p> <p>On [DATE], at 12:25 PM, V3 Assistant Director of Nursing (ADON) stated, there is no activity director and only 1 activity assistant.</p> <p>2. On [DATE], during the resident meeting, R11, R55, and F74 each stated the facility did not have a full-time social worker. R55 stated, They have a part-time woman that comes a couple of hours in the evening a few days a week, but we hardly ever see her. R55 stated she had an ongoing conflict with her new roommate with no resolution due to no one here to deal with it. R55 stated she needed someone's assistance to help her work with my insurance so I can find a dentist but there's no one to help do that either. R11 stated, I see my counselor (contracted psychiatric social worker) once a week when she comes in but, I have no one to talk to if I am upset and need to talk to someone when she isn't here.</p> <p>On [DATE] at 8:44 AM, V3 Assistant Director of Nursing stated, We have not had a full-time social worker in a long time. We have (V18 part-time Social Services) that comes in a few hours during the evenings, but she is part-time.</p> <p>3. On [DATE], during the resident meeting, R11 and R40 each stated there was not always a nurse assigned to the third floor on the night shift (11 PM-7 AM). R11 stated, There are nights we don't have a nurse. I get scared because what if I choke and no one is there to help me? When we don't have a nurse at night, my 6 AM meds (medications) are late. They aren't given until after 7 AM when the day nurse arrives.</p> <p>On [DATE] at 10:00 AM, R28 stated, There has been nights when we haven't had a nurse on the floor. One night I needed a pain pill but there was no one to tell.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On [DATE] at 2:00 PM, the facility's nursing schedules dated [DATE]-[DATE] were reviewed and showed the following:</p> <p>a. On [DATE] (Sunday), V34 Registered Nurse (RN) was assigned to both the second and third floors of the facility from 11 PM-7 AM. A daily census form dated [DATE] showed 1 Nurse (V34) was responsible for 87 residents from 11 PM-7 AM.</p> <p>b. On [DATE] (Monday), No nurse was assigned to the second floor of the facility from 11 PM-7 AM. V2 Director of Nursing (DON) was assigned to the third floor from 11 PM-7 AM. A daily census form dated [DATE] showed 1 Nurse (V2 DON) was responsible for 87 residents from 11 PM- 7 AM.</p> <p>c. On [DATE] (Monday), V34 RN was assigned to both the second and third floors of the facility from 11 PM-7 AM. A daily census form dated [DATE] showed 1 Nurse (V34) was responsible for 85 residents from 11 PM-7 AM.</p> <p>d. On [DATE] (Monday), V34 RN was assigned to both the second and third floors of the facility from 11 PM-7 AM. A daily census form dated [DATE] showed 1 Nurse (V34) was responsible for 86 residents from 11 PM-7 AM.</p> <p>e. On [DATE] (Sunday), No nurse was assigned to the second floor of the facility from 11 PM-7 AM. V34 RN was assigned to the third floor from 11 PM-7 AM. A daily census form dated [DATE] showed 1 Nurse (V34) was responsible for 85 residents from 11 PM-7 AM.</p> <p>On [DATE] at 7:43 AM, V19 RN stated, I always work the second floor. We are sometimes short-staffed. There have been nights when I am the only nurse for the whole building . If I work both floors, I don't pass 6 AM meds on the third floor. I don't have time. I will pass PRN (as needed) meds to residents on the third floor if they need them .I tell the CNA's on the third floor to call me if there is an emergency.</p> <p>On [DATE] at 10:07 AM, V16 RN stated, Yes, there have been days that I have come in for day shift and there has not been a night nurse. Sometimes then residents haven't gotten their 6 AM meds.</p> <p>On [DATE] at 11:56 AM, V2 DON stated she was responsible for completing the nursing schedule and ensure sufficient staffing. V2 stated she was aware the facility was short-staffed, specifically on nights (11 PM-7 AM). V2 stated, We are supposed to have one nurse assigned to the second floor and one nurse assigned to the third floor on nights. There are nights we only have one nurse for both floors, but I sleep here in case they need anything.</p> <p>4. R6's progress note dated [DATE] shows, Writer was called to R6's room, resident was choking. 911 was called. Heimlich maneuver was performed, a piece of tomato was expelled.</p> <p>On [DATE] at 1:02 PM, V5 (LPN) stated that at the time of the choking event, R6 was lying in bed. V5 was called into R6's room by V6 (Certified Nursing Assistant (CNA)). When V5 entered R6's room, R6 was purple and could not speak. V5 initiated the Heimlich maneuver on R6 and a tomato piece, approximately the size of a quarter, came flying out. V5 stated R6 was receiving a mechanical soft diet on [DATE] and is still on a mechanical soft diet.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>R6's progress note dated [DATE] shows, Resident readmitted from local hospital via local paramedics. He was on iv (intravenous) antibiotics to treat aspirated pneumonia while at local hospital . On minced moist diet with thin liquid .</p> <p>On [DATE] at 2:05 PM, V4 (Food Service Manager/FSM) stated he has been in his role as food service manager for about three years. V4 only has a food protection manager certification that has expired. V4 is not a certified dietary manager. V4 has not begun the process of signing up to take the certified dietary manager coursework as of [DATE]. V4 stated that he doesn't always know exactly what to do in his position. There isn't someone on site at all times for him to refer to when he has questions.</p> <p>V4's provided food protection manager certification shows an expiration date of [DATE].</p> <p>On [DATE] at 10:18 AM, V1 Administrator was asked what his responsibilities were as administrator of the facility. V1 stated, I think of my role as COO (Chief Operating Officer). I overlook the operations of the facility. (V2 Director of Nursing/DON) hires and fires staff. Both (V2) and I are responsible for making sure we have staff in key positions. V1 stated, I am aware we haven't had a full-time social service person in a while. I know (V2) is actively trying to fill that role. V1 stated he wasn't aware that residents' discharge planning, care plans, and grievances weren't being done in a timely manner or done at all due to not having dedicated full-time social services staff. V1 stated he was aware that V4 (Food Service Manager) had been in that role for three years and had never been certified for the position. V1 stated he never gave V4 a deadline as to when he needed to have his Food Service Manager certification. When V1 was asked if he was okay with V4 working in the role as food service manager while not being certified, V1 stated, No I am not okay with (V4) working as the food service manager and not being certified in the role. I can only do so much for this organization. V1 stated R6's [DATE] choking episode had not been reported to him prior to the week of [DATE]. V1 stated, I should have been notified. I also wasn't aware that the kitchen wasn't serving the right diets until you guys came in for survey. V1 stated he was aware the facility was without an activity director. V1 stated, I leave the hiring and firing of that position (activity director) to (V2 DON). V1 stated he wasn't aware that there had been nights when the facility only had one nurse for the entire building. V1 stated he thought (V2 DON) was taking care of any staffing issues. V1 stated he realized the lack of key staff members and the lack of resident cares associated with a lack of staff falls on him.</p> <p>On [DATE] at 10:40 AM, V29 (Medical Director) stated he was not aware the facility did not have an activity director or full-time social services staff. V29 stated he was not aware V4 Food Services Manager had been working in the role for three years and had never been certified for the role. V29 stated he was not aware there were nights the facility only had one nurse scheduled to care for all of the residents. V29 stated, I speak with (V1 Administrator) at least one-two times a month. He didn't tell me about any of these issues. I didn't know about any of this. He should have people in place to handle this. I just assumed he did.</p> <p>(continued on next page)</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility's Administrator job description (undated) showed, The purpose of this position is to establish and maintain systems that are effective and efficient to operate a facility in a manner to safely meet the residents' needs in compliance with federal, state and local requirements . The job description showed the administrator's responsibilities included, determining the personnel requirements of the facility and hire or arrange for sufficient staff to implement facility policies and procedures . supervise the recruitment, employment, performance, evaluation, promotion, and discharge of all staff . Assume responsibility with department supervisors to implement effective policies to assure adequate staffing to meet facility needs .</p>		

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<p>F 0850</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Hire a qualified full-time social worker in a facility with more than 120 beds.</p> <p>35541</p> <p>Based on interview and record review the facility failed to provide/employ a qualified, full-time social worker. This failure has the potential to affect all 84 residents in the facility.</p> <p>The findings include:</p> <p>The facility's Long-Term Care Facility Application for Medicare and Medicaid form dated 6/2/2024 showed a resident census of 84.</p> <p>The facility's Facility Assessment Tool revised 7/31/23 showed the facility has a maximum bed capacity of 230 beds.</p> <p>On 6/3/24, during the resident meeting, R11, R55, and R74 each stated the facility did not have a full-time social worker. R55 stated, They have a part-time woman that comes a couple of hours in the evening a few days a week, but we hardly ever see her. R55 stated she had an ongoing conflict with her new roommate with no resolution due to no one here to deal with it. R55 stated she needed someone's assistance to help her work with my insurance so I can find a dentist but there's no one to help do that either. R11 stated, I see my counselor (contracted psychiatric social worker) once a week when she comes in but, I have no one to talk to if I am upset and need to talk to someone when she isn't here.</p> <p>On 6/3/24 at 8:44 AM, V3 Assistant Director of Nursing stated, We have not had a full-time social worker in a long time. We have (V18 part-time Social Services) that comes in a few hours during the evenings, but she is part-time.</p> <p>On 6/3/24 at 11:44 AM, V1 Administrator state the facility had not had a full-time social worker in a while.</p> <p>On 6/3/24 at 12:12 PM, V18 (part-time Social Services) stated, I work very part-time there. I am under social services, but I am just helping out. I come in for 3-4 hours during the evening; 3-4 days a week. I help do care plans and MDS's (Minimum Data Set). V18 stated, I don't do any discharge planning. I don't handle grievances unless someone complains to me. I don't do anything with resident council. I don't help set up appointments or counsel residents unless someone stops me when I'm there. I don't do any behavior management counseling unless I see behaviors happening when I'm there.</p> <p>(continued on next page)</p>		

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<p>F 0850</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility's Social Service Director (Designee) job description (undated) showed, The purpose of this position is to provide social services to meet the social and/or emotional needs that affect the residents' ability to achieve their highest level of function; participate in the development of residents' comprehensive care plans; develop policies and procedures to provide social services to residents in compliance with federal, state and local regulations The job description showed the Social Service Director was responsible for developing and coordinating family and resident activities designed to promote social interaction . develop one-to-one professional relationships with residents and families as needed for counseling . assess, plan, and document residents' discharge needs . document the social service component of the Comprehensive Care Plan for each resident in a timely manner . refer residents to social, health and community resources and complete accurate documentation in residents' records concerning the results of such referrals .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47552</b></p> <p>Based on observation, interview, and record review the facility failed to ensure that a resident with a multi-drug resistant urinary infection was placed on contact isolation. The facility failed to initiate enhanced barrier precautions on residents with a catheter, tube feeding, and/or wounds. These failures apply to 5 of 20 residents (R51, R4, R84, R1, R24) reviewed for infection control in the sample of 20.</p> <p>The findings include:</p> <p>1. R51's Order Summary Report shows R51 is receiving Meropenem-Sodium Chloride (intravenous antibiotic), two times a day for a UTI (urinary tract infection). This order was started on 5/29/24.</p> <p>On 6/3/24 at 8:39 AM, R51's door or room had no signs of contact isolation precautions in place. At 9:09 AM, R51 was lying in bed receiving her scheduled intravenous antibiotic.</p> <p>On 6/3/24 at 8:26 AM, V3 (Assistant Director of Nursing) stated that R51 had ESBL (extended spectrum beta-lactamase; a multi-drug resistant organism) in the urine and that R51 was not on contact isolation and there is not an isolation cart of sign outside the room to notify staff. V3 stated R51 should be on contact isolation.</p> <p>Facility Isolation-- Initiating Transmission-Based Precautions policy dated 2009 states, . 1. If a resident is suspected of, or identified as, having a communicable infectious disease, the Charge Nurse or Nursing Supervisor shall notify the DON (Director of Nursing) and/or the NHA (Nursing Home Administrator) and the resident's Attending Physician for appropriate Transmission-Based Precautions.</p> <p>2. On 6/2/24 at 10:51 AM, R4 was lying in bed with a urinary catheter attached. In the corner of R4's room, next to the head of her bed, a tube feeding bag was suspended from a metal hanger but was not initiated. There were no enhanced barrier precaution signs on the outside of R4's room.</p> <p>R4's Minimum Data Set (MDS) dated [DATE] shows R4 has an indwelling catheter and receives 51 percent or more of her total calories and fluids through a tube feeding.</p> <p>3. On 6/2/24 at 1:58 PM, R84 was lying in bed with a urinary catheter attached. No enhanced barrier precaution sign was noted outside of R84's room.</p> <p>R84's Care Plan shows that the resident has an indwelling catheter.</p> <p>On 6/3/24 at 8:26 AM, V3 (Assistant Director of Nursing) stated they do not currently have a policy or follow guidance for enhanced barrier precautions.</p> <p>40085</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4.) On 6/3/24 at 10:10 AM, R24 was in bed with his feeding tube infusing into his gastrostomy tube via a pump. R1 who is R24's roommate also had a gastrostomy tube. V3 (Assistant Director of Nursing/ADON) completed a dressing change to R24's stage 2 sacral pressure injury. V24 (CNA) came into the room to assist her with the dressing change. V3 and V24 did not wear gowns during the dressing change (which are required with enhanced barrier precautions). There was no sign on the outside door to indicate either resident was on enhanced barrier precautions and there was no PPE (Personal Protective Equipment) cart outside of the room.</p> <p>On 6/3/24 at 8:30 AM, V3 stated enhanced barrier precautions are for residents who have catheters, feeding tubes and wounds but the facility has not gotten around to implementing that yet.</p> <p>On 6/6/24 at 1:10 PM V3 (Assistant Director of Nursing) confirmed the facility does not have an enhanced barrier policy.</p>

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  06/06/2024
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.

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35541</p> <p>Based on interview and record review the facility failed to ensure residents were screened for and received all recommended doses of the pneumococcal (pneumonia) vaccine for 2 of 5 residents (R388, R38) reviewed for the vaccine in the sample of 20.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. R388's immunization record (undated) showed R388 was admitted to the facility on [DATE]. The record showed R388 last received a pneumococcal vaccination on 12/26/2000 which showed R388 was currently eligible for an additional pneumococcal vaccine. R388's medical record was reviewed and showed no documentation R388 was screened for or offered a pneumococcal vaccine upon admission to the facility or at any time during his stay in the facility.</li> <li>2. R38's immunization record (undated) showed R38 was admitted to the facility on [DATE]. R38's Authorization and Release for Pneumococcal Vaccine form dated 8/25/2023 showed R38 was screened for the vaccine and consented to receive the vaccination. R38's medical records dated 8/25/2023-6/2/2024 were reviewed and showed no documentation R38 was administered the vaccine.</li> </ol> <p>On 6/4/2024 at 10:45 AM, V3 Infection Preventionist confirmed R38 had not received a pneumococcal vaccine in the facility and R388 had not been screened for or offered the vaccine. V3 stated residents should be screened for the pneumococcal vaccine upon admission to the facility. V3 stated, We should probably screen residents for the vaccine at least yearly, but we don't do that. I think we only screen residents when we they get admitted . We don't have a nurse responsible for the immunization program. I don't monitor any of that.</p> <p>The facility's Influenza and Pneumococcal Immunizations-Residents policy (undated) showed, All residents will receive immunizations that aid in preventing infectious diseases unless medically contraindicated or the resident has already been immunized during this time period . All new residents will be assessed for pneumococcal vaccine status upon admission. Residents without proof of previous pneumococcal vaccination should be offered the pneumococcal vaccine(s) unless contraindicated .</p>

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>35541</p> <p>Based on interview and record review the facility failed to ensure nursing staff received dementia care training and education, annually, as required.</p> <p>This failure has the potential to affect all 84 residents in the facility.</p> <p>The findings include:</p> <p>The facility's Long-Term Care Facility Application for Medicare and Medicaid form dated 6/2/2024 showed a resident census of 84.</p> <p>On 6/4/24 at 11:00 AM, the following employee files were reviewed:</p> <ol style="list-style-type: none"> <li>1. V22 Certified Nursing Assistant's (CNA) file showed V22 had been employed by the facility since 4/6/2014. V22's file showed V22 had received no dementia education or training in 2023 or 2024.</li> <li>2. V28's file showed V28 had been employed by the facility since 8/12/1991. V28's file showed V28 had received no dementia education or training in 2023 or 2024.</li> <li>3. V26's file showed V26 had been employed by the facility since 8/7/2015. V26's file showed V26 had received no dementia education or training in 2023 or 2024.</li> <li>4. V21's file showed V21 had been employed by the facility since 11/1/2017. V21's file showed V21 had received no dementia education or training in 2023 or 2024.</li> <li>5. V6's file showed V6 had been employed by the facility since 1/19/2022. V6's file showed V6 had received no dementia education or training in 2023 or 2024.</li> </ol> <p>On 6/4/24 at 11:05 AM, V17 Human Resources stated, I am responsible for providing the yearly abuse, harassment, and privacy education to our nursing staff. Social services usually does the staff dementia training every year but we don't have anyone in social services to do it. V17 confirmed V22, V28, V26, V21, and V6 had not received dementia training or education in 2023 or 2024.</p> <p>The facility's Facility Assessment Tool revised 7/31/2023 showed the nursing staff education and competencies to be completed, upon hire and as required, included education/training on abuse, resident rights, and dementia care.</p>