

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 02/06/2026
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)		
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** Based on interview and record review, the facility failed to follow their abuse policy and failed to protect one resident (R12) from physical abuse by R148. This failure affected one (R12) resident in a sample of 63 residents reviewed for abuse. These failures resulted in R12 being physically assaulted by R148, causing R12 to sustain bruising of right eye, right elbow, and multiple rib fractures that required hospitalization. Findings include: R12's face sheet documents an age of [AGE] years old and diagnoses that include but are not limited to multiple fractures of the ribs, left side, dementia, lack of coordination, muscle wasting and atrophy. R12's BIMS (brief interview for mental status) score, dated 12/02/25, is 12 which indicates R12's cognition is moderately impaired. R12's progress note, dated 8/21/25 at 12:00pm, documents, in part, It was reported to staff that resident (R12) was allegedly involved in social inappropriate interaction with peer. Both residents were separated immediately and placed on 1:1. Resident (R12) did verbalize that she feels safe in the facility. Resident (R12) was reminded she lives in a safe facility and staff is here to assist as much as possible. Resident (R12) was also reminded to report any incidents immediately to staff. Resident (R12) was reminded of coping skills of breathing in and out, watching television, and reading a book. Resident was reminded that social services always has their door open for any resident's concerns/issues. Resident (R12) was reminded to respect others and boundaries. Resident was reminded to attend psychosocial service group therapy Mon-Fri to help alleviate mood concerns or seek SS for 1:1 counseling. R12's progress note, dated 8/21/25 at 5:31pm, documents, in part, Resident (R12) Left the facility this afternoon on the stretcher with ambulance and two agents by her (R12) side to hospital for evaluation. R12's hospital records, dated 8/21/2025, documents, in part, (R12) presents for evaluation after physical altercation at nursing facility where she (R12) was punched in the left lower rib cage and also the right eye. Pt (R12) with bruising to R (right) eye and R (right) elbow. Found to have multiple fractures of left ribs. Plan for admission for continued monitoring given patient's age and risk for respiratory decline with multiple rib fractures. ED (Emergency Department) Diagnosis 1. Closed fracture of multiple ribs of left side, initial encounter. 2. Contusion of face, initial encounter. 3. Victim of assault. R12's x-ray of chest, dated 8/21/25, documents, in part, Findings indicative of posterior left seventh through ninth rib fractures. R12's progress note, dated 8/22/25 at 12:34pm, documents, in part, Writer called hospital and talked to nurse. Resident (R12) is going to admit with diagnosis of multiple left side rib fracture. On 2/04/2026 at 11:51am, R12 said, Oh, that was a while ago. Yeah, she (R148) was blaming me (R12) for the smoking times getting shortened or something. She (R148) was yelling at me and then I started yelling back. I got up to go back inside and she (R148) punched me (R12) in the face and then my side. There were a bunch of punches, almost felt like 2 people could have been hitting me (R12). She's (R148) always yelling at someone. I don't know. I think there was (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 0600 Level of Harm - Actual harm Residents Affected - Few	one staff member out there. I can't remember. I don't know which staff. Yeah, couple broken ribs, but I'm still moving. I mean, I guess I feel safe here. I have a lot of friends here. I don't want to leave. R12's care plan, dated 8/21/25, documents, in part, My (R12) comprehensive assessment reveals a hx (history) of suspected abuse &/or neglect or factors that may increase my susceptibility to abuse/neglect. R148's face sheet documents an age of [AGE] years old and diagnoses that include but are not limited to anxiety, schizoaffective disorder, alcohol abuse, and opioid dependence. R148's BIMS (brief interview mental status) score, dated 1/05/26, is 15 which indicates R148 is cognitively intact. R148's progress note, dated 8/21/25 at 12:00pm, documents, in part, It was reported to staff that resident (R148) was allegedly involved in social inappropriate interaction with peer. Both residents were separated immediately and placed on 1:1. Resident (R148) did verbalize that she feels safe in the facility. Resident (R148) was reminded she lives in a safe facility and staff is here to assist as much as possible. Resident (R148) was also reminded to report any incidents immediately to staff. Resident (R148) was reminded of coping skills of talking to the family, breathing in and out, and watching television. Resident was reminded that social services always has their door open for any resident's concerns/issues. Resident (R148) was reminded to respect others and boundaries. Resident (R148) was reminded to attend psychosocial service group therapy Mon-Fri to help alleviate mood concerns or seek SS for 1:1 counseling. On 2/04/26 at 1:45pm, R148 said, She (R12) kept pushing into me (R148) and walking into me (R148). So, I punched her (R12). How many times is someone going to run into someone? I'm gonna defend myself. I had to my whole life. I don't know how many times I punched her (R12). I know I did punch her (R12) in the face. R148's care plan, dated 1/22/24, documents, in part, The resident (R148) demonstrates significant mood distress related to: Feeling angry, guilty and/or out of control (e.g., powerless, hopeless, incomplete, incompetent). R148's care plan, dated 1/23/25, documents, in part, I (R148) demonstrate behavioral distress related to: Problems are manifested by: Verbally abusive behavior when agitated. Problems are manifested by: Physically abusive behavior when agitated. I (R148) presented verbal and physical aggression towards peer. R148's care plan, dated 8/21/25, documents, in part, I (R148) have a history of aggressive, inappropriate, attention-seeking and/or maladaptive behavior, but has demonstrated stability during the admission screening process & is therefore considered appropriate for admission. The history includes: Conflicts/altercations with others. Verbal or physical aggression. The resident (R148) has a diagnoses of: severe, chronic persistent mental illness. The resident (R148) has a diagnoses of: subs abuse disorder. The Resident (R148) has poor judgement & at times show being in denial of her Mental Health conditions, which can lead to depression. The Resident (R148) does at times show aggression but is easily redirected. The Resident (R148) does have signs of attention seeking as well as getting frustrated when not shown the attention she is seeking. I (R148) presented verbal and physical aggression towards peers. R148's progress note, dated 8/05/25 at 2:00pm, documents, in part, It was reported to staff that resident (R148) was allegedly involved in social inappropriate interaction with peer. Both residents were separated immediately and placed on 1:1. Resident (R148) did verbalize that she (R148) feels safe in the facility. Resident (R148) was reminded she lives in a safe facility and staff is here to assist as much as possible. Resident was also reminded to report any incidents immediately to staff. Resident (R148) was reminded of coping skills of breathing in and out, watching television, listening to music, and talking to family. Resident (R148) was reminded that social services always has their door open for any resident's concerns/issues. Resident (R148) was reminded to respect others and boundaries. Administration and DON was made aware. MD made aware. Message left for guardian. Police was called and notified. Care plan and assessment updated accordingly. R148's progress note, dated 8/05/25 at 8:59pm, documents, in part, (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	One of staff members told the writer that the resident (R148) was allegedly involved in social inappropriate interaction with another resident in the smoking area. Both residents were separated immediately and placed on 1:1. Head to toe assessment was completed with no injury noted. MD (Medical Doctor), DON (Director of Nursing), Nurse consultant and family were informed. The psychiatrist called and gave the order of sending the resident to hospital ER (emergency room) for Psych (psychiatry) evaluation. R148's progress note, dated 1/22/25, documents, in part, It was reported to writer that resident (R148) was allegedly involved in an altercation with peer. Both residents were separated immediately. Resident (R148) was reminded she (R148) lives in a safe facility and staff is here to address all her (R148) concerns and issues. Resident (R148) was counseled on conflict resolution skills. Resident (R148) was encouraged to utilize appropriate language and communication when any disagreements occurs. Resident (R148) was educated on behavior management techniques. Resident (R148) was educated to utilize coping strategies for managing heightened agitation. Resident (R148) was encouraged to report all derogatory behavior to staff. Resident (R148) was receptive towards counseling at this time. Care plan and assessment updated. SS (Social Services) will continue to assist. On 2/05/26 at 11:29am, V26 (Psychiatric Rehabilitation Services Coordinator/PRSC) said, I wasn't there (8/21/25). I cannot tell you what really happened. I was notified about it. She (R148) said she (R148) didn't do anything. It was reported by staff. I do not remember what staff. She (R12) bumped into her (R148), maybe cross paths. I wasn't aware that she (R12) had rib fractures. I'm sorry. I don't know much about the incident (8/21/25). On 2/05/26 at 1:59pm, V19 (Licensed Practical Nurse/LPN) said, I was at the nurse's station and Social Services came and said there was an altercation at smoking area. My patient was R12. R148 was claiming R12 hit her, so R148 hit R12 back. R12 denied hitting R148. I can't remember if R12 had injuries, but I did call the doctor, and the doctor gave an order to send R12 out. I think the rib fractures (R12) were prior to this (incident of 8/21/25). Let me check and find out for sure. On 2/05/26 at 3:10pm, V19 (LPN) said, I just checked into R12's rib fractures, and the rib fractures were not old. We (facility) don't have a copy of the x-ray results, but I read a few notes, and it looks like R12 was sent to the hospital the day of the altercation on the 21st (8/21/25) and came back with fractured ribs. On 2/5/26 at 3:44pm V34 (Psychiatric Rehabilitation Services Coordinator/PRSC), said, Yes, I was there (8/21/25). We (V34 and residents) was on the patio. I don't remember if other staff were out there. R12 seemed to get frustrated and round up, and I tried to redirect but she (R12) fell. She (R12) was trying to move to fast, and moved her chair, and slipped and fell. R12 and R148 were arguing back and forth. I heard them (R12 and R148) arguing, and tried to figure it out, and redirect her (R12) back in the building. I did not even see anyone hit anyone. I couldn't figure out what they (R12 and R148) were arguing about. On 2/05/26 at 3:56pm, V25 (Physician) said, Another resident punched her (R12) in the chest. I have been there for two or three years, and I have seen residents become aggressive; it happens frequently. When a person with rib injuries takes a deep breath, it causes pain and can lead to complications such as pneumonia or pneumothorax. If narcotics are administered, they may mask the pain, but healing will not occur. I understand that the pain is significant; however, masking the pain is not appropriate. Ice should be used instead. The benefits and risks must be carefully considered. On 2/6/2026 at 11:11 AM, V1 (Administrator) affirmed that V1 was on vacation and that V36 (Regional Nurse Consultant) was the abuse prevention coordinator in V1's absence. On 2/6/2026 at 11:16 AM, V36 (Regional Nurse Consultant) affirmed that V36 was the abuse prevention coordinator in V1's absence when the allegation occurred between R12 and R148. V36 explained that it was reported to V36 that R12 was pushed by R148. The facility completed an investigation, interviewed staff and residents and the statements showed that R12 was not pushed, that R12 was (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	pushing her (R12) weight trying to get through people and fell. Staff attempted to redirect her (R12), but it was unsuccessful, and she (R12) fell. R12 was sent to the hospital and sustained a rib fracture. She (R12) uses a rolling walker and often does not use it as intended, she (R12) picks it up instead of walking with it, which I think contributed to the situation. V36 stated that there was no video footage of the incident. Residents have the right to be free from abuse. Record review of resident witness interviews for FRI (facility reported incident), dated 8/21/25, documents, in part, that the residents present at the time of the incident did not see anything. Record review of facility policy titled, Abuse Prevention Program Facility Policy and Procedure, dated 1/14/19, documents, in part, Abuse is defined as the willful infliction of injury with resulting physical harm pain or mental anguish. Instances of abuse of all residents irrespective of any mental or physical condition cause physical harm pain or mental anguish. It includes verbal abuse sexual abuse physical abuse and mental abuse including abuse facilitated or an able through the use of technology. Willful, is 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. Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. Informing local law enforcement first suspected physical abuse involving physical injury inflicted on a resident by another resident except in situations where the behavior associated with dementia or developmental disability. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. You should receive the services and/or items included in the plan of care.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure that the ice machine and the ice machine filter were kept clean and free of dust; and the ceiling air vent above the juice dispenser was free of accumulated dust. These failures have the potential to affect all 197 residents that receive oral foods from the facility's kitchen. Findings include: On 2/2/26 after the entrance conference, V1 (Administrator) presented the facility's census as 199, minus 2 residents who have NPO status (receive nothing by mouth), total of 197 residents who receive food from the kitchen. On 2/2/26 between 10:10am and 10:30am during observation of the kitchen with V7 (Dietary Manager), the ice machine in the kitchen was observed with visible accumulated dust, and visible dirt. V7 stated that the ice machine is supposed to be wiped every day. On 2/5/26 at 11am, the ceiling air vent above the juice dispenser machine was observed with a lot of accumulated dust. V7 stated that the juice machine is in use and there should be no dust in the vent right above where juice is served for the residents. V7 stated that Maintenance would be notified to clean the ceiling vent. Facility's policy titled Chest/Ice Scoop/Ice Machine Cleaning and Disinfecting dated 8/2020 states: Purpose - To Plan and reduce the microorganisms on an inanimate object rendering it safe for use. The ice chest shall be cleaned and sanitized routinely by the dietary department. The ice machine will be cleaned and disinfected monthly by the dietary department. #3: Scrub all surfaces of machine using a clean cloth and fresh detergent solution. Facility's undated Dietary Daily Cleaning Schedule states Clean the ice machine, cards, and clean the walls by the ice machine.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their policy to provide wound care services in alignment with professional practice standards by permitting a wound care Certified Nurse Assistant to remove a stage 4 sacral area wound dressing and clean the wound site. The facility failed to have the low air loss mattress at the correct weight settings. The facility also failed to provide wheelchair cushions as a pressure ulcer prevention intervention for residents at risk for pressure ulcers. These failures have the potential to affect six residents (R1, R6, R11, R16, R21, and R46) reviewed for pressure ulcer care, prevention, and interventions, in a total sample of 63 residents. Findings include: On 2/2/26 at 10:45am and 12pm, during observation of residents in the Activity Room, R6, R1, R11, R21, and R46 were observed sitting in the wheelchair without pressure relieving cushion/devices. V13(Certified Nurse Assistant/CNA) in the dining room was notified and stated that those residents not sitting on cushions did not have any, and restorative staff need to provide cushions for them. V13 stated that she was aware that residents' skin can break down if they don't have cushion in the wheelchair. Again, during and after lunch around 1:30pm, the residents were still in wheelchairs without cushions. On 2/4/26 at 12:40pm, the residents still did not have wheelchair cushions. At this time, V21(Restorative Nurse) was notified and stated that she already notified the administrator, and they ordered the cushions for the residents some time ago, but they have not received any cushions yet. V21 added that the residents should have cushions on wheelchairs to prevent pressure ulcers. 1.) R6's Records show the following: Face sheet shows diagnoses which include but are not limited to Type 2 Diabetes with Foot Ulcer, Fracture of Left Lower Leg, Peripheral Vascular Disease, Morbid Severe Obesity, Depression, and Schizoaffective Disorder Bipolar Type. Pressure Ulcer assessment dated [DATE] shows that R6 is at risk for pressure ulcer. MDS (Minimum Data Status) section M dated 1/16/26 states that R6 is at risk of developing pressure ulcers/injuries. Care plan dated 4/17/25 states: R6 is at increased risk for alteration in skin integrity related to: Diabetes, limited mobility, and Resistant/Non-compliant with overall plan of care 2.) R11's records show the following: Face sheet shows diagnoses which include but are not limited to Disorganized Schizophrenia, Protein Calorie Malnutrition, and Acute Respiratory Failure with Hypoxia. Pressure Ulcer Risk assessment dated [DATE] shows that R11 is at risk for pressure ulcer. MDS section M dated 12/8/25 states that R11 is at risk of developing pressure ulcers/injuries. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care plan dated 6/27/25 states: R11 is at increased risk for alteration in skin integrity related to protein calorie malnutrition. 3.) R21's records show the following: Face sheet shows diagnoses which include but are not limited to Obesity, Dementia, Affective Disorder Bipolar Type, Low Back Pain, and Presence of Right Artificial Hip Joint. Pressure Ulcer assessment dated [DATE] shows that R21 is at risk for pressure ulcers. Care plan dated 8/26/25 states: R21 is at increased risk for alteration in skin integrity related to dx: dementia, incontinence of bowel and bladder and impaired mobility, and has MASD (Moisture Associated Skin Damage) to bilateral buttocks. 4.) R46's records show the following: Face sheet shows diagnoses which include but are not limited to Weakness, Schizoaffective Disorder Bipolar Type, Vitamin D Deficiency, and Obesity. Pressure Ulcer Risk assessment dated [DATE] shows that R46 is at risk for pressure ulcer. MDS section M dated 1/7/26 states that R46 is at risk of developing pressure ulcers/injuries. Care plan dated 12/5/24 states: R46 is at risk impaired skin integrity due to weakness and impaired mobility. 5.) R1's records show the following: Face sheet shows diagnoses which include but are not limited to Severe Protein Calorie Malnutrition, Dysphasia, Gastrostomy Type 2 Diabetes, Dementia, Schizophrenia, This Is Affective Disorder Bipolar Type, Hemophilia and Hemiparesis. Pressure Ulcer assessment dated [DATE] shows that R46 is at risk for pressure ulcers. MDS section M dated 1/7/26 states that R46 is at risk of developing pressure ulcers/injuries. Care plan dated 9/29/25 states: R1 is at increased risk for alteration in skin integrity related to dx: Diabetes Type 2 and hemiplegia, needs assistance with ADLs and is incontinent of bowel and bladder, and has a moderate rash to the groin, and bilateral buttocks related MASD. 6.) R16's current diagnoses include but are not limited to End Stage Renal Disease, Chronic Kidney Disease, Type 2 Diabetes Mellitus, Hypertension, Osteomyelitis, Sacral Region Stage 4 Pressure Injury to the Coccyx, and Palliative Care. R16's comprehensive assessment section C Cognitive Patterns dated 01/14/2026 documents a brief interview for mental status score of 8 out of 15 indicating he has moderate cognitive impairment. On 02/04/2026 at 11:21 AM, R16 was observed in bed on a low air loss mattress that is set to a weight of 400 lbs (pounds). (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V25 (Wound Care Certified Nursing Assistant/CNA) entered R16's room with supplies for his wound care and set them up on the bedside table next to the bed. V25 and V21 (Wound Care Nurse) put on isolation gowns, gloves, and pulled R16's privacy curtain. V25 approached R16's bed. This surveyor asked V21 (Wound Care Nurse) who V25 was and V25 said, I'm the CNA. V21 said, I'm the Wound Nurse. On 2/4/2026 at 11:26 PM, V25 (Wound Care CNA) entered the room, removed R16's soiled dressing to R16's sacral/coccyx area, removed V25's gloves, used hand sanitizer, and cleaned R16's wound with normal saline. V21 (Wound Care Nurse) described the wound stating, It's a stage four pressure ulcer, no tunneling, and it has a small area of slough. The wound care doctor comes every Tuesday, but she didn't come yesterday. R16's wound bed was observed to be pink with no foul odor or drainage noted. V21 then applied (Brand name ointment) and Calcium Alginate and covered the sacral wound with a 4 x 4 bordered gauze. On 02/04/2026 at 11:36 AM, V21 (Wound Care Nurse) was inquired of V25 (Wound Care CNA) doing wound care for R16. V21 stated, She's just supposed to prep it (the wound). That's how it's been since I've been here. She takes off the old bandage and she'll clean the area, and I come and put on the dressing and whatever order says. On 02/04/2026 at 11:47 AM, R16's physician orders for the coccyx wound were reviewed in electronic medical record. The order dated 2/4/2026 at 2:30 PM states to cleanse coccyx with NSS (normal saline solution) pat dry apply honey and alginate cover with dry dressing. Pressure reduction mattress in place date ordered 01/06/2026. On 02/04/2026 at 12:02 PM, V21 (Wound Care Nurse) was inquired about R16's low air loss mattress. V21 said, I think the floor nurses do the low air loss mattress. He has it because of his pressure ulcer to prevent wounds. It's to help his wound heal and prevent new wounds from developing. I'm not sure how it should be set for him, I'd have to check. On 02/05/2025 at 10:41 AM, V2 (Director of Nursing) was inquired about wound care. V2 said, V21 Wound Care Coordinator is responsible for wound care and on the weekends the floor nurses carry out the orders for it. CNAs aren't allowed to do any wound care. The CNA isn't a wound care nurse. The treatment wouldn't be effective. I didn't have any knowledge of CNAs doing wound care. This surveyor requested documentation of V21's wound care training for review. V2 did not provide the requested training documentation prior to the exit of the survey. On 02/05/2026 at 12:12 PM, R16 is asleep in bed on the low air loss mattress. The mattress is set to 400 lbs (pounds). R16's electronic medical documentation states a weight of 135.2 lbs (pounds) on 01/07/2026. There is no documented weight for February 2026. R16's 01/27/2026 physician wound care documentation by V30 (Nurse Practitioner) states in part: Wound care was placed on consult for evaluation and management. Objective: Sacrum: 1. Stage 4 pressure injury to coccyx (tail bone). Measures 8 x 5 x 1.5 cm (centimeters) with circumferential undermining (the separation of skin edges from underlying tissues creating a pocket of dead space in chronic non-healing wounds which indicates extensive damage) with deepest measurement of 3 cm. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wound is 70% granular tissue, 30% necrotic tissue (dead, non-viable tissue). Bone exposed. Moderate serous exudate (a thin watery clear to yellow fluid that seeps from blood vessels into tissues during the inflammatory phase of wound healing). Assessment: Stage 4 pressure injury to coccyx. Plan: Recommend honey (medical grade- a sterilized, antibacterial and anti- inflammatory agent used to treat chronic and acute wounds) and calcium alginate (wound dressing) with dry dressing daily and prn (as needed). Due to patient's multiple comorbidities, he is at high risk for developing new and worsening wounds. R16's 12/01/2025 revised care plan states in part: R16 has a stage IV (4) pressure ulcer on his coccyx. Goal: Management of the pressure ulcer. Intervention: low air loss mattress initiated 11/20/2025, Provide skin care per facility guidelines and PRN as needed date initiated 10/20/2025, Provide wound care per treatment order date initiated 10/20/2025. The (Low Air Loss Mattress) Operation Manual states in part (brand name) system is designed for prevention, treatment, and management of pressure ulcers. The (brand name) pump is a smart pump simple to operate and easy to use, constantly providing pressure redistribution and support to patients. The (brand name) system is intended to reduce the incidence of pressure ulcers while optimizing patient comfort. It also provides the following: Individual customized setting capability. Pain management as prescribed by a physician. PRODUCT FUNCTION Pump Unit The functions of the pump for (brand name) system are described below. v Power Key(1) &Oslash; Press Power key on the panel, the pump will start/stop operation. v Press Weight Range(2) &Oslash; Press minus or plus buttons to select the correct patient weight. Weight/Pressure set up Users can adjust air mattress to a desired firmness according to patient's weight or the suggestion from a health care professional. The Policy titled Pressure Injury Prevention was reviewed. Dated 10/2026 and revised 12/2025, the policy stated that the purpose is to provide guidance on how to prevent pressure injury. The procedure is 1. Maintain clean/dry skin during daily hygiene measures. 2. Inspect the skin several times daily during bathing, hygiene, and repositioning measures. Report immediately to the nurse any (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Chicago Ridge Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 10602 Southwest Highway Chicago Ridge, IL 60415	
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	new or worsening skin concerns. 3. Moisture barrier may be applied by CNAs as needed and may be kept at the bedside. 4. Residents may wear briefs in bed for comfort or during episodes of diarrhea. 5. Change bed linen whenever soiled with urine, feces or other material. 6. Turn and reposition dependent residents. 8. Assist resident with active and/or passive range of motion exercises as ordered by physician to improve circulation. 9. Pressure reduction mattress will be used for residents who are at moderate to high risk of skin breakdown. Pressure relieving mattress will be used for residents who are at severe risk of breakdown. 10. When using low air loss mattress, follow manufacturer's instructions related to use, setting and care. 12. Use positioning devices to relieve the pressure from heels, toes, knees and ankles. 13. Encourage residents to maintain adequate nutrition. 14. Offer snacks and fluids at regular intervals, as needed. 15. Refer to the dietitian and physician as needed. The Job description titled Certified Nursing Assistant updated 7/24 was reviewed and states in part responsibility for this position is with the Director of Nursing. The purpose of this position is to assist the nurses in the providing of resident care primarily in the area of the daily living routine. Main duties include 1. Support the facilities philosophy of care and strive to achieve its goals and objectives. 2. Be sensitive to residents' families and respond in an appropriate professional way as the situation required. 3. Carry out assignments for resident care including (but not limited to): bathing, dressing, grooming, shaving, feeding, restorative nursing procedures. 4. Keep resident' beds, dresser, bathroom, and general living area clean and tidy. 5. Answer call lights promptly, 6. Help check in all new residents and readmissions, as well as assist in the transfer of residents to different rooms. 7. Put resident's clothing away properly. 8. Report any changes in resident's condition &ndash; e.g. eating habits, behavior, temperature, etc. to the charge nurse of the unit. 9. Turn bedridden residents every two hours or sooner as indicated. 10. Wash, clean and dry all incontinent residents. 11. Assist the treatment nurse as assigned. 12. Complete assignment report to charge nurse at the end of each shift. 13. Be responsible for well-being and nursing care of all residents assigned to his/her unit while on duty. 14. Take vital signs and monthly weights (with assistance) and record results in EMR. 15. Document the following in the EMR for all assigned residents: a. vital signs, b. weight, c. meal intake, d. bowel and bladder, e. restorative records. 16. Detect and report situations that have a high probability of causing accidents or injuries to residents and/or staff. 17. Assure that work/assignment areas are clean and free of hazardous conditions i.e. spills, excess cart, etc. and that equipment, tools, supplies, etc. are properly stored while working, as well las before leaving such areas for breaks, mealtimes and end of the workday. 18. Assure that established infection control and universal precaution practices are maintained when performing nursing procedures. 19. Follow established safety precautions when performing tasks and when using equipment and supplies. 20. Assure that equipment is cleaned and prepared for the next shift. 21. Assure that work schedules are followed. 22. Maintain the confidentiality of resident information and honor his/her personal and property rights. 23. Attend nursing department, care plan and other meetings as directed by the Director of Nursing or Assistant Director of Nursing. 24. Attend and participate in in-service educational classes and on-the-job training programs as scheduled or as directed. 25. Turn in days off and payroll special request forms in a timely manner. 26. Follow established fire, disaster, safety, infection control and evacuation policies and procedures. 27. Perform other related duties as directed by the DON, ADON, charge nurse or the administrator. V21's (Wound Care Nurse) 12/09/2025 signed Treatment Nurse Job Description was reviewed. It (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	states that the primary purpose of your job position is to provide primarily skin care to residents under the medical direction and supervision of the residents' attending physicians, the Director of Nursing Services or the medical Director of the facility, with an emphasis on treatment and therapy of skin disorders. You will also assist in modifying the treatment regimen to meet the physical and psychosocial needs of the resident, in accordance with established medical practices and the requirements of this state and the policies and goals of this facility. Duties and responsibilities include 1. Confer with the Director of Nursing Services and/or other licensed nursing personnel regarding dermatologic disorders of residents in the facility. 5. Perform administrative duties such as completing medical forms, reports, evaluations, studies, charting, etc. 7. Make written and oral reports/recommendations to the attending physician, Medical Director or the Director of Nursing concerning the status of are of the residents. Under Personnel Functions, the treatment nurse duties and responsibilities include 2. Meet with and solicit advise from the Medical Director, Director of Nursing Services and nursing staff concerning the dermatologic care of residents. Under Medical Care Functions, duties and responsibilities include 1. Identify, manage and treat specific skin disorders and primary and secondary lesions, such as skin abrasions, foot problems such as corns and callouses, decubitus ulcers, bacterial, parasites and viral skin infections, scaling papular diseases, and benign tumors. 2. Provide assessment and diagnostic services to residents. Perform an assessment evaluation using techniques including observation, inspection and palpation. 6. Ensure that residents with decubitus ulcers receive appropriate prophylaxis and treatment, such as daily inspection, turning and activity, a well-planned diet, and maintaining a clean, dry bed.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure two licensed personnel conducted a physical inventory of controlled substances at each change of shift on the first floor and failed to ensure the narcotic count was correct for two residents on the second floor. These failures have the potential to affect nine residents (R24, R31, R60, R63, R102, R18, R148, R185, and R221) receiving controlled substances on the first floor and two residents (R151 and R163) receiving controlled substances on the second floor reviewed for medication administration in a sample of 63 residents. Findings include: On 2/4/26 at 11:01am, during observation of the second floor's controlled substances inventory with V17 (Licensed Practical Nurse/LPN). Surveyor observed R151's Controlled Drug Receipt/Record/Disposition Form for Buoren/Nalox Film 8 - 2mg which indicated a remaining count of 4 films; however, the actual count revealed 3 films. V17 stated, Oh, I haven't signed the one I gave this morning. V17 affirmed that the medication should be signed immediately after giving the medication. Also observed R163's Controlled Drug Receipt/Record/Disposition Form for Lacosamide 200mg tab indicated a remaining count 4 tablets; however, the actual count revealed 3 films. V17 stated, Yeah, again, I didn't sign out the ones from the morning after I gave them. Record review of facility document, untitled, undated, documents, in part, that there are 9 residents (R24, R31, R60, R63, R102, R18, R148, R185, and R221) receiving controlled substances on the first floor for the medication cart observed by surveyor. On 2/4/26 at 11:17am, during observation of the first floor's controlled substances inventory with V18 (Registered Nurse/RN), surveyor observed the Controlled Substances Check Form with the following: 2/4/26: The signature for the ongoing nurse was missing for AM (morning) shift.1/30/26: The signature for the off going nurse was missing for PM (evening) shift.1/30/26: The signature for the ongoing nurse was missing for AM shift.1/21/26: The signature for the off going nurse was missing for PM shift.1/20/26: The signature for the off going nurse was missing Night shift.1/20/26: The signature for the ongoing nurse was missing for PM shift.1/19/26: The signature for the off going nurse was missing for Night shift.1/19/26: The signature for the ongoing nurse was missing for PM shift.1/16/26: The signature for the off going nurse was missing for Night shift.1/16/26: The signature for the ongoing nurse was missing for PM shift.1/14/26: The signature for the off going nurse was missing for Night shift.1/11/26: The signature for the off going nurse was missing for Night shift.1/11/26: The signature for the off going nurse was missing for AM shift. On 2/4/26 at 11:17am, V18 (Registered Nurse/RN), said, I still need to sign off this morning. Yes, I did the count with the night nurse. I'm not sure why I didn't sign off. Yes, the controlled substance shift count should be signed off right away. On 2/5/26 at 4:21pm, V2 (Director of Nursing/DON) said, Narcotic (controlled substances) counts have 2 nurses perform a narcotic count on and off duty every shift. The reason the count is done is because if you come up short, you need to explain why the count is off. It's (controlled substance count) also done for safety all away around. Checks and balances per law under your license. Record review of facility policy titled, Policy and Procedure Controlled Medication, dated 1/2025, documents, in part, 3. Narcotic medication that is administered should be signed out on the individual narcotic sign out record and medication administration record (MAR). 4. The individual narcotic-controlled medication sign-out record should include the date and time given, dosage, signature of the nurse administering the medication, and the number of remaining medications. 6. Two nurses must count narcotics at the beginning and end of each shift, initialing the narcotic count record. The two nurses counting should be the incoming and outgoing nurses. 7. If there is a discrepancy in the narcotic count, the DON/designee should be (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notified immediately. If the DON/designee cannot reconcile the count, the administrator is notified. Record review of facility's Controlled Substances Check Form, undated, documents, in part, Irregularities must be reported immediately to the Director of Nurses. Record review of facility policy titled, Policy and Procedure Medication Storage, dated 1/25, documents, in part, Narcotics should be maintained in the medication cart and counted daily or destroyed if permanently discharged .		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to have a five percent (5%) or lower medication error rate. There were five medication errors out of 26 medication opportunities, resulting in a 19.23% medication error rate and affected four of four residents (R40, R95, R171, and R179) observed for medication pass. Findings include: On 2/05/26 at 8:55am, the following was observed while V20 (Registered Nurse/RN) passed medications: R40 was not administered Cholecalciferol 1000 Units (omission error). R40 requested a stool softener and was administered Docusate 100mg (unauthorized medication). Record review of R40's MAR (medication administration record) documents an order for Cholecalciferol Tablet 1000 unit Give 1 tablet by mouth one time a day for low Vit D due 8:00am, and lacks an order for Docusate 100mg. R95 was not administered Procardia XL 60mg (omission error). Record review of R95's MAR (medication administration record) documents an order for Procardia XL Oral Tablet ExtendedRelease 24 Hour 60 MG (Nifedipine) Give 1 tablet by mouth one time a day due 8:00am. R171 was not administered Docusate 100mg (omission error). Record review of R171's MAR (medication administration record) documents an order for Docusate Sodium Oral Capsule 100 MG (Docusate Sodium): Give 100 mg by mouth two times day due for 8:00am. R179 was prepared to receive a dose of Levetiracetam that exceeded the prescribed order (inaccurate dose). V20 was observed, holding a medication cup in the air, pouring 10 ml of Levetiracetam in a medication cup for R179. Review of R179's Medication Administration Record (MAR) indicated an order for Levetiracetam 5 ml by mouth twice daily for unspecified convulsions. Prior to administration, the surveyor questioned the 10 ml dosage prepared for administration. Surveyor requested V20 to put R179's medication cup with Levetiracetam on a flat surface to ensure the dosage was accurate. In response, V20 put R179's medication cup with Levetiracetam on the medication cart (flat surface) and verified that 10 ml of Levetiracetam was in the medication cup. V20 obtained an oral syringe, withdrew 5 mL of Levetiracetam from the medication cup, and returned the remaining 5 mL to R179's Levetiracetam bottle. Record review of R40, R95, R171, and R179's MAR showed the following: As of 2/05/2026 at 10:26am, R40's 8:00am dose of Cholecalciferol, was not signed out as given or refused by V20 (Registered Nurse/RN). As of 2/05/2026 at 10:24am, R95's 8:00am dose of Procardia XL was not signed out as given or refused by V20 (Registered Nurse/RN). As of 2/05/2026 at 10:15am, R171's 8:00am dose of Docusate was not signed out as given or refused by V20 (Registered Nurse/RN). As of 2/05/2026 at 10:30am, R179's 8:00am dose of Levetiracetam was not signed out as given or refused by V20 (Registered Nurse/RN). On 2/5/26 at 4:21pm, V2 (Director of Nursing/DON) said, Double dose of Levetiracetam potentially could cause a person that has a seizure disorder to have a seizure or adverse reaction. Yes, medications should be given per physician's order. Yes, after a medication is given, the medication should be signed off immediately after the medication is given. If a medication is held for whatever reason, the medication also needs to be documented as not given right away. Record review of facility policy titled, Policy and Procedure Medication Administration, dated 1/2025, documents, in part, To ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations. Medications shall be administered in physician's written/verbal orders upon verification of the right medication, dose, route, time and positive verification of the resident's identity when no contraindications are identified, and the medication is labeled according to accepted standards. The individual administering the medication shall initial the resident's Medication Administration Record (MAR) on the appropriate line and date for that specific day after administering the medication. 9. Should a drug be withheld, refused, or given other than at the scheduled time, the individual (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administering the medication shall initial and circle the MAR space provided for that particular drug and document a rationale. 10. If it is discovered, the person administering medications has forgotten to initial in the appropriate space, the supervisor shall notify that person to investigate if the medication/treatment has been administered/performed. If the response indicates the medication/treatment was administered the staff member shall return to the facility, initial the MAR. A late entry note will be documented indicating the administration of the medication. If the medication was not administered the missed dose/medication error protocol shall be followed. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. You should receive the services and/or items included in the plan of care.		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the opened container of the multi blood glucose test strips was labeled with the open date. These failures have the potential to affect six residents (R27, R63, R115, R122, R185, and R221) who received blood glucose monitoring tests residing on the first floor and reviewed for laboratory storage in the sample of 63 residents. Findings include: On [DATE] at 11:17am, with V18 (Registered Nurse/RN) during the observation of medication storage, an opened container of the multi blood glucose test strips with no open date labeled was observed in the medication cart on the first floor. The label on the container of multi blood glucose test strips states open date with a blank place to write the open date on the container. This observation was pointed out to V18. V18 stated, It's (open date) not on there. Let me check because it (open date) might be somewhere else on the bottle. Well, it's (open date) not on here (opened container of the multi blood glucose test strips). The strips expire after a certain number of days once the bottle is opened. Ummm. I'm not sure how long after the container is opened that the strips expire. I think like 30 or 60 days or something. I can check though. If the glucose strips are expired, they (glucose strips) might not work. Yes, possibly give a wrong result too. On [DATE] at 4:21pm, V2 (Director of Nursing) said, Yes, glucometer strips, once you open the bottle expire sooner. I'm not exactly sure how long after it's (glucometer strips container) opened, maybe 30 days expiration. Yes, the glucometer strips have to be labeled once they (glucometer strips container) have been opened. Nothing should be given or used if it is expired. Record review of facility presented document title, (Name of Facility) Blood Sugar Entry, dated [DATE], lists the six (R27, R63, R115, R122, R185, and R221) residents who receive blood glucose monitoring tests on the first floor. Record review of manufacturing manual inside the container of multi blood glucose test strips title (Blood Glucose Monitoring) Test Strips, undated, documents, in part, When you first open the vial, write the date on the vial label. Use the test strips within 3 months of first opening the vial. Do not use test strips beyond the expiration date. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. You should receive the services and/or items included in the plan of care.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident's indwelling urinary catheter drainage bag was covered with a privacy bag to maintain resident's right to privacy and dignity. This failure affected one resident (R19) of two residents, reviewed for privacy and dignity, in a total sample of 63 residents. Findings include: R19 was admitted to the facility on [DATE] with diagnoses which include but are not limited to Chronic Kidney Disease, Retention of Urine, Dementia, Acquired Absence of Kidney, Acute Kidney Failure, Bladder Neck Obstruction, Malignant Neoplasm of Kidney, And Benign Prostatic Hyperplasia. Physician order sheet POS dated 11/18/25 and 11/20/25 both show that R19 has physician order for indwelling urinary catheter. On 2/2/26 at 11:30am, R19 was observed in bed with indwelling urinary catheter drainage bag with yellow urine, hanging at the side of the bed visible to people walking down the hallway, and without privacy bag. Again at 12:45pm, the urinary drainage bag was still in the same position, visible to anyone walking down the hall. At this time, V13 (Certified Nursing Assistant/CNA) was notified. V13 stated she would let the nurse know. On 2/5/26 at 11:55am, V3 (Assistant Director of Nursing) was notified and V3 stated that there should be a privacy bag covering the drainage bag for the resident's privacy. V3 later informed the surveyor that staff members were given in-service training regarding the general care of indwelling urinary catheter. V3 later presented a document In-Service Record dated 2/5/26, with signatures of nursing staff members. This document states in part: Ensure Catheter bag is placed in a privacy bag. R19's care plan dated 5/22/25 states that R19 has an indwelling urinary catheter and Resident at higher risk for infection secondary to presence of catheter and candida auris to left axilla. Facility's policy on Dignity dated 01/15 and latest revision on 1/25 states: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Purpose- To establish guidelines in protecting their residents' rights to be treated with dignity and respect. #11: Examples of promoting dignity and respect include but are not limited to (a): Using privacy coverings for urinary catheter bags. Record review of a document titled, RESIDENTS' RIGHTS For People In Long-Term Care facilities, with latest revision date 11/18, documents, in part, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. You should receive the services and/or items included in the plan of care.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview and record review, the facility failed to follow their policy by failing to obtain informed consent for increasing dosage of psychotropic medication and failed to document symptom/behaviors for the use of the medication or any non-pharmacological behavioral interventions attempted prior to increasing the dosage of the medication. This failure affected one (R161) of five residents reviewed in a sample of 65. Findings include: R161 has resided at the facility since 2014. Medical history includes, but is not limited to major depressive disorder, schizoaffective disorder morbid (severe) obesity due to excess calories, other iron deficiency anemias, vitamin D deficiency, etc. On 2/2/2026 at 10:30AM, R161 was in his room, alert and oriented and said that he is concerned about staff giving him a higher dose of Quetiapine (Seroquel). R161 said that he was supposed to be on 100mg of Seroquel, but staff are giving him 300 to 600mg. R161 said he did not consent to the dosage changes and have been refusing the medication. R161 thinks that staff are messing with his medication on purpose. Review of physician order showed that R161 was on Seroquel 100mg at bedtime which started on 8/1/2021 and discontinued on 11/10/2022. Resident's dosage of Seroquel had been increased as follows: 11/10/2022 Seroquel 100mg, give 1.5 tablet (total of 150mg) at bedtime. 11/17/2022 Seroquel 100mg, give 2 tablets (total of 200mg) at bedtime. 11/21/2025 Seroquel 300mg, give 1 tablet at bedtime. 12/2/2025 Seroquel 300mg, give 2 tablets (total of 600mg) at bedtime. 1/23/2026 Seroquel 200mg and 300mg (total of 500mg) at bedtime. Surveyor requested consent for the above medication increases and facility provided a consent that resident refused to sign. R161 has a guardian, there was no documentation that the guardian was informed or consented to the dose increases. Residents have an order for behavior monitoring daily on all shifts, review of behavior monitoring sheets for December 2025, January 2026 and February 2026 shows that resident does not have any behaviors. On 2/5/2026 at 1:24PM, V32 (Power of Attorney/State Guardian) said, he is the guardian for R161, he requested for the doctors to review resident's medication due to the resident is always worrying about what others are doing, constantly calling the police. V32 said he is aware that resident is on Seroquel 100mg. He wanted his medication reviewed but no one called to inform him of the increase in dosage, he did not give his consent for the dosage increases. On 2/5/2026 at 2:04PM, V3 (Assistant Director of Nursing/ADON) said, if a resident is not exhibiting any behaviors, they probably should not be on psychotropic medications. Surveyor presented behavior monitoring documentation for R161 for the months of December 2025, January and February 2026 and she said that residents do not have any behaviors. Surveyor also presented a consent for R161's psychotropic medication that documented that resident refused to sign. V3 said that this is not an acceptable consent, R161 has a guardian who comes in occasionally, the facility should have called to get a consent from the guardian for the medication dosage increases. On 2/5/2026 at 2:18PM, V33 (Psychiatrist) said, R161's medication decreased recently when he was seen a few weeks ago. V33 said that you want to respect resident's wishes, but at the same time do not want to risk compensation, they are keeping the resident on the medication to avoid trying to get him to a therapeutic dose if anything happens. V33 said, R161 appears to be doing better lately, the staff are supposed to be documenting residents' behavior as ordered, and an informed consent is needed for administering psychotropic medications and dosage increase. On 2/5/2025 at 3:32PM V31 (Licensed Practical Nurse/LPN) said, R161 wanted the Seroquel decreased but the psychiatrist team refused. V31 said, R161 does not have any behaviors that she is aware of. On 2/6/2026 at 11:05AM, V37 (Psychiatrist Nurse Practitioner) said, R161 threatened to fire V37. The resident is very manipulative, (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Chicago Ridge Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 10602 Southwest Highway Chicago Ridge, IL 60415	
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	can go from very pleasant to being delusional and accusatory. V37 has witnessed some of residents' behavior and staff are also reporting same behavior. Surveyor informed V37 that a review of behavior monitoring documentation presented by the facility shows that residents do not have any behaviors. V37 said, he is aware that most facilities are not good with their documentation, but the resident's behaviors should be documented as ordered. V37 added that he orders treatments based on what he observes and what is reported by staff, it is the duty of the staff to make sure that an informed consent is obtained for any psychotropic medication. Psychotropic medication policy revised 7/1/2025 states in part, to establish the process for monitoring the use of and the reduction of doses of psychotropic medications without compromising the resident's health and safety, ability to function appropriately, or safety of others. Policy specification 1. Psychotropic medication shall not be prescribed without the informed consent of the resident, the resident's guardian or other authorized representative. Additional informed consent is not required for reductions in dosage level or deletion of a specific medication. The informed consent may provide for a medication administration program of sequentially increased dosages or combination of medications to establish the lowest effective dose that will achieve the desired therapeutic outcome. Procedural specifications: 5. Documentation of behaviors and conditions requiring the use of these medications must be done on a routine basis including resident response to the medication.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess the restorative needs and provide a left-hand resting hand splint for one resident with hand contracture to prevent further decline. This failure affected one resident (R21) of two residents, reviewed for restorative care, in a total sample of 63 residents. Findings include: On 2/2/26 between 10:35am and 11:55am, R21 was observed in the wheelchair in the hallway with left hand wrist contracted, and the left-hand fingers were in a fist. R21 did not have a device to prevent further contractures. On 2/4/26 at 12:00pm, R21's left hand was still in the same condition. R21 was asked if staff came to encourage him to do exercise his arm and hand, but R21 stated that no one had done anything for him. On 2/4/26 at 12:35pm, V21 (Restorative Nurse) stated I'm new here. I work together with Therapy department to know what needs to be done for each resident, but I'm not aware that his hand is contracted. V21 stated the restorative nurse usually will see the resident and assess the resident to see what restorative services will benefit the resident or refer the resident for therapy. On 2/4/26 at 12:45pm, V22 (Therapy Manager) came and stated that no one told them that R21 has contracture. V22 asked R21 to open his hand and stretch the wrist, but R21 attempted it and said it was painful. V22 stated He will benefit from a left-hand resting splint. V22 stated later presented the physician order sheet dated 2/4/26 that states Apply left hand resting splint daily every morning. Remove before bedtime and assess skin with each removal. Face sheet shows that R21 was admitted to the facility on [DATE] with diagnoses which include but are not limited Obesity, Schizoaffective Disorder Bipolar Type, Low Back Pain, Presence of Right Artificial Hip Joint. Care Plan dated 2/15/24 states in part: (R21) will engage in active range of motion active range of motion (AROM) to all 4 extremities. Facility's Restorative Nursing Care Policy dated 9/14 states in part: It is the policy of this facility that a resident is given the appropriate treatment and services to maintain or improve his/her abilities, as indicated by the resident's comprehensive assessment, to achieve and maintain the highest practicable outcome. #3: The facility's restorative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence. #5: The resident care plan, the goals of restorative nursing care are reinforced in the restorative services. Facility's document Restorative Nurse Job Description states in part: #3 - Evaluate all newly admitted residents for their rehabilitation/restorative appropriateness. Review quarterly and with change of condition. #15: Consult and coordinate with the physical, occupational, and speech therapist and other adjunctive professionals each residence rehabilitation plan of care and follow up with the related staff and personnel. #22: Supervise the management of the rehabilitative/restorative equipment such as special mattresses, wheelchairs, walkers, restraints, and splints.		

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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 upon observation, interview, and record review the facility failed to follow their medication administration policy by leaving medications at the bedside and failed to ensure that residents remained free from significant medication errors for two (R158 and R179) residents reviewed for medication administration in a sample of 63 residents. Findings include: 1.) On 2/05/26 at 9:41am, during observation of medication pass with V20 (Registered Nurse/RN), V20 was observed, holding a medication cup in the air, pouring 10 ml of Levetiracetam in a medication cup for R179. Review of R179's Medication Administration Record (MAR) indicated an order for Levetiracetam 5 ml by mouth twice daily for unspecified convulsions. Prior to administration, the surveyor questioned the 10 ml dosage prepared for administration. Surveyor requested V20 to put R179's medication cup with Levetiracetam on a flat surface to ensure the dosage is accurate. In response, V20 put R179's medication cup with Levetiracetam on the medication cart (flat surface) and verified that 10 ml of Levetiracetam was in the medication cup. V20 obtained an oral syringe, withdrew 5 mL of Levetiracetam from the medication cup, and returned the remaining 5 mL to R179's Levetiracetam bottle. On 2/05/26 at 9:41am, V20 (Registered Nurse/RN) said, Oh, it looked like 5 ml. Yes, the medication cup should have been put on a flat surface. Well, the flat surface evens out the liquid so you know the actual amount the patient is getting. Thanks for catching that. R179's face sheet documents diagnoses that include but are not limited to unspecified convulsions and personal history of traumatic brain injury. R179's BIMS (brief interview for mental status) score, dated 2/04/26, is 15 which indicates R179 is cognitively intact. R179's MAR (medication administration record), start date 7/30/21, documents, in part, Levetiracetam: Give 5 ml orally two times a day related to unspecified convulsions. On 2/5/26 at 4:21pm, V2 (Director of Nursing/DON) said, Double dose of Levetiracetam potentially could cause a person that has a seizure disorder to have a seizure or adverse reaction. Yes, medications should be given per physician's order. Yes, after a medication is given, the medication should be signed off immediately after the medication is given. If a medication is held for whatever reason, the medication also needs to be documented as not given right away. 2.) R158's current diagnoses include but are not limited to Multiple Sclerosis. R158's comprehensive assessment section C Cognitive Patterns dated 12/05/2025 documents a brief interview for mental status score of 13 out of 15 indicating he is cognitively intact. On 02/02/2026 at 11:01 AM, R158 is alert and oriented while sitting in his room sitting in his motorized wheelchair. He was inquired about his concerns. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/02/2026 11:15 AM, R158 opened the top drawer of his dresser in his room and took out 2 medicine cups with 2 white round pills inside. He put the cup on the top of the dresser and said, I have this medicine in my drawer. It's 2 or 3 days old. It's all the time. The nurse comes in and sets my meds down and leaves. I know they're supposed to watch me. The meds lower my heart rate and blood pressure. Sometimes I feel weak after I take them. All the nurses have left the meds before depending on what's going on. On 02/02/2026 at 12:09 PM, V3(Assistant Director of Nursing/ADON) was asked about the medications found in R158's room. This surveyor brought V3 into R158's room and showed V3 the medication. This surveyor asked V3 to identify each pill. V3 opened R158's electronic medical record to his physician orders to verify the pills. V3 confirmed each pill with R158's medication administration record and were identified and also verified using Daily Med (U.S. National Library of Medicine; https://dailymed.nlm.nih.gov/dailymed/). R158's physician orders state in part: Tizanidine Hydrochloride 4mg give 1 tablet by mouth every 6 hours for muscle spasms dated 1/15/2026. Baclofen 10mg give 1 tablet by mouth every 6 hours for muscle relaxant/spasms dated 11/27/2025. On 02/02/2026 at 12:12 PM, V3 (ADON) said, They (nurses) can never leave it (medicine) at the bedside. Other residents can come get it (medicine) or the resident can miss his dose. Both medications are active, he (R158) gets it every 6 hours. On 02/05/2026 at 11:51 AM, V2 (Director of Nursing) was asked about nursing staff leaving medications at the bedside during medication administration. V2 said, The nurse should ID (identify) the resident, follow the five rights of medication administration, then administer the medicine at the right time per the order and watch the resident take it, then document it. If the nurse doesn't watch the resident it (medication) might not be taken at the right time, taken by the wrong person or not taken at all. The facility policy titled, Policy and Procedure Medication Administration, dated 1/2025, documents, in part, To ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations. Medications shall be administered in physician's written/verbal orders upon verification of the right medication, dose, route, time and positive verification of the resident's identity when no contraindications are identified, and the medication is labeled according to accepted standards. The individual administering the medication shall initial the resident's Medication Administration Record (MAR) on the appropriate line and date for that specific day after administering the medication. 9. Should a drug be withheld, refused, or given other than at the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that particular drug and document a rationale. 10. If it is discovered, the person administering medications has forgotten to initial in the appropriate space, the supervisor shall notify that person to investigate if the medication/treatment has been administered/performed. If the response indicates the medication/treatment was administered the staff member shall return to the facility, initial the MAR. A late entry note will be documented indicating the administration of the medication. If the medication was not administered the missed dose/medication error protocol shall be followed. (continued on next page)		

Department of Health & Human Services
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. You should receive the services and/or items included in the plan of care.		

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F 0778 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident make transportation arrangements to and from radiology services. Based on observation, interview, and record review, the facility failed to assist a dependent resident with making transportation arrangements to scheduled appointments, failed to notify physician about missed appointments and failed to re-schedule the appointments. This failure affected one (R179) of 4 residents reviewed in a sample of 63. Findings include: On 02/02/2026 at 11:10AM, R179 was observed in bed, awake and alert, stated that he was supposed to go for an MRI appointment today but did not because the facility does not have anyone to go with him. R179 said that this appointment was supposed to be in November, but it was also cancelled and rescheduled. Resident stated that he is frustrated about missing his appointments. Face sheet the following past medical history for R179: personal history of traumatic brain injury, unspecified convulsion, obstructive and reflux uropathy, disease of gall bladder, bipolar disorder, etc. A list of scheduled appointments for R179 presented by V2 (Director of Nursing/DON) showed an appointment for January 22 at 4:30PM, an MRI scheduled for February 2, 2026, at 10:00AM, and an appointment with Neurosurgery scheduled for February 13 at 1:00PM among others. On 2/4/2026 at 3:10PM, V2 (DON) said, R179 gave her the list of his appointments. The person who was scheduling appointments for residents abruptly quit her job; the responsibility then fell on her and the Assistant Director of Nursing. V2 said that she thought that the veteran clinic arranges for their own transportation. V2 added that R179 missed his January appointment due to transportation and missed the one for February. V2 presented email communication between her and the veteran affairs dated January 21, 2026, and according to the communication, V2 was directed to contact a non-VA facility with a contact number because R179 is not under VA contract, but the arrangement was not made. V2 added that the scheduler is supposed to document it in medical records and notify the physician, as well as reschedule the appointment when residents miss their appointments. V2 is not sure if resident's appointments have been rescheduled. On 2/4/2026 at 12:12PM, V16 (Scheduler) said that she gets appointment information from the residents or nurses, she then schedules the appointment and arranges for transportation. V16 said that R179 had an appointment on Monday (2/2/2026) but he did not go because the transportation people did not show up. V16 said that she just started in this role, the transportation company they are using now has been cancelling a lot, she is in the process of making transportation arrangements with a different company. Review of resident's record did not show any documentation of the missed appointments; no record of resident's physician being notified or that the appointments were rescheduled. Surveyor requested a facility policy on assisting residents with transportation to source of service, but none was provided.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain consistent hospice communication for one (R16) of two residents reviewed for hospice care in the sample of 63 residents. Findings include: R16's current diagnoses include but are not limited to End Stage Renal Disease, Chronic Kidney Disease, Type 2 Diabetes Mellitus, Hypertension, Osteomyelitis, Sacral Region Stage 4 Pressure Injury to the Coccyx, and Palliative Care. R16's comprehensive assessment section C Cognitive Patterns dated 01/14/2026 documents a brief interview for mental status score of 8 out of 15 indicating he has moderate cognitive impairment. On 2/04/2026 at 11:07 AM, upon entrance to the room R16 is lying in bed. R16 was asked what hospice facility he is working with or when hospice sees him. R16 was not able to answer. On 02/04/2026 at 11:40 AM, V25 (Wound Care Certified Nursing Assistant/CNA) and V21 (Wound Care Licensed Practical Nurse/LPN) were inquired of R16's hospice care/staff. V21 said, I'm not sure what hospice he's on. V25 CNA said, I've seen the hospice nurse come but I don't know which one (hospice) he's on. On 02/04/2026 at 12:24 PM, V17 (LPN) was asked about R16's hospice nurse and his hospice binder was requested. V17 stated that she was unable to locate the binder. V17 called the hospice agency twice and stated that the hospice agency had R16's binder. V17 stated that there is no documentation of R16's hospice care at the facility at this time. On 02/04/2026 at 1:00 PM, V2 (Director of Nursing/DON) and V3 (Assistant Director of Nursing/ADON) were inquired of R16's hospice communication while at the nurse's station. V2 and V3 were unable to find any hospice communication for R16 at the nurse's station. On 02/04/2026 at 3:15 PM, V3 presented a hospice binder for R16. The documents in the hospice binder were dated 2/04/2026 and timed at 2:48 PM. The admission note documents a visit frequency which states in part: Week of 12/31/25 - 01/06/26- nurse visits = 2. No other visits scheduled for other disciplines (hospice aide, social worker, chaplain). Week of 02/04/26- 02/10/26 nurse visits = 1. No other visits scheduled for other disciplines. R16's physician orders document resident admitted under hospice with Dx (diagnosis) End Stage Renal Disease. R16's care plan dated 01/07/2025 states in part: I present with a terminal diagnosis related to End Stage Renal Disease. Interventions: Collaborate with the hospice team to integrate services provided by the facility and hospice. On 02/05/2026 at 1:51 PM, V28 (Hospice Nurse) was inquired of ensuring there is written hospice communication for the facility staff. V28 said, He (R16) was admitted to hospice on January 6th for end stage renal disease. There was an admission nurse that set him up. I see him twice a week. The first time I saw him was on January 7th. The hospice aide should be seeing him twice a week too. I communicate verbally with the staff. There should be a folder, but I haven't seen it. There should be a sign in sheet when we see him and a place to chart to give staff a quick refresher of what happened during my visits. I would be responsible for the folder being there with the other disciplines, social worker, and chaplain. I never noticed he did not have a folder. The admission nurse should have set that up. It is for communicating with the staff and hospice. On 02/05/2026 at 2:43 PM, V2 (DON) was inquired of ensuring there is written hospice communication for the facility staff. V2 said, V3 and I would be responsible for making sure it was here. There is no sign in documentation of R16 receiving hospice visits from the nurse, aide, social worker, or chaplain from the date of admission on [DATE] to 02/05/2026. There is no written documentation of hospice communicating R16's condition after each visit with the nursing facility staff. The Hospice Policy revised on 1/25 was reviewed. It states in part that it is the policy of the facility to honor the advanced directives and care preferences (continued on next page)		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents may desire when terminally ill and to provide care that ensures dignity and comfort during the end stages of life. The facility will provide hospice services either directly or through arrangements with a qualified service provider. The purpose of the policy is to ensure that appropriate hospice services are available to residents and families and to outline the responsibilities of hospice service providers as well as facility staff. 4. Hospice service professionals and staff will adhere to all facility policies and procedures related to resident's rights, resident care, safety and infection control when in the facility. 5. Hospice service providers will conduct assessments and develop a hospice plan of care, which will be integrated with the resident's overall plan of care and maintained in the medical record or interdisciplinary care plan. 6. Hospice service staff will attend care plan conferences and participate in the resident care planning process as appropriate. 9. Pain and symptom management will prioritize the least invasive routes to minimize discomfort unless other routes are contraindicated or ineffective.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to follow their infection control and hospice services policy ensuring hospice service professionals adhered to all facility policies and procedures related to infection control when in the facility by failing to adhere to the enhanced barrier precautions designation by failing to use a gown during high contact resident care while changing a resident's incontinent brief for one (R3) resident, and failed to transport/handle linen in a manner that prevents contamination. Findings include: 1.) R3's current diagnoses include but are not limited to Cerebral Palsy, Dementia, Unstageable Pressure Injury to the Right Buttock, and Type 2 Diabetes Mellitus. R3's comprehensive assessment section C Cognitive Patterns dated 12/24/2025 documents a brief interview for mental status score of 3 out of 15 indicating she has severe cognitive impairment. On 02/02/2026 at 12:31PM, the entrance to R3's room has an enhanced barrier precautions sign with instructions on what PPE (personal protective equipment) is needed according to the care to be provided. There is a PPE bin with gowns, gloves and face masks at the door. There is a hand sanitizer container on the wall near the room. Upon entrance to the room R3 is lying down in bed awake and alert. R3 was asked how she was feeling. R3 said, I feel tired. R3 is lying on a low air loss mattress. She had an indwelling urinary catheter draining dark amber urine with sediment noted. On 02/02/2026 at 12:39PM, V11 (Hospice Nurse) entered R3's room and stated she was the hospice nurse. V11 was inquired of R3's care. V11 said, I see her once a week. The aide and the musician come once a week. She was treated for a urine infection, and she has a right hip wound that's unstageable. She has a catheter because of her wound and a low air loss mattress. V11 turned R3 in bed and saw she was soiled. V11 said, I'm going to get you cleaned up R3, you pooped. At 12:44 PM, V11 took a pair of gloves from the PPE bin at R3 door and put the gloves on without performing hand hygiene or washing her hands. A facility CNA brought in towels and a gown to the room for R3. V11 filled a wash basin with water and soap and brought it to R3's bedside. V11 removed R3's incontinent brief and began to provide perineal care. R3 has a wound dressing to the right buttock. On 02/02/2026 at 12:46 PM, V11 (Hospice Nurse) was inquired of R3 being on transmission-based precautions- EBP (Enhanced Barrier Precautions) and what PPE (personal protective equipment) should be worn during high contact care. R3 said, What do you mean about enhanced barrier precautions. She doesn't have any infection when it comes to transmission, I just wear gloves. V11 proceeded to continue with R3's perineal care and did not put on an isolation gown during this high contact care. On 02/05/2026 at 11:48 AM, V2 (Director of Nursing/DON) was inquired of hospice staff following infection control practice and procedures regarding enhanced barrier precautions. V2 said, Education (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Chicago Ridge Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 10602 Southwest Highway Chicago Ridge, IL 60415	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for the vendors by the IP (Infection Prevention Nurse). The hospice nurse should follow the isolation procedures and don and doff (put on and take off) PPE (personal protective equipment) as required. R3's physician orders state in part admit to hospice 09/05/2024 related to CVA (Cerebrovascular Accident). Foley catheter insertion for wound prevention 12/15/2025. Enhanced Barrier Precautions related to wounds and foley catheter every shift for infection control PPE (personal protective equipment) must be worn during direct care 12/19/2025. R3's 01/27/2026 wound documentation by V30 (Nurse Practitioner) states in part: Objective: Buttock and Groin: 1. Unstageable pressure injury to right buttock. Reopened. Measures 3.6 x 2.5 x 0 cm (centimeters). Wound is 65% granular tissue, 35% necrotic (dead non-viable) tissue. 2.) On 2/2/2026 at 12:55 PM, observed soiled linen room with V38 (Housekeeping Manager). V38 opened the door to the linen chute and visibly soiled washcloths, shirts, clothing and linen fell into the soiled linen bin. V38 confirmed the observation and stated, the CNA's (certified nursing assistants) should be bagging the linen before they send it down the chute. It should not be loose and not in a bag like this. V38 explained that soiled linen is bagged by the CNA, labeled with the resident's information, and sent down the chute, where it is then sorted and transferred into the washers. On 2/2/2026 at 1:07 PM, observed the laundry room with V38 (Housekeeping Manager). Observed an open bag of chips in the area where the clean linen was folded, chemical (bleach/detergent) barrels connected to the washers on the floor of the laundry room, and dirt/dust around the floors of the clean linen area/shelving area. V38 stated that the floors are supposed to be swept and mopped daily. Observed a bottle of purple fabric detergent on top of the washers that was not the same brand as the facility's bulk detergent. V38 stated, it (the facility's detergent) just doesn't get the clothes clean enough, especially when there is (faces) in the linen. So, I go to (the store) and purchase my own for when the clothes and stuff are real bad. We only have two settings on the washer, one is for detergent, one is for bleach. We don't have other options if it is real badly soiled. V38 was unsure if the store-bought detergent and the facility's bulk detergent were able to be mixed together. On 2/5/2026 at 11:55 AM, V4 (Infection Preventionist, Licensed Practical Nurse) affirmed that soiled linen must be bagged when using the laundry chute to prevent contamination of the chute. The Hospice Policy revised on 1/25 was reviewed. It states in part that it is the policy of the facility to honor the advanced directives and care preferences residents may desire when terminally ill and to provide care that ensures dignity and comfort during the end stages of life. The facility will provide hospice services either directly or through arrangements with a qualified service provider. The purpose of the policy is to ensure that appropriate hospice services are available to residents and families and to outline the responsibilities of hospice service providers as well as facility staff. 4. Hospice service professionals and staff will adhere to all facility policies and procedures related to resident's rights, resident care, safety and infection control when in the facility. The policy titled Enhanced Barrier Precautions was reviewed. The revised 4/28/2025 policy states in part that the purpose of this policy is to reduce the transmission of novel or targeted multi-drug-resistant organisms (MDRO). The procedure includes 1. Enhanced Barrier Precautions (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(EBP) require the use of gown and glove during high contact resident activities. High-contact resident care activities include: dressing, bathing/showering, transferring, providing hygiene (e.g. brushing teeth, combing hair, shaving), changing linens, changing briefs or assisting with toileting, device care or use of an indwelling medical device, such as urinary catheter, feeding tube, central line (e.g. hemodialysis catheter, PICC line), tracheostomy or ventilator, wound care: any skin opening requiring a dressing (focusing on wound at high risk or acquiring an MDRO, such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic wounds such as chronic venous stasis ulcers. Consideration is taken related to the length of time of resident contact and bundled tasks. Individual tasks may not require EBP. Note: Gown and gloves are the minimum level of PPE. Additional PPE may be required depending on the situation/resident (e.g. face shield may be used when splashes and sprays are likely to occur). 7. Adhere to other infection control practices such as hand hygiene, cleaning and disinfection of environmental surfaces and equipment care. The Infection Control policy issued on 1/2024 was reviewed. The policy of the facility is to maintain an infection control program designed to provide a safe, sanitary and comfortable environment, and to prevent or eliminate, when possible, the development and transmission of disease and infection. The purpose of the policy is to establish methods and criteria, necessary with facility and its operation, to prevent and control infections and communicable diseases. Procedure number 14. All facility personnel are required to routinely wash hands and use appropriate barrier precautions to prevent transmission of infection. 15. All facility personnel shall adhere to the infection Control Program in the performance of their daily assignments. Facility policy titled, Linen and Laundry Handling for the Laundry Dept (10/2014) documents in part, Purpose: To ensure proper handling of soiled and clean linen and personal laundry to prevent the spread of microorganisms. Standards: 1. The laundry department should be designed so that there is a flow of functions that prevents contamination of clean linen. 2. Chemical barrels and other supplies are stored on skids to aid floor care. Work surfaces should be cleaned daily, including sinks, lint traps, and washer dryer surfaces by laundry personnel. 4. Soiled linens shall be placed in plastic bags by nursing personnel. 10. Heavily soiled linens shall be pre-treated prior to washing. 14. Cleaning agents and detergents shall be of sufficient strength to assure linens and laundry items are free of microorganisms.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to post nursing staffing information in a highly visible area for residents and failed to include required information. These findings have the potential to affect all 199 residents that reside within the facility. Findings include: Facility census (2/2/2026) documents that 199 residents reside in the facility. On 2/4/2026 at 1:42 PM, observed the door to the foyer from the first-floor unit (resident areas) locked and required to be unlocked by the receptionist. On 2/4/2026 at 1:45 PM, the facility daily staffing posting was observed taped to the windows located at the front desk in the facility's foyer area. Facility daily staffing posting (2/4/2026) did not document the total number of hours worked and actual number of hours worked for registered nurses, licensed practical nurses and certified nursing assistants. On 2/4/2026 at 1:46 PM, V16 (Scheduler) affirmed that V16 is responsible for completing the daily staffing posting. V16 reviewed the staffing posting (2/4/2026) and affirmed that the number of total and actual hours for registered nurses, licensed practical nurses, and certified nursing assistants were not on the staffing posting. V16 was unsure if having total hours and actual hours worked on the posting was a regulatory requirement and explained that V16 had recently started in the role and would check. On 2/4/2026 at 1:49 PM, V1 (Administrator) affirmed that the foyer is locked and residents cannot get into the foyer area without ringing the buzzer. V1 affirmed that residents could not freely enter the foyer area (where the posting is located). On 2/4/2026 at 1:34 PM, V1 affirmed that there is no facility policy for the daily staffing posting. No policy was provided prior to the exit of the survey.		

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to ensure that the outside dumpster garbage disposal was covered with lid and failed to ensure that the floor around the dumpsters were free of trash, thus creating an unsanitary environment. These failures have the potential to cause harboring of rodents which can affect all 199 residents in the facility. Findings include: On 2/2/26 after the entrance conference, V1(Administrator) presented the facility census as 199. On 2/2/26 at 10:25am, after kitchen observation with V7(Dietary Manager), the outside dumpster was observed to be open without lids, with bags of trash and spilled trash on the floor around the dumpster. V7 stated that this dumpster was for the oil, and she (V7) was not sure if there was a lid for this oil dumpster. V7 asked V12(cook) and V12 stated there is lid to cover the oil dumpster. On 2/5/26 at 10:20am, the surveyor observed one of the dumpsters without covers and with trash on the floor around the dumpster. V7 stated that she (V7) would send the dietary aide to go and cover the dumpster. V7 added that maybe the housekeeping staff left the dumpster open. V7 stated that leaving dumpsters open could cause rodents to come around the building. Facility's policy titled Waste Management dated 5/14 states: Purpose - Prevent the spread of infection. #5: Maintenance and housekeeping personnel shall ensure the dumpster area is kept clean and all trash bags are inside the dumpster, and dumpster lids are closed. #7 states: Dumpsters will be emptied by a contract trash removal service on a regular basis in sufficient frequency to minimize odors and rodents/insects harborage.		

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to ensure direct care staff were involved in the completion of the facility assessment, failed to consider staffing needs by shift and resident unit. This failure has the potential to affect all 199 residents that reside within the facility. Findings include: Facility census (2/2/2026) documents in part that 199 residents reside within the facility. Facility assessment (reviewed 6/27/25) indicates that the Administrator, Director of Nursing, governing body, and Medical Director were involved in the completion of the facility assessment. There is no indication that direct care staff were involved in the completion of the facility assessment. The staffing plan of the facility assessment documents in part that 14-16 licensed nurses are needed, 18-22 nurse's aides are needed, as well as other management, social services, food and nutrition staff. There is no identification of staffing needs based on shift and unit within the facility assessment. Record review of the facility assessment review signature form (undated) lists V1's (Administrator) signature, the Medical Director's signature, the former Director of Nursing's signature. On 2/4/2025 at 1:57 PM, V1 affirmed that V1 was involved in the development of the facility assessment. V1 explained the purpose of the facility assessment is to govern the facility, identify types of residents it takes, categories the facility can service and to make sure we have appropriate staffing/systems in place to provide care to residents. V1 stated that the facility assessment is updated once per year and as needed. V1 reviewed the facility assessment and affirmed that there was no documentation that direct care staff were involved in the development of the facility assessment. V1 denied that involving residents, their families and direct care staff was a regulatory requirement. V1 reviewed the facility assessment again and affirmed that the facility assessment does not have staffing needs identified by shift and by unit. V1 affirmed that the facility assessment has total staff needs but is not broken down by unit or shift. V1 affirmed that identifying resident staffing needs per shift and per unit is a regulatory requirement. V1 explained that V1 believed this was an old facility assessment and that there had been another facility assessment reviewed and updated that V1 would provide to the survey team. V1 reviewed the Facility Assessment Review Signature Form (undated) and affirmed that the representative of the governing body's signature was blank. V1 stated that V1's regional participated in the development, but must have forgot to sign. On 2/5/2025 at 10:38 AM, V1 affirmed that V1 found the current, most updated, facility assessment and would provide the assessment to the survey team. No further facility assessment was provided prior to the exit of the survey. Facility policy titled, Facility Assessment Policy (1/2025) documents in part, Purpose To provide guidance regarding the completion of the Facility Assessment, as part of the Medicare and Medicaid program requirements. Procedure 1. The facility must conduct a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The policy does not document the requirements for direct care staff to be involved in the development of the facility assessment and does not document the requirement that staffing needs must be considered for each unit and shift.		