STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145639	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chicago Ridge Snf	10602 Southwest Highway Chicago Ridge, IL 60415

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44570 Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by a resident. This failure applied to two of two (R5, R15) residents reviewed for abuse. Findings include: R5 [AGE] years old, was initially admitted to the facility 2/1/23 with diagnoses that include Major Depressive Disorder, Anxiety Disorder and Chronic Kidney Disease Stage III. R15 is [AGE] years old, admitted to the facility from the hospital on 3/11/24 with diagnoses that included Schizophrenia. The facility reported to IDPH an incident that occurred on 3/11/24 which indicated that R15 found R5 in the hallway and hit them unprovoked. R5 did not sustain any injuries and did not require hospitalization R15 discharged from the facility Against Medical Advice later that evening. On 5/29/24 at 11:02AM V15 PRSC (Psychiatric Rehabilitative Services Coordinator) said that R15 was in their office while conducting an admission assessment, when all of a sudden, R15 abruptly got up, went into the hall and hit R5, unprovoked. V15 said the residents were immediately separated, and R15 was moved to a different unit. V15 said they didn't know about V15's behavior prior to initiating the assessment and did not probe the hospital records to determine if R15 was at risk for exhibiting abusive or aggressive behaviors. On 5/30/24 at 12:10PM V29 Regional Nurse Consultant said R15 was admitted to the facility for a seizure disorder, status post craniotomy and it was during med pass that he arrived. The PRSC noted that the nurses were occupied with medication pass and took R15 to their office to complete Social Worker assessments. While they were meeting, R5 knocked on the door to speak with the PRSC and was easily redirected to come back at a later time. R15 finished the interview with the PRSC and was on the way back to the room when they came upon R5 in the hall and hit them. R15 was immediately placed on 1:1 and given a cigarette. Later he discharged home with the father. (continued on next page)

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Plan dated 3/12/24 for R5 includes a focus as stated in part; My comprehensive assessment reveals [history] of suspected abuse &/or neglect or factors that may increase his/her susceptibility to abuse/neglect. Goals of the care plan include I will be treated with respect, dignity & reside in the facility free of mistreatment (i.e., abuse/neglect) The facility's Abuse Policy, revised 11/2018 states in part: II. Pre-Admission Screening of Potential Residents- This facility shall check and review the criminal history background for any resident seeking admission to the facility in order to identify previous criminal convictions. This facility will: 1. Request a Criminal History Background Check within 24 hours after admission of a new resident, 2. Check for the resident's nae on the Illinois Sex Offender Registration Web site 3. Check for the resident's name on the Illinois Department of Corrections sex registrant search page. 4. While the background from fingerprint checks, and/or identified Offender Report and Recommendations are pending, the facility shall take steps necessary to ensure safety. IV. Establishing a Resident Sensitive Environment This facility desires to prevent abuse, neglect, exploitation, mistreatment ad misappropriation of resident property by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive quality management approach involving the following: Resident Assessment- As part of the resident social history evaluation and MDS assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, or misappropriation of resident property or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of abuse, neglect, exploitation, mistreatment, or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches on a regular basis. For residents who are identified offenders, the facility shall incorporate the Identified Offender Report and Recommendations Report into the identified offender's plan of care including the security measures listed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on observation, interview, and record review, the facility failed to follow their policy and procedures for behavior Management for Agitated Behavior by not providing one to one supervision for a resident, with a history of self-harming behavior, who was threatening and attempting self-harm and being physically aggressive towards staff. This failure applied to one of three residents (R9) reviewed for accidents and injury and resulted in R9 sustaining a fracture to their right arm. Findings include: R9 is a [AGE] year-old female with a diagnoses history of Quadriplegia, Multiple Sclerosis, Vitamin Deficiency, Anxiety Disorder, and Recurrent Major Depressive Disorder who was admitted to the facility 03/21/2022. On 05/28/2024 at 12:23 PM R9 is observed sitting in her wheelchair in her room with a cast and brace on her right arm. R9 stated it was a soft cast and her arm was broken through in 2 pieces. R9 stated one evening between 8-9 PM she blocked her room door from V6 (Licensed Practical Nurse) and V7 (Licensed Practical Nurse) with her wheelchair and told them she wasn't ready to go to bed. R9 stated she was yelling, and they didn't care and put her in bed anyway. R9 stated she was yelling the entire they picked her up from her chair. R9 stated after they left the room, she was being rebellious and tried to get out of bed. R9 stated she swung her feet out of bed first and doesn't recollect how she got her arm caught in the rail, but it makes sense that's how she injured her arm. R9's progress note created by V6 (Licensed Practical Nurse) on 5/7/2024 at 2:20 PM documents on 05/05/2024 resident was asked can she be assisted to bed, because she was asleep in the wheelchair by the elevator, resident became verbally aggressive and went into her room and tried to block the door with her wheelchair. Staff was able to talk her into opening up the door, resident became very aggressive trying to throw herself out the chair onto the floor. Resident released her seat belt and tried to slide herself out her chair. Writer and the other nurse were able to prevent her from sliding onto the floor. Writer and the other staff transferred resident onto the bed resident and began fighting stating that it's my right to throw myself on the floor. Writer repositioned the resident for comfort. The certified nursing assistant was walking by and noticed the residents legs hanging out the bed, Writer and the other nurse came in and saw that the resident legs and arms were stuck between the chair and the side rail. Resident stated leave me alone it's my right to throw myself on the floor, I don't care. Writer turned and repositioned the resident so she wouldn't fall. Resident stated it's my right leave me alone. Writer explained the importance of not trying to cause harm to herself and that she would cause an injury, resident stated that it's my body and my right. R9's Progress note created by V6 (Licensed Practical Nurse) dated 5/5/2024 9:07 PM documents resident was being very aggressive trying to take her seat belt off to throw herself on to floor. Resident was swinging and trying to hit writer. Resident's right arm got caught between the bed rail and her motorized wheelchair trying to throw herself out the bed stating that it was her right to harm herself. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R9's Stricken note created by V6 (Licensed Practical Nurse) on 5/5/2024 at 10:28 PM documents resident refused to be changed and she is trying to climb out the bed. Writer entered the room saw resident trying to climb out the bed and she was stuck between the bed and wheelchair. Writer asked a Certified Nursing Assistant to help to get resident back in the bed. R9's Hospital Admission report dated 05/06/2024 - 05/08/2024 documents it was reported she was being moved into bed by nursing staff when her right arm was injured; she was reportedly being combative and was being placed back into bed and apparently forearm got caught in the railing and sustained injury; past medical history includes Multiple Sclerosis; an x-ray of her arm showed a fracture likely due to a combination of trauma and pathological osteoporosis/osteopenia as there was evidence of bone demineralization. Facility Reported Incident Investigation Reports initiated 05/06/2024 documents on 05/06/2024 R9 reported that V6 (Licensed Practical Nurse) and V7 (Licensed Practical Nurse) were rough while transferring her to her bed causing her to have a bruise on her right arm, upon body assessment staff noted R9's right arm was swelled and bruised; the facility contacted the physician by phone and orders were given to send R9 to local hospital for further evaluation where it was reported that she has a fracture to her right arm; During staff and resident interviews it was noted that R9 was attempting to throw herself on the floor while sitting in the wheelchair; while attempting to throw herself to the floor she started to slide out of the wheelchair when V6 and V7 prevented the fall and assisted R9 to bed; While R9 was in bed and noted to be calmed the CNA (Certified Nursing Assistant) walked by and observed R9 in a prone position on the edge of the bed with her right arm between the rail and wheelchair. Witness statement dated 05/05/2024 from V45 (Certified Nursing Assistant) documents R9 was sleep in her wheelchair, she heard R9 was asked if she could move from in front of the elevator, R9 became upset, went to her room and blocked the door; V45 was in the room and R9 was yelling at her and telling her to go back to Mexico, R9 moved and V7 and V6 were trying to calm her. R9 kept trying to put herself onto the floor, started sliding out and they stopped her from falling and put her into the bed; All the while R9 was in the bed she was yelling; V45 walked by and R9 's legs were stuck between the wheelchair and turned onto her side trying to move the wheelchair; R9 kept saying she had the right to fall; V45 and others had to move the wheelchair to prevent R9's legs from getting hurt. Witness statement dated 05/05/2024 from V7 (Licensed Practical Nurse) documents R9 was screaming out loud and using profanity and insisted she has rights; R9 tried to throw herself on the floor, and he stopped her by placing his hand across her chest area; R9 tried to release her seat belt; V7, V6 (Licensed Practical Nurse), V45 (Certified Nursing Assistant) and V39 (Certified Nursing Assistant) placed R9 in the bed and she continued to scream; V7 came back into the room and R9 was trying to reach over and turn her motorized chair on and he moved the chair out of the way. R9's current physician order documents an active order effective 02/17/2024 for Behavior Monitoring. R9's current care plan initiated 03/01/2024 documents she has a history of self-harmful ideation (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(thoughts) and/or behavior. This appears related to: Evidence of severe mental illness (i.e., active psychosis, major depression, lack of sound judgment, poor contact with reality) with interventions including: as warranted conduct/carry out Behavior monitoring of the resident, look especially for any change. A safety contract was established with R9 and documents on 03/01/2024 R9 she signed an agreement to not harm herself in any way. R9's Screening Assessments for Evaluation of Self Harm/Suicide Risk dated 03/01/2024 and 04/24/2024 document she has a history of suicidal ideations and is at risk. On 05/29/2024 at 10:46 AM V6 (Licensed Practical Nurse) stated on the date of R9's incident at 10:30 PM R9 was being combative. V6 stated R9 was sleeping in her wheelchair at the nurses station and was asked by V27 (Certified Nursing Assistant) if she could ambulate herself in her wheelchair to her room. V6 stated R9 became combative and didn't want to get in her bed and she responded to R9 fine she'll just document that she refused to get in bed. V6 stated R9 started taking her seat belt off and appeared as though she may fall. V6 stated V7 (Licensed Practical Nurse) broke R9's fall by catching her in the front of her chest with his arms. V6 stated V7 then repositioned himself behind R9 and lifted her underneath her arms while she then assisted V7 by grabbing R9's legs and both placed her in bed. V6 stated she and V7 had left the room and a Certified Nursing Assistant walking by R9's room noticed her legs were hanging out of her bed and called her for assistance. V6 stated she then went into the room to assist that CNA (Certified Nursing Assistant) along with V7 and another CNA with getting R9 back into bed and R9 became combative. V6 stated R9 then began fighting, tried to bite V7 multiple times and hit her in the chest with her right arm. V6 stated she believes R9 may have been on smoke restriction and when this happens she becomes combative. On 05/29/2024 at 11:13 AM V45 (Certified Nursing Assistant) stated on the date of R9's incident V27 (Certified Nursing Assistant) informed her she needed help with R9 because she was partially out of her bed. V45 stated when she entered the room she observed R9 bent over her side rail with her arm pinned underneath her and her legs underneath her wheelchair which was directly next to the bed. V45 stated she, V27, V6 (Licensed Practical Nurse), and V7 (Licensed Practical Nurse) rolled R9 back into her bed and R9 hit V6 in the chest. V45 stated she believes R9's vape was taken and when this happens, she becomes out of control. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 05/29/2024 at 4:20 PM V7 (Licensed Practical Nurse) stated on the date of R9's incident she was in her chair at the nurses station and he believes there was a conversation about someone getting ready to change her and she wanted to stay in the chair to be changed. V7 stated R9 was told it was not safe to be changed in the chair and needed to be in the bed probably for safety. V7 stated R9 didn't want to be changed, became angry, she ambulated in her motorized wheelchair to her room and then tried to close her door. V7 stated on a previous day R9 closed her room door and tried to place her motorized wheelchair in front of the door to prevent anyone from entering. V7 stated he and V6 (Licensed Practical Nurse) stopped R9 from closing her door during this instance. V7 stated R9 then stated well I'll just throw myself on the floor then took her hand and unbuckled her seat belt. V7 stated R9 then leaned forward as if she was about to throw herself on the floor. V7 stated he then grabbed R9 from underneath her arms from in front of her and the repositioned himself behind R9's wheelchair and V6 grabbed her feet. V7 stated he then grabbed R9 from behind her back underneath her arms and V6 grabbed her feet and both placed her in the bed. V7 stated he and V6 put up the side rail and lowered R9's bed all the way down as low as it can go. V7 stated R9 was still angry and cursing. V7 stated he and V6 left the room and then someone came back to check on R9 five or ten minutes later and she was still in the bed but it was like she was trying to throw herself out of bed. V7 stated R9 was observed lying against the side rail of her bed in a sideways lying position and her feet were still in the bed. V7 stated R9's wheelchair was next to the bed and he thinks she may have tried to turn it on or grab a hold of it to pull herself out of the bed. V7 stated R9 was caught in the side rail, so he came in with two other aides, V45 (Certified Nursing Assistant), V27 (Certified Nursing Assistant), and the Nurse and all of them helped R9 out of the siderail and she was still angry and cursing. V7 stated when R9 is angry she just does things. V7 stated in his time at the facility for the past 2 and a half years R9 has exhibited these behaviors. V7 stated he has documentation of R9 in the past year stating she was going to throw herself on the floor. V7 stated R9 has a history of making verbal threats of self-harm of throwing herself on the floor when something isn't going her way. V7 stated R9 is able to take off her seatbelt and show that she can throw herself on the floor. V7 stated he believes R9 is physically capable of throwing herself out of the chair. On 05/30/2024 at 12:34 PM V29 (Regional Nurse Consultant) stated during R9's incident on 05/05/2024 she became aggressive, blocked her room door, unbuckled her seat belt, and attempted to throw herself on the floor. V29 stated R9 has a history of this behavior. V29 stated R9 was placed in her bed to prevent her from falling on the floor. V29 stated R9 has a history of osteoporosis and osteopenia and could have had worse than a fracture. V29 stated because of R9's Multiple Sclerosis she couldn't fully place herself on the floor, however R9 obtained a fracture because of her behavior and because of how she was positioning herself out of bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 05/30/2024 at 12:42 PM V2 (Director of Nursing) stated due to R9's condition it's unsafe for her to be alone in her room by herself. V1 (Administrator) stated when R9 declined to have staff in her room the appropriate response would be verbal de-escalation, talking to her through the door to get her to remove her wheelchair. V2 stated after breaking R9's fall from her wheelchair when trying to throw herself on the floor, the nurses should have seen if it's ok to place her in bed, or somewhere they know she would be safe. V2 stated she would expect staff to make a decision of where R9 can be kept safe whether it's place her back in her bed or chair. V2 stated after it was determined R9 would be safer in her bed whomever was in the room should have then placed R9 in the bed and monitored her. V2 stated with the behaviors R9 was exhibiting she would expect staff to implement 1:1 (one to one) monitoring or have someone in the room with R9, then the nurse should have called the doctor and notified the family. V2 stated If R9 was not closely monitored, she could have experienced harm and safety would be a significant concern. V2 stated one to one monitoring was necessary because R9 threatened to place herself on the floor and threatened to harm herself. V2 stated if staff left the room after R9 threatened to place herself on the floor and hear her yelling, they should immediately respond and see what is going on. On 05/30/2024 at 1:27 PM V44 (Restorative Nurse) stated R9 can slide out of her wheelchair if sitting straight up in it. Behavior Management for Agitated Behavior Policy received/reviewed 05/30/3034 states: Observe resident for behavior escalation of aggression such as a loud voice tone, swearing, yelling, and/or other irritability. Allow time to calm down with 1:1 (one to one) explanation of why behavior is inappropriate and unacceptable in a calm, soft voice. Allow time for resident to voice feelings and frustration. If uncontrolled anger, aggression cannot be redirected, i.e. (in other words). the resident is in danger of harming self or others after attempting the above interventions, administer physician ordered medication for anxiety for the symptoms being exhibited. Document all interventions attempted and administered and the resident's response to medical interventions. Notify the physician of the resident's signs/symptoms and lack of response to medications and other interventions. Monitor the response to the drug therapy 1:1 (one to one) until dangerous symptoms are reduced. If the resident responds to the medication by becoming quiet and anxiety free and aggressive acts have minimized, i.e. (in other words) no longer harm to self, 1:1 (one to one) monitoring will be discontinued. In the event staff needs to physically intervene to prevent the resident from harming self or others, techniques to provide interim control will be implemented which include non-violent crisis intervention. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	When interim control is used, the physician will be notified, and a determination made as to the need for acute mental health services. R9's progress notes and medical records do not include documentation of an attempt to provide medical interventions nor provision of 1:1 (one to one) monitoring during the course of exhibiting self-harming and physically aggressive behaviors. R9's May 2024 Medication Administration Record does not document any evidence of administration of medication for anxiety, aggression, or self-harming behaviors on 05/05/2024 between 8-10:30 PM.