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 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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S 000	Initial Comments Complaint Investigation: Facility Reported Incident of May 29, 2021-IL135253	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are 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	S9999		

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S9999	Continued From page 2 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 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.	S9999		

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S9999	Continued From page 3 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 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.	S9999		

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S9999	Continued From page 4 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 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.	S9999		

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S9999	Continued From page 5 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. 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	S9999		

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S9999	Continued From page 6 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 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. (A)	S9999		