Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002687	A. BUILDING: ______ B. WING ______	C 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN VILLAGE NRSG & RHB	5838 NORTH SHERIDAN ROAD CHICAGO, IL 60660

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S 000	Initial Comments Investigation of Facility Reported Incident of 03/20/24/IL171459 - F689	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)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 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	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/03/24

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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:

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.

These requirements are not met as evidenced by:

Based on observation, interview and record review, the facility failed to adequately supervise one resident (R3). This failure affected 1 resident (R3) causing R3 to sustain a right eyebrow laceration with one suture to R3's face.

Findings include:

R3's Brief Interview for Mental Status (BIMS) dated 03/07/24 show that R3 has no BIMS score and indicates that R3 has memory problems.

The facility's initial Reportable Incident to the local state agency dated 03/21/24 at 7:18 pm documents, in part that CNA (Certified Nursing Assistant) reported to the nurse on duty that R3 was observed in a sitting position on R3's bedside floor mat. Upon nurse head to toe assessment and observation, R3 was noted with a ½-by-½ laceration and minimal amount of blood to the right side of R3's brow. R3 was sent to the local hospital.

The facility's final Reportable Incident to the local

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state agency dated 03/29/24 at 6:34 pm documents, in part R3 returned to the facility the same evening of R3's fall from the local hospital and was noted with one suture to R3's right eyebrow.

On 04/08/24 at 12:27pm, R3 was observed sitting across from the fourth-floor nursing station. R3 was alert but unable to communicate verbally with Surveyor. R3 able to point at objects to express R3's needs. R3 was not interviewable for this investigation.

On 04/09/24 at 11:54 am, V13 (Registered Nurse, RN) stated that V13 was R3's nurse on 03/20/24 during the time of R3's fall. V13 stated that R3's Certified Nursing Assistant (CNA) informed V13 that R3 was on the floor in R3's room. V13 stated that V13 observed R3 on the floor mat on the side of R3's bed with a small laceration to R3's eyebrow (V13 could not recall which one of R3's eyebrows were affected). V13 stated that V13 applied pressure to R3's eyebrow and called R3's physician who gave an order to send R3 to the local hospital for evaluation. V13 stated that V13 called R3's family to inform them of R3's condition. V13 stated that R3 was sent to the local hospital for evaluation and received one suture to R3's eyebrow and returned to the facility the same day. V13 stated that V13 saw R3 wandering in the hallway ten to fifteen minutes prior to R3's fall on 03/20/24. V13 explained that R3 is a resident known to have frequent falls and that R3's whereabouts are constantly monitored to avoid R3 from falling. V13 also explained that R3 propels R3's wheelchair back and forth in the hallway to the dining room and R3 is always in view of staff. V13 then stated, "I (V13) know that R3 is a high risk for falls but on this day I (V13) didn't know where R3 was. It was the beginning

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of the shift, and I was trying to do a lot of other things that I needed to do for the day." When V13 was asked regarding the importance of supervising residents who are high risk for falls V13 stated, "It is important for the resident safety, but we cannot supervise all the time."

On 04/10/24 at 10:50 am, V21 (R3's Physician) stated that R3 is a resident who has some levels of dementia and confusion. V21 stated that R3 is a resident who has had frequent falls at the facility and that V21 is not surprised that R3 has not had more falls at the facility. V21 stated that V21 recalls R3 falling on 03/20/24 and V21 gave orders to send R3 to the local hospital for evaluation. V21 explained that R3 received one stitch due to R3's fall at the facility on 03/20/24. V21 stated in V21's professional opinion, it is safer for R3 to have staff supervise R3 to prevent R3 from an injury.

On 04/10/24 at 12:58 pm, V2 (Director of Nursing, DON) stated that R3 is a resident that is alert to self, difficult to understand and has difficulty communicating needs. V2 explained that R3 ambulates with a wheelchair, is a high risk for falls, requires supervision and assistance from staff for transfers and R3's care. V2 stated that on 03/20/24 staff reported responding to R3's call light and observed R3 sitting on the floor in R3's room. V2 explained staff did not know how long R3's call device was alarming. V2 then explained that V13 (RN, R3's nurse at the time of R3's fall), assessed R3 on the floor, R3 was observed with a laceration to R3's right eyebrow. V2 explained that V13 called V21 (R3's Physician) who gave orders to send R3 out for an evaluation. V2 stated that R3 was transferred to the local hospital and returned with one suture to R3's right eyebrow. When V2 was asked in V2's professional opinion

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if a resident is high risk for falls and requires assistance from staff for transfers and care; should they be supervised? V2 stated, "Yes." When V2 was asked if a resident who is high risk for falls, sustains a fall, could the resident sustain an injury, V2 stated, "In most cases, yes." V2 also stated that nurses and CNAs should be supervising the residents, answering call lights promptly and rounding every hour to check on the residents at the facility.

The facility's document dated 12/08/24 through 04/08/24 and titled "All Falls For the Facility" shows that in the past 120 days, R3 sustained a fall on 03/20/24, 02/13/24 and 01/24/24.

R3's progress note dated 03/20/24 at 3:51 pm, authored by V13 (Registered Nurse, RN) documents in part, CNA responded to call light and noted R3 in a sitting position on her floor mat. V13 was called to the room and observed R3 had a small amount of blood to the right side of R3's face ... physician notified with orders to send R3 to the local hospital.

R3's progress note dated 03/20/24 at 10:39 pm, authored by V13 (Registered Nurse, RN) documents in part, resident back to the facility via ambulance from local hospital with one suture to the laceration to right eyebrow. Sutures to be removed in seven days.

R3's care plan dated 03/14/24 documents in part: Problem: R3 is high risk for falling due to unsteady gait, impaired mobility, uses wheelchair for locomotion. Approach: Educate never to transfer without staff assistance ... observe frequently and place in supervised area when out of bed.

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R3's hospital records dated 03/20/24 documents in part that R3 was sent to the emergency room from skilled nursing facility after mechanical fall where R3 struck her head ... Irrigated and sutured by physician assistant (PA) at the local hospital. Assessment/Plan: Head injury, Laceration of face (right eyebrow), right hip pain, and left hip pain.

R3's Fall Risk Observations dated 01/24/2024, 02/13/2024 and 03/21/24 indicate that R3 is high risk for falls.

The facility's undated document titled "Routine Resident Checks and Safety Room Checks" documents, in part: "Routine checks shall be made to ensure the resident safety and wellbeing are maintained."

The facility's job description titled "LPN (Licensed Practical Nurse)\Charge Nurse" documents in part: Purpose: The primary purpose of this position is to: Supervise the day-to-day CNA services for assigned unit to assure that care is being rendered in accordance with current federal, state, guidelines, and regulations ... Duties and Responsibilities/Function: 3. Closely monitor and supervise all facility residents per facility policies and as warranted by good nursing judgement."

(A)