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	IL6002687	A. BUILDING: _____ B. WING _____	C 10/26/2021

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SHERIDAN VILLAGE NRSG & RHB	5838 NORTH SHERIDAN ROAD CHICAGO, IL 60660

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S 000	Initial Comments Complaint Investigation: Facility Reported Incident IL138735 of September 15, 2021	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 meet as evidenced by: Based upon interview and record review, the facility failed to provide supervision for one resident (R1) reviewed for supervision in the sample of 7. The facility failure resulted in R1 eloping from the facility, falling 2 times and sustaining multiple fractures and a brain bleed. Findings include: On 10/19/2021 at 1:19pm, surveyor inquired about the incident on 09/14/2021. R1 stated, "I (R1) was outside, walking. Then I (R1) fell and	S9999		

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S9999	Continued From page 2 broke my (R1) arm." Surveyor asked R1, how she (R1) got out of facility door. R1 stated she (R1) does not know, I (R1) was outside walking. On 10/20/2021 at 12:07pm, V10 (PRSD - Psychiatric Rehabilitation Service Director) stated, "R1 has history of mental illness. Schizo affective depressive type. R1 hears voices. R1 requires a lot of encouragement to participate in activities. R1 is heavily dependent on staff to maintain ADL (Activity of Daily Living)." On 10/20/2021 at 2:49pm, V11 (Dietary Aide) stated, "I (V11) left around 7:30pm, (V14) and I (V11) were punching the code, we (V11 and V14 (Cook)) pushed the door. The first door was closing slowly, and we (V11 and V14) pushed the 2nd door. We (V11 and V14) walked down the stair in front of the building when V14 realized someone (R1) was behind us (V11 and V14). R1 walked past us, she (R1) was walking fast. We (V11 and V14) walked back to the building and asked the janitor who she (referring to R1) was. The janitor did not see either because it happened so quickly. The two of us (V11 and V14) went back to her (R1) and walked behind her (R1). I (V11) asked her (R1) if she (R1) wanted to go back to the building to get a cigarette, she (R1) was walking fast, she (R1) was wearing big gym shoes, slopping then fell, and boom, (R1) was right back up. (R1) walked towards the school by the train station - redline. (R1) fell again and hit her (R1) headfirst on the gate of the school, face down. She (R1) tried to get back up. I (V11) told her (R1) to stay down. She (R1) tried to get back up. V14 called 911 the first time she (R1) fell. We (V11 and V14) also called the security desk prior to the first fall. Couple of CNAs and a nurse came. V2 (DON) came too. We (V11 and V14) called 911 the	S9999		

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second time she (R1) fell and trying to get up again. About less than 5 minutes 911 came." V11 further stated, "I (V11) have training about elopement, but I (V11) did not know it was a resident at first. I (V11) face time my friend V24 (smoke monitor) and she (V24) told me (V11) it was R1 before she (R1) even fell because I (V11) don't want to just walk behind anybody. Because I (V11) am not sure if she (R1) is a resident. I (V11) was close with her (R1) to make sure she (R1) was safe.

On 10/20/2021 at 2:55pm, V11 (Dietary Aide) stated, "The security that day was (V20). I (V11) think (V20) was in the bathroom." I (V11) did see the Janitor cleaning.

On 10/20/2021 at 3:30pm, V2 (Director of Nursing) stated, "In an ideal world, there should be someone monitoring the door due to safety issue."

On 10/20/2021 at 3:39pm, V20 (Security) stated, My Job Description: I (V20) answer the phone, I (V20) buzz people in and out, answer the door, I (V20) pass cigarettes and make sure everything remains peaceful and calm. My (V20) responsibility is to make sure I (V20) know who is coming and who is going.

On 10/20/2021 at 3:42pm, V20 (Security) stated, "I (V20) was on duty when (R1) left the building. I (V20) think it happened around 7:30pm I (V20) was in the washroom when it happened. I (V20) went to the ladies' room. I (V20) asked the housekeeper (V12) to watch my post so I (V20) could go to the bathroom/washroom." I (V20) know that she (R1) is a resident here. He (V12) said okay, and I (V20) just rushed to the

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washroom. I (V20) told him (V12), "Can you watch the front so I (V20) could go to the washroom." And he (V12) said "okay" when I (V20) got back he (V12) was telling me (V20) that something was wrong. He (V12) was telling about V2 the DON. V2 outside. I (V20) received a phone call from the smoke monitor, V24, that I (V20) needed to call a code yellow because R1 had got out and I (V20) immediately did that to let the staff know and the staff came downstairs, and I (V20) told them what was going on and what direction she (R1) was going.

10/20/2021 at 4:12pm, V12 (Housekeeping) with V17 (Mental Health Professional) translating for V12 stated, "On 09/14/2021 at around 7:30pm, (V20) did not ask me to watch the door. On that day, I (V12) saw V20 walked away from the security desk, came back and told me (V12) "I (V20) just went to the bathroom. What happened?"

On 10/20/2021 at 4:40pm, V12 stated, "I (V12) don't feel oblige to monitor the door because sometimes (V20) would just walk at the end of the lobby and would come back right away."

On 10/21/2021 at 9:23am, surveyor inquired if R1 would thrive in the community. V21 (Primary Care Physician) stated, "I (V21) find it difficult for (R1) to be on her (R1) own. For one thing, (R1) will not be taking her (R1) medication. Second thing, I (V21) don't know how she (R1) is gonna eat, and the weather is cold. (R1) would probably have starvation, missed her (R1) medication, be in pain and the weather is cold. All these things are worrisome and have effect on her (R1) health."

10/21/2021 11:34am, V13 (Registered Nurse/ADON) stated, I (V13) am familiar with

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R1's care. I (V13) was up there as the nurse, passing med, v/s taking care of all the residents on the unit, prior to what happened with R1. I (V13) remember R1 being at nurse's station, she (R1) was in a wheelchair, smiling in a wheelchair, 10-15 minutes go down the elevator. 15-20 minutes, I (V13) start hearing a code yellow, twice, called down the first floor to ask who the code was yellow on. I (V13) finish with resident. Problem, her (R1) wheelchair is right there I (V13) run outside. I (V13) could not imagine, roaming the area, came back, some of us, ambulance was there too, and R1 they were putting R1 in the ambulance. She (R1) had a red spot on her forehead, made comfortable, 2 other nurses on the scene. Bleeding to the forehead. There should be security at the door down stairs, monitoring the residents from going out the door. What I (V13) was told security lady, went to the bathroom, on the camera. 2 staff members came out the door, R1 parked the wheelchair in the lobby, before the door completely close, she (R1) caught and went out the door. Walked to the left, and the 2 staff members were going towards their right, running back inside the building, to see if R1 was one of the residents. Security was in the bathroom, one of them followed, V11 followed. Security, she (V20) was supposed to monitor the door but she (V20) stepped out to go to the restroom. Couple of other things. I (V13) believe she (V20) should be endorsing her (V20) post to someone but to who, I (V13) don't know. Safety issue.

On 10/21/2021 at 11:45am, surveyor inquired if R1 would thrive in the community. V13 stated, "(R1) is unstable in walking. I (V13) don't believe (R1) would be able to take (R1) medication. I (V13) don't think (R1) would survive in cold weather. There are risks to (R1) physical and

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S9999	Continued From page 6 medical status if (R1) is outside, in the community." 10/21/2021 at 11:57am, V22 (Nurse Practitioner) stated, I (V22) know she (R1) eloped and got a wound or a fracture last week I (V22) am only seeing her (R1) for mental health issue. I (V22) saw her last week. The staff told me (V22) that R1 eloped and that they found R1 on the street and R1 hit her (R1) head and broke her (R1) hip. Prior to elopement mental status. Her (R1) baseline: she (R1) is alert and oriented to herself (R1), she (R1) does not talk much. Surveyor asked V22 if she (V22) would expect R1 to thrive in the community. No, she (R1) is taking medications, how will she (R1) do that in her (R1) state, she (R1) cannot have independent life. She (R1) is not stable to live independently. Risks: She (R1) is psychotic, paranoid schizophrenia, we're giving her (R1) medication. If she's (R1) not taking her (R1) medication, she (R1) will be a harm to herself (R1) and to people around her (R1). Medical condition, we already know what happened to her (R1). She (R1) got a fracture. It is a safety issue. On 10/21/2021 at 12:14pm, V14 (Cook) stated, "On 09/14/2021 around 7:30pm, I (V14) was standing by the door, waiting for security to buzz us (V14 and V11) out. The security was not there." R1's Face Sheet was reviewed; R1's diagnoses include: Schizoaffective disorder, depressive type; Displaced fracture of base of neck of right femur; fall on same level; encounter for other orthopedic aftercare-status post right HEMI AND ORIF (Hemiarthroplasty and Open Reduction Internal Fixation) Presence of right artificial hip joint-Right hemiarthroplasty; unsteadiness on	S9999		

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feet; contusion and laceration of right cerebrum without loss of consciousness; Colles' fracture of right radius

Review of Prescription Order shows R1 was receiving significant medications.

Hospital history and physical reports in part for R1 dated 9/14/2021 shows, XR Hip 2-3 Views w/AP Pelvis Right Impression: Mid cervical fracture. XR Femur 2 Views Right Impression: Right femoral neck fracture. CT Brain/Head w/o Contrast Impression: The finds are concerning for a small acute hemorrhagic contusion in the right frontal lobe anterolaterally.

R1 (08/31/2021) Community Access Observation documented, in part "Is the resident able to participate in this Community Access Observation? No. If no, indicate reason: (R1) may not participate in independent community access due to history of elopement attempts, poor symptom management, impaired decision making, and low motivation to participate in programming to improve autonomy. Determination Score: 4. Level: Resident may not access the community independently related to safety factor."

R1's (09/15/2021) Reportable Event documented, in part "Description of Occurrence. On 09/14/2021 R1 eloped from the facility ... Called Hospital to follow up on R1 and was informed that (R1) had been admitted with DX (diagnoses): multiple fractures and a small brain bleed."

R1 (Print date 09/22/2021) Inpatient Discharge Instructions documented, in part "Your Diagnosis: Fall, Fracture of femoral neck, right, distal radial fracture, contusion of right frontal lobe."

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S9999	Continued From page 8 R1's (09/29/2021) Elopement Risk Review documented, in part "(R1) eloped from facility on 09/14/2021 resulting in hospitalization due to injury experienced during the elopement." R1's (10/04/2021) Resident Assessment Instrument documented, in part "Section C. Brief Interview for Mental Status (BIMS) score: 14. Section G. A. Bed Mobility: 3/3 Extensive assistance / Two+ persons physical assist." R1's (10/17/2021) Care plan documented, in part "Problem: (R1) readmitted with surgical wound to left frontal lobe Resolved 9/29/21 and Right hip/post-surgical dehiscence as of 10/13/21 and cast to right wrist (procedure noted as RLE (Right Lower Extremity) Hip Arthroplasty, RUE (Right Upper Extremity) distal radius fracture treated with cast, and sutures to Let frontal lobe). The (undated) Security Guard/Door Monitor (pertaining to Security Guard job Description) documented, in part "Purpose: The primary purpose of this position is to: Provide increased supervision and security. Greet all ... residents upon entering or leaving. Ensure the resident ... environment is as free from accidents and hazards as is possible. Immediately correct/address potential safety risk as prudent and warranted." The (undated) Housekeeping Aide Job description documented, in part "Purpose: The primary purpose of this position is to: provide housekeeping services to assure that a clean, orderly and home-like environment is maintained in accordance with current federal, state and local regulations. Duties/Responsibilities/Function: Ensure the resident/employee environment is as	S9999		

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S9999	Continued From page 9 free from accident and hazards as is possible. Immediately correct/address potential safety risks as prudent and warranted. Ensure that all elements of the facility's Abuse and Neglect policies are maintained and enforced as is possible. All other duties assigned." The (undated) LPN (Licensed Practice Nurse)/Charge Nurse - pertaining to LPN/Charge Nurse Job Description documented, in part "Purpose. The primary purpose of this position is to: Provide licensed nursing care to residents on assigned unit in accordance with current federal, state, and local standards, guidelines, and regulations. Duties/Responsibilities/Function. 3. Closely monitor and supervise all facility residents per facility policies and as warranted by good nursing judgement." (A)	S9999		