STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510562	A. BUILDING: _____ B. WING _____	C 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN AT OAK BROOK	2055 CLEARWATER DRIVE OAK BROOK, IL 60523

(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 Incidents: IL196366 FRI 7/8/25 substantiated IL197047 FRI 7/28/25 unsubstantiated Annual Licensure Survey Violations: 295.5000 c) 1) 2) 3) 4) 5) 6) 7) d) f) 4) 5) 295.6000 a) 13)	A 000		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: General Violation Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage c) Supervision of self-administered medication means assisting the resident with self-administered medication using any combination of the following. Supervision of self-administered medication by unlicensed personnel shall be under the direction of a licensed health care professional. 1) Reminding residents to take medication; 2) Confirming that residents have obtained and are taking the dosage as prescribed; 3) Reading the medication label to residents; 4) Checking the self-administered	A5000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510562	A. BUILDING: _____ B. WING _____	C 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN AT OAK BROOK	2055 CLEARWATER DRIVE OAK BROOK, IL 60523

(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
A5000	Continued From page 1	A5000		

medication dosage against the label of the medication;

5) Opening the medication container for a resident who is physically unable to do so;

6) Confirming that residents have obtained and are taking the dosage as prescribed; and

7) Documenting in writing that the resident has taken (or refused to take) the medication.

d) Medication administration refers to a licensed health care professional employed by an establishment engaging in administering routine insulin and vitamin B-12 injections, oral medications, topical treatments, eye and ear drops, or nitroglycerin patches. Non-licensed staff may not administer any medication. (Section 70 of the Act)

f) If an establishment provides medication administration or supervision of self-administered medication, the establishment's medication policies and procedures shall be approved by a physician, pharmacist, or registered nurse and shall address:

4) Assisting in the self-administration of medication and medication administration, as applicable; and

5) Recording of medication assistance provided to residents and maintenance of medication records.

These Requirements are not met as evidenced by:

Based on interview and record review, facility failed to:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510562	A. BUILDING: _____ B. WING _____	C 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN AT OAK BROOK	2055 CLEARWATER DRIVE OAK BROOK, IL 60523

(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
A5000	Continued From page 2 Maintain medication administration records. R3 was to receive medications including but not liimited to cardiovascular health and treatment of urinary tract infections. Facility staff failed to document medication administration. Either follow preadmission evaluation with respect to medications which required R3 to have medications administered or complete self-administration medication evaluation as required by facility policy and procedure; and ensure resident receives medications as ordered when resident displays confusion. This deficient practice affects 1 resident(R3) out of 3 reviewed for medications in a sample of 8 and has high probability of resulting in R3 not taking important prescribed medications as required. Findings include: E2(Director of Nursing) is new to the facility and was not an employee at the time of the R3's admission to the facility. R3 has an initial admission nursing note on 2/3/2025 and has diagnoses of Vitamin D deficiency, Depression, Low Back Pain, anxiety and acute urinary tract infection (2/19/25). Nursing note of 3/27/25 documents R3 is sent to the hospital after being found on the floor and diagnosed with a right humerus fracture. A 3/28/25 nursing note states, "decision has been made that surgical intervention would not be necessary. R3 did not return to the facility after 3/27/25 and was not present in the facility during this review.	A5000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510562	A. BUILDING: _____ B. WING _____	C 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN AT OAK BROOK	2055 CLEARWATER DRIVE OAK BROOK, IL 60523

(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
A5000	Continued From page 3 Based on medication pre-admission assessment of 1/31/25 completed by E3(former Assistant Director Nursing), R3 requires "total" staff assistance with medications. However, based on nursing documentation of 2/4/25, 2/6/25, 2/23/25 R3's medications are "self-administered." A physician order or physician certification giving R3 ability to self-administer medications was not found to cover time period from admission to 3/20/25. 5-page physician plan of care also known as physician certification and dated 1/6/25 does not identify R3 as able to self-administer medications. E2(Director of Health and Wellness/Nursing) was informed after review of hard copy chart and electronic records, a physician order and self-administration assessment to support R3's ability to self administer medications was not found. E2 was asked to check the record for these documents. E2 forwarded a copy of a physician certification/plan of care dated 3/20/25 in which the advanced practice nurse writes R3 "May self-administer medications. Medication may be kept in resident's room and taken without staff supervision." This order was quickly rescinded on 3/24/25 or 4 days later when an order is written to discontinue self-administration of medications. Even with the APN's order to self-administer medications on 3/20/25, the Self-Medication Administration policy on page 1 under point 6 states, "A physician order does not supersede the requirement to demonstrate their ability to safely self-administer medications. The physician along with the HWD(health and wellness director) will	A5000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510562	A. BUILDING: _____ B. WING _____	C 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN AT OAK BROOK	2055 CLEARWATER DRIVE OAK BROOK, IL 60523

(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
A5000	Continued From page 4	A5000		

make the final determination of the residents' ability to self-administers based on the guidelines set forth in this policy." This policy also requires completion of a self medication administration assessment which based on review and interview was not completed.

There is no credible presented evidence such as the required self-administration assessment along with physician order required by facility policy and procedure titled, "Self-Medication Administration," to support R2 was able to self-administer medications safely.

E2 was informed of above and request for documentation supporting R3's ability to self administer medications was not forwarded.

Nursing note of 2/19/25 10:03 am documents, "(R3) with increased confusion and forgetfulness with complaints of pain while urinating." Urinalysis with culture was collected on 2/19/25 and as per 2/22/25 nursing note was positive for urinary tract infection with order to start Bactrim DS, 1 tab orally BID(twice a day) x 5 days. Despite documented confusion of 2/19/25 on 2/23/25 nursing note documents R1 "self-administered abt (antibiotic)."

On 9/2/26 at 12:15 pm, E2(Director of Health and Wellness) who was not employed by the facility at the time of these events stated, (R3) was never a self-administer meds. (E3) Assistant Director of Nursing marked (R3) as staff to administer. Empty spot (medication) not administered by staff. Maybe (R3) was taking pills on own? Should not have given herself meds when she's confused. (Reviewed notes from 2/25 with E2). The medication evaluation tool was not triggered because E3(former Assistant Director of Nursing)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510562	A. BUILDING: _____ B. WING _____	C 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN AT OAK BROOK	2055 CLEARWATER DRIVE OAK BROOK, IL 60523

(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
A5000	Continued From page 5	A5000		

in evaluation of 1/31/25 documented (R3) as "total: Resident requires assistance with medication." Service plan of 1/31/25 with scheduled reevaluation dated 10/9/25 identifies R3 as needing Total staff assistance with medication.

All orders for R2 were requested from E2(Director of Health). Completeness of orders forwarded cannot be verified. Physician's hand write orders.

Review of medication administration record for timeframe of 2/4/25 to 2/28/25 and 3/1/25 to 3/22/25 does not include documentation of medication administration for R3 as required by medication policy .

The following medications are listed on the medication administration record for February and March:

Amlodipine Besylate Oral Tablet 5 mg 1 tablet by mouth once (AM) daily. Amlodipine is a calcium channel blocker, a class of medications used for cardiovascular conditions.
Diazepam 2 mg tablet once daily. Acts as a sedative, anticonvulsant and muscle relaxant.
Metoprolol Succinate ER 25 mg once daily. Metoprolol is a Beta Blocker which treats cardiovascular issues.
Mirtazapine Oral Tablet 45 mg 1 tablet by mouth at bedtime. Mirtazapine is an anti-depressant.
Sulfamethoxazole-Trimethoprim (Also known as Bactrim) Oral Tablet 800 - 160 mg twice daily for 5 days(indication UTI(urinary tract infection). Start date is listed as 2/22/25. On 2/25/25 the medication administration record has nurse initials with DNA(drug not available) listed. On 2/23/25 at 7:00 am, the MAR documents administration by a nurse. The rest of the entries,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510562	A. BUILDING: _____ B. WING _____	C 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN AT OAK BROOK	2055 CLEARWATER DRIVE OAK BROOK, IL 60523

(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
A5000	Continued From page 6 2/23 at 7:00 pm, 2/24 am and pm, 2/25 am and pm, 2/26 am and pm, 2/27 am for this medication contain "X" in the administration box. According to the abbreviation explanation on the back of the MAR, an X refers to Self-administration without charting. Vitamin D3 2,000IU (50 mcg) tab 1 tablet by mouth once daily. Used to treat diagnosis of Vitamin Deficiency. Acetaminophen Oral Tablet 325 mg as needed every 6 hours. Acetaminophen is an analgesic. Diazepam 2 mg tablet 1 tablet by mouth every evening as needed. Ibuprofen oral tablet 400 mg 1 tablet by mouth every 6 hours as needed. It is not until March 24th the MAR starts to include nurse initials for administration of medications. It is not until March 24th, the MAR starts to include nurse initials for administration of medications.	A5000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: General Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect	A6000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510562	A. BUILDING: _____ B. WING _____	C 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN AT OAK BROOK	2055 CLEARWATER DRIVE OAK BROOK, IL 60523

(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
A6000	Continued From page 7	A6000		

or financial exploitation or to refuse to perform labor;

These Requirements are not met as evidenced by:

Based on interview and record review, facility failed to provide adequate supervision to prevent elopement by one resident (R6) out of 7 reviewed for elopement. Facility was not aware R6 had eloped during the nightshift until the hospital emergency room contacted them. This deficient practice has high probability of endangering R6 due to cognitive impairment, safety issue and facility delay in recognizing elopement during the night shift at 4:03 am.

Findings include:

At the time of this review, R6 was no longer a resident in the facility.

After 1 month in the Assisted Living facility, R6 elopes. Based on mental status evaluation performed at the facility and service plan, R6 is not safe to be outside unsupervised.

Accident incident report of 1/25/25 at 4:03 am documents elopement by R6 from the facility. The reports reads:
"Resident (R6) was seen on camera speaking with security guard then security letting him leave the facility. They didn't realize (R6) was a resident. (R6) was brought into () hospital 1 hour later by an unknown person. Bruising to right eye and scrapes to right hand/fingers."

According to 1/25/25 at 10:53 am nursing note, "Writer checked resident 2x this morning but was not in room, asked if caregiver has seen resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510562	A. BUILDING: _____ B. WING _____	C 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN AT OAK BROOK	2055 CLEARWATER DRIVE OAK BROOK, IL 60523

(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
A6000	Continued From page 8	A6000		

and caregiver stated no ..." Around 9:45 am, writer received a phone call from () ER (emergency room). Nurse() reporting that resident has been in the ER for 4 hours and 18 minutes ..."

Hospital after summary visit dated 1/25/25 document diagnoses of "contusion of scalp, laceration of scalp and renal insufficiency." Cerebral tomography of 1/25/25 shows, "subcutaneous hematoma over the right frontal region."

Facility nursing note of 1/25/25 at 11:53 am describes R6 as having "redness on right forehead, right eyebrow abrasion, bruising around right eye, redness on nose, cuts on left ring and middle finger ..."

R6's admission nursing note to Assisted Living is on 12/19/24. R6 has face sheet diagnoses including Mild cognitive impairment, encephalopathy, Depression, Bipolar disorder, Benign Prostatic Disorder, and Gastroesophageal reflux disorder. Glaucoma is listed as a diagnosis on a 3/20/25 physician certification. St. Louis University Mental Status examination of 12/23/24 is scored as 14. R6's score on 1/25/25 is lower and scored as a 4. A score of 14 and 4 indicates Dementia according to the scoring grid on the examination results. Born on 11/9/1952, R6 is 72 years old.

R6's service plan of 12/23/24 under neurocognitive heading includes statement describing R6 as "has current or history of occasional disorientation to person, place, time or situation that does not interfere with functioning in familiar surroundings ..." Psychosocial heading describes R6 as resistive to care and "needs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510562	A. BUILDING: _____ B. WING _____	C 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHERIDAN AT OAK BROOK	2055 CLEARWATER DRIVE OAK BROOK, IL 60523

(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
A6000	Continued From page 9 protection and supervision because participant makes unsafe or inappropriate decisions ..." After reviewing the documentation, on 8/26/25 at 1:30 am E2(Director of Health/wellness/Nursing) stated, "No should not be left outside alone building because unsafe and needs supervision."	A6000		