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	04/14/2025

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 - 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** 46066 Based on interviews and record review, the facility failed to protect a resident's right to be free from physical abuse from another resident for one (R5) of five residents reviewed for abuse in a sample of 14. This failure resulted in R5 being physically assaulted and emergently transferred to the hospital for evaluation of facial trauma. Findings inlcude: R5 was dmitted to the facility on [DATE] with diagnosis including but not limited to Gout, Unspecified; Hypothyroidism, Unspecified; Chronic Obstructive Pulmonary Disease, Unspecified; Essential (Primary) Hypertension; Hyperlipidemia, Unspecified; Other Muscle Spasm; and Nondisplaced Fracture of Cuboid Bone Of Right Foot, Subsequent Encounter For Fracture With Routine Healing. According to R5's MDS (Minimum Data Set) assessment dated [DATE] under section C, R5 has BIMS (Brief Interview of Mental Status) score of 15 indicating, indicating intact cognition. Prior to 03/02/2025 absent are any care plans related to R5's susceptibility to abuse. R6 was admitted to the facility on [DATE] with diagnosis including but not limited to Schizophrenia, Unspecified; Primary Insomnia; Opioid Dependence with Withdrawal; Chronic Obstructive Pulmonary Disease, Unspecified; Chronic Viral Hepatitis B Without Delta-Agent; Unspecified Viral Hepatitis C Without Hepatic Coma; Essential (Primary) Hypertension; and Opioid Dependence, Uncomplicated. According to R6's MDS (Minimum Data Set) assessment dated [DATE] under section C, R6 has BIMS (Brief Interview of Mental Status) score of 14 indicating, indicating intact cognition. Prior to 03/02/2025 absent are any care plans related to R6's predisposition to abuse. R10 is a [AGE] year-old male admitted to the facility on [DATE] with diagnosis including but not limited to Chronic Obstructive Pulmonary Disease, Unspecified; Edema, Unspecified; Hypotension, Unspecified; Hypertensive Heart Disease Without Heart Failure; Type 2 Diabetes Mellitus Without Complications; Hypokalemia; Major Depressive Disorder, Single Episode, Unspecified; and Schizoaffective Disorder, Unspecified. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	According to R10's MDS (Minimum Data Set) assessment dated [DATE] under section C, R10 has BIMS (Brief Interview of Mental Status) score of 15 indicating, indicating intact cognition. On 04/02/2025 at 1:27 PM Surveyor observed 19 residents in the third-floor dining room, no monitoring staff present. On 04/02/2025 at 1:36 PM Surveyor observed 11 residents in the second-floor dining room, no monitoring staff present. On 04/07/2025 at 10:57 AM Surveyor observed 3 residents in the second-floor dining room, no monitoring staff present. On 04/02/2025 at 12:23 PM, R5 stated, On 03/02/2025 around 7:00 PM, I was sitting in the dining room (third-floor unit). (R6) came up to me and wanted to grab a chair that I was using to keep my leg elevated. My right ankle was fractured at that time. There were multiple empty chairs in the dining room. I told (R6) to leave it and then he just punched me. I had a black eye out of that, but it healed. I was sent out to the hospital after the incident. There was no staff in the dining room at the time of the incident. (R10) was there, he can confirm there was no staff monitoring. Surveyor asked if R5 feels safe in the facility, R5 said apprehensively, I feel safe in the facility. This is what I think, if I stay in my room, nothing is going to happen, right? Surveyor did not observed trauma on R5's face at this time. On 04/02/2025 at 12:39 PM, R6 said, I had no altercation with no other residents. On 04/02/2025 at 12:41 PM, R10 said, I saw when (R6) hit (R5). It was in the dining room. There was no staff monitoring the dining room. All staff came in after they heard the commotion; otherwise, they're never there. On 04/08/2025 at 12:06 PM, V22 (Social Service Assistant Director) said, The altercation between (R5) and (R6) happened on the evening of 03/02/2025, which was Sunday. I don't work on Sundays, so I was notified the following day. I was told that (R6) was the aggressor, and both residents were sent out, (R5) due to injury and (R6) for behavioral evaluation. I don't remember why they got into a fight. On 04/08/2025 at 2:35 PM, V26 (Licensed Practical Nurse/LPN) said, I worked on 03/02/2025 3:00 PM - 11:00 PM. (R5) came to the nursing station in the evening and complained about being hit by (R6). We notified (V1 (Administration/Abuse Prevention Coordinator)) and (V3 (Director of Nursing)). We assessed (R5)'s face. (R5) had swelling to the left side. (R5) said Don't worry about it, but I told him that the (V1) had to be notified. The doctor and the family were notified as well, and I received an order to send (R5) out for evaluation. We went and looked for (R6). (R6) was smoking on the smoking patio. We brought (R6) back to the third-floor unit. (R6) had no injuries and was sent out later in the evening for behavioral evaluation. We usually have, 1 to 2 CNAs on afternoon shifts on weekends and sometimes weekdays. 1 nurse passes medications and another nurse along with the CNA monitors. Some of the residents stay in the dining room to watch TV but we don't have to monitor all the time. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 04/08/2025 at 3:22 PM, V27 (Certified Nurse Assistant?CNA) said, I worked on 03/02/2025 from 3:00 PM to 11:00 PM. I was the only CNA on duty on the third-floor unit that evening. I was staying in the dining room for 30 to 35 minutes at the time and alternating with one of the two nurses who worked with me that evening. Towards the end of my shift, (R5) came up to the nursing station. (R5)'s face was red; you could see right away that something happened. (R5) said that (R6) punched him when they were in the dining room. No one was monitoring the dining room at that time, so I didn't see the altercation. Both nurses were charting, and I was completing my forms at that time, it was almost the end of the shift. I know that (R10) was there and saw what happened. I was assigned to watch (R6) after the altercation. (R6) told me that (R5) is just exaggerating. (R6) was pacing around the unit, so I just followed him around. At some point, (R6) went into his room and fell asleep. On 04/09/2025 at 2:51 PM, V28 (Psychiatric Nurse Practitioner) said, Residents with psychiatric diagnosis should be monitored, especially, if they are in the common area with other residents. Safety is a major reason to monitor residents with psychiatric diagnosis. On 04/14/2025 at 10:07 AM V1 (Administrator/Abuse Prevention Coordinator) said, I was notified of the incident on the same evening (03/02/2025). I was told that there was an altercation between (R5) and (R6) and that they were separated immediately. (R5) and (R6) were arguing over a chair. It happened in the dining room; (R5) and (R6) may have been left alone at the time of the incident. All residents should be monitored while they're in the dining room. However, the investigation revealed that R6 denied hitting R5 and there were no witnesses who witnessed the incident; therefore, the incident was unsubstantiated. The investigative process is always the same. We obtain involved residents' statements, staff, and other residents who may have witnessed the incident. We always make a police report and send residents out if ordered by the physician. I send an initial report to (regulatory agency), inform responsible parties for the residents' and then continue with the investigation until concluded what happened. Progress note dated 03/02/2025 at 8:50 PM written by V26 (LPN) reads in part, Writer was informed via staff member that resident (R5) was hit by co-resident (R6). Head to toe assessment completed with slight swelling noted to left eye. First aid rendered, denies pain at present time. VSS. Residents separated and in close observation with staff. Administrator, MD, Family member made aware. Obtained order via MD to send pt out to hospital for medical and psychiatric eval. R5's hospital record dated 03/02/2025 reads in part, (R5) reports he got an argument with another resident (R6). (R5) had a chair, other resident (R6) tried to take the chair from him. The other resident (R6) punched him in the face. Differential diagnosis includes but not limited to Blunt trauma, contusion, assault. Police report dated 03/02/2025 8:16 PM reads in part, Physical altercation between two residents in the day room; event number provided over the phone; both parties separated. Facility staffing for 03/12/025 3:00 PM to 11:00 PM shows V27 (CNA) as the only aid working on the third-floor unit housing 75 residents. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility Abuse Prevention Program last reviewed 01/04/2019 reads in part, Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. This facility desires to prevent abuse, neglect, exploitation, mistreatment, and 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; Staff Supervision.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46066 Based on interviews and record review, the facility failed to notify a physician of a resident refusing psychotropic medication for one (R7) of three residents reviewed for quality of care in a sample of 14. Findings include: R7 was admitted to the facility on [DATE] with diagnosis including but not limited to Schizoaffective Disorder, Unspecified; Hyperlipidemia, Unspecified; Paranoid Schizophrenia; Brief Psychotic Disorder; Restlessness And Agitation; Anemia, Unspecified; Body Dysmorphic Disorder; Gastro-Esophageal Reflux Disease Without Esophagitis; Other Specified Phobia; Obsessive-Compulsive Disorder, Unspecified; and Other Schizoaffective Disorders. According to R7's MDS (Minimum Data Set) assessment dated [DATE] under section C, R7 has BIMS (Brief Interview of Mental Status) score of 15 indicating, indicating intact cognition. According to R7's MDS (Minimum Data Set) assessment dated [DATE] under section E, R7 has a history of refusing of care, including refusing taking medications. R7's care plan (R7) requires psychotropic medication to help manage and alleviate: OCD, Suicidal ideation, Schizophrenia, Schizoaffective Disorder dated 01/04/2022 reads in part, Carry out the medication management regiment as prescribed. Report changes, complications to the doctor. On 04/02/2025 at 1:24 PM, Surveyor attempted to interview R7, R7 refused to talk to the surveyor. On 04/08/2025 at 10:58 AM V9 (Licensed Practical Nurse) said, I worked on 03/05/2025 from 7:00 AM to 3:00 PM on the third-floor unit. At the start of my shift, (R7) was already spiraling down. (R7) can be very manic at times and wants to do things when she wants them done. I suspect (R7) didn't get what she wanted on a previous shift and that's why she spiraled down on my shift. (R7) doesn't often need PRN psychotropic medication, but when she needs them, she needs them. You can tell when (R7) spirals down, she starts to pace, sorts through clothes, wants only specific garments, and wants to bathe. There are definitely signs based on which you can tell (R7) is spiraling down. Not sure why other staff don't recognize those signs, I think I work with (R7) the most, that's why I can see when she needs intervention. On the morning of 03/05/2025, (R7) went to the first-floor unit and was trying to go to (R12)'s room to use a bathroom. I followed (R7) to give her PRN (as needed) psychotropic medication. (R7) was having a behavioral crisis. Before I was able to bring (R7) back to the third-floor unit to administer the medication, (R7) hit (R12). I witnessed what happened. I was the one who separated both residents. I was then able to bring (R7) back to the third-floor unit and give her the medication. I then assessed (R7), notified the doctor, (V3 (DON)), and guardian. The doctor gave an order to send (R7) out to the hospital for behavioral assessment. I don't remember if I gave (R7) her scheduled psychotropic medication on 03/02/2025, (R7) might have refused. I didn't have a chance to document or let anybody know that (R7) refused her scheduled psychotropic medication. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/09/2025 at 2:51 PM V28 (Psychiatric Nurse Practitioner) said, I am familiar with (R7). We usually see residents on monthly basis, last time I saw (R7) was 03/24/2025. From what I'm told by the nurses, (R7) doesn't have a lot of behavioral episodes. I was not aware that (R7) hit another resident on 03/05/2025. (R7) is on scheduled long-acting injectable psychiatric medication. I was not aware that (R7) refused her long-acting injectable psychiatric medication scheduled to be given on 03/02/2025. Nurses should notify me if that happens. If resident a resident misses a dose of scheduled medication, they can become delusional, psychotic, or even aggressive. It is possible that missing a dose of the scheduled medication led to (R7)'s behavioral decline on 03/05/2025, it is definitely possible. Some of the behavioral clues that a resident's behavior is declining, and they may need interventions, or that a resident needs a PRN (as needed) medications are delusions, psychosis, or aggression. On 04/09/2025 at 2:24 PM V3 (Director of Nursing) said, If a resident refuses psychotropic medication scheduled every 30 days, the nurse should offer it again, even the next day. If a resident still refuses, the nurse should let the doctor know. Medication refusal should also be documented in the resident's chart. Absent are any progress notes showing (R7) refused scheduled medication and a physician was notified on 03/02/2025. R7's physcian order dated 11/02/2024 [NAME] in part, Haloperidol Decanoate Solution 100 MG/ML Inject 100 milligram intramuscularly one time a day every 30 day(s) for agitation. R7's Medication Administration Record for March 2025 shows that R7 refused scheduled long-acting injectable psychiatric medication on 03/02/2025. The facility Charge Nurse job description read sin part, Main Duties: Administer all parenteral, intramuscular, and sub-cutaneous injections; Administer all medications; Direct charting in his/her shift and make monthly detailed evaluation of all resident charting so that charts reflect progress and condition of residents in the EMR system.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46066 Based on interviews and record review, the facility failed to assess and identify resident's new onset of right hip pain and administer PRN (as needed) pain medications for one (R8) of three residents reviewed for pain in a sample of 14. This failure resulted in R8 having increased pain level for 24 hours before R8 was hospitalized for pain management and later surgery of the right hip fracture. Findings include: R8 was admitted to the facility on [DATE] with diagnosis including but not limited to History Of Falling; Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus; Restlessness And Agitation; Paranoid Schizophrenia; Hypertensive Heart Disease Without Heart Failure; Cognitive Communication Deficit; Need For Assistance With Personal Care; and Other Abnormalities Of Gait And Mobility. On 04/02/2025 at 1:31 PM, Surveyor attempted to interview R8, R8 answered surveyor's questions unintelligibly. Surveyor unable to interview R8. On 04/07/2025 at 12:41 PM, V19 (Therapy Director) said, (R8) was seen by therapy 2/14/2025, 2/18/2025, 2/19/2025, and 2/20/2025. (R8)'s pain to the legs was first documented by me on 2/19/2025. I reported the pain in the IDT (interdisciplinary team) meeting later in the day on 2/19/2025, nursing staff was notified. I also noticed change in (R8)'s condition, most of all, (R8) became not ambulatory. (R8) was then hospitalized on [DATE]. During the hospitalization (R8) had ORIF (open reduction internal fixation) of right hip. On 04/08/2025 at 12:40 PM, V4 (Assistant Director of Nursing) said, On 2/19/2025, (V19 (Therapy Director)) notified me that (R8) was complaining of pain to his right hip. I went and talked to (R8), and he said that he has pain in the right leg. I asked (R8) about the number on pain scale but (R8) didn't give me a number. I tried to do ROM (range of motion) but (R8) refused. I notified (V23 (Licensed Practical Nurse)) and (V24 (Family Nurse Practitioner)). (V24) placed an order for x-ray. X-ray service came in late that night and results were reported on 2/20/2025 around 3:25 AM. X-ray showed fracture in the right hip and (R8) was sent out to the hospital on 2/20/2025 around 10:15 AM. (V23) was told to give (R8) pain medication. I didn't give (R8) anything for pain after my assessment. On 04/08/2025 at 12:56 PM, V24 (Family Nurse Practitioner) said, I was in the facility on 02/19/2025 when (V23) told me about (R8)'s pain. I went to assess (R8), and he said he's scared to move his right leg due to pain. I ordered an x-ray and told the nurse to offer (R8) pain medication. I reviewed the x-ray on 2/20/2025 at 9:57 AM, it showed right femoral neck fracture, and R8 was sent out to the hospital shortly after. As far as pain, nurses were supposed to give (R8) his PRN (as needed) pain medication, there was already order for that. When a resident complains of pain, nurses should do assessment first, and give pain medication. Pain medication administration is important to prevent any additional physical symptoms, such as elevated blood pressure, stress, tachycardia, or even depression. (R8) stated his pain was 6/10 on the pain scale and it was definitely appropriate for nurses to administer pain medications. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 04/08/2025 at 3:58 PM, V25 (Registered Nurse) said, I worked on 2/19/2025 from 3:00 PM to 11:00 PM. I never heard (R8) complain of pain on my shift, so I didn't give (R8) any pain medications. I knew (R8) was waiting for an x-ray due to pain in his leg, but that's all I know. On 04/09/2025 at 11:37, AM V23 (Licensed Practical Nurse) said, I worked on 2/19/2025 and 2/20/2025 from 7:00 AM to 3:00 PM. I know (R8) very well, I take care of him almost every day. I was doing my morning medication pass on 2/19/2025 when (V4 (Assistant Director of Nursing)) told me that (V19 (Therapy Director)) notified her of (R8)'s pain in the hip and asked me to give (R8) pain medication. I went to get pain medication and gave it to (R8). I didn't document it. (R8) was complaining of hip pain on 2/19/2025 but never gave me a number on the pain scale. I did not document any pain assessments for (R8). I didn't give (R8) any additional pain medications after the morning of 2/19/2025 nor before (R8) was sent out to the hospital (2/20/2025 10:15 AM). I noticed that (R8) wasn't getting out of bed few days prior to 2/19/2025. It was a pretty big change for (R8) because normally he would walk around but I didn't ask him why (R8) is not himself, I thought he was just not in the mood to get out of bed. On 04/09/2025 at 2:24 PM, V3 (Director of Nursing) said, If a resident complains of pain, nurses should first assess a resident to determine location, intensity, and number on the scale related to pain. Nurse should document a pain review. Nurses should then administer pain medication if there is an existing order for PRN (as needed) pain medication. The pain review should be completed with any change in resident's condition, new pain, or fall. Absent are any progress notes or pain reviews related to R8's new onset of pain in the right hip on 2/19/2025. R8's physician order dated 02/12/2025 reads in part, Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth every 8 hours as needed for pain. R8's Medication Administration Record for February 2025 does not show any pain medication given to R8 on 02/19/2025 nor 02/20/2025. Progress note dated 02/19/2025 written by V19 (Therapy Director) reads in part, Response to session interventions: (R8) required max encouragement to participate with skilled interventions. (R8) c/o BLE (bilateral lower extremities) discomfort during functional bed mobility performing self-care tasks, nursing notified. Progress note dated 02/19/2025 1:35 PM written by V24 (Family Nurse Practitioner) reads in part, HPI: (R8) seen for complaints of right hip and thigh pain. (R8) was found lying in bed stated he is scared to move his right leg, rated pain 6/10. Assessment/Plan: Localized pain, continue pain management, 3 views x-ray of right hip and thigh. R8's x-ray physician order dated 02/19/2025 1:53 PM reads in part, Right hip and thigh x-ray, 3 views; standard diagnostic. R8's Radiology Results Report read sin part, Examination date: 02/19/2025; Reported date: 02/20/2025 3:25 AM' reviewed by V24 (FNP) on 02/20/2025 9:57 AM. Clinical information: Post Fall, r/o, Fracture. Findings Right Hip: Examination reveals impacted subcapital fracture of the right femoral neck with varus deformity and no significant displacement. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	R8's hospital record dated 02/20/2025 reads in part, (R8) was sent form his (facility) to outpatient XR which showed right hip fracture and was send to ED for further evaluation. (R8) states he fell out of bed a couple of days ago, he says he does not know why he didn't come after his fall. (R8) says that his pain 8/10. R8's Operative Notes dated 02/21/2025 read sin part, Procedure: Right Hip Anterior Hemiarthroplasty. The facility Pain Management and Assessment policy last reviewed 11/2022 reads in part, It is the policy of the facility to assess the resident for the presence of pain in order to determine the appropriate interventions. Assess and document pain including onset and duration, location, severity, alleviating, and aggravating factors, possible causes, and accompanying signs and symptoms. Identify the pain rating scale used for consistency with subsequent assessments. Routine pain assessment reviews will be conducted quarterly, upon significant change in condition, and more frequently as necessary to evaluate the effectiveness of the individualized pain management program and comfort level of the resident.