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	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chicago Ridge Snf	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46344 Based on interview and record review, the facility failed to ensure an altercation between two residents (R1 and R4) was identified and investigated as abuse. This failure applied to two (R1, R4) of three residents reviewed for abuse. Findings include: R1 is a [AGE] year-old female who admitted to the facility on [DATE] and continues to reside in the facility. R1 has multiple diagnoses including but not limited to the following: anxiety, depression, COPD, PTSD, and psychoactive substance abuse. Per Minimum Data Set, dated dated dated [DATE] states residents has a Brief Interview of Mental Status (BIMS) of 15 meaning resident is cognitively intact. R4 is a [AGE] year-old female who originally admitted to the facility on [DATE] and continues to reside in the facility. R4 has multiple diagnoses including but not limited to the following: hypertension, panic disorder, psychoactive substance abuse, borderline personality disorder, bipolar disorder, and depression. On 10/7/2024 at 11:50AM, R1 was interviewed regarding incident with R4. R1 said a week or so ago, R4 physically assaulted me and I feel as if the facility is trying to cover it up. R1 said R4 was my roommate at the time and stole a water bottle from me. I called her a liar which made her very angry and she punched me in the chest. R1 said V4 (Registered Nurse / RN) and V9 (Certified Nursing Assistant / CNA) were there when it was going on so they are aware. They tried to send me out to the hospital but I refused to go. They made me and R4 switch rooms and I have seen her since in the hallway. At 12:25PM, V7 (Social Service Director) was interviewed regarding incident with R1 and R4 and policy regarding abuse allegations. V7 said my understanding was that R1 and R4 got in a verbal disagreement over a water bottle. I was never told that there was a physical altercation. V7 said if there was a physical altercation, we would have put the residents on 1:1 supervision and sent them out to the hospital. R4's progress note dated 9/30/24 states in part but not limited to the following: R4 sent out via 911 for psych evaluation. R4 was found having an altercation with R1. (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

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 10/10/2024
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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's progress note dated 9/30/24 states in part but not limited to the following: R1 was found to be in an altercation with R4. R1 refused to be sent out for a psych evaluation. R1 placed on 1:1 supervision. At 12:39PM, V4 (RN) was interviewed regarding altercation between R1 and R4. V4 said I was the nurse on duty during R1 and R4's altercation. V9 (CNA) was calling my name from their room and when I entered R1 was on the bed pointing her finger in R4's face. They were both yelling at each other. V9 was in the middle of the two residents and it looked as if they were going to lunge at one another. They were being very aggressive. We attempted to separate both of them but anytime they would get back in the vicinity of one another, they would argue again. They were both being very disruptive and I was afraid it would get physical. We placed both residents on 1:1 supervision and attempted to send both of them out for a psych evaluation. R4 went to the hospital via 9-1-1 but R1 refused to go. V4 said, at no point was I made aware of any physical altercation between the two residents, but they were being very aggressive and I feel as if we didn't separate them, there could have been a physical altercation. On 10/8/24 at 12:04PM, V9 (CNA) was interviewed regarding incident with R1 and R4. V9 said I heard commotion coming from R1 and R4's room. When I walked into the room, R1 was standing on her bed and pointing her finger in R4's face, yelling at her. She was calling R4 a liar and they were both very irritated and yelling at each other. I did not witness any physical altercation, I just heard yelling. V9 said we placed both residents on 1:1 supervision and attempted to send them both to the hospital. R4 went to the hospital but R1 refused to go. At 1:35PM, V2 (Assistant Administrator) was interviewed regarding incident with R1 and R4 and abuse investigations. V2 said I was not made aware of this situation until 10/7/24 when this surveyor started asking questions. V2 said we investigate all the abuse concerns including but not limited to: verbal, mental, physical, etc. Verbal abuse is investigated when the residents want to fight each other or if the conversation is very heated. If the residents are very aggressive, that can be considered verbal abuse. On 10/9/24 at 11:35AM, V1 (Administrator/Abuse Coordinator) was interviewed regarding incident with R1 and R4 and abuse investigations. V1 said they report all abuse allegations including but not limited to the following: verbal, mental, physical, etc. V1 said verbal abuse would be considered when someone is calling names, cussing, swearing, being intimidating or aggressive. V1 said we did not consider the incident with R1 and R4 to be abuse. Abuse Policy with last review date of 1/4/2019 states in part but not limited to the following: Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. Supervisors shall immediately inform the administrator of all reports of incidents, allegations, or suspicion of potential abuse. Upon learning of the report, the administrator shall initiate an incident investigation.