

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 02/06/2026	
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				
	Annual Licensure Survey.						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610a)						
	300.3210t)						
	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 300.3210 General						
	t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.						
	This REQUIREMENT is not met as evidenced by:						
	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.						

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 Findings include: R12's face sheet documents an age of 90 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."		S9999				

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S9999	Continued from page 2 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 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 55 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		S9999				

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S9999	Continued from page 3 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,		S9999				

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S9999	Continued from page 4 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, "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	S9999					

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S9999	Continued from page 5 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		S9999				

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S9999	Continued from page 6 not pushed, that R12 was 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." "B"		S9999				

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