

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145639	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Chicago Ridge Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 10602 Southwest Highway Chicago Ridge, IL 60415	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718</p> <p>Based on observations, interviews, and record reviews the facility failed to follow their environmental policy and procedures by not ensuring resident living areas were kept free of mold or mold promoting conditions. This failure applied to three of three residents (R1, R13, and R14) reviewed for environment.</p> <p>Findings include:</p> <p>R1 is a [AGE] year-old male with a diagnoses history of Local Infection of the Skin, Rheumatoid Arthritis, Chest Pain, Cellulitis of Right Lower Limb, Non-Pressure Chronic Ulcer of Right Ankle, Pulmonary Nodule, and Pericarditis who was admitted to the facility 04/11/2024.</p> <p>R13 is a [AGE] year-old male with a diagnoses history of Schizoaffective Disorder, Anxiety Disorder, and Benign Prostatic Hyperplasia who was admitted to the facility 10/10/2023.</p> <p>R14 is a [AGE] year-old male with a diagnoses history of Type 2 Diabetes Mellitus with Hyperglycemia, Atherosclerotic Heart Disease, History of Pulmonary Embolism, and Metabolic Encephalopathy who was admitted to the facility 05/02/2022.</p> <p>On 09/10/2024 at 12:35 PM Observed 4 large dark discolored stains with a fuzzy growth on the ceiling tiles near R1's bed that appeared to be mold. R1 did not comment on the surveyors observations but did sigh in agreement about the surveyors concerns about the condition of the ceiling tiles.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/11/2024 from 10:19 AM - 11:00 AM V9 (Maintenance Director) stated if water stains sit on ceiling tiles for too long, they can begin to change colors, decay, or turn into mold. V9 stated mold is a fungus and a growth that can be a range of colors depending on what it's growing on. V9 stated mold is also distinguished by shape and texture V9 stated mold can be black, green, or even purple if its sitting on an object of that color. V9 stated if ceiling tiles become discolored, he will change them out. V9 explained that the facility's air conditioning system does cause some moisture to drop onto the ceiling panels. V9 stated this issue is more common in certain areas of the building such as the first-floor area that were observed with discolored and water-stained ceiling tiles. V9 stated if staff observe discolored ceiling tiles, they are trained to document these observations on work order forms which he also tries to address within 24 hours. Observed 4 large dark discolored stains with a fuzzy growth on the ceiling tiles near R1's bed. V9 stated the dark discolored stains on the ceiling tiles near R1's bed appear to be mold. V9 agreed that staff that have entered R1's room should have reported the discolored ceiling tiles. V9 stated if mold is observed in a residents room they would be removed from the room, he would don a mask and gear and remove the panels. V9 agreed that mold is dangerous. Observed a large dark discolored stain with a fuzzy growth on the ceiling tile directly outside of R13's room. V9 stated the dark discolored ceiling tile directly outside of R13's room looks like it's turning into mold. Observed a dark discolored ceiling tile in a non-occupied room. V9 stated he would say that the dark discolored ceiling tile in the non-occupied room is mold. V9 stated no one is currently living in that room but the room is being prepared for admitting residents. V9 stated the ceiling tiles in the non-occupied room would need to be removed. Observed multiple discolored water-stained panels in R14's room and bathroom. V9 stated the multiple discolored water-stained panels in R14's room and bathroom are becoming discolored and should be changed.</p> <p>The facility's Preventative Maintenance Policy Received 09/13/2024 states:</p> <p>The purpose of the policy is to:</p> <p>To conduct regular environmental tours/safety audits to identify areas of concern within the facility.</p> <p>The responsible parties include:</p> <p>Maintenance Director and/or Housekeeping Director.</p> <p>Protocol includes:</p> <p>Random rounds conducted by the Director of Maintenance and/or Director of Housekeeping Services.</p> <p>Monitor random rounds in writing to review in the Monthly QA Meeting.</p> <p>Preventative Maintenance Program will review the following areas during random rounds:</p> <p>All facility areas are kept clean and in safe condition,</p> <p>Ceiling tiles are free from watermarks or spots.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718</p> <p>Based on interviews and record reviews, the facility failed to follow their policy and procedures for internal reporting requirements of abuse allegations by not reporting a family reported allegation of abuse to the abuse coordinator (Administrator). This failure applied to one of three residents (R2) reviewed for abuse.</p> <p>Findings include:</p> <p>R2 is a [AGE] year-old male with a diagnoses history of Schizoaffective Disorder, Adult Failure to Thrive, Dementia, Major Depressive Disorder, Bipolar Disorder, and History of Falling who was admitted to the facility 03/09/2021.</p> <p>On 09/10/2024 Abuse investigation reports from June - September 2024 were reviewed with no reports included regarding V18's abuse allegation regarding R2.</p> <p>On 09/11/2024 at 2:06 PM V18 (Family Member) stated on approximately 08/18/2024 or 08/19/2024 at approximately 2 or 3 PM on the second day after R2's admission, V19 (Certified Nursing Assistant) came in with V20 (Certified Nursing Assistant) to change R2's brief and sheets. V18 stated they would turn R2 on his left then right to remove his adult brief and sheet. V18 stated when V19 attempted to turn R2 on his left side and grabbed R2 by his shoulder and back and pushed him over on his side, R2 raised his fist and said don't do that. V18 stated V19 then began yelling at R2 stating uh uh we're not gonna [sic] have that, we are not gonna have that, not today. V18 stated she told V19 R1 doesn't understand, but V19 ignored her. V18 stated she reported to the nurses at the nurses station that day that V19 was rough with her father, and she didn't want him changing R2 anymore. V18 stated there were about 6 or 7 nursing staff present at the nurses station. V18 stated the next day V20 came into R2's room and she told her she's glad V19 is not coming back because he was rough with her father. V20 stated that's ok she can take care of R2 by herself. V18 stated V19 then came into the room, and she said excuse me I'm in the middle of talking, and he responded uh uh, uh uh, hello. V18 stated V19 then yelled at her I'm not gonna put up with that (swear word) today, and told V20 you take care of him then and stomped out of the room. V18 stated she reported how V19 was roughly handling R1 to V22 (Licensed Practical Nurse). V18 stated she also reported this to V2 (Director of Nursing) and she listened then told her ok I will have a talk with V19. V18 stated she advised she doesn't want V19 taking care of R2 anymore and V2 replied ok she'll have a talk with him.</p> <p>On 09/11/2024 at 4:06 PM V2 (Director of Nursing) stated a couple of weeks ago V18 (Family Member) reported she didn't like the way V19 (Certified Nursing Assistant) was talking to her and in response she had a long conversation with V19. V2 stated V18 did not report to her that V19 handled R2 roughly. V22 (Licensed Practical Nurse) reported by phone to surveyor that V18 did report to her that V19 handled R2 roughly and she did report this to V2. V1 (Administrator) confirmed that based on what V18 reported about V19 handling R2 roughly, an investigation would have to be started. V2 and V1 stated V22 should have reported this to V1 and if it was reported to V2, V2 would have had to report it to V1. V1 stated if this incident would have been reported to her V19 would have been removed from the schedule, she would have reported this to the state within two hours, and initiated an investigation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Abuse Prevention Program Facility Policy and Procedure received 09/13/2024 states:</p> <p>Employees are required to report any allegation of potential abuse they observe or hear about to the administrator immediately or to an immediate supervisor who must then immediately report it to the administrator. In the absence of the administrator, reporting can be made to an individual who has been designated to act as administrator in the administrator's absence.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure bed linens were changed as needed for a resident who requires assistance with activities of daily living. This failure applied to one of three residents (R1) reviewed for activities of daily living.</p> <p>Findings include:</p> <p>R1 is a [AGE] year-old male with a diagnoses history of Local Infection of the Skin, Rheumatoid Arthritis, Chest Pain, Cellulitis of Right Lower Limb, Non-Pressure Chronic Ulcer of Right Ankle, Pulmonary Nodule, and Pericarditis who was admitted to the facility 04/11/2024.</p> <p>On 09/10/2024 at 12:35 PM Observed both of R1's hands with contractures. Observed R1's linens and pillowcases with stains that appeared old.</p> <p>On 09/18/2024 at 12:48 PM fell ow surveyor observed R1's bed linens with stains that appeared old.</p> <p>On 09/19/2024 at 1:24 PM V17 (Family Member) stated a couple of weeks ago when she and other family member's visited R1 she observed R1's bed linens stained.</p> <p>On 09/19/2024 at 2:35 PM V17 (Family Member) stated she reported R1's stained bed linens to all the nurses that were present when she and her family visited R1 a couple of weeks ago and to V6 (Social Services Designee). V17 stated she has reported this to multiple people multiple times and was told they would investigate it. V17 stated she submitted a written report regarding R1's bed linens to the state agency and to others as well.</p> <p>On 09/19/2024 at 3:19 PM V2 (Director of Nursing) stated she was not aware of any reports of soiled bed linens for R1. V2 stated if bed linens are stained the certified nursing assistants should change it. V2 stated to her knowledge there has been no incidents of R1 not allowing staff to change his linens.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718</p> <p>Based on observations, interviews, and record reviews, the facility failed to follow their policy and procedure for wound treatments by not ensuring residents received wound treatments daily as ordered by the physician, with multiple missed wound treatments. This failure applied to two of three residents (R1 and R3) reviewed for wound care.</p> <p>Findings include:</p> <p>1) R1 is a [AGE] year-old male with a diagnoses history of Local Infection of the Skin, Rheumatoid Arthritis, Chest Pain, Cellulitis of Right Lower Limb, Non-Pressure Chronic Ulcer of Right Ankle, Pulmonary Nodule, and Pericarditis who was admitted to the facility 04/11/2024.</p> <p>On 09/10/2024 at 12:35 PM R1 stated the bandage on his right leg is changed every few days or so and was last changed on Friday or Saturday. Observed R1's bandage on his right leg with some reddish brown stains.</p> <p>R1's current care plan documents he is at increased risk for alteration in skin integrity related to post surgical wound to his right heel, and right lateral ankle with interventions including Administer Wound Care (Treatments) per physician orders.</p> <p>R1's current physician order summary includes an active order effective 09/11/2024 for paint right heel with topical anesthetic. Cover with antibiotic pad, and wrap with wound care gauze.</p> <p>R1's July, August, and September 2024 Treatment Administration Records document missing information on multiple days for wound care treatments as actively ordered.</p> <p>R1's September 2024 Treatment Administration Record received from the facility 09/13/2024 was modified to fill in the missing information for wound care treatments after the surveyor reviewed it originally on 09/11/2024.</p> <p>2) R3 is a [AGE] year-old male with a diagnoses history of Dementia, Polyneuropathy, Peripheral Vascular Disease, and Cellulitis of Left and Right Lower Limbs who was admitted to the facility 11/07/2022.</p> <p>On 09/10/2024 at 10:45 AM R3 stated he called the police on Monday 09/09/2024 because wound care hadn't been provided. R3 stated wound care hadn't changed his bandage and he has a skin ulcer inside the right ankle. Observed R3's ankle covered with a bandage with some reddish-brown stains. R3 stated he was told that on weekends the nurses half to provide wound care and change bandages. R3 stated his bandage was last changed yesterday and prior to that on Friday.</p> <p>R3's current physician orders document an active order effective 05/31/2024 for apply topical anesthetic to right ankle topically every day-shift for wound healing, cleanse ankle with saline and apply topical anesthetic daily.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R3's August and September 2024 treatment administration record documents missing information for multiple days including Saturday 09/07/2024 and Monday 09/09/2024 for wound treatments as actively ordered.</p> <p>On 09/12/2024 at 11:45 AM V15 (Licensed Practical Nurse) stated nurses perform wound care on weekends if there is no wound nurse available.</p> <p>On 09/12/2024 at 3:34 PM V2 (Director of Nursing) stated nurses are responsible to provide wound care on the weekends if there is no wound nurse available.</p> <p>On 09/19/2024 at 8:46 AM V2 (Director of Nursing) agreed even if a resident has a history of refusing wound treatment the facility should still offer it. V2 stated if there is no documentation in the treatment administration record of the resident receiving wound treatment or refusing it this indicates it was not done.</p> <p>On 09/19/2024 at 1:53 PM V8 (Wound Nurse/Licensed Practical Nurse) stated she misunderstood the surveyors request to explain the missing entries on R1's September 2024 Treatment Administration Record and thought the surveyor was asking the facility to correct the missing entries. V2 (Director of Nursing) and V8 stated it appears V3 (Assistant Director of Nursing) modified the missing entries in R1's September 2024 Treatment Administration Record the day the surveyor spoke to V8 about this record.</p> <p>The facility's Wound Care Policy received 09/13/2024 states:</p> <p>The purpose of the policy is To promote healing of existing pressure and non-pressure ulcers.</p> <p>The goals of wound treatment are to:</p> <ol style="list-style-type: none"> a. Keep the ulcer bed moist and the surrounding skin dry, b. Protect the ulcer from contamination, and c. Promote healing. 		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718</p> <p>Based on observations, interviews, and record reviews the facility failed to follow their policy and procedures for weight management by not ensuring specialized dietary orders were followed, not following a physician's supplemental recommendations from hospital records, not honoring a residents supplemental preference, not accurately documenting supplement administration, not obtaining dietary preferences, not providing feeding assistance as needed, and not accurately documenting meal consumption for a resident at high risk for and exhibiting signs of severe malnutrition. This failure applied to one of one resident (R1) reviewed for nutrition status.</p> <p>Findings include:</p> <p>R1 is a [AGE] year-old male with a diagnoses history of Local Infection of the Skin, Rheumatoid Arthritis, Chest Pain, Cellulitis of Right Lower Limb, Non-Pressure Chronic Ulcer of Right Ankle, Pulmonary Nodule, and Pericarditis who was admitted to the facility 04/11/2024.</p> <p>On 09/10/2024 at 12:35 PM Observed R1 with multiple missing teeth.</p> <p>On 09/10/2024 at 1:31 PM Observed both of R1's hands with contractures. Observed V15 (Licensed Practical Nurse) assisting R1 with eating his meal. R1 stated he can't eat everything because some foods are hard to chew or just completely hard. R1 showed surveyor that his chicken was tough by bending it back and forth. Observed chicken to be tough and uncut. R1 stated V17 (Family Member) brings him cereal and soup and things he can chew. Observed V15 did not attempt to cut R1's meat while assisting him with eating then take R1's tray after he said he couldn't eat the meal anymore without encouraging him to eat more or offering him alternative foods. Observed R1's meal tray with leftover food including 2 full chicken tenders, 1/2 cup of slaw, 1 slice of bread, and approximately 1 Tbsp of apple crisp. Observed R1 ate 15-20% of his meal. Observed R1's meal ticket did not include preferences. V15 stated R1 hasn't been eating so well.</p> <p>R1's point of care reports for amount of food eaten on 09/10/2024 documents during his lunch meal he ate 75-100% of his meal.</p> <p>R1's current physician order summary includes an active order effective 08/15/2024 for General Mechanical Soft texture diet with Regular, 1 Scoop (Protein Supplement) two times a day for weight management; and 120 ml Nutritional Protein Supplement two times a day for weight management and does not include nutritional shake.</p> <p>On 09/10/2024 at 1:54 PM V17 (Family Member) stated R1 has lost weight since he's been in the facility. V17 stated R1 has reported difficulty with chewing food, and she has observed them leaving him with his tray and he needs help with being fed. V17 stated R1 has been at the facility since April and he's going to die there if they are not helping him.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/12/2024 from 9:50 - 10:10 AM V15 (Licensed Practical Nurse) stated R1 refused his ordered protein supplement when she offered it to him this morning and preferred to drink his milk. V15 opened R1's medication administration record at the nurses station computer upon surveyor's request which documented that 1 scoop of protein supplement was administered to R1 during morning medication pass. V15 could not explain why she marked the protein supplement as administered although R1 declined it. Observed V15 attempt again to offer R1 his protein supplement. R1 declined it and asked for Nutritional shake. R1 stated he used to receive a case of nutritional shake through his insurance. V15 stated R1's family sometimes brings him nutritional shake. R1 stated the nutritional shakes comes in different flavors that he likes.</p> <p>R1's September 2024 Medication Administration Record was reviewed to be inconsistent with surveyors observations on 09/12/2024 from 9:50 AM - 10:10 AM.</p> <p>R1's Hospital Report dated 07/09/2024 documents he was observed to be underweight and frail, suspected to have inadequate intake, severe muscle and adipose wasting observed upon physical nutritional assessment consistent with severe malnutrition, and a recommendation to provide advanced nutritional shake three times daily to enhance diet.</p> <p>R1's current care plan initiated 09/10/2024 documents he requires assistance with his meals as evidenced by diagnosis of Rheumatoid Arthritis at multiple sites related to: Contracture of Muscle at multiple sites with interventions including staff to assist with cutting meat and vegetables for all meals; current care plan initiated 08/22/2024 documents his nutritional status is compromised secondary to: Low Body Mass Index, Chronic renal failure with resultant abnormal labs, Present Weight at 90 below Ideal Body Weight of 133-163 lbs. with interventions including prepare/serve R1's nutritional diet as ordered, Determine R1's food preferences through one-to-one interview and/or family interview, and provide dietary supplements as ordered.</p> <p>On 09/12/2024 at 11:43 AM Observed R1 weighed to be 92.2 lbs.</p> <p>On 09/12/2024 at 12:20 PM V7 (Dietary Manager) stated R1 did not have any food preferences when she asked him on admission.</p> <p>On 09/12/2024 at 2:20 PM V21 (Dietitian) stated the facility should be able to order the nutritional shake that R1 prefers. V21 stated R1's ordered nutritional protein supplement is nutritionally similar to the nutritional shake and may be better quality however if he doesn't like it he won't drink it. V21 stated usually the facility can find a way to order the Nutritional shake. V21 stated mechanical soft food is what's ordered for R1. V21 confirmed it is important that R1 receives supplements if he doesn't eat well. V21 stated it is important that R1 is eating regular foods as well. V21 stated 92.2 pounds is definitely low even though R1's Body Mass Index is in a normal range. V21 stated it would be good if R1 gained weight and Body Mass Index doesn't take into account body composition or mass. V21 stated we would want R1 to get enough vitamin C and iron from adequate intake of whole foods as well as supplement intake.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/12/2024 at 3:15 PM V35 (Licensed Practical Nurse) stated R1 doesn't like the 120ml (Milliliter) Nutritional Protein Supplement and usually declines it preferring to drink soda or milk. Observed R1 decline his prescribed 120ml Nutritional Protein Supplement when offered by V35. R1 stated the Nutritional Protein Supplement tastes like medicine and he prefers Nutritional shake which has different flavors and tastes like a shake. R1 stated he drinks milk with no issue and the nutritional shake, but his ordered Protein Supplement and Nutritional Protein Supplement taste like medicine.</p> <p>On 09/12/2024 at 3:34 PM V2 (Director of Nursing) stated staff should encourage or cue R1 to eat if he is refusing to eat. V2 stated if R1 refuses the protein supplements provided by the facility an alternative should be offered to him.</p> <p>On 09/12/2024 at 3:56 PM V21 (Dietitian) stated she spoke with V1 (Administrator) and she will work on getting the Nutritional Shake for R1 and the facility should be offering other alternatives if the Nutritional Shake is unavailable such as calorie dense shake, protein enriched frozen dessert, and fortified ice cream. V21 stated if it is not possible to order the Nutritional Shake there should be some other alternatives available.</p> <p>On 09/17/2024 at 2:24 PM When surveyor asked V7 (Dietary Manger) if she ever asked R1's family about his food preferences she stated she has never met or encountered R1's family but if any dietary issues come up during care conferences, she will address those concerns.</p> <p>On 09/19/2024 at 8:46 AM V2 (Director of Nursing) stated the facility does use recommendations from hospital records and if necessary, the facility will work with the dietitian to implement any recommended interventions or any alternatives to those recommendations.</p> <p>On 09/19/2024 at 1:24 PM V17 (Family Member) stated R1 likes to eat chicken nuggets because they're soft, hamburger meat without the bun because it's too hard, French fries, and likes milk shakes a lot. V18 stated R1 previously had a lot of favorite foods and prefers Mexican food such as burrito's, tacos, soups, and beef. V18 stated the facility never asked her about his favorite foods or food preferences and assumes they just provide him whatever is on the menu for all the residents.</p> <p>The facility's Policy for Weight Assessment and Intervention received 09/13/2024 states:</p> <p>Interventions for undesirable weight changes may take the following considerations: resident's preferences, rights, and use of supplements, as ordered by the physician.</p> <p>The facility's Resident Tray Delivery Policy received 09/18/2024 states:</p> <p>Check name, diet order and preferences on dietary card on tray</p> <p>Avoids errors in served items, or omissions.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145639	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Chicago Ridge Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 10602 Southwest Highway Chicago Ridge, IL 60415	
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 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718</p> <p>Based on observations, interviews, and record reviews the facility failed to follow their policy and procedures for providing specialized diets by not ensuring specialized dietary orders were followed and not providing feeding assistance as needed for a resident who receives a mechanical soft diet. This failure applied to one of one resident (R1) reviewed for specialized diet.</p> <p>Findings include:</p> <p>R1 is a [AGE] year-old male with a diagnoses history of Local Infection of the Skin, Rheumatoid Arthritis, Chest Pain, Cellulitis of Right Lower Limb, Non-Pressure Chronic Ulcer of Right Ankle, Pulmonary Nodule, and Pericarditis who was admitted to the facility 04/11/2024.</p> <p>On 09/10/2024 at 12:35 PM Observed R1 with multiple missing teeth.</p> <p>On 09/10/2024 at 1:31 PM Observed R1 both of R1's hands with contractures. Observed V15 (Licensed Practical Nurse) assisting R1 with eating his meal. R1 stated he can't eat everything because some foods are hard to chew or just completely hard. R1 showed surveyor that his chicken was tough by bending it back and forth. Observed chicken to be tough and uncut. R1 stated V17 (Family Member) brings him cereal and soup and things he can chew. Observed V15 did not attempt to cut R1's meat while assisting him with eating then take R1's tray after he said he couldn't eat the meal anymore without encouraging him to eat more or offering him alternative foods. Observed R1's meal tray with leftover food including 2 full chicken tenders, 1/2 cup of slaw, 1 slice of bread, and approximately 1 Tbsp of apple crisp. Observed R1 ate 15-20% of his meal. V15 stated R1 hasn't been eating so well.</p> <p>On 09/12/2024 at 2:20 PM V21 (Dietitian) stated mechanical soft food is what's ordered for R1. V21 confirmed it is important that R1 receives supplements if he doesn't eat well. V21 stated it is important that R1 is eating regular foods as well. V21 stated 92.2 pounds is definitely low even though R1's Body Mass Index is in a normal range. V21 stated it would be good if R1 gained weight and Body Mass Index doesn't take into account body composition or mass. V21 stated we would want R1 to get enough vitamin C and iron from adequate intake of whole foods as well as supplement intake.</p> <p>R1's current care plan initiated 09/10/2024 documents he requires assistance with his meals as evidenced by diagnosis of Rheumatoid Arthritis at multiple sites related to: Contracture of Muscle at multiple sites with interventions including staff to assist with cutting meat and vegetables for all meals; current care plan initiated 08/22/2024 documents his nutritional status is compromised secondary to: Low Body Mass Index, Chronic renal failure with resultant abnormal labs, Present Weight at 90 below Ideal Body Weight of 133-163 lbs. with interventions including prepare/serve R1's nutritional diet as ordered.</p> <p>R1's current physician order summary includes an active order effective 08/15/2024 for General Mechanical Soft texture diet.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Chicago Ridge Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 10602 Southwest Highway Chicago Ridge, IL 60415	
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 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Restorative progress note created dated 9/10/2024 documents writer asked out of concern was assistance from staff needed with his meals. R1 stated, at times he does need assistance with cutting his meats and, some vegetables.</p> <p>The facility's Resident Tray Delivery Policy received 09/18/2024 states:</p> <p>Check name, diet order and preferences on dietary card on tray</p> <p>Avoids errors in served items, or omissions.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718</p> <p>Based on observations, interviews, and record reviews the facility failed to follow their policy and procedures for providing effective pest control interventions by not adequately assisting residents with maintaining a clean environment and not providing pest control treatments consistently. This failure applies to all 202 residents currently in the facility.</p> <p>Findings include:</p> <p>R1 is a [AGE] year-old male with a diagnoses history of Local Infection of the Skin, Rheumatoid Arthritis, Chest Pain, Cellulitis of Right Lower Limb, Non-Pressure Chronic Ulcer of Right Ankle, Pulmonary Nodule, and Pericarditis who was admitted to the facility 04/11/2024.</p> <p>On 09/10/2024 at 12:35 PM Observed gnats flying around R1's room. R1 stated he sees roaches and flying insects in his room.</p> <p>On 09/10/2024 at 1:54 PM V17 (Family Member) stated she has observed R1's tray to be full of flies and another visiting family member took a video of his tray being left in the room and it being full of flies.</p> <p>On 09/11/2024 at 11:55 AM Observed gnats flying in first floor hallway.</p> <p>R2 is a [AGE] year-old male with a diagnoses history of Schizoaffective Disorder, Adult Failure to Thrive, Dementia, Major Depressive Disorder, Bipolar Disorder, and History of Falling who was admitted to the facility 03/09/2021.</p> <p>On 09/11/2024 at 2:06 PM V18 (Family Member) stated she's seen a roach crawling in R2's room.</p> <p>R3 is a [AGE] year-old male with a diagnoses history of Dementia, Polyneuropathy, Peripheral Vascular Disease, and Cellulitis of Left and Right Lower Limbs who was admitted to the facility 11/07/2022.</p> <p>On 09/10/2024 at 10:45 AM R3 stated there are issues with roaches, flies, and gnats.</p> <p>R8 is a [AGE] year-old male with a diagnoses history of Schizoaffective Disorder and Iron Deficiency Anemias who was admitted to the facility 10/17/2014.</p> <p>On 09/17/2024 at 1:25 PM R8 reported there was a roach in his coffee this morning. R8 stated he had pictures. Observed a picture in R8's cell phone dated 09/17/2024 at 9:24 AM of a roach in a cup of coffee.</p> <p>R11 is a [AGE] year-old male with a diagnoses history of End Stage Renal Disease, Dependence on Renal Dialysis, Heart Failure, Convulsions, and Need for Assistance with personal care who was admitted to the facility 03/27/2012.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Chicago Ridge Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 10602 Southwest Highway Chicago Ridge, IL 60415	
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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 09/11/2024 at 10:12 AM R11 stated the roaches are taking over at night and are all over the building. R11 stated the roaches are just running wild. R11 stated there are a few gnats.</p> <p>R12 is a [AGE] year-old female with a diagnoses history of Heart Failure, Candidiasis, End Stage Renal Disease, and Asthma who was admitted to the facility 11/04/2022.</p> <p>On 09/11/2024 at 10:13 AM R12 stated she sees a lot of roaches in her room.</p> <p>On 09/11/2024 at 11:59 AM V10 (Housekeeping Supervisor) confirmed the facility does have roach problems, and stated once she is made aware of it she notifies the pest control and walks with them to nutritional shake the rooms are treated. V10 stated pest control comes out each time she calls. V10 stated food, wall cracks, and clutter need to be eliminated to eliminate roach problems. V10 stated the pest control rep stated the room walls also need to be kept clean. V10 stated room trays need to be removed timely and rooms kept free of food waste and kept clean. V10 stated while these issues are being addressed the facility should be treated for roaches weekly. V10 stated the pest control rep has observed food on the wall, diapers not in the garbage bag, feces on the wall in the soiled utility room, trays being left in the soiled utility room, food and clutter in the residents room and advised the facility needs to eliminate some of the clutter and food kept in residents rooms. V10 stated they don't call the pest company out for gnat treatment; however, they remove garbage and clean any waste that attracts gnats. V10 stated if residents have concerns about gnats in their room, she'll come into their room and identify any food or waste that are attracting the gnats, she will have the waste removed and have the area cleaned to remove the gnats. V10 stated she would not use fly catchers to remove gnats.</p> <p>Pest Control Siting Logs from June - September 2024 document multiple reports of roaches throughout the facility.</p> <p>Pest Control Invoices from June - September 2024 document sightings of roaches in multiple areas of the facility including residents rooms, nurses stations, janitor closet, shower room, utility rooms, offices, library, and kitchen; reports of food, food related items present on walls and on floors, clutter, and wall openings in resident areas reportedly making it impossible to effectively treat roaches with a recommendation to address these issues in order to help keep pest down in residents rooms; and that the facility only received roach treatments every other week.</p> <p>The facility's Pest Control Policy received 09/13/2024 states:</p> <p>The purpose of this policy is to prevent or control insects from spreading disease.</p> <p>The pest control program will be conducted on a regular and as needed basis.</p> <p>Food will be covered and/or refrigerated as applicable, to prevent pest invasion and spoiling.</p> <p>Residents shall be allowed to keep limited amount of open food at their bedside in sealed containers.</p> <p>The facility shall be kept in such condition and cleaning procedures used to prevent the harborage or feeding of insects.</p>		