

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057091		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/08/2025	
NAME OF PROVIDER OR SUPPLIER CHICAGO RIDGE SNF				STREET ADDRESS, CITY, STATE, ZIP CODE 10602 SOUTHWEST HIGHWAY , CHICAGO RIDGE, Illinois, 60415			
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S0000	Initial Comments		S0000			08/20/2025	
	Complaint Investigation: 2597283/2582489						
S9999	Final Observations		S9999			08/20/2025	
	Statement of Licensure Violations:						
	300.610a)						
	300.1210a)						
	300.1210b)						
	300.1210d)3)6)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to prevent incident of resident-to-resident physical assault. This affected three of three residents (R1-R3) reviewed for physical abuse/assault. This failure resulted in R1 physically assaulting R2 and R3, however as a result of the assault, R1 sustained bilateral nasal bone fracture and blunt abdominal trauma. The findings include: On entry to the facility R1 had been hospitalized on 8/5/25. According to progress notes, R1 returned to the facility on 8/7/25 at approximately 8:00PM. On 8/8/25 at 9:44AM R1 on patio, sitting, smoking. R1 looking down, away from surveyor, not making eye contact, did		S9999				

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S9999	Continued from page 2 not interact or greet surveyor. R1 kept looking away. Observed under eyes swollen, light purple crescent shape under each eye, flat scratches/abrasions on right side of nose along bridge. R1 would not speak to surveyor. On 8/8/25 at 10:55AM R2 her room, no visible injury on hands or face. Ambulates freely. R2 said I was sitting outside having a smoke and that lady (R1) came up to me, got in my face and tried to hit, I hit her back. R2 said I'm not hurt. R2 said she not my friend I don't know why she wanted to fight me. R2 said yeah, we were fighting. R2 said V2 (Social Service Aide) was there she saw it. R2 said then R1 got in a fight with another lady; I just came inside. R2 said we was outside on the smoking patio. R1's diagnosis includes but are not limited to Anxiety Disorder, Cognitive Communication Deficit, and Unspecified Psychosis. R1's cognitive assessment dated 7/6/25 identifies she is cognitively intact. R1's behavior assessment dated 7/6/25 identifies delusions for potential indicators of psychosis. Witness statement with R1's name with no signature or date states "I ran up to (R3) and attempted to hit (R3) and she hit (back). I got in (R2's) face and (was) trying to fight her." Witness statement with R3's name and signature states "(R1) hit me and (I) hit her back and we started fighting." Witness statement with R2's name and signature states "(R1) came in my face and R1 hit me, and I defended myself. I hit, grabbed her hair, and kicked her." On 8/7/25 at 11:22 V2 (Social Service Aide) said R1, R2, and R3 were outside on the smoking patio. V2 said V2 was inside, and one monitor was outside. V2 said V2 heard arguing and walked out, and saw staff try breaking up the fight. R1 and R2 were yelling at each other, and they were swinging at each other. R1 hit R2 first. R2 was sitting and R1 was standing over R2. V2 saw that R1 and R2 were getting separated. V2 said during that time R1 got away and hit R3, and then they start fighting. V2 said V2 saw R3 swinging at R1. V2 said as we were walking away, I saw R1 had blood on her nose. V2 said R1 came out, she looked frustrated and mad when she came outside, that is usual for her. At 2:11PM V2 said when R1 came down, V2 told her she could not go outside. V2 said I kept redirecting her and R1 took it upon herself to go outside anyway. V2 said V2 did not give her a cigarette. V2 said R4 said R1 woke		S9999				

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S9999	Continued from page 3 up mad and irritated. V2 said when a resident is on restriction, Social Service Staff will give us the list, I was told the day before that R1 was on restriction. V2 said V2 told R1 she could not go out, she continued to walk past me, she said she wanted to go out. V2 said when R1 got out there, they started arguing. V2 said it was not reported to anyone that R1 was on the patio until after the fight had occurred. V2's witness statement signed and dated 8/5/25 states R1 went out the door and (V2) heard arguing. I saw V5 (Social Service Assistant) was trying to "break up a fight" between R2 and R1. I went to help and R1 ran to R3 and hit her, then they started fighting. On 8/7/25 at 12:23PM V3 (Licensed Practical Nurse/LPN) stated R1 was brought to the unit and V3 was notified she had been in altercation with another resident. V3 said V3 assessed her and cleansed her nose. V3 said V3 put an ice pack on her nose. V3 said she was not aware if R1 was on a smoking restriction. On 8/7/25 at 12:47PM R4 said on 8/5/25 R4 was on the patio smoking with R1. R4 said R1 was upset because the smoke girl had told her she can't come out and smoke the rest of the day. R4 said the other lady, lives on the first floor (R3) told her to mind her business. R4 said that made R1 mad and I told R1 to stay here, finish your smoke, be good, and then come back in. R4 said I came inside to talk to the smoke monitor inside. R4 said then I saw V2 run outside, and I just knew it was R1. R4 said when R1 came inside I saw blood on her nose and her cheek. R4 said R1 said she got in a fight. R4 said I spoke to R1 on the phone today, she said they were checking her out because she had blood on the brain. On 8/7/25 at 1:32PM V5 (Social Service Assistant) said R1 and R2 were arguing and then R1 hit R2. They were fighting. V5 said V2 (Social Service Aide) came to help me break up the fight. Then R1 went and hit R3. V5 said I was outside on the patio when the fight happened. V5 said R2 was sitting on the bench near where I was and then R1 walked up to R2, and they were arguing and then they were hitting (each other). V5 said R1 and R2 exchanged "some words" and R1 was mad. R1 had an "attitude" the whole time she was there. V5 said I sensed she was angry when she came out. V5 said R1 was on smoke restriction and was not supposed to be on the smoking patio. On 8/7/25 at 1:55PM V1 (Social Services) said R1 was on smoking restriction because she had got caught smoking in her room. V1 said R1 was on restriction for 30 days.	S9999					

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S9999	Continued from page 4 V1 said R1 can go outside for fresh air but she can't be out there for smoking time. V1 said R1 wasn't supposed to be down there on 8/5/25. V1 said the V2 (Social Service Aide) should have stopped R1. V1 said V2 was trying to stop her from going out. On 8/7/25 at 2:24PM V6 (Director of Nursing) said R1 became aggressive with one resident and another resident jumped in and separated them. V6 said R1 had scratches on her face, and she was the aggressor. She tried to beat up 2 people at the same time. V6 said if a resident is on restrictions, they should not be on the patio with the smokers. V6 said we need to be vigilant to make sure to not allow the person to be outside. The surveyor asked V6 if not smoking can cause a smoker to be cranky. V6 replied "absolutely" can be cranky. V6 said for nicotine withdrawal we can offer them something else. V6 said I am not sure if R1 was offered something. V6 said I did not know R1 was on restriction until after the incident happened. V6 said R1 was not even supposed to be down there, on the smoking patio. V6 said if the smoke monitors cannot redirect the resident, they should call the nurse and social services for direction to ensure R1 did not violate her restriction. V6 said the staff did not tell anyone R1 was outside. Review of R1 progress notes include screaming and cursing at staff and punch and choke staff on 1/30/25. On 5/12/25 progress notes states R1 presented verbal inappropriate behavior with obscene language to the writer. On 8/8/25 at 1:17PM V7 (Physician) said I was notified that R1 was attacked by 3 others. V7 said I know I got a call about R1 having been attacked by 3 other residents. V7 said I was told she was bleeding, but not from where. I told them to send her out for an evaluation. V7 said they're supposed to have a staff on the balcony (smoking area) watching the residents. V7 said the purpose for them to be watching is for safety. V7 said nasal fractures and blunt abdominal trauma can be a result of trauma or impact. V7 said they didn't tell me where she was hit when they called me. R1's Screening Assessment for Indicators of Aggressive and/or Harmful Behaviors dated 6/7/25 states history or recent episode of aggressive/agitated behavior is substantial or significant problem. It was reported R1 was allegedly involved in inappropriate interaction with peer. Assessment dated 7/5/25 states R1 has history of aggression. Smoking Risk review dated 7/24/25 documents R1 was		S9999				

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S9999	Continued from page 5 smoking in room with peer. R1 presented with verbal inappropriate behavior. Smoking Risk review dated 4/24/25 documents R1 smoking in hall bathroom. R1 refused to sign smoke contract and not receptive. Smoking Risk review dated 4/22/25 documents R1 smoking in peer's room. R1 counseled on facility policy and safe smoking. R1 not receptive. R1 smoking contract dated 7/24/25 states verbalized to resident, R1 refused to sign. R1's care plan dated 7/24/25 states R1 demonstrates non-compliance with safe smoking regulations by smoking in rooms, bathrooms, halls, stairways, elevators, and other non-designated areas. Smoking at non designated times. Interventions include explaining the safe smoking policy and policy for non-compliance. R1's care plan dated 8/5/25 (revised date) states history of aggressive, inappropriate behavior, includes conflicts/altercations with others, threatening behavior, verbal or physical aggression. Intervention includes intervene when inappropriate behavior is observed. R1's progress notes dated 8/5/25 states involved in social inappropriate interaction. R1 in altercation on patio during smoke break. Skin tear to her face, redness near right side of her face and bridge of her nose. R1 sent to hospital for evaluation. Progress notes dated 8/6/25 state R1 transferred to hospital with diagnosis of Assault & Fracture Nasal bones. R1's facility obtained medical records dated 8/7/25 stated schedule this patient for follow up in plastic surgery clinic to discuss her recent bilateral nasal bone fractures. Hospital discharge diagnosis includes Abdominal pain, Blunt Abdominal Trauma. R3's diagnosis includes anxiety disorder and Psychoactive Substance Abuse. R3's cognitive assessment dated 7/5/25 identifies cognitive intact. Behavior assessment dated 7/5/25 identifies no potential indicators of psychosis. Progress notes 8/5/25 document R3 involved in social inappropriate interaction with peer. R3 sent to hospital for psych evaluation. (R3 remained hospitalized upon exit of survey.) R3's care plan includes history of aggression, inappropriate behavior, conflicts/altercations with others, verbal or physical aggression. R3 has severe, chronic persistent mental illness. At times shows		S9999				

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S9999	Continued from page 6 aggression. Physically abusive behavior when agitated. R2's diagnosis includes but are not limited to Schizoaffective Disorder, Altered Mental Status, Violent Behavior, and bipolar disorder. R2's cognitive assessment dated 6/6/25 identifies she is cognitively intact. R2's Behavior assessment dated 6/5/25 identifies delusions for potential indicators of psychosis. Progress notes dated 8/5/25 states R2 involved in social inappropriate interaction with peer. R3 said another resident approached and attempted to make contact with her and she defended herself. Progress noted dated 8/5/25 at 1:14PM states R1 has been arrested two times for domestic battery. The facility behavior management policy and procedure dated 11/22 states it is the policy of the nursing department to determine the cause of behaviors when possible and initiate interventions to reduce control or prevent identified behaviors. In the event the behavior cannot be managed staff will implement protocols to prevent the residents from harming self or others. The purpose is to prevent the residents from harming self or others. Procedure: notify social service of any behaviors as soon as possible initiate behavior monitoring and recording to provide pattern of behaviors and response to planned interventions when applicable. Targeted behavior agitated behavior which represents a danger to self and others. Preventative measure observe residence for behavior escalation of anxiety aggression such as loud voice tone handwringing swear and yelling and other irritability. Removed from problem area. Allow time for the resident to voice feelings and frustration. "A"		S9999				