STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145482	A. BUILDING _____ B. WING _____	C 07/02/2021

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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F 000	INITIAL COMMENTS Complaint Investigation: Facility Reported Incident of May 29, 2021-IL135253 - F689 2183778/IL134471 - No Deficiency 2183467/IL134061 - F580, F686 2183294/IL133851 - No Deficiency	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		7/23/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/21/2021

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F 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on records review and interviews the facility failed to notify family and /or representative for resident treatment of pressure ulcer and decline of activity of daily living (ADL) for 1 (R3) out of 3 residents (R2, R3 and R8) reviewed for family and /or representative notification in a total sample of 8 resident. Findings include: R3's notes by V9 (Wound Coordinator / Licensed Practical Nurse) dated 7/21/2020 reads that R3 was transferred to the hospital emergency	F 580	PLAN OF CORRECTION F 580 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC.) Please accept the following as the facility□s credible allegation of compliance (Please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility□s admission of non-compliance with any standard, requirement, or regulation.):	

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F 580	Continued From page 2 department after seen by V15 (Wound Doctor) due to glans penis redness, purulent drainage and swelling. Before transfer V19 (Nurse Practitioner) for V17 (Medical Doctor / Primary Care Physician) were informed and ordered the transfer. R3's health record was reviewed related to notification of family and /or representative as to change of condition that includes pressure injuries and decline of ADLs; and there were no notes or any written forms that indicated there was notification. R3's therapy records for both Physical Therapy (PT) and Occupation Therapy were started on 8/14/2021 due to decline of R3 on his upper and lower extremities. On 6/30/2021 at 11:01 AM V9 (Wound Coordinator / Licensed Practical Nurse) stated that she cannot remember if there was family or representative notification related to pressure ulcer of R3, but will look if there was any. After a while V9 stated she could not find any. On 7/1/2021 at 10:45 AM. V10 (Restorative Director) stated that R3 was started on therapy (Physical Therapy (PT), Occupational Therapy (OT)) because of decline on R3 upper and lower strength. V10 also stated that he cannot find any family and / or representative notification related to decline of ADLs. On 7/2/2021 at 12:49 PM. V22 (Director of Nursing) stated, "After review of R3's health record, the only notice of family and /or representative notification that she can find was on 8/13/20 when R3 was sent to the hospital due to low oxygen saturation.	F 580	1. Corrective actions which will be accomplished for those residents found to have been affected by the alleged deficient practice: R3 is no longer a resident at the facility. He was discharged on 11-24-2020. 2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: All residents with pressure ulcers and residents with a decline of ADL□s are identified to have the potential to be affected by the same alleged deficient practice. The DON/ADON have reviewed the medical records of all residents with pressure ulcers and residents with a recent decline in ADLs□, to ensure the family and/or representative have been notified. 3. The measures the facility will take or systems the facility will alter to ensure that the alleged deficient problem will be corrected and will not recur: All staff nurses have been in serviced on the facility□s Notification of Resident Change in Condition policy and promptly notifying a resident□s representative of changes in condition and documenting the notification in the progress notes.	

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F 580	Continued From page 3 After review of R3's notes for July and August 2020 there was no charting related to notification of family and /or representative related to pressure injuries or decline of ADLs.	F 580	4. Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent: A QA audit tool will be completed by the DON/designee on all residents with a change in condition weekly for 8 weeks to ensure any change in a residents condition has been communicated to the family promptly and documented in the progress notes.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review the facility failed to maintain pressure ulcer treatment, to provide a pressure wound appointment with a Urologist as ordered, to include pressure ulcer in the assessments, include it in the care plan and failed to maintain reduction of pressure ulcer for 2 (R2 and R3) out of 3 residents (R2, R3 and R8) reviewed for	F 686	PLAN OF CORRECTION F686 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE ULCER Please accept the following as the facility s credible allegation of compliance (Please note that this POC is	7/23/21

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F 686	Continued From page 4 pressure ulcer prevention and treatment for a total sample of 8 residents. Findings include: R3 was not in the facility during on-site review inclusive dates from 6/29/21 to 7/1/21. R3's notes written by V9 (Wound Coordinator / Licensed Practical Nurse) dated 7/21/2020 reads that R3 was transferred to the hospital emergency department after seen by V15 (Wound Doctor) due to glans penis redness, purulent drainage and swelling. Before transfer V19 (Nurse Practitioner) for V17 (Medical Doctor / Primary Care Physician) was informed and ordered the transfer. On the same date (7/21/2020) R3 came back to the facility with a discharge order for Keflex antibiotic, to be seen by V17 and to make an appointment to see V20 (Urologist). Review of V15 (Wound Doctor) wound assessment dated 7/26/2020, reads that R3 has a wound on the penis that it was categorized as a Pressure Wound Unstageable (due to a device / dressing). V15's additional wound detail reads: R3 was sent to the ED for split gland penis where he had his indwelling catheter replaced. R3 was started on Keflex antibiotic and sent home with recommendation to follow up with V17 (Medical Doctor / Primary Care Physician) and make appointment with urologist in 10 days. I will sign off on this site. Notes for R3 dated 11/12/20 reads: 11/14/2020 01:35 PM. Confirmed that R3 was admitted to the Hospital with diagnosis of Congestive Heart Failure CHF), Chronic Obstructive Pulmonary	F 686	submitted per State and Federal requirements only. It should not be construed as the facility□s admission of non-compliance with any standard, requirement, or regulation.): 1. Corrective actions which will be accomplished for those residents found to have been affected by the alleged deficient practice: R3 is no longer a resident at the facility. He was discharged on 11-24-2020. A heel protector was placed on R2 immediately. The DON monitored R2 to ensure the heel protector was in use as per the physician order. 2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: All residents with pressure ulcers are identified to have the potential to be affected by the same alleged deficiency. 3. The measures the facility will take or systems the facility will alter to ensure that the alleged deficient problem will be corrected and will not recur: The treatment nurse and all staff nurses were in serviced on ensuring: " Pressure ulcer treatments are completed and documented. " Pressure ulcer assessments are completed and documented.	

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F 686	Continued From page 5 Disease (COPD), Pneumonia and Shortness of Breath. All departments notified. V21 (Daughter of R3) emergency contact notified. R3's Census Report reads that on 11/24/2020 at 04:02 PM he was discharged. On 6/30/2021 at 11:01 AM V9 (Wound Coordinator / Licensed Practical Nurse- LPN) stated, "The wound site on R3's penis was due to a catheter. V15 (Wound Doctor) was seeing R3 once a week, sometimes every other week and comes every Tuesday. Wound was due to catheter pulling on his penis. R3 was referred to Urologist. The wound was first noticed on 7/16/21 and it was resolved on 7/28/21. It was resolved not because it was healed but because V15 stopped treating the wound because it was referred to a Urologist. No, the wound was not healed. I don't know if R3 even went to Urology appointment. There was no pressure ulcer included on all MDS. I might have missed it. I do the care plan and there was no care plan I can see on this (pointing at facility provided full care plan) related to the both wounds. Treatment Administration Record (TAR) must be signed every time a nurse performs an order treatment. I do not know why there are many treatments not signed but these should have been signed. Signature means that treatment was performed." On 6/30/21 at 2:17 PM V15 (Wound Doctor) stated, "When I saw the wound that day (7/21/20) it was red and purulent I told V18 (Director of Nursing) and V17 (Medical Doctor / Primary Care Physician) to send R3 to hospital because of the wound. My instruction was to change the site of the catheter and I thought R3 was to be admitted instead his catheter was changed. I stopped	F 686	" Care plans for pressure ulcers are completed and kept updated. " Interventions to maintain pressure ulcer prevention are in place. " Referrals for appointments to physicians are scheduled and provided for pressure wounds. 4. Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent: A QA audit tool will be completed by the DON/designee on all residents with pressure ulcers weekly for 8 weeks to ensure: " Pressure ulcer treatments are completed and documented. " Pressure ulcer assessments are completed and documented. " Care plans for pressure ulcers are completed and kept updated. " Interventions to maintain pressure ulcer prevention are in place. " Referrals for appointments to physicians are scheduled and provided for pressure wounds.	

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F 686	Continued From page 6	F 686		

treating the wound on the penis but continue treating the right heel pressure ulcer. My instruction was for R3 to see a Urologist for further treatment. The facility should have followed instruction for R3 to see Urologist and follow discharge instructions from the hospital."

On 6/30/21 at 2:56 PM V2 (Assistant Director of Nursing) stated, "R3 was not able to go to Urology appointment, all I can see that there was a transportation problem."

R3's Patient Discharge Transition Record from the hospital dated 7/21/2020 reads: Discharge Instructions, additional follow up instructions: To see V20 (Urologist) and to start Keflex antibiotic.

R3's Minimum Data Set (MDS) for Section M - Skin Conditions dated 3/20/2020, 6/18/2020, 9/16/2020 and 11/14/2020 does not include any Pressure Ulcers / Injuries.

R3's Full Care Plan does not include identification, goal setting and intervention for Pressure Ulcers / Injuries.

R3's Treatment Administration Records (TAR) for July and August 2020 has multiple dates without signature indicating treatment was not performed as ordered by the physician.

On 6/29/21 at 1:04 PM R2 was seen on his bed able to verbalize his thought during conversation. R2 was not aware if he has any pressure wound.

Review of V15 (Wound Doctor) wound assessment for R2 dated 6/29/21 reads: On 6/29/21 R2 developed right heel pressure injury unstageable 5 cm length and 4.5 cm width. V15

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F 686	Continued From page 7 recommended repositioning and air boot. On 7/1/21 at 12:05 PM R2 was seen sitting on his wheelchair in the dining room. R2 right foot has dressing and was seen on the footrest hard surface. V16 (LPN) stated, "Yes, wound care told me that R2 has a pressure wound on the right heel and it needs protection or place a heel protector when on bed or when sitting on the wheelchair when the heel is touching any surface. The only time that R2 does not need to use the heel protector is when walking." V16 then went to the dining room and stated, "Yes, he needs heel protector. I will take care of it." Facility Policy on Pressure Ulcer and Wound Prevention / Management Program reads: Policy: Ensure that residents who enters the facility without pressure ulcers do not develop pressure ulcers unless the individual's clinical condition demonstrates that the pressure ulcers were unavoidable. Ensure a resident who has been admitted with pressure ulcers or develops pressure ulcers in-house receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing, when possible. To prevent and manage wound care through a group of health professionals.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		7/23/21

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F 689	Continued From page 8 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and records review, the facility failed to ensure that the resident environment remains safe, free of hazards and hazardous practices by leaving a bedside table in the hallway. This failure resulted in R2 tripping over the bedside table, falling and sustaining a right hip fracture that required hospitalization and right hip surgery. Findings include: R2's Face Sheet documents resident is a 66 year old with diagnoses including but not limited to: Nondisplaced subtrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, Schizophrenia, unspecified, Foot drop, right foot, Presence of right artificial hip joint, History of falling, Difficulty in walking, not elsewhere classified, Unsteadiness on feet, Muscle weakness (generalized), Weakness, Other lack of coordination. Surveyor attempted to reach V11(LPN), the nurse on duty at the time the fall incident occurred on 06/29/2021 and on 06/30/202, unsuccessfully. On 07/01/2021 surveyor was able to reach V11 to obtain interview, but V11 refused to speak to surveyor by disconnecting the phone conversation once surveyor introduced self. On 06/30/2021 at 11:21am V8 (Certified Nursing Assistant- CNA) stated, "Therapy gets R2 up	F 689	PLAN OF CORRECTION F 689 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Please accept the following as the facility□s credible allegation of compliance (Please note that this POC is submitted per State and Federal requirements only. It should not be construed as the facility□s admission of non-compliance with any standard, requirement, or regulation.): 1. Corrective actions which will be accomplished for those residents found to have been affected by the alleged deficient practice: The Administrator and DON ensured R2□s environment is safe and free from hazards. R2 remains on skilled therapy services with fall prevention measures in place. 2. How the facility will identify other residents having the potential to be affected by the same alleged deficient practice: All residents assessed to be at risk for falls are identified to have the potential to	

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F 689	Continued From page 9 every day and they also get him dressed. Since R2 sustained the fracture he is under the care of therapy and right now the therapists get the resident out of bed and help him get dressed. Therapy have not yet allowed the CNAs to get R2 out of bed. When R2's condition improves therapy will let us know that we can get R2 out of bed, but so far we have not received clearance. Prior to the fall on May 29, R2 was independent, he was able to transfer himself and walk independently. After the fall he is not able to ambulate and transfer independently due to the hip fracture." On 06/30/21 at 11:29am V10 (Restorative Director) stated, "R2 sustained a fall on 05/29/21 close to 1 am. R2 usually sits in the dining room and watches television. On May 29, R2 was walking back to his room after he was done watching TV and fell. The nurse on duty documented that she heard a sound in the hallway and observed R2 laying on the ground. R2 complained of pain after the fall to the right side of his hip. When I reviewed the camera footage which captured the entire incident, I saw that R2 tripped over a bedside side table which was left in the hallway. The bedside table was not being used at the time of the incident and was not put back where it belongs. Sometimes staff use a bedside table for meals in order to space the residents out, and they also use the side tables for activities. The side table was not in use and they did not place the side table back. There was no reason as to why the bedside table was left behind in the hallway. The reason R2 had the fall is because he tripped over a piece of furniture that should not have been there in the first place." On 06/30/2021 at 12:42pm V14 (Certified	F 689	be affected by the same alleged deficiency. The Administrator/DON ensured the resident environment was safe and free of hazards and hazardous practices. 3. The measures the facility will take or systems the facility will alter to ensure that the alleged deficient problem will be corrected and will not recur: All staff were in serviced on ensuring the resident environment remains as free of accident hazards and hazardous practices as possible. Furniture should not be stored in the hallway as it can be a tripping hazard and cause a resident injury. The Safety Committee will conduct safety rounds daily and discuss findings to ensure immediate interventions to any hazards are in place. 4. Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent: A QA audit tool will be completed by the Administrator/designee 2 times a week for 8 weeks to ensure the resident environment remains as free of accident hazards as possible.	

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F 689	Continued From page 10	F 689		

Occupational Therapy Assistant- COTA) stated, "Prior to the fall, which occurred on 05/29/2021, R2 was ambulatory. He was able to transfer, walk independently. After the fall R2 is ambulatory with contact guard assist, minimal assist from sit to stand position. R2 is stand by assist from wheelchair level. Upper body is minimal assist. R2 lower body requires maximum assistance. R2 requires total assist with putting on shoes and maximum assistance with putting on pants. R2's bed mobility requires minimal to moderate assistance, depending on his pain level at the time. R2 is getting out of bed with the help of therapy at this point. When R2's condition improves and we feel that he is stronger, we will let the staff know that it's safe to get R2 up, but not at this time. R2's condition still has to improve."

Surveyor attempted to interview R2 on 06/30/21 at 9:36am and 07/01/21 at 10:01am, however; R2 stated that he was sleepy and took pain medication.

On 07/01/2021 at 2:20pm V1 (Administrator) stated, "There is not supposed to be any furniture stored in the hallway. The bedside table should not be in the hallway. The table should not have been there. Sometimes they use those tables during mealtimes to provide social distancing for the residents, but when the table is not in use, it would have been removed especially from the hallway."

Progress note (05/29/2021 12:49am) and fall incident report (05/29/2021 7:50am) documented by V11 (LPN) reads, "R2 stumbled fell hard to his right side in the hallway, not able to stand or perform full Range Of Motion, sent to (hospital's

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(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) COMPLETION DATE
F 689	Continued From page 11	F 689		

name) ER."

Video footage of fall incident was requested by surveyor for review. Surveyor received response from V1 on 07/01/2021 stating that video footage of fall incident is not available.

Accident/Incident Management Meeting (IDT) Form pertaining to date of incident 05/29/2021 determined the root cause of R2's fall to be: Resident tripped on a table, lost balance and fell. The document states a fall prevention intervention related to the root cause of the fall is to ensure floors and hallway is free of obstacles for safe ambulation.

Per Facility Assessment Tool (dated 08/18/2017): Provide person-centered direct care identify hazards and risks for residents.

Fall Care Plan (dated 03/16/2021) lists one of the fall prevention intervention is to provide resident an environment free of clutter.

Fall Risk Assessment (dated 03/15/2021 1:15pm) prior to fall incident on 05/29/2021 states that R2 activity level was up and about as desired (UP Ad Lib) and independent for elimination and has balance problems while walking. Post incident Fall Risk Assessment (dated 06/01/2021) states that R2 has balance problems while standing, walking and has change in gait pattern when walking through doorway; requires assistance with elimination/up to commode. Fall Risk Assessment (dated 06/09/2021) states that R2 is confined to chair, totally unable to ambulate without assistance and requires wheelchair for locomotion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145482	A. BUILDING _____ B. WING _____	C 07/02/2021

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Physical Therapy Discharge summary (dated 04/16/2021 prior to fall) documents R2 functional activity performance as: Static Standing: good; Transfers: 1/7; requires no assistive devices. Physical Therapy (dated 06/02/2021 post fall) documents R2 as: Toileting: total assistance; standing during ADLs: poor.

Minimum Data Set (MDS) Section G (dated 04/16/2021) scored R2 as (1) needing supervision with transfers, walking, toilet use, dressing, bed mobility. MDS Section G (dated 06/08/2021 post fall) scored R2 as (3) needing extensive assistance with bed mobility, (4) needing total dependence with personal hygiene, toilet use, dressing, transfer, (8) activity did not occur with walking.

Comprehensive Fall Review (dated 06/02/2021) states R2 was observed walking from the dining area to his bedroom, tripped over a table, lost balance, and fell on his right side.

Facility Incident Final Report Form Occurrence Resolution (dated 05/29/2021) states R2 tripped over a bedside table in hallway. This incident was also observed on camera review.

Hospital Medical Records Progress note (dated 05/31/2021 10:29 CDT) documents R2 arrived to the emergency room department after mechanical fall complaining of right hip pain. Right hip x-ray showed acute subcapital femoral fracture.

Care plans will be developed for any resident who is identified at risk (Mild / Moderate / High / Severe Risk) according to the Braden risk assessment score and for any resident who

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F 689	Continued From page 13 currently has an ulcer. The care plan should address: " Diagnosis, behaviors, factors, and conditions that put resident at risk or impede healing status such as co-morbid conditions, medications, or complications. " Goals that are appropriate and measurable. " Interventions individualized to the resident's condition / situation to prevent the development of an ulcer, or if present, for the care and treatment of the ulcer. " Disciplines that will implement each intervention.	F 689		