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 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN VILLAGE NRSG & RHB	5838 NORTH SHERIDAN ROAD CHICAGO, IL 60660

(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) COMPLETE DATE
S 000	Initial Comments COMPLAINT INVESTIGATION: 2188561/IL140393 Facility Reported Incident IL139517 of October 4, 2021	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2) 300.1210d)5) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 well-being of the resident, in accordance with 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: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements are not meet as evidenced by: Based on observation, interview and record review, the facility failed to perform the physician order for a wound care treatment dressing change; failed to perform a wound care dressing treatment according to facility protocol; failed to perform appropriate hand hygiene during a wound care treatment observation; failed to perform and document on the treatment administration record (TAR) that a wound care treatment was completed; failed to follow their	S9999		

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policy for turning and repositioning a bed bound resident; and failed to follow their facility policy on low air loss (LAL) mattresses. These failures caused R3's sacral pressure ulcer wound to decline and increase in size.

Findings include:

R3's Face Sheet documents, in part, that R3 is a 79 year old with diagnoses of cerebral infarction unspecified and pressure ulcer of sacral region, stage 3.

R3's Minimum Data Set (MDS), dated 11/4/21, documents, in part, that R3 has a Brief Interview for Mental Status (BIMS) score of 15 which indicates that R3 is cognitively intact.

On 11/29/21 at 12:26 pm, R3 was observed lying in bed with blankets covering R3's body from the waist to the foot of the bed. When this surveyor asked R3 when the last time R3 was turned and repositioned in the bed, R3 stated, "Early this morning," but R3 couldn't recall the exact time. R3 stated to this surveyor that nursing staff does not turn and reposition R3 every two hours as ordered. R3 stated that R3 stays in R3's bed in the room.

On 11/29/21 at 12:31 pm, V7 (Certified Nursing Assistant, CNA) entered R3's room, and this surveyor requested an incontinence check of R3 from V7. V7 donned gloves and pulled back R3's blanket, and a smell of urine was noted. V7 then left R3's room and returned with donned gloves, towels and clean linen. V7 cleaned R3's labia and groin, and V7 turned R3 to the left side by using the linens underneath R3. V7 stated, "There's not supposed to be two of these sheets against the wound." This surveyor verified with

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V7 that a flat sheet that was quadrupled folded and a thick incontinence pad was in between R3 and the low air loss mattress (LAL) on R3's bed. V7 next pulled back R3's quadruple folded flat sheet and thick incontinence pad that was underneath R3, and a strong odor of urine was noted along with a stain of urine that was observed extending to the borders of the folded sheet. R3's sacral pressure ulcer wound dressing was observed as soiled with a maroon, brown color and not intact. R3's sacral wound dressing was observed as not in contact with R3's wound. This surveyor asked V7 if R3's sacral wound dressing was intact to the wound, and V7 stated, "Yes." This surveyor asked V7 if R3's sacral wound dressing was touching the wound bed, and V7 stated, "No. I will tell (V8, Licensed Practical Nurse, LPN)." V7 completed cleansing R3's rectum and buttocks, and V7 removed R3's sacral wound dressing due to the tape falling off the side of the dressing. V7 did not cover the wound with any dressing and placed a clean, double folded flat sheet under R3. V7 turned R3 to the left side and positioned R1 with a pillow. V7 did not place any barrier cream on R3.

On 11/29/21 at 12:36 pm, this surveyor observed a sign posted on the wall in clear view above R3's head of the bed which documents, in part, "All Shifts: Please turn resident every 2 hours for wound healing ... Apply moisture barrier after each incontinent episode ... Per Wound Manager (V14)."

On 11/29/21 at 12:42 pm, V7 (CNA) stated that she (V7) was R3's assigned CNA. V7 stated that when she (V7) performed the incontinence check per this surveyor's request, it was the first incontinence care that she (V7) provided to R3 since at least 9:00 am this morning. The time

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S9999	Continued From page 4 frame from 9:00 am to 12:31 pm is approximately three and a half hours. On 11/29/21 at 12:49 pm, V8 (LPN) was observed opening the treatment cart drawers at nurse's station. V8 then pushed the treatment cart in front of R3's room. V8 stated that V14 (Wound Care Coordinator) was not in the facility today and that she (V8) would be performing R3's wound care treatment to the sacral wound. V8 reviewed the green treatment book on top of the treatment cart with R3's treatment administration record (TAR), and V8 said that she (V8) can see R3's order for a betadine rinse, but there is no betadine rinse in the cart. This surveyor and V8 read together R3's current treatment order from the TAR and retrieved the treatment supplies from the cart and placed them in a clean, clear bag. V8 stated, "I washed my hands in the bathroom before I came out with the cart." R3's November 2021 TAR, documented, in part, R3's orders as: "Site: Sacrum - Cleanse area with betadine rinse with NSS (normal sterile saline); pat dry. Apply gauze packing strips 1" (one inch), Calcium Alginate cover with dry protective dressing once daily and prn (whenever needed); order dated 10/21/21" and "Turn and reposition q (every) 2 hrs (hours) and prn; order dated 5/26/20." R3's November TAR contains missing documentation entries noted on dates of: 11/24/21, 11/25/21 and 11/26/21. On 11/29/21 at 12:54 pm, V8 walked over to nurse's station and removed gloves from a box and then knocked on R3's door with right bare hand. V7 was observed in R3's room and had positioned R3 to the left side with a sheet covering R3's body. V8 placed the bagged treatment supplies on top of R3's dresser and	S9999		

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S9999	Continued From page 5 removed the gauze packing strips bottle and normal saline syringe and placed them directly on top of the dresser table. V8 donned gloves without performing any hand hygiene and removed dry gauzes from supply bag and opened the normal saline syringe; then squeezed normal saline on the dry gauzes and cleaned R3's sacral wound. V8 doffed dirty gloves and did not perform hand hygiene. V8 did not perform the ordered betadine rinse. On 11/29/21 at 12:57 pm, V8 donned new gloves and used her (V8) left hand to hold the bottle of the gauze packing strips. V8 continually pulled out approximately four feet of gauze packing strip from the bottle, then balled up the gauze packing strip with her (V8) gloved hands and placed it on top on R3's sacral wound bed. V8 did not pack the tunneling area of R3's sacral wound. V8 then placed a 6 inches by 6 inches Calcium Alginate dressing on top of the gauze packing strip. V8 then asked V7 to hold the Calcium Alginate dressing in place, which V7 did with her (V7) gloved hand, while V8 removed the 4 inches by 4 inches dry border, protective dressing. V8 stated that she (V8) needed to "date" the outside of the dry border, protective dressing, so staff would know when it was changed. V8 then removed V8's gloves and walked out of room. V8 did not perform any hand hygiene. V8 opened all drawers of the treatment cart that was positioned directly outside R3's room. On 11/29/21 at 1:00 pm, V8 yelled out to R4 who was attempting to stand up from the reclining wheelchair in the hallway. V8 walked over and repositioned R4's legs back into the reclining wheelchair. On 11/29/21 at 1:01 pm, V8 walked over to nurse's station sink and washed her (V8) hands	S9999		

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S9999	Continued From page 6	S9999		

with soap and water for only 10 seconds. V8 then entered R3's room where V7 was still holding the Calcium Alginate dressing on top of R3's sacral wound. V8 then donned new gloves, dated the 4 inches by 4 inches dry border, protective dressing with "11/29/21" date and placed it on top of the 6 inches by 6 inches Calcium Alginate dressing. V8 attempted to attach the left side of the border dressing to R3's left buttock cheek, but it didn't stick to the skin. V8 then pressed the remainder of the dry border dressing on top of the Calcium Alginate dressing where the three remaining sides of the dry boarder dressing did not cover the outer edges of the Calcium Alginate dressing. This surveyor asked V8 if R3's wound dressing is intact to R3, and V8 stated, "That's the order in the box. I didn't have a bigger gauze (dry border dressing). I used what I had. There was no supply. I had to use the small one (dry border dressing)."

On 11/29/21 at 1:03 pm, after V7 and V8 completed R3's sacral pressure ulcer wound care dressing change, V7 did not place any barrier cream on R3.

V21 (Wound Physician) documented, in part, in R3's "Wound Evaluation and Management Summary" on 11/18/21 that R3's dressing treatment plan is to add Metronidazole gel daily; continue the primary dressing of Calcium Alginate and gauze packing strips; and the secondary dressing gauze island with border dressing.

R3's Physician Order Report (POS), documents, in part, current active orders, dated 5/26/21: "Site: Peri area/Buttock, May apply moisture barrier with each incontinent episode. Special instructions: May keep at bedside for CNA to apply. Every shift; days, evenings nights" and "Turn and

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S9999	Continued From page 7 reposition q (every) 2 hours & (and) prn (whenever needed). Every shift; days, evenings, nights." R3's POS, documents, in part, order dated 5/29/20, "Pressure reducing mattress. Continuous; days." R3's POS, documents, in part, order dated 10/21/21, "Site: Sacrum - Cleanse area with betadine rinse with NSS (Normal Sterile Saline), pat dry. Apply gauze packing strips 1" (one inch), Calcium Alginate cover with dry protective dressing once daily and PRN." R3's POS, dated 11/19/21, documents, in part, current active order, "Metronidazole gel, 1 % (percent); Topical; Once A Day; 9:00 am." V8 did not apply the Metronidazole gel during this surveyor observation of R3's observed wound care treatment on 11/29/21. On 11/29/21 at 1:07 pm, when asked how long V8 (LPN) should wash her (V8) hands with soap and water, V8 stated, "20 seconds." When asked about the wound care treatment order and supplies, V8 stated that she (V8) goes by the physician treatment order in the treatment book on top of the treatment cart. V8 stated that there are more treatment supplies in the basement of the facility and that V14 normally sets up the treatment cart with supplies. V8 stated that if the supply is not in the treatment cart, she (V8) will usually ask V15 (Central Supply Staff) for the supplies. When asked if V8 called V15 about treatment supplies not stocked in the treatment cart, V8 admitted that she (V8) did not call V15 because she (V8) was "in the middle of it" and she (V8) "did not check before I (V8) ever got started." When asked about the dry border, protective dressing being smaller in size than the Calcium Alginate dressing, V8 stated that she	S9999		

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S9999	Continued From page 8 (V8) didn't have a big border dressing in the treatment cart. V8 stated that one sheet should be used on a LAL mattress. R3's Care Plan, dated 1/7/20, documents, in part, that R3's problem of a Stage 4 pressure ulcer to sacrum, will be treated with the following approaches: "Assess the pressure ulcer for location, stage, size (length, width and depth), presence/absence of granulation tissue and epithelization. Keep clean and dry as possible. Minimize skin exposure to moisture. Keep resident off wound site. Provide incontinence care after each incontinent episode. Turn and reposition every 2 hours." R3's Care Plan, dated 5/12/21, documents, in part, that R3's problem of incontinence, will be treated with the following approaches: "Apply moisture barrier to skin as needed. Keep perineal area clean and dry. Provide incontinence care after each episode." V7 stated that R3 does not wear an incontinence brief because "it would keep the wound moist." On 11/30/21 at 1:08 pm, V14 (Wound Care Coordinator) stated that she (V14) is the only wound care nurse in the facility, and when she (V14) is not working, the floor nurses will perform the wound care treatments. When asked about the wound care treatment process from start to finish, V14 stated that the ordered treatment is located in the green treatment book on every floor and in the electronic medical record of the resident. V14 stated that nurses must "follow that specific order because that's what I (V14) get from the (wound) doctor." V14 stated that she does prepare and fill the treatment cart with supplies, and if the floor nurses find a lack of supplies in the cart, they are to contact V15	S9999		

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S9999	Continued From page 9 (Central Supply Staff) or V2 (Director of Nursing, DON). V14 stated that the nurse should wash hands before entering room or use alcohol based hand sanitizer (ABHS). V14 stated that another staff member will help with assisting R3 in turning in bed. V14 stated that the treatment supplies in the clean, clear bag will be place on top of the cleaned, bedside table. V14 stated with gloved hands, the nurse will remove the dirty wound dressing, put in dirty garbage bag, and wash hands or uses ABHS. V14 stated that the nurse will don new gloves and clean the wound. V14 stated that the nurse will remove gloves after cleaning wound and wash hands. V14 stated, nurse "don't want to go from a dirty surface to a clean surface" without performing hand hygiene. V14 stated that the nurse will next don gloves and apply the clean wound dressing treatment. V14 stated that R3's order for the sacral wound is for the Metronidazole gel. V14 stated that V21 (Wound Physician) recently changed to this order. V14 stated that with R3's gauze packing strip, the nurse will use a cotton swab or tongue depressor to place the gauze packing strip in the wound "because it's tunneling and must cover all hidden areas." V14 stated that the nurse will then insert the Calcium Alginate dressing in the wound and cover the wound with the dry, protective dressing. V14 stated that the Calcium Alginate dressing should not extend beyond the border of the wound. V14 stated, "It (Calcium Alginate) is a treatment and needs to be protected." V14 stated that she (V14) and floor nurses place their initials of their name on the TAR to show that the wound care treatment was done on a specific date and shift. V14 stated that the LAL mattress prevents sacral wounds from worsening by "distributing air throughout the mattress so resident is not on hard frame" and that it "relieves tension on the sacrum." V14 stated that one flat	S9999		

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S9999	Continued From page 10 sheet should be used on top of a LAL mattress. V14 stated, multiple layers of linens on a LAL mattress "will impede air flow and create moisture." V14 stated that she (V14) typed the sign for R3 that is posted above R3's bed. V14 stated that nursing staff is to turn R3 every two hours, keep R3 "clean and dry" and to perform incontinence care every two hours. V14 stated that she (V14) doesn't "want (R3's) wound soaked in urine" which would cause "bigger break down and infection." V14 stated that CNA's should apply barrier ointment after each cleansing and drying of the skin after each incontinent episode. When V14 was asked how often she (V14) is assessing R3's wound for size measurements and characteristics of the wound, V14 stated that the assessments are done every week, and "The documentation should be there." V14 stated that the facility did change wound care physicians recently so there are "gaps" in weekly wound assessments. On 11/30/21 at 2:23pm, V14 was asked for weekly skin assessments for R3 from 8/27/21 to current date, V14 provided this surveyor R3's weekly skin assessments for the requested time frame which was missing all of September. V14 stated, "September is not there. I can't tell you why I didn't do them. I am being honest with you. I do a lot and I am here by myself." At 2:46 pm "Me (V14) or the wound doctor wasn't here. It was Thanksgiving on 11/25/21. It should be every 7 days." V25 (Wound Physician) documented in R3's "Wound Evaluation and Management Summary" on 9/21/21 that R3's sacral wound measured "2.8 centimeters (cm) in length by 2.2 cm in width by 1.3 cm in depth," and no undermining is documented.	S9999		

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S9999	Continued From page 11 V21 (Wound Physician) documented in R3's "Wound Evaluation and Management Summary" on 10/7/21 that R3's sacral wound measured "5.1 cm in length by 2.6 cm in width by 1.3 cm in depth with 5.5 cm undermining at 12 o'clock." On 12/2/21 at 11:20 am, V21 (Wound Physician) stated that she (V21) has seen R3 for "about four" wound care visits and that she (V21) "inherited R3" from a previous doctor and is continuing R3's wound care weekly assessments. V21 stated that R3 has a stage 4 pressure ulcer to the sacrum. V21 stated that she (V21) sees R3 weekly and performs weekly measurements of the wound. V21 stated, "I (V21) did not see (R3) last Thursday because it was Thanksgiving, and I (V21) don't work on Thanksgiving." V21 stated that if she (V21) is not available to come to the facility weekly, then V14 will "see the resident and measure the wound." V21 stated, "R3 has an infection in (R3's) wound." V21 stated, "The fact that (R3) has not healed over time is there is a bioburden in place in the wound which will cut the healing, and our primary goal is to heal the wound. Bacteria will delay in wound healing. (R3) has a heavy bioburden with a stage 4 wound. Our goal is to decrease the bioburden and thus decrease infection." V21 stated that there is a daily treatment order for R3's sacral wound. When asked what V21's expectation of the facility staff is to perform the daily treatment dressing change as V21 ordered, and V21 stated, "Yes." V21 stated that using the Metronidazole gel will help R3's wound "heal from the inside out." When asked what V21's expectations are of the nursing staff to assist with wound healing, V21 stated that nurses are to keep doing what they are doing so to "prevent bacteria from taking over the wound." Asked V21 if staff should secure the dry border	S9999		

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	IL6002687	A. BUILDING: _____ B. WING _____	C 12/02/2021

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

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S9999	Continued From page 12	S9999		

dressing to minimize the amount of potential toxins entering the wound, and V21 stated, "Yes. The dressing should be secured all the time." Asked V21 if any harm or potential harm could be caused to R3's wound from this surveyor's observations, and V21 stated that bacteria can migrate into the wound. V21 stated that R3's wound is packed with the gauze packing strip which has antimicrobial properties. V21 stated, "R3's wound is colonized with bacteria, and (R3) doesn't have enough of an immune response." V21 stated, "The (gauze packing strip) is packed to all of wound so it will absorb any secretions." V21 stated that the purpose of the gauze packing strip and Calcium Alginate is to "absorb secretions" to remove secretions from the wound. V21 stated that R3 has secretions from the sacral wound. When V21 was asked if it is important then for nursing staff to maintain the intactness of the border dressing over the wound, V21 stated, "It needs to be secure outside the wound to have the (gauze packing strip) and calcium alginate stay put. It (border dressing) protects the (gauze packing strip) and Calcium Alginate."

On 12/1/21 at 11:26 am, V2 (Director of Nursing, DON) stated that residents are to be turned and repositioned every two hours, and incontinence care is to be provided by CNA's every two hours and whenever needed. V2 stated, "We want to prevent skin from being wet" with incontinent urine because this will "cause skin breakdown with urine eating at the skin." V2 stated that the facility has a "stock" barrier cream that is used for protection of a resident's skin against urine or feces. V2 stated, "CNA's are to use it (barrier cream) every time they change residents." V2 stated, "Hand washing is actually the number one thing to prevent any spread of infection." V2 stated that staff must wash their hands for a total

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S9999	Continued From page 13 of 20 seconds. R3's census report documents, in part, that R3 did not have any hospitalizations in 2021. Facility policy, dated January 2020 and titled "Prevention of Pressure Wounds," documents, in part: "The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors ... Interventions and Preventive Measures: General Preventive Measures: ... Residents with Risk Factors - Moisture: 1. Use a moisture barrier ... 4. Place resident on a minimum of a q (every) 2 hour check and change program ... Residents with Risk Factors - Bed-Fast: 1. Change position at least every two hours and more frequently as needed. 2. Use a special mattress that meets clinical condition ... Residents with Risk Factors - Bowel/Bladder Incontinence: 1. Check resident for incontinence at least q 2 hours and clean skin when soiled." Facility policy, dated January 2020 and titled, "Dressings Non-Sterile (Aseptic)," documents, in part: "Purpose: The purpose of this procedure is to provide guidelines for the application of non-sterile dressings. Preparation: ... 2. Review the resident's care plan, current orders ... 3. Check the treatment record. 4. Assemble the equipment and supplies as needed ... Equipment and Supplies: The following equipment and supplies will be necessary when performing this procedure. 1. Non-sterile dressing supplies ... 4. Alcohol based hand gel ... 6. Tape, scissors as needed. Procedure: 1. Prepare a clean, dry work area at bedside. 2. Bring supplies into resident's room. Individual resident supplies may be placed on the over bed table after it has been disinfected and a protective barrier placed on the table (clean	S9999		

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S9999	Continued From page 14 towel, plastic bag, small chux, foam tray and etc.) ... 5. Wash hands. 6. Prepare/open any necessary supplies on top of clean barrier ... 12. Apply clean gloves. 13. Clean or irrigate area/wound with solution specified in treatment order ... 15. Apply prescribed ointment and/or dressing per physician treatment order. 16. Secure dressing in place, if needed ... 21. Initial Treatment Administration Record (TAR) ... Documentation: The following information should be recorded in the resident's medical record or Treatment Administration Record: 1. The date and shift the dressing was changed. 2. The initials of the individual changing the dressing. 3. The type of dressing used and wound care given." Facility policy, dated March 2020 and titled "Hand-Washing/Hand Hygiene Policy," documents, in part: "Policy: It is the policy of the facility to assure staff practice recognized hand-washing/hand hygiene procedures as a primary means to prevent the spread of infections among residents, personnel, and visitors. Alcohol based hand rubs (ABHR) can be used for hand hygiene when hands are not visibly soiled or contaminated with blood or bodily fluids. Policy Specifications: 1. All personnel shall be educated on recognized hand-washing/hand hygiene procedures and shall follow such procedures ... 3. Facility staff must wash their hands for no less than twenty (20) seconds using antimicrobial or non-antimicrobial soap and water. a. Wet hands with clean running water (warm or cold) and apply soap. b. Lather hands by rubbing them together with the soap. c. Scrub all surfaces of your hands, including the palms, backs, fingers, between the fingers, and under your nails. Keep scrubbing for 20 seconds (e. g. hum/sing the Happy Birthday song twice). d. Rinse hands under clean, running	S9999		

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water. e. Dry hands using a clean towel. f. Turn off facet with a clean paper towel. 4. When hands are NOT visibly soiled, employees may use an alcohol-based hand rub (foam, gel, liquid) containing at least 60% alcohol in all of the following situations: a. before direct contact with residents ... c. before donning gloves ... f. before handling clean or soiled dressing, gauze pads, etc. ... j. after handling used dressings ... 6. The use of gloves does NOT replace compliance with hand-washing/hand hygiene procedures."

Facility document, undated and titled "Extended Care: Turning-Repositioning and Offloading Educational Training," documents, in part: "Goals: Preventions of Pressure Ulcers. Relieving Pressure from a Bony Prominence. Promotion of Skin Integrity. Relieve the Pressure: Reposition and turn residents frequently. Turn and reposition at a minimum of q 2 hours while in bed."

Facility policy, undated and titled "Low Air Loss Mattress Policy," documents, in part: "Policy: It is the policy of this facility to use Low Air Loss Mattress for pressure reduction. It is recommended for residents with stage III and IV pressure ulcers. Purpose: To provide additional pressure reduction and aid in the healing of stage III and IV pressure ulcers. Procedure: ... 2. It is recommended to reduce pressure therefore use mattress with a loosely fitted sheet or 1 pad or 1 draw sheet. It is not necessary to use a sheet with this product."

The undated, facility provided manufacturer guidelines for R3's LAL mattress documents, in part: "Combines two clinically effective therapies: Alternating Pressure with Low Air Loss in a portable blower based system. Provides proper pressure redistribution for the prevention and

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S9999	Continued From page 16 treatment of Stages I-IV pressure ulcers." Facility undated job description, titled "LPN/Charge Nurse," documents, in part: "The primary purpose of this position is to: Supervise the day to day CNA services for assigned unit to ensure that care is being rendered in accordance with current federal, state and local standards, guidelines and regulations. Provide licensed nursing care to residents on assigned unit in accordance with current federal, state and local standards, guidelines and regulations ... Duties/Responsibilities/Function: ... 7. Provide licensed care to assigned residents as ordered by physician and in accordance with facility, federal, state and local standards, guidelines and regulations ... 10. Ensure that appropriate documentation/charting is completed as required and in accordance with established policies and procedures. 11. Ensure that an adequate supply of floor stock medications, supplies and equipment is on hand to meet the nursing needs of the residents. Report needed items to the ADON and/or DON ... 20. Ensure that all aspects of resident care plans are implemented and maintained ... 23. Ensure compliance with infection control standards." Facility undated job description, titled "CNA," documents, in part: "The primary purpose of this position is to: Assist nursing personnel in providing nonprofessional nursing care and simple technical nursing services ... Duties/Responsibilities/Function: ... 4. ... Keeps incontinent residents clean at all times, changing linens as often as necessary ... 7. Making on-going rounds on assigned wing(s)/unit(s) no less than every two hours ... 11. Ensure that all residents assigned are turned and repositioned as care planned and promote positioning for	S9999		

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S9999	Continued From page 17 comfort." (B)	S9999		

LTC07202

COMPLAINT DETERMINATION FORM

FAC. NAME: SHERIDAN VILLAGE NRSG & RHB COMPLAINT #: 0140393
LIC. ID #: 0056143
DATE COMPLAINT RECEIVED: 11/16/21 14:00:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1
119	SOCIAL ACTIVITIES	2
206	HOUSEKEEPING	2
311	MENUS & MEALS NO VARIETY/SUBST/SMALL AMT	2
402	LACK OF STAFF	2

X The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

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