

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  04/29/2025
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>38796</p> <p>Based on interview and record review the facility failed to follow professional standards of care to transcribe and follow the physician orders for one of one resident (R1) to monitor the right foot for increased discoloration, to assess pedal pulse, and monitor for temperature changes. This affects one of three residents reviewed for professional standards.</p> <p>Findings include:</p> <p>R1 face sheet shows diagnosis of occlusion and stenosis of right carotid artery, essential hypertension, and anemia.</p> <p>On 4/23/25 at 11:50am V11 (Nurse Practitioner) said R1 complained of discoloration to her right foot, and she ordered a doppler ultrasound for R1's feet bilaterally. V11 said she assessed R1 foot, R1 denied pain. V11 said she observed R1 right foot to be cool to touch (cooler than the left foot) and R1 had edema bilaterally to the feet. V11 said the doppler results was negative for deep vein thrombus (DVT). V11 said she was not concerned for ischemia because the doppler was negative for DVT. V11 said although the doppler was negative, the plan of care was to monitor R1's foot due to the lateral discoloration. V11 said the plan was to monitor for increased discoloration, monitor the pedal pulse and assess the temperature of R1's foot. V11 omitted the time frame for monitoring R1's foot. V11 said she gave a verbal order to the Nurse. V11 said she don't recall the Nurse's name, she recalls giving the verbal order to a female Nurse.</p> <p>On 4/23/25 at 12:29pm, V12 (Licensed Practical Nurse/LPN) said she sent R1 to the hospital after the fall on 4/6/25. V12 said she did not assess R1's feet after the unwitnessed fall. V12 said she was not aware of any orders to monitor R1's right foot for increased discoloration, assess the pedal pulse and assess the temperature of R1's foot. V12 said she was aware that R1's right foot was darker than the left foot and that there was a doppler ordered and completed for R1. V12 said she should have assessed R1 from head to toe. V12 said she was educated to assess the resident from head to toe after an unwitnessed fall. V12 said she would have notified the physician, Director of Nursing, and administrator of the changes to R1's foot had she assessed R1's foot.</p> <p>On 4/23/25 at 1:53pm V13 (Certified Nursing Assistant/CNA) said she was R1's aide before her assignment of R1 switched. V13 said R1 had a bandage on her right foot, V13 said she was made aware days prior that R1 had a blister on her foot, and it had burst. V13 said the Nurse wrapped R1's foot.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4/25/25 at 11:31am V17 (Medical Doctor) said R1 has history of chronic ischemia, the blister to the right foot is due to poor perfusion and ischemia, the blister is a result of vascular disease. V17 said ischemia to R1 foot is not a result of the facility, R1 has chronic comorbidities, including cardiovascular issues, poor perfusion, and she smoke. V17 said the Nurse was correct to wrap the foot when she observed the blister. V17 said he may have been notified, he would have order to wrap the foot and to monitor the foot. V17 said he agrees with the orders from the Nurse practitioner for monitoring for discoloration, checking the pulse, and monitoring the temperature. V17 said R1 decline treatment in the hospital for the ischemia. V17 said the blister is a result of the poor perfusion, the blister would be expected, V17 said the blister is fluids. V17 said the blister was observed on the 4th, and R1 was sent to the hospital on the 6th, one day would not have changed R1 outcome for the chronic ischemia.</p> <p>On 4/25/25 at 12:05pm V16 (LPN) said V11 gave her the orders to monitor R1's foot. V11 said she forgot to transcribe the orders. V11 said she's the Nurse that wrapped R1's foot with the bandage.</p> <p>Review of R1's physician order sheet, there are no orders noted for monitoring of R1's right foot for increase in discoloration, assessment of the pedal pulse, nor monitoring the temperature of R1's foot.</p> <p>Review of R1's progress notes there are no documentation denoting that R1 foot or feet were monitored/ assessed for increased discoloration on 4/4/25 all shifts, 4/5/25 all shifts and on 4/6/25.</p> <p>R1 emergency room records dated 4/6/25 denotes in-part diagnosis lower limb ischemia, open wound of right foot, anasarca.</p> <p>Facility physician orders policy dated 1/2024 denotes in-part policy and procedures physician orders, purpose to provide guidance to ensure physician orders are transcribed and implemented in accordance with professional standards. All orders (telephone, verbal, written) shall be provided by licensed practitioners (physician, nurse practitioner, or physician assistant) authorized to prescribe such orders. Orders must be recorded in the medical records by the licensed nurse authorized to transcribe such orders. Physician orders must be documented clearly in the medical record (PCC). Clear and complete orders will be transcribed to the appropriate administration record ( MAR/TAR) Medication administration record/treatment administration record).</p>		