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	01/30/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to follow its grievance policy by not documenting, investigating, and providing a timely written response to a resident grievance regarding a missing phone. This deficient practice affected one of three residents (R10) reviewed for grievances. Findings include: On 1/27/26 at 1:45 PM, R10 stated that she reported to V15 (Social Service Director/SSD) on 9/17/25 that between 11:00 AM and 12:30 PM on 9/17 R10's personal phone went missing from her room while she was out of her room. R10 stated that V15 wrote the information down on paper but did not give R10 a copy of it. R10 stated that she also informed nurses and CNAs (Certified Nursing Assistants) that her phone was missing. R10 stated that the staff told her they would find her phone and give it back to R10. R10 stated that a staff member informed her that her phone was in the medication room. R10 stated that V15 never followed up with her about her phone. R10 stated that she is afraid if she keeps asking about her phone she will get in trouble and social services won't help her to get a community pass and discharge from this facility. R10 stated that she just wanted her phone back. On 1/28/26 at 12:17 PM, V13 (Registered Nurse/RN) stated that R10 informed V13 of her phone missing months ago, September or October 2025. V13 stated that V13 informed R10 to talk to social services about it. V13 stated that she did not follow-up or report concern of phone missing to anyone. On 1/28/26 at 1:00 PM, R10 showed this surveyor an activity calendar for September 2025. In the box for September 17th R10 noted ‘V15 (SSD) was notified between 11:00 AM and 12:30 PM R10's cell phone was taken from R10's room'. On September 22nd R10 noted ‘found a cell phone in a medication storage room'. R10 stated that a staff member came to her room earlier today regarding R10's missing phone. R10 stated that she wrote down when she reported phone missing and to whom, but staff would not wait for her to find the paper. R10's pre-admission hospital record, dated 8/23/2024, notes the number for R10's personal phone listed is the same number R10 verbalized during the interview on 1/27/26. On 1/29/26 at 9:35 AM, V15 (SSD) denied R10 informing V15 of her phone missing. V15 stated that whoever is informed of a resident concern is expected to document on a concern form, give this form to her, and once she receives the form, she gives the concern to the department involved for resolution. On 1/29/26 at 11:56 AM, V19 (CNA) stated that R10 informed her that R10's personal phone was missing around 9/29/25. The facility's grievance binder, September until present, does not note R10's grievance regarding her missing phone. On 1/28/26 at 11:05 AM, the facility presented a grievance form/opportunity resolution form. The name of the person completing this form is not documented. It notes R10 has had phone since admission to this facility and phone may have been taken by another resident, R11. R10's belongings inventory, dated 8/30/24, notes R10 with one long sleeved shirt, one sweatshirt/hoodie, and one pair of sweatpants. R10's belonging inventory, dated 6/19/25, notes a pair of eyeglasses. R10's admission photo shows a red blanket not listed on either inventory sheet. There is no documentation noting the scarf that R10 wraps around her head or any other personal items in her room. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Neither belonging inventory sheet contain R10's signature to indicate staff documented all R10's belongings. The facility's belongings policy, dated 04/2014, notes resident belongings will be recorded upon admission and whenever brought in. Check and record all belongings brought to facility on clothing list. Resident is to sign for belongings. If resident is unable to sign note this on the clothing list.The facility's grievance policy, revised 01/2025, notes the director of social services will oversee the grievance process to ensure grievances are addressed promptly. All concerns will be documented in writing. Concern resolutions are expected within 72 hours. The concern forms will be maintained in the grievance binder. The records will be kept for at least three years.

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F 0600 Level of Harm - Minimal harm or potential for 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** Based on interview and record review, the facility failed to implement its abuse prevention policy to prevent a resident-to-resident physical assault. This deficiency affected two of three residents (R10 and R11) reviewed for abuse. Findings include:On [DATE] at 1:45 PM, R10 stated that R10 had been friends with R11 for a long time. R10 stated that when R11 came into R10's room on [DATE], he saw a milk carton on her nightstand. R10 stated that R11 became very upset and began yelling at her about having expired milk in her room. R10 stated that the milk wasn't expired. R10 stated that R10 was trying to speak with R11, but R11 was becoming more upset. R10 stated that R11 picked up the milk carton and hit her on the right side of her head with it. R10 stated that R11 then pushed R10 on the bed and grabbed her by her upper arms and began shaking her violently. R10 stated that other residents came in to get R11 off her and then staff came in and removed R11 from R10's room. On [DATE] at 4:15 PM, V20 (Nurse) stated that she heard a commotion at the back hall and then shouting. By the time V20 got to R10's room, another resident, R13, from first floor nursing unit had already pulled R11 off R10 and was standing between R10 and R11. V20 stated that R13 was telling R11 ‘you don't hit a lady‘. V20 stated that R13 informed her R13 was passing by R10's room and heard screaming and saw R11 hitting R10. V20 stated that R10 was lying on her bed with her arms covering her face to prevent further hits. V20 stated that one of R10's roommates also stated that R11 was hitting R10. V20 stated that V20 reported this event to V1 (Administrator) immediately. V20's note, dated [DATE], stated V20 heard loud voices arguing and asking for help at back hall and observed a male resident, R13, blocking another resident, R11, from trying to reach out for R10 who was moving out of R11's reach. R11 was immediately removed out of the room and brought to social services while R10 was assessed for any injury. R10 complained of a little pain on her right forearm where R11 had held her and moderate pain at the back of her right ear. R11's statement regarding this event, dated [DATE], notes R11 entered R10's room and saw an expired milk carton. R11 stated it was dirty. R11 asked R10 why it was still in R10's room. R11 hit R10's head. When R11 was told, he was not allowed to hit people he responded that having spoiled milk in your room is worse than not showering. R11 no longer resides in this facility and was unable to be interviewed. R13's statement, dated [DATE], notes R13 heard R11 screaming about a phone then about spoiled milk. R13 didn't know who R11 was yelling at, then he heard smacks, R13 got out of his wheelchair to see who R11 was yelling at, saw R11 hitting R10. R13 pulled R11 off R10 and stood between them to protect R10. R11 left R10's room.R13 no longer resides in this facility and was unable to be interviewed. R14's statement, dated [DATE], notes when R14 walked into R10 and R14's room, R11 was on top of R10 punching her in the face. R14 stated other residents and nurses came in trying to get him off R10. On [DATE] at 3:20 PM, R14 was able to state the same details of event as she provided on [DATE]. R11's medical record notes diagnoses including but not limited to unspecified psychosis not due to a substance or known physiological condition, auditory hallucinations, schizophrenia, and bipolar disorder. R11's POS (Physician Order Sheet), dated [DATE], notes orders for mirtazapine 15mg (milligrams) by mouth at bedtime related to bipolar disorder; Risperdal 2mg by mouth one time a day for schizophrenia; Risperdal 1mg by mouth one time a day; trazodone 150mg by mouth at bedtime for bipolar disorder; uzedy subcutaneous suspension 200mg/0.56ml (milliliters) one time a day starting on the 18th for 56 days for psychosis, disorganization, paranoia; and lithium 600mg by mouth two times a day for bipolar disorder. R11's MAR (Medication Administration Record), dated [DATE], notes R11 refused mirtazapine on 9/16, 9/19, 9/20, 9/21, 9/22, 9/23, 9/26, 9/27, and 9/28. R11 refused Risperdal 2mg on 9/16, 9/18, 9/19, 9/20, 9/21, 9/22, 9/23, 9/24, 9/25, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/26, 9/28, and 9/29. R11 refused Risperdal 1mg on 9/16, 9/18, 9/19, 9/20, 9/21, 9/22, 9/23, 9/25, 9/26, 9/27, 9/28, and 9/29. R11 refused trazodone on 9/16, 9/19, 9/20, 9/21, 9/22, 9/23, 9/26, 9/27, and 9/28. R11 refused uzedy 9/19, 9/20, 9/21, 9/22, 9/25, 9/26, 9/27, 9/28, and 9/29. R11 refused morning dose of lithium on 9/16, 9/18, 9/19, 9/20, 9/21, 9/22, 9/23, 9/24, 9/25, 9/26, 9/27. 9/28, and 9/29; and the evening dose on 9/16, 9/19, 9/20, 9/21, 9/22, 9/23, 9/26, 9/28, and 9/29. Prior to R11's hospitalization on 9/10, R11 refused his psychotropic medications 8-9 days out of 10.There is no documentation in R11's medical record, dated 9/16-9/29, noting R11's attending physician and psychiatrist were notified each time R11 refused psychotropic medications. The nurse practitioner's notes, dated 9/17 and 9/25, notes ‘no concerns from the nursing staff'.R11's medical record notes R11 was hospitalized [DATE] - [DATE] for aggressive behavior.The facility's abuse investigation dated [DATE] - [DATE], notes statements from R11, R13, and R14 that R11 was hitting R10. The facility did not provide any staff interviews regarding this event. The final report notes no credible evidence that abuse occurred. The facility's abuse prevention policy, reviewed [DATE], notes the facility desires to prevent abuse by establishing a secure resident environment. The investigator will attempt to interview the person who reported the incident. Any written statements will be reviewed.

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F 0689 Level of Harm - Minimal harm or potential for 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 implement appropriate interventions to supervise and monitor a resident (R11) with a known history of aggressive behavior to prevent entry into another resident's room. This failure affected two of three residents reviewed for supervision. (R10, R11). As a result, R11 was not adequately supervised and was able to enter R10's room, where R11 verbally and physically assaulted R10.Findings include:On [DATE] at 1:45 PM, R10 stated that R10 had been friends with R11 for a long time. R10 stated that when R11 came into R10's room on [DATE], he saw a milk carton on her nightstand. R10 stated that R11 became very upset and began yelling at her about having expired milk in her room. R10 stated that the milk wasn't expired. R10 stated that R10 was trying to speak with R11, but R11 was becoming more upset. R10 stated that R11 picked up the milk carton and hit her on the right side of her head with it. R10 stated that R11 then pushed R10 on the bed and grabbed her by her upper arms and began shaking her violently. R10 stated that R11 only hit her the one time in the head but the way he was shaking her may have given others the impression he was hitting her multiple times. R10 stated that other residents came in to get R11 off her and then staff came in and removed R11 from R10's room.On [DATE] at 4:15 PM, V20 (Nurse) stated that she heard a commotion at the back hall and then shouting. By the time V20 got to R10's room, another resident, R13, from first floor nursing unit had already pulled R11 off R10 and was standing between R10 and R11. V20 stated that R13 was telling R11 ‘you don't hit a lady'. V20 stated that R13 informed her R13 was passing by R10's room and heard screaming and saw R11 hitting R10. V20 stated that R10 was lying on her bed with her arms covering her face to prevent further hits. V20 stated that one of R10's roommates also stated that R11 was hitting R10. R11's statement regarding this event, dated [DATE], notes R11 entered R10's room and saw an expired milk carton. R11 stated it was dirty. R11 asked R10 why it was still in R10's room. R11hit R10's head. When R11 was told, he was not allowed to hit people he responded that having spoiled milk in your room is worse than not showering.R11 no longer resides in this facility and was unable to be interviewed.R11's behavior care plan, initiated [DATE], notes R11 demonstrates behavioral distress related to: ineffective coping mechanisms. Problems are manifested, in part, by physically abusive behavior when agitated; attempting to push, shove, scratch, hit, slap, kick, grab, or otherwise harm another person. Interventions, in part, give psycho-active medications as ordered. Record behavioral symptoms.R11 psychotropic medications care plan, initiated [DATE], notes R11 requires psychotropic medications to help manage and alleviate diagnoses schizophrenia, psychosis with hallucinations, and bipolar disorder. Interventions, in part, note report abnormalities to physician. Carry out the medication management regimen as prescribed, report changes, complications to physician. If behavioral symptoms are observed, record and document on behavior tracking form.R11's behaviors care plan, initiated [DATE], notes R11 has a history of behaviors related to severe mental illness. R11 has lack of sound judgement, poor impulse control. Interventions, in part, daily monitoring and supervision.R11's medical record, dated [DATE], notes R11 refused to be medication compliant. R11 was counseled by social services and will be given cues, reminders, and re-direction on the importance of being medication compliant.On [DATE], social services counseled R11 on complying with medications.On [DATE], social services counseled R11 on complying with medications.On [DATE], psychosocial social worker met with R11 in a 1:1 session. It is noted R11's comprehension is moderately impaired; R11 presents with delusions of grandeur, paranoid, delusional material expressed; insight moderately impaired; poor self-awareness; racing thoughts, disorganized thought processes.On [DATE], social services met with R11 regarding noncompliance with medications and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refusal of care. R11 not receptive to counseling.On [DATE] at 11:37 AM, social services met with R11 to discuss his refusal of care and medications. R11 not receptive to counseling on taking his medications. R11 presents with auditory hallucinations.R13's statement, dated [DATE], notes R13 heard R11 screaming about a phone then about spoiled milk. R13 didn't know who R11 was yelling at, then he heard smacks, R13 got out of his wheelchair to see who R11 was yelling at, saw R11 hitting R10. R13 pulled R11 off R10 and stood between them to protect R10. R11 left R10's room.R13 no longer resides in this facility and was unable to be interviewed.R14's statement, dated [DATE], notes when R14 walked into R10 and R14's room, R11 was on top of R10 punching her in the face. R14 stated other residents and nurses came in trying to get him off R10.On [DATE] at 3:20 PM, R14 was able to state the same details of event as she provided on [DATE].

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on interview and record review, the facility failed to follow its Community Access Determination policy by not completing required Community Survival Skills assessments at least quarterly, annually, and when residents requested outside passes. This failure affected four of four residents reviewed for Social Services assessments (R1, R10, R17, and R18) in a sample.Findings include:On 1/28/26 at 10:42 AM, V9 (Social Services) stated that community survival skills assessments are completed quarterly, annually, and if resident requests outside pass. V9 reviewed R10's medical record with this surveyor. V9 acknowledged that the last community survival skill assessment completed is dated 3/31/25. V9 stated that maybe she did not lock her assessment and that is why it is not showing up. V9 was informed that even an assessment in progress would appear in the resident's electronic medical record.R1's medical record notes his last community skills assessment was completed on 7/9/25.R17's medical record notes his last community skills assessment was completed on 8/1/25.R18's medical record notes his last community skills assessment was completed on 9/8/25.The facility presented a document titled admission, quarterly, annual, and significant change assessments. This document notes community skills assessments are completed on admission, with significant change, and annually. This document is not in alignment with the facility's policy regarding the frequency of community skills assessments.When V2 (Director of Nursing) and V8 (Assistant Director of Nursing) were asked to clarify if this document is a policy, neither responded until after V2 communicated with V1 (Administrator). After discussing with V1, V2 stated that this is not a policy, it is just a document created noting which assessments are to be completed and when. The facility's guidelines for community access determination policy, dated 2/8/23, notes, in part, a community skills assessment will be completed by social services upon admission, quarterly. The community access assessment should be completed quarterly on all residents.