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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>145482  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY COMPLETED<br><br>02/02/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Sheridan Village Nrsg & Rhb  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5838 North Sheridan Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45110</b></p> <p>Based on interview and record review the facility failed to report alleged abuse allegations to the proper authorities within the prescribed time frame for one [R1] of three [R3, R4] residents reviewed for abuse.</p> <p>Findings Include:</p> <p>R1 clinical record indicate the following: R1 is a thirty-nine-year-old admitted with medical diagnosis including but not limited to cerebral palsy, schizoaffective disorder, chronic obstructive pulmonary disease, morbid obesity, hypertensive heart disease, sleep apnea, psychosis, bipolar disorder, and mood affective disorder. R1's minimum data set brief interview indicates R1 is cognitive intact.</p> <p>R1's care plan:</p> <p>12/23/24, R1 has persistent mental illness. R1 experienced psychosis in the form of both auditory hallucinations [hearing voices, information in her head often of a negative nature] and delusional [falsely believing things that never happened, not true nor valid]. R1 made an allegation against staff member that may be the result of a disordered thinking R1 told a staff member certified nurse assistant, broke her legs while receiving patient care. R1 psychosis, hallucinations, and delusions will not interfere with R1's participation in ADL care. R1 will work with staff to reality test her thoughts and beliefs.</p> <p>11/27/23, R1 is at risk due to verbal aggression, poor symptom management and treatment noncompliance. R1 made an allegation of abuse against staff, history of refusing care despite encouragement.</p> <p>12/10/24, R1 has dysregulated behavior. Display multiple behavior symptoms. R1 has chronic mental illness and thinking, and judgement are compromised. R1 becomes angry, agitated, and impulsive. R1 has limited ability to manage distress. 12/10/23, R1 grabbed and hit a certified nurse assistant that came into my room to provide assistance.</p> <p>R1's progress notes:</p> <p>V7 [Registered Nurse]:</p> <p>(continued on next page)</p> |  |  |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>11/15/2024, 1:25 PM, The CNA [V8 Certified Nurse Assistant] taking care of R1 called me to R1's room. R1 is being verbally rude and aggressive and not wanting V8 to care for her. Writer went and asked R1 if she wanted V8 to continue the care and R1 said 'yes it's her job, V8 should change me and get me up so I can call the police and tell them V8 hit me. Writer said that is fine and the CNA [V8] completed her work and writer helped get R1 up in her wheelchair. R1 then proceeded to call the police. Social service was called and informed of the situation.</p> <p>V7 [Registered Nurse]:</p> <p>11/19/2024, 1:49 PM, R1 made false accusations towards a CNA who was not assigned to her, that the CNA was digging his hands into his pants while standing in front of the nursing station, with other resident and staff around.</p> <p>Interviews:</p> <p>On 2/1/25, at 10:20 AM, R1 stated, All the staff members have fondled my breast all time every day. I do not know their name or what they look like. I have very large breasts and the staff like to play with them while washing me up and changing my clothes. The staff be lifting up my breast and moving them around washing underneath them, but I don't like them touching my breast. I could hold up my breast while the staff wash me, but I will not hold up my breast, they are heavy. The staff is getting paid to wash me up, I should not have to help them. When I got clean up today and dressed, my breast was not fondled. The president of the United States told me I can run any marathon I want to be in. I called the police, because I heard the current president is sending people back to where they belong. It is a lot of Africans here and I will call the police today so they can come and round up all the Africans and send them back to [NAME], before they touch my breast again. I be wet all the time the nurse assistants don't want to clean me up, because they do not like me. I have a menstrual cycle every month. My menstrual cycle came in November, December, and January. I do not have any concerns regarding my monthly cycle. I like being here in this facility. I have not been abused and I feel safe here. No one has called me any names, because I would have called the police.</p> <p>On 2/1/25, at 1:30 PM, V7 [Registered Nurse] stated, On 11/15/24, Certified Nurse Assistant [V8] asked me to speak to R1 because she was being verbally abusive to her [V8]. I asked R1 did she want V8 to continue given her [R1] ADL care and to get her dressed. R1 told me it was okay because it was V8's job to provide care. R1 also said, once I get dressed and, in my wheelchair, I'm going to call the police and tell them that V8 hit me. I told her that was fine and V8 continued to get R1 cleaned, dressed and I assisted V8 placing R1 into her wheelchair. R1 did in fact call the police. I did not report the allegation of abuse to the administrator, because R1 makes false allegations often. I documented the incident as a behavior note. I did not notify the administrator, director of nursing nor nursing supervisor, because I felt it was a behavior. On 11/19/24, R1 said the male certified nurse assistant put his hands inside of his pants at the nursing station facing her [R1]. I was at the nursing station typing. I could not see everything and everyone was moving around the nursing station. I did not report the allegation to the administrator or director of nursing because I felt the allegation was not true. I completed abuse training a few months ago. The abuse coordinator is the administrator. I know when to report abuse. For R1, her allegations are behavioral and delusional.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>On 2/1/25, at 2:15 PM, V8 [Certified Nurse Assistant] stated, On 11/15/24, R1 started to yell and swear at me during the ADL care process. R1 sometimes would be in a different mood and start yelling for no apparent reason. R1 was easily agitated, and tried to hit me, but a moved out the way. I left the room and got the nurse [V7] to assist me. I told V7 that R1 tried to hit me while I was providing care. V7 came into the room and spoke with her and calmed R1 down and asked was it alright if I proceeded to get her [R1] dressed and washed up. R1 said it was okay and that it was my job to do so anyway. R1 also reported to the nurse [V7] that I hit her after she knew that she tried to hit me. Also, R1 told me and V7 that once she gets up, she was going to report me to the police. V7 and I got her up in the wheelchair and R1 called and reported me to the police. I did not report the incident to the administrator nor director of nursing because I thought V7 was going to report the incident. On 11/19/24, I was not present at the nursing station to witness any male staff placing their hands in their pants. I received abuse training around December. The abuse coordinator is the administrator.</p> <p>On 2/2/25, at 8:52 AM, V16 [Licensed Practical Nurse] stated, R1 is smart, manipulative, and likes attention. R1 also has a lot of delusions with everyone. I hear her on her cell phone all the time having delusional conversations with the president of the United States and other people, but no one is on the other end of the phone. R1 likes to control everything, refuses care all the time. On all three shifts from time to time I work all three shifts and I'm very familiar with R1. There is a two person assist at all times with R1, due to so many accusations of abuse and delusions. However, if R1 tells me of any allegations I will report the allegation to the abuse coordinator. It is not up to me if the allegation is false or not. R1 has not reported staff calling her names. R1 receives care and supervision appropriately, from two person assist.</p> <p>On 2/2/25, at 9:30 AM, V17 [Licensed Practical Nurse] stated, R1 makes frequent allegations in the past, but R1 has two person assist at all times, which has slowed down the allegations. One day R1 told me that my hair was ugly and rough, that I need to be deported back to [NAME] and R1 called the police to come pick me up and deport me back to [NAME]. Even if I am having a conversation with another staff or resident R1 would join the conversation and think we were talking about her [R1]. Often R1 refuses ADL care, even if she is wet. Until she feels like being changed. R1 has not reported to me that staff or other residents has called her names. If R1 reported an allegation of abuse to me, I would immediately report it to the administration. If it involved a staff member, I would separate the two. The administrator is the abuse coordinator, I received abuse training about four months ago.</p> <p>On 2/1/25, at 3:15 PM, V1 [Administrator] stated, I was the assistant administrator here for five years, and the administrator for two weeks. If there were any abuse allegations while I was the assistant administrator, I would have been involved and made aware. I was not made aware of the reported allegations to V7 on 11/15/24, and 11/19/24 involving R1. I was not made aware on any recent allegation from R1 alleging staff members had fondled her [R1] breast, until today. I will submit the initial report to IDPH (Illinois Department of Public Health) today and start an investigation. All new hires receive abuse training and a test during orientation. All staff receives abuse training annually and as needed. I make rounds and talk with R1 often at least a few times per week. R1 has not reported any allegations of abuse. R1 does have delusions, psychosis, and bipolar disorder. Due to R1's delusions, R1 requires at all times two person assist. All staff received abuse training and know to notify the administrator of all alleged abuse allegations for proper investigations. V7 should have reported all allegations from R1 to me, immediately. It is not his responsible to determine if the allegations were true or not. V7 will be educated today.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Respond appropriately to all alleged violations.</p> <p>45111</p> <p>Based on interviews and records review, the facility failed to assess and conduct investigations for allegations of physical abuse for one (R1) resident in a sample of three reviewed.</p> <p>Findings include:</p> <p>R1's medical diagnosis includes but not limited to: Cerebral Palsy, unspecified, Schizoaffective disorder, unspecified, Morbid (severe) obesity, Unspecified Psychosis not due to a substance or known physiological condition, Bipolar disorder, unspecified.</p> <p>R1's MDS (Minimum Data Set) section C dated 01/06/2023 documents R1's Brief Interview for Mental Status (BIMS) as 13/15, indicating R1 has intact cognitive functional abilities. MDS section GG-Functional Abilities documents R1 needs Substantial/maximal assistance, dependent on staff for Activities of Daily Living (ADL) care, uses a mechanical lift for transfer and uses a manual wheelchair for mobility.</p> <p>On 02/01/2025, at 1:33 PM, R1 stated that last year (no date provided) during a mechanical lift transfer, staff hurt her knee and she thought staff did it intentionally, therefore R1 called emergency services because she was in pain, and she also informed V7(Registered Nurse-RN) but nothing was done. Nursing progress noted dated 10/07/2024, document R1 reported to V7 (Registered Nurse-RN) that R1 called emergency services stating staff hurt her during mechanical lift transfer.</p> <p>On 02/01/2025, at 12:44 PM, V7 (Registered Nurse-RN) stated he was R1's nurse on 10/07/2024, when R1 reported to him that during mechanical transfer, staff had injured her knee. V7 stated he did not assess R1, and he did not notify R1's physician because R1 has behavioral health issues and V7 did not think R1 was injured during transfer, therefore V7 notified Social Services instead. V7 stated he should have assessed R1 for any injuries and based on his findings, notify R1's physician and V1 (Administrator), so that R1's allegation of being hurt by staff during mechanical lift transfer can be investigated.</p> <p>On 02/01/2025, at 3:03 PM, V2 (Director of Nursing-DON)stated when R1 reported to V7 that during mechanical lift transfer, R1's knee was hurt by staff, V7 should have assessed R1 to make sure there were no injuries, notified R1's physician, V1 and V2 so that the physician can give orders for R1 and allegation of physical abuse can be investigated to determine if R1 was hurt intentionally or if it was an accident. V2 stated assessing and investigating allegations of abuse helps prevent resident abuse. V2 stated if V7 did not document his findings, then it was not done.</p> <p>On 02/01/2025, at 3:26 PM, V1(Administrator) stated that when R1 notified V7 that R1 was hurt during mechanical transfer on 10/07/2024, and that R1 had called emergency services, V7 should have notified R1's physician, V1 and V2 so that the allegation can be investigated to determine if R1 needed to be sent to the hospital for further assessments and possible treatment. V1 stated not reporting an allegation of abuse or incident can put a resident in danger. V2 stated she does in-services for reporting incident report to staff once a year and as needed.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Policy titled: Abuse Prevention Policy dated 10/2022 documents: -Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment, or misappropriation of resident property. Upon learning of the report, the administrator or a designee shall initiate an incident investigation.</p> <p>Policy titled Hoyer (Mechanical) Lift documents: A Hoyer (Mechanical) lift assists staff to lift and move a resident as safely and as easily as possible.</p> |  |  |