Illinois Department of Public Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		IL6005177	B. WING		C 07/14/202	2
NAMEOF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		-
APERIO	N CARE LAKESHORE		RTH SHERIE), IL 60626	DAN ROAD		
(X4)ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COME	(5) PLETE NTE
S 000	Initial Comments		S 000	<u> </u>		<u> </u>
	Complaint Investiga	ation 2285004/IL148406				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	a) The facility s procedures governing facility. The written be formulated by a l Committee consisting administrator, the administrator, the administrator, the administrator, the administrator, the administrator, the administrator, the facility and other policies shall comply The written policies the facility and shall by this committee, d and dated minutes of	dvisory physician or the mmittee, and representatives r services in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least annually locumented by written, signed of the meeting.	iet. A		#1	
	h) The facility s physician of any acc change in a residen health, safety or wel but not limited to, the manifest decubitus t	Medical Care Policies shall notify the resident's cident, injury, or significant t's condition that threatens the fare of a resident, including, e presence of incipient or ulcers or a weight loss or gain ore within a period of 30 days.				
	The facility shall obt	ain and record the physician's care or treatment of such		Attachment A Statement of Licensure Violations		
ois Deartr	ment of Public Health					_

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

TITLE

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	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		с	
		IL6005177	D. 111113		07/1	14/2022
IAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S			
PERIO	N CARE LAKESHOR	E	RTH SHERIDA D, IL 60626			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
S9999	Continued From p	age 1	S9999			1
		change in condition at the time				
	Section 300.1210 Nursing and Perso	General Requirements for anal Care			<i>i</i> t	
	b) The facility care and services	shall provide the necessary to attain or maintain the highest				
	well-being of the re	al, mental, and psychological esident, in accordance with				
	plan. Adequate an	mprehensive resident care d properly supervised nursing care shall be provided to each	8			10
8		e total nursing and personal	N 19			
ļ	nursing care shall	o subsection (a), general include, at a minimum, the be practiced on a 24-hour,				
		basis: atments and procedures shall s ordered by the physician.				
	5) A regul treat pressure sore	lar program to prevent and es, heat rashes or other skin				
	seven-day-a-week enters the facility v	e practiced on a 24-hour, basis so that a resident who vithout pressure sores does not				
	clinical condition d	sores unless the individual's emonstrates that the pressure dable. A resident having				
	pressure sores sha services to promot	all receive treatment and te healing, prevent infection,				
	and prevent new p	ressure sores from developing.	14			
	These requiremen	ts are not met as evidenced by:				
		tion, interview, and record				
	phone physician or	failed to correctly enter a rder, resulting in the improper being utilized; failed to report				
•	ment of Public Health		<u> </u>	· · · · · · · · · · · · · · · · · · ·		<u>.</u>
TE FORM	4		6699 51	39Z11		ation sheet (

Illinois Department of Public Health

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		
	OF CORRECTION	IDENTIFICATION NUMBER:				e survey Pleted
						с
<u>_</u>	<u></u>	IL6005177	8. WING			14/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
APERIO	N CARE LAKESHORE	7200 NOI	RTH SHERID	AN ROAD		
		CHICAGO	D, IL 60626			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			<u> </u>
11 12	abnormal findings t ensure wound treat ordered for one of t for wounds. These developing an infec	o the physician; and failed to ments were provided as hree residents (R2) reviewed failures resulted in R2 tion in R2's left foot wound nd requiring hospitalization.				
10	dated 6/27/22, dete indicating R2 is cog R2's Admission Rec diagnoses include, l diabetes mellitus, h	terview for Mental Status), rmined R2 had a score of 14, nitively intact. cord documents R2's medical but are not limited to: type 2 eart failure, acute kidney sis, and non-pressure chronic		2. 1.1 1.1		
	R2's Treatment Adn that Santyl Ointmen be applied topically day, with a start date discontinue date of there were 7 missin Santyl administratio order is documented with a D/C (discontin April 1st, until the D/ treatment document wound treatment or with a D/C date of 4 treatment document D/C date. R2's left p documented as QO	5/17/22. Within those dates, g documentations for the n. R2's left bunion treatment d as QOD (Every other day), nue) date of 4/14/22. From /C date, there were 5 missing tations. R2's left plantar foot der documented as QOD, /19/22, shows 6 missing tations from April 1st until the lantar foot wound order D, with a start date of 4/20/22 6 missing treatment				
		Assessment Details charted ADON/Assistant Director of				

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If continuation sheet 3 of 7

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND FLAI		IDENTIFICATION NUMBER:	A. BUILDING	i:	COM	COMPLETED	
	IL6005177		B. WING			C 14/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE			
		7200 NOE	RTH SHERI				
APERIO	N CARE LAKESHORE), IL 60626				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C			
PRÉFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 3	S9999				
	Nursing) document Moderate, Type - Po	s, in part, "Exudate: Amount - urulent."					
	physician note docu Doctor) documents, Illnesspresents to infection of left foot of purulent discharg	mergency Department) Imented by V30 (MD/Medical in part, "History of Present DED from nursing home for an woundthere is a focal point leMedical decision making: nfected wound left foot,					
-	start date of 7/12/22 Plantar Foot: Clean pat dry, apply Derma dressing) and Cal (o wound bed. Cover it gauze bandage) and	view Report, with an order documents, "Wound: Left with NSS (normal saline) and aCol (collagen matrix calcium) alginate on the with ABD pad, Kerlix (woven d tape. QOD (every other day) nunication type: Phone."					
	documented by V24 Practice Nurse), doc Application: DermaC	I Care consultation noted, (Wound Specialist/Advanced cuments, in part, "Topical Col Ag (collagen matrix plus CalAlginate (calcium			2		
	V15 (LPN/Licensed Nurse) prepare a col calcium alginate drea woven gauze banda V15 stated the woun every other Tuesday the dressing order to			đ.			
1	on R2's Treatment A	M, the surveyor inquired why dministration record from remany empty boxes. V15			\$		
	nent of Public Health						
ATE FORM		63	•• F	39Z11	if continuati	on sheet 4 of 7	

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY IPLETED
	<u></u> .	IL6005177	B. WING			C 14/2022
NAMEOF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
APERIO	N CARE LAKESHORE		RTH SHERIDA), IL 60626	N ROAD		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	COMPLE
S9999	Continued From pa	ge 4	S9999	<u></u>		+
1	nobody charted." V	e, but maybe means that 15 agreed if it is not charted, sure if the treatment was				
	inquired if V23 notif purulent exudate or stated she (V23) do notified the physicia	PM, when the surveyor ied the physician of the n R2's foot on 5/12/22, V23 pesn't remember if she (V23) in at that time, but added t notifying the physician."				
	puts in the order wh makes a new recom treatment? V15 stat pointed out the curr and V24's consultat (V15) used the (adv	PM, the surveyor inquired who ten the wound specialist mendation to the wound ted, "I do." The surveyor ent wound treatment order ion note. V15 stated she ranced wound care) dressing 2's dressing change on 7/12, er in incorrectly.	-			
	which indicates the added he (V24) wou type of drainage. V2 recall being notified V24 added if a wour ordered, that can lea exudate and eventu- infected." The surve the foot wound can l "Yes, especially a pa explained an infecte sepsis very easily du	ted purulent drainage is pus, presence of bacteria. V24 uld expect to be notified of that 44 stated he (V24) does not R2 had purulent drainage. Ind dressing is not changed as ad to "Extra fluid collection, ally of course it can become yor inquired if an infection in lead to sepsis. V24 replied, atient with diabetes." V24 d foot wound can lead to ue to poor skin resistance to			* ²	
	bacteria penetration The Wound Nurse J	in diabetic patients. ob Description, dated , in part, "Summary: The				

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С IL6005177 B. WING 07/14/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7200 NORTH SHERIDAN ROAD **APERION CARE LAKESHORE** CHICAGO, IL 60626 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (D (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S9999 Continued From page 5 S9999 Wound Nurse is responsible for providing primary skin care to residents under the medical direction and supervisor of the residents' attending physician, the Director of Nursing, or the Medical Director of the facility, with an emphasis on treatment and therapy of skin disorders. Essential Duties and Responsibilities include but are not limited to "Examine the resident and his/her records and charts and discriminate between normal and abnormal findings, in order to recognize when to refer the resident to a physician for evaluation, supervision or directions: identify, manage, and treat specific skin disorders ... foot problems such as corns and callouses, decubitus ulcers, bacterial, parasitic and viral skin infections." The Registered Nurse (RN) and Licensed Practical Nurse (LPN) job descriptions, dated 5/02/17, documents in part, "The RN/LPN is responsible for providing direct nursing care to the residents ... to ensure that the highest degree of quality care is maintained at all times." Essential duties and responsibilities include but are not limited to "Receive and transcribe telephone orders from physicians and record on the Physician's Order Form." The "Physician Orders-Entering and Processing" policy, dated 8/22/17, documents, in part, "Purpose: To provide general guidelines when receiving, entering, and confirming physician or prescriber's orders (a prescriber is noted as a physician, nurse practitioner, and a physician's assistant). Guidelines ...3. Notify the resident's physician (if not the prescribing physician), for verification if applicable." The "Foot Care" policy, undated, documents, in part, "Purpose: to provide comfort and prevent Illinois Department of Public Health

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If continuation sheet 6 of 7

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DAT	(X3) DATE SURVEY	
			A. BUILDING:			PLETED	
		IL6005177	B. WING			C 14/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		14/2022	
APERIO	N CARE LAKESHORI	E 7200 NO	RTH SHERID				
		CHICAG	O, IL 60626	·····			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET(DATE	
S9999	Continued From pa	age 6	S9999		······································	<u> </u>	
8 	time, date, treatme observations and d	and include pertinent and include pertinent escription of feet."					
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