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	06/06/2025

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to timely provide foot care treatment and ensure that residents received follow up visits per physician orders and recommendations for residents at risk for foot disorders. This failure applied to two (R5, R6) of three reviewed for podiatrist services. Findings include: 1.) R5 is a [AGE] year-old resident admitted to the facility on [DATE] with diagnoses including but not limited to: diabetes, hypertension, depression, and gastroesophageal reflux disease. (MDS) Minimum Data Set assessment of 4/8/2025 section C the BIMS (Brief Interviewed Mental Status) score was 15/15 and indicates cognitive intact. 6/4/2025 at 10:20 AM, R5 said, I have not seen a foot doctor for a long time. R5 removed his shoes and showed the surveyor his toenails. The toenails were long, discolored, and thick. R5 said, I need to see a foot doctor because I have diabetes and I want my nails cut. I don't want any problems with my feet. I requested to see a doctor a long time ago, and I am still waiting. Review of physician orders dated 1/17/2025 read: May see a podiatrist. Facility provided visit notes from Podiatrist for R5 dated 01/03/24, 03/06/2024, and 08/12/2024. Note dated 08/12/2024 documents .feet at risk PVD (peripheral vascular disease) .follow up visit 9 weeks. There was no additional information provided by the facility indicating that R5 was seen by the podiatrist after 08/12/2024. 2.) R6 is a [AGE] year-old resident admitted to the facility on [DATE] with diagnoses including but not limited to: diabetes, hypertension, acute kidney disease, and hyperlipidemia. (MDS) Minimal data Set assessment of 4/4/2025 section C the BIMS (Brief Interviewed Mental Status) score was 15/15 and indicates cognitive intact. 6/4/2025 at 10:25 AM R6 removed shoes and showed toenails to the surveyor, which were long thick discolored nails on both feet. Both big toenails and second toenails were curling up. R6 said, I am a diabetic and I do not recall the last time I had a podiatrist cut my nails. They are too long and I need them cut. R6 verbalized requesting to see a podiatrist but has not seen one for a long time. (continued on next page)

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

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reviewed physician orders for R6 dated 4/16/2023, which read: May see podiatrist, and Podiatry consult due to diabetes, annual foot exam dated 10/31/2023. 6/4/2025 at 11:05 AM V5 (Social Service Director) said, for residents that require podiatry services, the only thing that I do is to add their names to the list and send the list to the podiatrist's office. The podiatrist will come to the facility and see residents in the units. 6/4/2025 at 2:47 PM V3 (Director of Nursing) said, I expect residents to be seen by the podiatrist as needed when residents request to be seen. The podiatrist provider will come to the facility once a month and will go to the units and see residents on the list but will not see all residents at one time. The surveyor requested to see the list of residents and asked V3 when R5 and R6 were seen last time. V3 responded that only residents who requested services are on the list. V3 did not provide a list of residents when requested. Facility provided visit notes from podiatrist for R6 dated 04/01/2024 and 09/24/2024. Note dated 09/24/2024 documents .feet at risk patient is diabetic .follow up visit 9 weeks. There was no additional information provided by the facility indicating that R6 was seen by the podiatrist after 09/24/2024. On 6/5/2025 at 10:06 AM V1 (Administrator) provided policy titled, Policy & Procedure Foot Care Assessment (reviewed date 11/2022), which includes: Policy It is the policy of the nursing department to perform an assessment of the resident's feet at the time of admission, updated quarterly, and when significant changes occur. Purpose To identify treatable conditions, prevent infections, provide treatment, and comfort. Procedure: 8. Follow physician's orders. Refer to a podiatrist if needed. 9. Refer all diabetics to podiatrist for follow-up

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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** Based on interview and record review, the facility failed to follow their stated protocol for signing residents out on community pass by not verifying the identity of the individual who signed out a resident (R11). The facility did not have an effective supervised community pass protocol in place. This failure applied to one (R11) of two residents reviewed for community pass and resulted in R11 leaving the facility on pass on 4/30/2025 and not returning. R11 has a significant history of substance abuse disorders and R11's whereabouts are currently unknown. Findings include: R11 is a [AGE] year-old female who originally admitted to the facility on [DATE]. R11 has multiple diagnoses including but not limited to the following: multiple orbital fractures, nasal bone fracture, psychoactive substance abuse, opioid dependence, and alcohol abuse. R11's BIMS (Brief Interview for Mental Status) Score is 15. Community Survival Skills assessment dated [DATE] shows that R11 is not capable of unsupervised outside pass privileges at this time. R11's care plan states in part but not limited to the following: Interventions: A community survival skills assessment will be conducted to reasonably determine the person's ability to safely and respectfully negotiate within the outside community. Progress note dated 4/29/2025 states in part that V21 (R11's Friend) will be taking R11 on a day pass on 4/30/2025 from 5PM-7PM. Pass Request Form states in part but not limited to the following: Pass to begin on 4/30/2025 at 5PM and end on 4/30/2025 at 7PM and accompanied by V21. It is to be noted that the ID scanned and attached to the community pass is not the same name/person listed on the Community Pass Request Form (V21). On 6/3/2025 at 9:40AM, V7 (Psychosocial Rehabilitation Services Clinician/PRSC) said our process for the facility is that when a resident needs a supervised pass: the family/friend they are going out with requests to take them out. We get the name and phone number of this person. We document where they are going, when they are leaving, and when they will return. When the date and time comes, the visitor takes the pass, the nurse signs off on it, then the receptionist makes a copy of the ID of the individual taking them out. The copy of the ID is done to ensure the person taking the resident out on supervised pass is the same individual listed on the pass request form. We explain the rules to them and to ensure they are safe that way. On 6/3/25 at 1:30PM, V22 (R11's Family Member) said R11 is constantly drug seeking. Before she came to the facility, she was in the hospital due to someone assaulting her. She is unsafe to herself and others when in the community. I have an order of protection against her for me and my family's safety. R11 is very manipulative. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/3/25 at 1:50PM, V16 (Licensed Practical Nurse) said I was the nurse on duty on 4/30/2025 when R11 said she had a pass to go out to the grocery store for a couple hours. A friend came and picked her up, I scanned the ID. I then gave the pass and the copy of the ID to the receptionist. After 7PM came and went, I called to follow up. R11 never came back to the facility, to my knowledge. On 6/3/25 at 3:00PM, V6 (Social Service Aide) said I was the receptionist on 4/30/25 when R11 went out on pass. However, I was passing out cigarettes and not at the front desk at the time R11 left. The receptionist usually scans the ID of the person taking the resident out on pass, but I was busy. I never spoke with the person that took R11 out. The reason we scan the ID is to ensure that the ID matches the name on the pass request form. This is for the resident's safety, in case of an emergency where we would have to call the police or if the resident does not come back to the facility. On 6/4/2025 at 11:45AM, V1 (Administrator) said when a resident has a supervised pass, a pass request form is filled out listing the name of the person taking the resident out including the date and time the resident is leaving and when they will return. The person's ID is scanned to ensure that the pass and the ID match. V1 said when R11 did not return to the facility, we did not notify the police. I do not consider this elopement. It is to be noted that facility policy titled Community Pass does not lay out the procedure of the facilities supervised pass system.