**Section 1: Lede**

The Sheridan Village Nursing and Rehabilitation Center’s website describes the facility as a place “where you can rehabilitate, heal and recover,” but the nursing home’s incident reports of the last two years say otherwise. One of the incident reports shows that the absence of staff around the elevators allowed a physical altercation between residents with punches thrown to go unnoticed without any awareness of the incident for days. This is just one example of abuse hindering residents’ abilities to safely heal and recover. In another, a resident grabbed another resident’s shoulders and unzipped his own pants repeatedly while saying sexually inappropriate phrases and touching his own private part despite the victim saying to stop several times. Additionally, the facility’s website claims staff continuously monitors both the medical and psychological progress of each resident in their care, but the incident reports include several instances of careless, improper documentation. Multiple incidents of abuse, sexual abuse and failure to document and monitor residents’ progress has led to extensive harm and delays toward recovery.

**Section 2: Nutgrafs**

Over the past couple years, the state has cited Sheridan Village Nursing and Rehabilitation for a variety of problems, including lack of supervision leading to residents being abused, not assuring residents their right to be free of sexual harassment and not properly documenting patient and staff assessments.

The facility is rated as a one-star facility by IDPH, which is the entity that holds nursing homes accountable and tracks their performance in safe execution of residents’ recoveries and treatment during their time there. This story is based on incident reports that have been filed on the official IDPH website. Despite all the incidents of harm that have been reported, the nursing home has only been fined by IDPH twice for a total of $50 thousand in the last ten years; they received fines for failure to ensure documentation of weekly wound assessments, failure to ensure adequate care for residents with pressure ulcers and failure to supervise a resident who subsequently eloped.

The nursing home is in Edgewater, Chicago on Sheridan Ave, a very busy street close to the lake right off the north end of Lake Shore Drive. The average annual household income in the neighborhood is above $85 thousand, with very nice apartment buildings and condos surrounding the nursing home and lighting up the streets for blocks all around it. The nursing home is big enough that it occupies a block to itself separate from other buildings. It seems nice and upkept from the outside, with an illuminated sign of the nursing home’s name and a ramp going up to the doorway. I could only enter the lobby and it appeared well-kept, clean and fitting of the nice, visually appealing neighborhood it resides in.

The facility’s administration staff wouldn’t return repeated phone calls and emails in an effort to question them on the incident reports. The receptionist’s response was always that all administrators and owners were busy, in meetings or out of the building. The nursing home’s administrator is Della Richardson, and the owners are David Mashiach, Jake Mashiach, Rhonda Mashiach — all sharing the last name of Yechiel Mashiach, who at least partially owns fifty Illinois nursing homes with an average rating of 1.5 stars — and Rita Lipshitz.

A family member of one of the facility’s residents said the nursing home is “just like any other one I’ve seen — not the best.” However, the most recently available annual inspection report on April 15, 2022, only shows one complaint with a listed status of “no deficiency” and one facility-reported incident; keep in mind the IDPH, whom no entity is responsible to hold accountable, monitors and puts out the inspection reports for Illinois nursing home. Additionally, the inspection reports likely represent a mere fraction of the true magnitude of the problems consistent in nursing homes for several reasons: not all issues are documented since inspectors only visit once a year; many residents can’t speak up for themselves due to an inability to speak and dementia among many possibilities; and many residents would likely hesitate to complain out of fear for their conditions to get worse.

**Section 3: Harm**

The incidents reported include these two examples of harm:

* **06-05-2022:** The facility failed to prevent R1 from being physically abused by R2, who has a history of aggressive behavior. On 06/04/22, R1 and R2 were both on an overcrowded elevator together along with several other residents. R2 felt like R1 was invading their personal space, so R2 pushed R1 with considerable force to which R1 reacted by punching R2 in the face. The altercation ended by the time the elevator doors opened and the two residents, who used to be roommates, each went out to smoke. Neither R1, who has been diagnosed with schizoaffective disorder, nor R2, who has been diagnosed with paranoid schizophrenia, reported the incident and none of the staff knew about it until E6 (R2’s social worker) asked R2 about his black eye. R5, one of the residents on the overcrowded elevator who witnessed the altercation, also didn’t report the incident because they said, “It’s not my business.” Both R1 and R2 also said they still “feel safe” at the facility. E1 (Administrator) confirmed the accuracy of the actions reported according to camera footage.

**Facility Response:** The facility updated the Risk for Abuse Observations and Care Plans for R1 and R2, and social service monitoring will continue for each resident as well. All staff have also received in-services on the facility’s Abuse Prevention Policy and Procedures. Supervision by the elevator will also be increased to both prevent it from becoming overcrowded and monitor resident behavior. An administrator will complete an audit twice weekly for eight weeks to ensure interventions are in place for R1 and R2 as well.

* **01-19-2023:** The facility failed to assure R2 her right to be free of abuse,not following their Abuse Prevention Policy. On 12/30/22, R2, a 55-year-old woman diagnosed with Schizophrenia, was victim to R1 grabbing her collar and pushing her to the floor after catching R2 taking his snacks from his room. E3 (Social Service Director) was the first to respond to the incident as no other staff was seen in the area on-camera. E4 (Nurse) said they were assigned two floors to tend to and didn’t get to the incident until E3 was already talking to the residents. E5 (CNA) said they’re familiar with R2’s tendency to go into others’ rooms but wasn’t there for the incident at all because they were grabbing papers from the first floor. The facility sent R1 to the hospital for psychiatric evaluation and moved R2 two floors up, where she’d then get in an altercation with her new roommate, R3, on 01/19/23, in which R3 hit her in the head “three or four” times. R3 then pulled R2’s hair out, causing a bald spot, after R2 stole money from her purse. E1 (Administrator) said she recovered and returned 11 out of the 15 dollars that were stolen from R3, and the facility moved R2 to a different floor again. Care plans were also revised for R1 and R2, but R1 was found to have no emergency contact after his psychiatrist ordered him to be sent to the hospital.

**Facility Response:** There is no plan of correction included in the incident report.

**Section 4: Trends**

Some violations happened more than once, such as the facility’s dangerous trend of failing to protect residents from sexual abuse:

* **03-18-2022, 09-08-2022:** The facility has several recorded instances of failure to prevent sexual harassment and abuse, not following the Abuse Prevention Policy. For the 03/18/22 incident report, the facility failed to provide supervision for R3, a cognitively impaired woman, who was kissed without consent by R2, an oriented male resident. R3 has been diagnosed with paranoid schizophrenia and R2 has been diagnosed with schizophrenia. On 02/21/22, R2 approached R3 in the third-floor dining room and started kissing her, followed by R4 going to the nursing station to tell E8 (Licensed Practical Nurse), E9 and E10 (CNAs) who immediately separated them but couldn’t see the incident on cameras somehow. R4 claimed there were no staff or other residents around, and E5 (R.N.) said this is probably because the CNAs were gathering other residents for the early breakfast at 7 a.m., which was the usual time for R2, R3 and R4. E10 said that R3 is “very passive” and wouldn’t initiate anything like that, while also noting that R2 and R4 used to be in a consensual relationship, and each got reprimanded for publicly kissing and “fondling” each other. E10 also mentioned that R2 would commonly roam around at night, going into peers’ rooms and do “whatever he wants.” Both R2 and R3’s care plans were already up to date. For the 09/08/22 incident report, the facility failed to ensure a resident their right to be free from physical and sexual abuse. Both male residents, R1 grabbed R2’s shoulders and wouldn’t stop unzipping his own pants while R2 repeatedly said no and tried pushing his hands away. R2 also said R1 told him he’d “bust my booty” and kept his hand placed on his private part. E12 (Nurse) found this happening and immediately intervened followed by calling E1 (Administrator). There’s an additional incident of similar nature from 01/21/22 in which an oriented male resident sexually abused a cognitively impaired female resident by making contact to her breast over her clothing.

**Facility Response:** For the 03/18/22 incident, R2 was discharged to a hospital and never returned to the facility while the Abuse Risk Assessment and Care Plan were updated for R3. Interventions with R3 were also added into his plan for increased monitoring and supervision. An administrator will also update the audits for all cognitively impaired residents weekly for eight weeks. These audits will also be reviewed by the Quality Assurance committee for two months. All Care Plans will also be reviewed for all these same residents, as well as all residents who have shown sexually inappropriate behavior. For the 09/08/22 incident, R1 was immediately discharged, and the facility called the police as he became agitated while being reprimanded. No one ended up returning for the results of the investigation, and R1 never returned. For R2, his Abuse Risk Assessment and Care Plan were updated, and the facility ensured social service monitoring would continue to assure he feels safe. All staff members also received in-services on the facility’s Abuse Prevention Policy, and an administrator will complete weekly audit updates for two months.

**Section 5: Ending**

In addition to the physical and sexual abuse residents have been subjected to from other residents in the building, the staff’s lack of attention to detail with documentation has also caused more than one resident harm during their stay. This is just one case of such events:

* **01-06-2022:** The facillity failed to ensure documentation of weekly wound assessments, to follow the Low Air Loss Mattress Policy (LALM) and to ensure the LALM was appropriate for two residents (R2 and R3) to use. The 12/09/21 pressure ulcer report shows that R2 and R3 each sustained stage-4 sacrum pressure ulcers since being admitted to the facility that haven’t healed yet. The 01/05/22 pressure ulcer report was submitted incorrectly, as E8 (Assistant Director of Nursing) claimed E4 (Wound Care Nurse) must have missed at least a couple weeks because she submitted an old report from weeks earlier. E6 (Licensed Practical Nurse) said, “I don’t know too much about the settings,” when questioned about R2’s LALM mode that’s required by policy according to R2’s care plan. Subsequently, R2 had too many layers and folded blankets on the bed with them when the resident’s notes state “a draw sheet” is all that’s allowed on the bed while in LALM mode. E7 (CNA) said, “I don’t touch the settings... I actually don’t know,” when questioned about R3’s bed settings, and E4 said they didn’t receive any in-service on appropriate use of the LALM settings. E10 (Medical Director) said if the weekly wound assessments aren’t conducted, the resident won’t get better and sacrum wounds won’t heal without the treatment plans being followed.

**Facility Response:** R2 remains in the hospital while R3’s LALM setting has been set properly with one unfolded sheet under the resident as the policy states. All nursing staff have received in-services on updated LALM policy and the settings of the beds, weekly wound assessments being filed timely and notifying the nurse when the treatment isn’t secured. A designated administrator will also complete weekly audits on all residents with pressure ulcers for eight weeks to ensure weekly wound assessments are completed in a timely manner. A similar audit will be completed three times a week for residents with LALM settings required in their care plans.