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	09/03/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 have an effective contraband policy to prevent illicit drugs from being brought into the facility, distribute and used by the residents. The facility failed to develop a plan to determine how the illicit drugs are coming into the facility. This affects 2 of 2 (R7 and R14) residents that tested positive for fentanyl and opiates and had the potential to affect all 13 (R3, R4, R6, R7, R8, R14, R16, R17, R18, R19, R20, R22, and R23) residents reviewed for illicit substance/contraband within the facility. R7 was observed slumping forward in the wheelchair, fell to the floor, was cyanotic and required Narcan (opioid antagonist/opioid reversal agent) to be given. R14 was transported to local hospital emergency room for a change in condition. R14 tested positive for fentanyl and opiates metabolites.Findings include: The immediate jeopardy which began on [DATE] when R7's urine test was positive for opiates, R7 later was observed slumping forward in wheelchair, R7 fell to the floor, vital signs were very low, R7 was cyanotic, code blue announced, Narcan given. On [DATE] R7 complained of suicidal ideations, sent to hospital tested positive for fentanyl. On [DATE], R14 observed drowsy, opening his eyes and then closing them, 911 summons, R14 tested positive for fentanyl, and opiates metabolites in the emergency room. On [DATE] at 9:53 am, V12 (Corporate Nurse Consultant) was informed of the immediate jeopardy that began on [DATE]. The immediacy was removed on [DATE] after the facility provided an acceptable removal plan on [DATE]. On [DATE] and [DATE] the surveyor was onsite to confirm the removal plan was implemented. Although the immediacy was removed, the deficiency remains at the Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Local police report, dated [DATE] at 2:53pm report number xxxx-xxxxx, denotes in-part: on [DATE] at approximately 253hrs, Reporting Officer (R/O) #XXX was dispatched to Chicago Ridge Nursing Home located at (facility address) reference a report of narcotics inside of the facility. Upon arrival, R/O made contact with the social worker for the nursing home, V13 (Social Service consultant). V13 advised that staff had interviewed three people who advised the following. V13 advised an unknown female nighttime worker at the facility is bringing in narcotics and selling them to a resident named R6. These narcotics are believed to be Cannabis, Methamphetamine, and Heroin. R6 is then selling the narcotics to two other residents: R3 and R8. R3 and R8 are then distributing narcotics to six other residents: R23, R20, R16, R22, R17, and R19. V13 advised that R6, R3, R8, and R23 are being Involuntarily discharged from the facility due to their involvement. V13 advised all of the other above listed subjects are able to stay, for now. V13 then handed R/O a garbage bag containing drug paraphernalia. R/O discarded the garbage bag when he returned to (Police Department). The nursing home is going to continue to attempt to identify the worker who is providing the narcotics to the patients; therefore, this case is to be considered open at this time. Nothing further. On [DATE] at 12:16pm V2 (Administrator) said the facility was cited for a drug overdose in [DATE] and was cleared on [DATE]. V2 said on [DATE] she was made aware that R3, R6 and R8 was involved with selling drugs in the facility. During a follow up interview on [DATE] at 11:11am V2 said, no residents have been transferred to the hospital for illicit drug overdose, suspicion of illicit drug over, or illicit drug related issues. On [DATE] at 2:06pm V13 (Social Services Consultant) said on [DATE] the maintenance staff informed her that when he was routinely changing a ceiling tile in a resident room, he found some items in the ceiling. V13 said the items was identified as drug paraphernalia. V13 said the police was called and all the ceilings in the rooms on the first floor was searched. V13 said, Residents were interviewed, and a male resident informed her that a female staff with burgundy hair that works the night shift was bringing the drugs into the facility and selling them to the residents. V13 said she informed the police of the description of the female staff. V13 said she can't recall who the male resident is, who informed her of the description of the female staff. V13 said she will go and review her information and follow up with the surveyor. V13 said she can't recall the description of the male resident that informed her of the female staff. V13 said she informed the V2 (Administrator) of the description of the alleged female staff supplying the residents with drugs, and allegedly the administrator said that could be anybody. During this survey V13 did not follow up with the surveyor regarding who is the identified resident that gave the description of the female staff with burgundy hair. Review of the police report filed by V13 dated [DATE], there is no documented description of female staff with burgundy hair in the police report, only description given is a female night staff. On [DATE] upon entrance to the facility, the posted notice was observed to be updated to include staff belongings will be searched. On [DATE] and [DATE], the posting did not include search of staff belongings, observed by multiple surveyors. 1.R7 MDS dated [DATE] denotes BIMS score of 15 (cognitively intact). R7 face sheet shows diagnosis of anxiety, depression, presence of pacemaker, chronic atrial fibrillation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:30pm, R7, observed alert to person, place, and situation. R7 stated that he was given cocaine on [DATE], stated that he was hospitalized on [DATE]. R7 said he thought he was purchasing cocaine, and not fentanyl. R7 said he doesn't want to name the female resident that gave him the drug, he doesn't want to get her in trouble because she doesn't have anyone. R7 said he used cocaine in the past, stated that once he took the cocaine that he got from the female he knew it wasn't cocaine, it was different. R7 said he does remember he went to the hospital the next day. R7 said the female resident still resides at the facility. R7 declined to give description of the alleged female resident. [DATE] at 3:40pm V11 (Licensed Practical Nurse/LPN) said she was working on evening shift [DATE], R7's speech was slurred. V11 said it was reported by the day shift Nurse that R7 needed to provide a urine specimen and R7 was unable to provide it during the day shift. V11 said she assumed that R7 was behaving suspiciously on day shift; that's the only reason why staff would collect a urine drug screen. V11 said when R7 was giving the urine sample, R7 kept standing and sitting. V11 said R7's urine specimen tested positive for opiates. V11 said when R7 came out of room after eating dinner, R7 was in a wheelchair. R7 was slumping forward in the wheelchair, then fell to the floor. V11 said R7 vital signs were very low, oxygen was applied to his face, R7 was cyanotic. V11 said she called a code blue. V11 said she administered two doses Narcan. The medical doctor said to monitor R7, neuro checks are scheduled in (electronic records) and vs (vital signs) were done every two hours. V11 said she asked R7, who gave him the illicit drugs? R7 responded, I don't know, I only take my scheduled medications. V11 said she documented the code blue in risk management and the vitals were documented in the records. On [DATE] at 12:38pm V4 (Substance Abuse Coordinator) said R7 did not have a community pass on [DATE] or [DATE] and does not recall him visiting with his family on [DATE] or [DATE]. V4 said she signs and gives the residents community access passes. On [DATE] at 3:01pm V10 (Director of Nursing/DON) said R7 informed him that he got cocaine from a resident but refused to talk about it and give information on the resident. R7's care plan with initiate date of [DATE] denotes in-part, the resident has a history of substance abuse chemical dependency related to clinical depression and anger history of mental illness severe mental illness, poorly developed ability to control impulse, allowing negative inappropriate persons to influence his use of substance. Problem and symptoms are manifested by going into the community to become intoxicated, problems and symptoms are manifested by failure to accept responsibility for actions and to be honest with oneself. The drug of choice is opioids. Date initiated [DATE]. Goals, I will refrain from using non prescribed substance through the next review date. Resident will attend substance abuse group two times a week to address issues of addiction. Staff will conduct random room searches provide supervised visits, and search residents belongings as needed as it relates to substance use. Staff will perform random drug screening to assess for substance use. Upon suspicion that resident has illicit drugs or used illicit drugs they will be placed on one-to-one monitoring/supervision. Work with the resident to establish a verbal or written behavior contract; specify what is and what is not allowed. Make sure the resident is aware of rules prohibiting use of alcohol, illicit substance and intoxication. Meet with the ID team to discuss the extent of the resident's illness the physician may consider a referral for psychiatrist spam or write borders restricting pass privileges. Provide leisure counseling to the resident to help him use free time and productive nondestructive ways. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R7's progress note dated [DATE] completed by V11 (LPN) denotes in-part resident was observed with signs and symptoms of substance abuse, Physician notified obtained order for drug screen. Resident tested positive for opioids; order received to monitor vs (vital signs) every 4 hours x 72hours. Restrict pass, supervised pass until further notice. Okay to give scheduled medications. Notify MD (medical doctor) of any additional changes or AMS (altered mental status). Administrator, DON (Director of Nursing), and family member notified. R7's progress note dated [DATE] at 9:27am completed by V4 (Substance Abuse Counselor/SAC) denotes in-part: it was brought to SAC (substance abuse counselor) & SS (social service) attention that the Resident was presenting suspicious behavior affiliated with Substance Abuse. The Resident was showing oddly behavior such as anxiety, sweating, showing a red complexion, and fidgeting with his nose as well as mumbling to himself. The Resident was asked to complete a drug screening whereas at the time stated he cannot go due to using the washroom ten minutes ago. The Resident was present during the room searched and no contraband was found. The Resident was placed on 1:1's with SAC & SS and later with SSA's (social service assistant). This took place on [DATE] at 1:00pm. It was brought to SAC & SS attention that the Resident completed the drug screening, and it was positive for opioids, which the Resident does take Hydrochlorothiazide; a form of the opioids family. SAC spoke with the Resident whereas he stated he did not take any illicit substance and was very adamant on not letting his sister know of what's going on because it's not true. The Resident also was asked; what happened yesterday during the time the Narcan was used, he stated he does not remember. The Resident explained why his test results were positive for Opioids and began mentioning SI (suicidal ideations), which he was placed on 1:1 monitoring until being D/C (discharged) to the hospital. SAC will update the Resident care plans, assessments, and will upload signed documentation to (electronic records). R7's hospital/emergency room records dated [DATE] denotes in-part chief complaint AMS (Altered Mental Status), elevated blood pressure, and noncompliance. Social history positive for opioid use, urine drug screen is positive for fentanyl, also on prescription narcotic pain medication, smoking positive although unable to quantify, nursing home resident, issues of compliance with medication. Treatment plan hypertension, atrial fibrillation, history of pacemaker placement, peripheral neuropathy chronic low back pain, seizure disorder, hypothyroidism, fentanyl abuse and intoxication, psychosis. Labs collected on [DATE] at 2:36pm urine opiates screen; positive- reference range; negative. Urine fentanyl collected [DATE] at 2:36pm positive, reference range; negative. Review of R7's physician order sheet there are no active or discontinue orders for fentanyl. 2. R14's MDS dated [DATE] denotes BIMS score of 15 (cognitively intact). R14's face sheet shows diagnosis of hemiplegia following cerebral infraction affecting left dominate side, chronic obstructive pulmonary disease, psychoactive substance abuse, pulmonary embolism. On [DATE] at 1:35pm R14 observed alert to person, place time and situation, sitting in wheelchair, able to self-propel. R14 said he purchased twenty dollars' worth of heroin from R3 on [DATE]. R14 said he was sent to the hospital, and the hospital told him that he tested positive for fentanyl. R14 said he didn't know that fentanyl was in the heroin. R14 said, that was not the first-time buying drugs from R3. R14 said the hospital doctor told him he could have died from fentanyl drug overdose. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at 12:38pm V4 (Substance Abuse Coordinator) said she was not aware that R14 was sent to the hospital and returned with diagnosis of poly substance abuse on [DATE]. V4 said she should have been made aware. V4 said she was not aware that R14 used illicit drugs on [DATE], no one informed her. V4 said R14 does have a substance abuse history. V4 said R14 was readmitted to the facility after relapsing at home. V4 said R14's sister did not visit him on [DATE]. V4 said she is not aware that R14 went out on a community pass on [DATE]. V4 said she signs and gives the residents community access passes. On [DATE] at 3:45pm V17 (LPN) said he was the Nurse on duty on [DATE], when a female staff got off the elevator with R14 and said, “this is your resident”. V17 said he didn't assess R14 at that time. V17 said he don't recall who the Aide was. V17 said he was passing medications, and a resident approached him and said, “there's something wrong with R14”. V17 said that's when he assessed R14 by calling his name, checking R14's vitals, continuing to call R14's name and doing a knuckle rub to R14's chest. V17 said R14 was drowsy, opening his eyes and then closing them. V17 said he called 911, when 911 arrived R14 was more alert. V17 said he did not give R14 any medication that would make him drowsy or any medications after observing R14 drowsy. V17 denied giving R14 Narcan and denied that any other staff gave R14 Narcan. V17 said he was the receiving Nurse upon R14's return to the facility. V17 said he reviewed the after-visit summary from the hospital, and it was documented that R14 diagnosis was transient alteration of awareness, polysubstance abuse, and dyspnea. V17 said he understands polysubstance abuse is when the resident is using medications and illicit substance together. V17 said he notified the Director of Nursing of R14's return and diagnosis. V17 said he doesn't recall if the Director of Nursing gave him any directives for R14. V17 said if the facility gave an in-service on when to administer Narcan, he was not at the facility. V17 said Narcan is used to reverse the effects of illicit drugs. V17 said R14 symptoms was different from someone that's overdosing on drugs. V17 declined to give the signs and symptoms of someone overdosing on drugs. V17 denied having knowledge if R14 has a substance abuse history. V17 did not give a response when asked should he have documented R14's presenting condition on [DATE] or the language “change in condition”. V17 said he don't know what the progress notes show. V17 was presented with R14's progress note that was presented by the facility. V17 said he could see the document. On [DATE] at 3:01pm V10 (Director of Nursing) said he was made aware that R14 tested positive in the hospital for fentanyl. V10 did not respond when asked; when was he was made aware of R14 testing positive for fentanyl. V10 said he was concerned because R14 does not have a physician order for fentanyl. When asked how did R14 say he ingested the fentanyl, V10 said that's a good question. V10 said R14 mentioned that he purchased the heroin from R3, he didn't know fentanyl was in it. V10 said he did not inform the administrator that R14 test positive for illicit drug fentanyl and opiates. V10 decline to answer when asked when the staff should administer Narcan. R14's progress note dated [DATE] completed by V17 (LPN) denotes in-part during routine rounds, resident was observed with a change in condition. Assessment was conducted, and resident was found unresponsive and unable to be aroused. With knuckle rub stimulation, the resident was able to open eyes briefly for a few minutes. Vital signs were as follows: BP: 139/83, Pulse: 116, Respirations: 20, Temperature: 98.2°F, O2 Saturation: 97%. 911 was called, and the resident was transported to (Hospital name) for further medical evaluation. MD (medical Doctor), family member, and ADON (Assistant Director of Nursing) were notified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R14's baseline care plan dated [DATE] denotes in-part, I will comply with the intake procedures of substance abuse treatment program by the next care plan review date. I will refrain from using non-prescribed substance through the next review date. I will behave in a safe manner consistent with resident conduct policies through the next review date. R14's emergency room after visit summary dated [DATE] denotes in-part chief complaint, altered mental status, fatigue. Visiting diagnosis: transient alteration of awareness, polysubstance abuse, and dyspnea. Medications given furosemide, naloxone (Narcan) and sodium chloride. Instructions stop using any drugs that are not prescribed to you or any street drugs at all. Review of R14's physician order sheet there are no active or discontinue orders for fentanyl. 3. On [DATE] at 10:37am R4 observed to person, place, time and situation. R4 said the last time he used drugs was on [DATE]. R4 said he got the crack from R3. R4 said he doesn't have money to buy the drugs and R3 was giving him drugs to keep his mouth shut because he was aware of what was going on. R3 said, he told the administrator at the facility everything. R4 said R3 removes the drugs from under his testicles or from between his butt cheeks when a resident wants to buy it. R4 said a staff member was involved with R3 getting drugs into the facility, and that's why R3 was giving him drugs to keep quiet about it. R4 said when he reported the female staff, the administrator didn't want to hear what he had to say and asked him to leave the office. On [DATE], V2 (Administrator) made aware of the specific name of the alleged staff member given by R4. 4. R3's progress note dated [DATE] at 4:31pm denotes in-part resident present as a risk to himself and others as evidenced by using and selling illicit substance in the facility. Resident is a danger to himself and others due to providing drugs to residents with medical and psychiatric issues. Resident has been placed on one to one with staff until local police and EMT's arrived at the facility. Per peer report, resident had a visitor who dropped off the illegal substance to the resident and he was hiding the items in his body cavity. The resident was immediately notified and given a notice of the need to conduct a room search, resident agreed. Upon room search, staff found a crack pipe. In the search contraband was recovered and discarded. The resident declined to a drug screen. Social service staff offered the resident another level of treatment such as inpatient or residential treatment for his substance use disorder. Resident decline. Resident was counseled on the safety risks associated with bringing in contraband. The resident was interviewed to obtain information on where contraband was coming from. At this time the resident will not identify the person who brought the contraband. The physician has been notified, and assessments have been updated as well as care plan. The resident has been given IVD (involuntary discharge) due to noncompliance related to contraband. R3's progress note dated [DATE] at 4:29pm denotes in-part writer spoke with resident regarding discharge planning to another facility or a shelter. The resident was given a list of shelters that were accepting males. The resident refused help with discharge planning and stated that he is not going anywhere. Resident was educated on the facility rules and substance abuse policy and continues to not sign behavior contract. Resident is currently on one-to-one staff will continue to monitor behavior as needed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] the V14 (Assistant Director of Nursing) presents a “investigation” witness statement dated [DATE], statement completed by V4 (Drug Abuse Counselor) denotes in-part resident/staff involved R3, R6, and R8 name is listed. “I conducted multiple residents' room for contraband, and nothing was found”. Review of this “investigation”, there is no information documented that R3, R6, and R8 was interviewed about selling drugs in the facility, this investigation does not denote what areas of the room was searched. Witness statement dated [DATE] completed by V3 (Social Service) denotes in-part resident/staff involved R3, R6, and R8 name is listed. “I conducted a room search that (state surveying agency) mentioned, no contraband found”. Review of this investigation, there is no information documented that R3, R6, and R8 was interviewed about selling drugs in the facility, this investigation does not denote what areas of the room was searched. R22's witness statement dated [DATE] documents: Resident involved R8. R8 came to my (R22) room yesterday and sold me twenty dollars' worth of crack and heroin. V6's (Maintenance Staff) witness statement dated [DATE] documents: I was changing the ceiling tiles in room xxxb, contraband was in the ceiling, suspected illicit drugs. Police report xxxx-xxxxx. R16's witness statement dated [DATE] documents: Resident involved (R6). I was given heroin over the weekend by R6. R20's witness statement dated [DATE] documents: Resident involved (R8). Last week when I got caught on the patio smoking cigarettes during fresh airtime. I was given a cigarette that was laced with crack cocaine by (R8). R19's witness statement dated [DATE] documents: Resident involved (R3 and R8). R3 and R8 sell me drug when I have money. They will sell me crack cocaine and marijuana. R17's witness statement dated [DATE] documents: Resident involved R3. R3 sell cocaine and he has a person who gives him the drugs. He gave me crack cocaine on [DATE]. I told them a letter of a name. R4's witness statement dated [DATE] documents: Resident involved R3, R6, R8. I (R4) witnessed R8, R3, and R6 sell drugs in the facility. They will sell heroin, crack cocaine and marijuana to resident. R20's witness statement dated [DATE] documents: Resident involved (R8). Last week, when I got caught on the patio smoking cigarettes during fresh air time. I was given a cigarette that was laced with crack cocaine by R8. R18's witness statement dated [DATE] documents: Resident involved (R3). R3 sold me crack cocaine [DATE]. R14 witness statement dated [DATE] documents: Resident involved (R3). The man in xxxB gave me fentanyl at 10:30pm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility policy titled policy on “Contraband Materials and Inspection of Rooms”, this organization follows federal standards concerning removal of contraband. If the suspected contraband is in plain sight, it shall be promptly removed. If there is reason to suspect/believe that a resident has contraband items/materials in his /her possession the individual will be asked to provide permission to search. If permission is not forthcoming, the individual may be notified that the local police will be notified and asked to complete a search, at the discretion of administration. The following items are NOT ALLOWED in the resident rooms at any time and are not allowed in the resident person. Drugs deemed illegal by federal and state government, prescription medication in the possession of someone to which they were prescribed, alcohol. The organization will try to balance individual rights against the safety needs of peers, visitors, and staff members in making decisions about further investigation of contraband. In situations where illegal activity appears to have taken place appropriate authorities will be notified. Again, safety and security are of the utmost concern. During this survey the facility failed to present witness statements/investigation from female staff with description of burgundy hair. Per V13's (social service consultant) interview, a male resident described a female staff with burgundy hair, selling illicit drugs to residents. During this survey there were multiple staff members observed with hair color hue of burgundy. Upon exit of this survey, the facility failed to present policy/practice related to when to administer Narcan. During this survey V12 (Consultant) was asked, and V10 (Director of Nursing) was asked. It is not clear to surveyor as to when the staff should administer Narcan to a resident. The facility has resident residing that is identified with illicit substance abuse issues. The Immediate Jeopardy began on [DATE]. The immediacy was removed on [DATE]. The surveyor on [DATE] and [DATE] via observation, interview and record review confirmed the following removal plan was implemented by the facility to remove the immediacy: The Chicago Ridge Nursing & Rehabilitation Center outlines its plan to prevent illicit drug use and possible drug overdose among residents. The facility has implemented various measures to monitor residents to ensure a safe environment. R3 no longer resides in the facility. R6 is currently in the facility and is in stable condition. Remains under increased staff supervision. 1:1 supervision with a minimum of 3 days based on compliance with the plan-of-care. R7 is currently in the facility and is in stable condition. Remains under increased staff supervision. 1:1 supervision with a minimum of 3 days based on compliance with their plan-of-care. R8 is currently in the facility and is in stable condition. Remains under increased staff supervision. 1:1 supervision with a minimum of 3 days based on compliance with their plan-of-care. R 14 is currently in the facility and is in stable condition. Remains under increased staff supervision. 1:1 supervision with a minimum of 3 days based on compliance with the plan-of-care. · Immediate health assessments were performed by facility staff and hospital staff on R7 and R14. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	· Immediate increased supervision was initiated for R3, R6, R7, R8, and R14. · The facility initiated an investigation into the allegation of staff involvement and had no credible evidence that staff had any involvement in the distribution of illegal substances. · The facility conducted a comprehensive search of the facility to locate and remove any illicit drugs or paraphernalia. · The facility enlisted the involvement of external authorities, the (local) Police Department, and the Mayor's Office for assistance and support. · The facility increased surveillance in key areas identified as potential points of vulnerability, such as the residents' rooms, patio area, and facility entrance. Compliance Oversight and Documentation Plan for 1:1 Supervision The following measures will be implemented to support the effectiveness and accountability of the Removal Plan: Responsible Parties for Compliance Administrator: Oversees overall implementation and ensures regulatory compliance. Director of Nursing (DON) and Assistant Director of Nursing (ADON): Responsible for clinical oversight, staff supervision, and adherence to 1:1 monitoring protocols. Social Services Director: Ensures proper assessment, documentation, and coordination of care for residents with substance use history. Interdisciplinary Team (IDT): Reviews resident progress and adjusts care plans accordingly. IDT members include: MDS, Social Services, Wounds, Restorative, Dietary, Activities, DON and ADON. Documentation of 1:1 Supervision, Compliance, and Outcomes Start Date 08-22-205 (ongoing). Daily Logs: Staff assigned to supervision 1:1 will complete detailed logs documenting: Start and end times of supervision: See Exhibit 1 Resident behavior and interactions Any incidents or concerns Compliance with plan-of-care Electronic Health Record (EHR): All 1:1 supervision entries will be uploaded to the resident's EHR, including rationale for initiation, duration, and outcome. (continued on next page)

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	09/03/2025

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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Weekly Review: The Administrator or DON will conduct weekly audits of 1:1 supervision documentation to ensure accuracy and completeness. Outcome Tracking: Residents will be assessed based on behavioral changes, adherence to care plans, and preparedness for transitioning out of 1:1 supervision. Enhanced Monitoring Measures started 08-22-2025 (ongoing). · Resident Rooms: Random room searches will continue as part of ongoing surveillance efforts to ensure safety and compliance. · Patio Area: During the resident patio period, at least two staff members will be assigned to observe and supervise the area. · Facility Entrance: Monitoring at the main entrance will be increased, and two employees will be assigned to supervise access and activities from 8 am until 8 pm. · Any staff member suspected of involvement in the trafficking or distribution of an illicit substance will be immediately suspended pending investigation. An internal investigation will begin, and an external investigation may occur if appropriate. · Initiation of random drug urine tests was implemented for residents at risk for drug use. · All facility staff have been in-service in person or via telephone. Staff who have received training via telephone will be required to attend in-person training before the start of their shift. Upon completion of the in-person in-service, the staff will sign the in-service sheet. The administrator and/or social service director will conduct weekly spot checks to ensure the facility staff are knowledgeable of the content. Any staff who were unable to attend the in-service due to a planned vacation or leave of absence will be in-serviced on their next workday before the start of their shift. This in-service training will be conducted by the Administrator, Social Services Director, Director of Nursing (DON), or Assistant Director of Nursing (ADON), with an initial completion date of [DATE]. Ongoing training will be provided for all new hires, and

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interviews and record reviews, the facility failed to follow its medication administration policy and consistently monitor the effectiveness of pain medication. The facility also failed to accurately document the administration of controlled substances for 1 resident (R7) out of 3 reviewed for receiving high alert medications in a sample of 22.Findings include: On 8/15/25 at 10:27 AM, V14 (Assistant Director of Nursing) stated that when a controlled substance medication (hydrocodone-acetaminophen) is administered, the nurse is expected to document in the resident's MAR (Medication Administration Record) at the same time. V14 stated that it is important to document in the MAR when an as needed medication is administered so the nurse will know what time the medication is administered and when the next dose can be administered. V14 stated that the nurse is expected to assess the resident for the effectiveness of the medication and document the resident's response in the MAR. V14 reviewed R7's controlled substance sheet for hydrocodone-acetaminophen. V14 reviewed R7's August MAR. V14 stated staff are not documenting when the medication was administered in R7's MAR. V14 acknowledged that nurses are not documenting accurately when controlled substance is given. On 8/19/25 at 11:00 AM, V16 (Licensed Practical Nurse) stated that the nurse is expected to document on the controlled substance sheet and the resident's MAR when administering a controlled substance. V16 reviewed R7's MAR and controlled substance sheets for July and August 2025. V16 acknowledged that she did not document in R7's MAR every time she signed out hydrocodone-acetaminophen on the controlled substance sheet. V16 is unable to give reason why she did not chart in MAR. R7's POS (physician order sheet), dated 8/31/24, notes an order for hydrocodone-acetaminophen 7. 5-325mg (milligrams) give one tablet by mouth every 12 hours as needed for pain. R7's MAR, dated July and August 2025, notes R7 received hydrocodone-acetaminophen on the following dates and times: On 7/18 at 6:00 PM, pain 6 out of 10 generalized pain. On 7/19 at 6:36 AM, pain 5 out of 10, back pain. On 7/31 at 8:07 PM pain 8 out of 10, back pain. On 8/1 at 8:32 AM, pain. On 8/3 at 9:24 AM, pain 6 out of 10, back pain. On 8/4 at 9:50 AM, back pain. On 8/5 at 9:08 AM, pain 6 out of 10, back pain. On 8/6 at 9:29 AM, pain 6 out of 10, back pain. On 8/8 at 9:23 AM, pain 6 out of 10, back pain. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12 at 9:18 AM, pain 6 out of 10, back pain. R7's controlled substance sheets, dated July and August, notes that hydrocodone-acetaminophen was signed out by the nursing staff twice a day. There is no documentation found in R7's medical record noting the nursing staff monitored the effectiveness of R7's pain medication consistently. R7's pain care plan, initiated 5/5/23, notes R7 is at increased risk for alteration in pain/discomfort related to general aches/pains. Interventions include but not limited to administer analgesic medication as ordered per plan of care, observe resident for effectiveness of pain relief, notify physician for any new resident complaints of pain or signs/symptoms of pain to obtain new order for medication regimen or break-through pain management, offer as needed analgesic medication as indicated for pain management. The facility's administering medications policy, dated 1/1/2020, notes the individual administering the medication shall initial the resident's medication administration record (MAR) before administering the medication. The director of nursing is responsible for the supervision and direction of all personnel with medication administration duties and functions. If it is discovered the person administering medications has forgot to initial on the MAR, the supervisor shall notify that person to investigate if the medication has been administered. If the response indicates the medication was administered, the staff member shall return to the facility and document in the MAR as a late entry.