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	04/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheridan Village Nrsg & Rhb	5838 North Sheridan Road Chicago, IL 60660

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 02569 Based on observation, interview and record review the facility failed to provide adequate supervision to prevent a fall during incontinence care for one (R1) of three residents (R1, R3 and R4) reviewed for falls. This failure resulted in a fall by R1 who sustained a laceration on the forehead and was sent to the hospital emergency room receiving stitches to repair the laceration. Findings include: R1 is a [AGE] year old male resident with a diagnosis including COPD, Paranoid schizophrenia, Heart failure, Diabetes 2, Anxiety disorder, Depressive disorder severe with psychotic features and Obesity. R1 has a BIMS (Brief Interview for Mental Status) score of 12/15. R1's Minimum Data Set section GG scores 1 (Dependent) for toileting, 2 (Substantial / Maximal assistance) for Shower/bath self and 2 (Substantial / Maximal assistance) To roll left and right. R1's care plan dated 4/16/24 shows R1 is at risk for deterioration in bed mobility, transfer, walking in room, walking in corridor, locomotion on unit, locomotion off unit, dressing, eating, toilet use, personal hygiene. R/T weakness and poor skills. Requires extensive/total staff assistance. R1 is a high risk for falls R/T weakness, poor bed mobility poor safety awareness. R1's 4/21/24 progress note states resident is alert and oriented. Resident was being changed by CNA and accidentally rolled out of bed. Resident has an open area to the right side of his forehead. Resident noted lying on stomach and hitting head on the floor. Forehead cleaned and pressure applied to open area by staff while waiting for ambulance to arrive to take to hospital. Full Body assessment performed. Resident Eyes are reactive to light, Neurological checks provided, and level of conscious is normal. Resident skin is warm to touch and has laceration to left side of forehead. Resident Mucous membrane pink and moist, and no open area to mouth. Resident lung sounds in normal limits, and no respiratory distress noted. Resident heart rate with normal limits. Resident has full range of motion to upper and lower extremities, and no bruise, redness, or open areas to extremities. Resident Abdomen is soft and round, bowel sounds present times 4 quads, and no distention noted. Resident is assisted into bed with 2 person assistance and pressure to the open wound on the forehead to continue to be applied till 911 arrives. Resident has no complaints of pain or discomfort. ADON and Guardian Notified. Physician is notified and gave order to send to hospital. R1's hospital record dated 4/21/24, shows R1 sustained a right forehead laceration, 5 cm laceration to right side of forehead. This required 13 stitches to repair. (continued on next page)

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

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	04/28/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Facility incident report dated 4/26/24 shows, on 4/21/24 approximately 2:35pm, R1 had a witnessed fall from the bed. The resident slid out of the bed, landing on his face on the floor in his room. The resident was immediately assessed by the nurse on duty and noted a facial laceration and bloody nose. First aid applied, bleeding controlled, 911 called. R1 transferred to ER for further evaluation and treatment. On 4/26/24 at 10:35 AM R1 was observed in his room. R1 was in his bed. R1 had stitches on the forehead and a right black eye. On 4/26/24 at 10:35AM R1 stated the CNA (V3) came to change me. He rolled me over and I fell from the bed to the floor. I hit my head hard. I had to get stitches at the hospital. The CNA was by himself and could not stop me from falling. They usually change me with two people. On 4/26/24 at 10:38AM R1 stated I am not in the original bed I fell from. The mattress on the other bed used to fall off the edge of the bed frame. I almost fell before because of that. On 4/26/24 at 10:40AM V3 (CNA) stated it was on Sunday I went to R1's room to change him. I started to roll him over. The mattress shifted off the edge of bed frame. R1 tried to help by rolling over himself. With me rolling him and him trying to help he went off the opposite edge of the bed and fell to the floor. I tried to stop him, but my hands were wet, and he slipped from my grip. On 4/26/24 at 11:31AM V2 (Assistant DON) stated R1 is a two person assist with transfers but to change it is a one person. V3 (CNA) should know if he needs help to just ask. On 4/26/24 at 12:30PM V5 (Physician) stated R1 had an injury due to his fall from bed on 4/21/24. R1 is sometimes non complaint with ADL care. He had one CNA providing care and as I am aware R1 tried rolling himself over and didn't stop when directed by the CNA. One person for this ADL care is probably ok but two people would have been better. It is unfortunate that this happened. On 4/26/24 at 1:10PM V6 (Restorative Nurse) stated V3 CNA was doing care and instructed R1 to stay still and R1 kept rolling and fell from bed. There was just one staff present. Facility policy titled Fall Reduction Program states including: Objective: 1. It is the policy of this facility to have a Fall Reduction Program that promotes the safety of residents in the facility. The programs intent is to assist clinical staff in determining the needs of each resident through the use of standard assessments, the identification of each residents' individual risks, and the implementation of appropriate interventions, supervision, and /or assistive devices deemed appropriate. Quality Assurance Program will monitor the program to assure ongoing effectiveness.