

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/06/2025
NAME OF PROVIDER OR SUPPLIER SHERIDAN AT TYLER CREEK, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 508 NORTH MCLEAN ELGIN, IL 60123		
(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
A 000	Initial Comment Facility Reported Incident IL198548 295.2000a)d)e)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 3 Violation Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) d) A resident with a condition listed in subsection (c) shall have their residency terminated in accordance with Section 295.2010. (Section 75(d) of the Act) e) Residency shall be terminated in accordance with Section 295.2010 when services available to the resident in the establishment are no longer adequate to meet the needs of the resident. This provision shall not be interpreted as limiting the authority of the Department to require the residency termination of individuals. (Section 75(e) of the Act)	A2000		

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/06/2025
NAME OF PROVIDER OR SUPPLIER SHERIDAN AT TYLER CREEK, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 508 NORTH MCLEAN ELGIN, IL 60123		
(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
A2000	Continued From page 1 Based on observation, interview and record review, the facility failed to terminate the residency of a resident whose needs could not be met by the facility for one resident (R1) out of three residents reviewed for residency requirements. Findings include: R1's medical record documents R1 has a diagnosis of dementia and depression. R1's 10/22 progress notes document "At approx 0400 CNA called NOD (Nurse on Duty) to resident room. Resident found laying flat on his back. Alert and verbally responsive. Complains of neck pain and that he hit his head on the floor. Said he was asleep and does not remember the fall, only waking up on the ground, no socks or shoes on. Resident being on eliquis and fall unwitnessed with head pain, NOD called 911. NOD took BP on L wrist, BP 153/93 P55, 2 paramedics arrived, put resident in c collar w/ tape and put him on back board, took VS, helped him to gurney, wife insisted to go with, so she and resident went to (Local) hospital via ambulance by 0425." Review of R1's falls in October and November show R1's fall happen during sleeping hours and R1 is found on floor next to bed. R1's Service plan documents R1 is independent with transfers, toileting and showers. R1's SLUMS (St Louis University Mental Exam) documents R1 is a 7/10 indicating R1 has severe cognitive impairment/dementia. On 12/5/25 at 9:40 AM, upon entry of R1's apartment, a very strong urine like odor was	A2000			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/06/2025
NAME OF PROVIDER OR SUPPLIER SHERIDAN AT TYLER CREEK, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 508 NORTH MCLEAN ELGIN, IL 60123		
(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
A2000	Continued From page 2 present, black stains on the carpet and R1 was sitting in his wheelchair with clothes on that do not appear clean. R1's hair is disheveled and as R1 approached this surveyor, a very strong urine like smell was coming from R1. R1 said the black stains are from him pouring his coffee on the carpet. When asked if he meant spilt, R1's wife spoke up and said "No, he pours his coffee on the carpet." R1 was asked about the falls and R1 was unable to recall any of the falls. R1 was asked if he uses his pendant to call for assistanc when he needs to go to the bathroom. R1 stated he doesn't need help and can do things on his own. At this time, this surveyor terminated the interview and had to step out of the apartment due to the foul odors. On 12/5/25 at 9:50 am, E4, Nurse, was asked about R1' apratment condition and E4 stated, "It really smells bad in there. (R1)'s apartment smells like that because (R1) urinates on himself, furniture. wheelchair and carpet, but refuses to get cleaned up." E4 stated that R1 has episodes of incontinence, but sometimes doesn't wear a depends. E4 stated the family won't provide any and R1 won't buy any. E4 stated that R1 also refuses to take showers sometimes weeks at a time and refuses housekeeping all the time. Staff try to talk into taking a shower, but he refuses and starts yelling and cussing at them. R1 also refuses to eat meals in the dining room and eats all his meals in his apartment. E4 was asked about the coffee stains on the carpet and E4 stated they don't know why he does that. On 12/5/25 at 9:55 AM, This surveyor asked E6, Housekeeping Supervisor, if he had to time to discuss R1's aparment. E6 replied "Let me guess, it's about the smell and staings." E6 stated that housekeeping has been trying to get in and	A2000			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/06/2025
NAME OF PROVIDER OR SUPPLIER SHERIDAN AT TYLER CREEK, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 508 NORTH MCLEAN ELGIN, IL 60123		
(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
A2000	Continued From page 3 clean R1's apartment, but he refuses all the time. The last time they were able to shampoo the carpet was back in March 2025. On 12/5/25 at 10:00 AM, E1, Executive Director, stated that R1 has been given an involuntary discharge due to non-payment and received a court order for eviction, but they have not been able to find him placement due to his refusals of care. E1 stated the family has nothing to do with him so they also filed for a state guardian. They have been trying for months to discharge him, but the court finally issued an extension on their eviction. E1 stated that the facility can not meet his needs. On 12/5/25 at 12:02 PM, E1 provided this surveyor with a list of facilities they have called for placement along with the state guardian request information, the signed lease and IVD information. On 12/5/25 at 5:50 PM, E2 provided this surveyor with R1's progress note dated 5/25/25 that documents "Resident continues to refuse ADL care from staff, which includes, showering, skin checks, grooming reminders, toileting. Resident is incontinent of bladder and bowel at times. Resident has a strong odor of urine. This writer explained the risks of skin breakdown related to prolonged sitting in wheelchair daily and urine incontinence. Resident stated, "Do you think I care if I smell like urine or 'explicit'. I don't care about that stuff." Writer again explained the risks of skin breakdown and the need for consistent hygiene for good health. Resident unwilling to shower or have writer check skin. This writer encouraged resident to consider allowing staff to offer stand by assist in the shower and for nurse to perform skin check. (E4), nurse was present	A2000			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/06/2025
NAME OF PROVIDER OR SUPPLIER SHERIDAN AT TYLER CREEK, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 508 NORTH MCLEAN ELGIN, IL 60123		
(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
A2000	Continued From page 4 for portion of conversation. Staff will continue to offer assistance and encourage showers and toileting assistance. Resident and wife did agree to allow house keeping to provide services." E2 followed this up by saying that R1 has been refusing housekeeping for a few months. On 12/5/25 at 5:48 PM, E1 stated that some of the facilities that they called for placement refused to take R1 because R1 and his family refuse to divulge any financial information to the facility or Medicaid. On 12/6/25 at 11:50 AM, E2 stated that R1 was almost always laying next to his bed when he attempted to get up to use the bathroom. He refused to shower, allow housekeeping to clean his apartment, it was hit or miss if he would wear a depends, urinates on himself then refuses to get cleaned up, gets verbally aggressive and swears at staff when they try to help and he rarely comes out of his room. E2 stated she had to convince R1 to take a showers because therapy was refusing to work with him due to the smell. E2 said one of the big problems is that R1 is independent with toileting, showers and transfers. He's on frequent rounding where staff check on him throughout the night. He knows to use the pendant when he falls. but refuses to use it at night. He pours coffee on his carpet, but not sure why. Housekeeping tried to clean, but R1 would refuse a lot so they had to come back another day and try again. She had to throw away a pair of his shoes because they were so saturated with urine and smelt really bad. E2 stated they thought this was all due to behaviors so they asked Psych services to do an evaluation on him, but he refused to be evaluated by the Psych Nurse Practitioner. E2 stated they have tried about everything they know but R1 keeps refusing	A2000			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/06/2025
NAME OF PROVIDER OR SUPPLIER SHERIDAN AT TYLER CREEK, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 508 NORTH MCLEAN ELGIN, IL 60123		
(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
A2000	Continued From page 5 everything. E2 Confirmed R1's SLUMS was a 7/30, but questions if the score was accurate due to his behaviors because he knows when to use the pendant and can confirm that he's been asked to use it for assistance at night. E2 stated they talked about moving him to the MC unit of the facility. E2 stated they have tried discharging R1, but all the facilities they've contacted won't take him because of all his refusals of care. E2 stated they are unable to meet R1's needs in the facility. On 12/6/25 at 1:03 PM, E1 was asked if R1 had been evaluated and considered for placement in the facilities memory care unit. E1 stated "We have discussed with the (R1)'s wife about R1 moving to memory care. They have refused, which they have the right to do. They want to live together and refuse to be apart. Even when we send (R1) to the ER, she always goes with him and will not let him go unless she goes along. We do not know their financial situation, but we can only assume it is dire, as they haven ' t paid their living expenses in many months. We cannot make the decision for them to take on a bigger debt without an advocate on their behalf. There has been and eviction notice in place for a while and the Sheriff has actually come to the building to evict them and we stopped it from happening because they did not have a safety net in place. The last time he was at (Local) hospital I spoke at length with the physician on his case as well as the nurse manager. I talked about his needs and the position we are in with no advocacy. The state is working on getting a guardian on their behalf, but the process is quite slow. (Local Hospital) refused to keep him but said they would follow up with a department that works on cases like this. I never heard back from them. We have an agency working on expediting guardianship on their	A2000		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ASL510318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/06/2025
NAME OF PROVIDER OR SUPPLIER SHERIDAN AT TYLER CREEK, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 508 NORTH MCLEAN ELGIN, IL 60123		
(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	
A2000	Continued From page 6 behalf. But until they have an advocate, we cannot force him to memory care if he refuses."	A2000			