STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001697	A. BUILDING: _____ B. WING _____	C 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHICAGO RIDGE SNF	10602 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2594775/IL193307, 2594887/IL193479	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1010b) 300.1210b) Section 300.1010 Medical Care Policies b) The facility shall have and follow a written program of medical services which sets forth the following: the philosophy of care and policies and procedures to implement it; the structure and function of the medical advisory committee, if the facility has one; the health services provided; arrangements for transfer when medically indicated; and procedures for securing the cooperation of residents' personal physicians. The medical program shall be approved in writing by the advisory physician or the medical advisory committee. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. This REQUIREMENT is not met as evidenced by:	S9999		

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S9999	Continued From page 1	S9999		

Based on interview and record review, the facility failed to follow their stated protocol for signing residents out on community pass by not verifying the identity of the individual who "signed" out a resident (R11). The facility did not have an effective supervised community pass protocol in place. This failure applied to one (R11) of two residents reviewed for community pass and resulted in R11 leaving the facility on pass on 4/30/2025 and not returning. R11 has a significant history of substance abuse disorders and R11's whereabouts are currently unknown.

Findings include:

R11 is a 32-year-old female who originally admitted to the facility on 4/8/2025. R11 has multiple diagnoses including but not limited to the following: multiple orbital fractures, nasal bone fracture, psychoactive substance abuse, opioid dependence, and alcohol abuse.

R11's BIMS (Brief Interview for Mental Status) Score is 15.

Community Survival Skills Assessment dated 4/15/2025 shows that R11 is not capable of unsupervised outside pass privileges at this time. R11's care plan states in part but not limited to the following: Interventions: A community survival skills assessment will be conducted to reasonably determine the person's ability to safely and respectfully negotiate within the outside community.

Progress note dated 4/29/2025 states in part that V21 (R11's Friend) will be taking R11 on a day

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S9999	Continued From page 2 pass on 4/30/2025 from 5PM-7PM. Pass Request Form states in part but not limited to the following: Pass to begin on 4/30/2025 at 5PM and end on 4/30/2025 at 7PM and accompanied by V21. It is to be noted that the ID scanned and attached to the community pass is not the same name/person listed on the Community Pass Request Form (V21). On 6/3/2025 at 9:40AM, V7 (Psychosocial Rehabilitation Services Clinician/PRSC) said our process for the facility is that when a resident needs a supervised pass: the family/friend they are going out with requests to take them out. We get the name and phone number of this person. We document where they are going, when they are leaving, and when they will return. When the date and time comes, the visitor takes the pass, the nurse signs off on it, then the receptionist makes a copy of the ID of the individual taking them out. The copy of the ID is done to ensure the person taking the resident out on supervised pass is the same individual listed on the pass request form. We explain the rules to them and to ensure they are safe that way. On 6/3/25 at 1:30PM, V22 (R11's Family Member) said R11 is constantly drug seeking. Before she came to the facility, she was in the hospital due to someone assaulting her. She is unsafe to herself and others when in the community. I have an order of protection against her for me and my family's safety. R11 is very manipulative. On 6/3/25 at 1:50PM, V16 (Licensed Practical Nurse) said I was the nurse on duty on 4/30/2025	S9999		

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S9999	Continued From page 3	S9999		

when R11 said she had a pass to go out to the grocery store for a couple hours. A friend came and picked her up, I scanned the ID. I then gave the pass and the copy of the ID to the receptionist. After 7PM came and went, I called to follow up. R11 never came back to the facility, to my knowledge.

On 6/3/25 at 3:00PM, V6 (Social Service Aide) said I was the receptionist on 4/30/25 when R11 went out on pass. However, I was passing out cigarettes and not at the front desk at the time R11 left. The receptionist usually scans the ID of the person taking the resident out on pass, but I was busy. I never spoke with the person that took R11 out. The reason we scan the ID is to ensure that the ID matches the name on the pass request form. This is for the resident's safety, in case of an emergency where we would have to call the police or if the resident does not come back to the facility.

On 6/4/2025 at 11:45AM, V1 (Administrator) said when a resident has a supervised pass, a pass request form is filled out listing the name of the person taking the resident out including the date and time the resident is leaving and when they will return. The person's ID is scanned to ensure that the pass and the ID match. V1 said when R11 did not return to the facility, we did not notify the police. I do not consider this elopement.

It is to be noted that facility policy titled Community Pass does not lay out the procedure of the facilities supervised pass system.

"B"