STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEALSHIRE CTR OF EXCELLENCE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(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 Change of Ownership Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations Finding 1 of 5 300.661 Section) within 10 days of being hired. This failure has the potential to affect all 68 residents residing in the facility. Findings include: The facility provided census sheet dated 7/31/23 shows there are 68 residents in the facility. 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act [225 ILCS 46] and the Health Care Worker Background Check Code (77 Ill. Adm. Code 955). This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to conduct a background check for 5 Certified Nursing Assistants (CNAs The facility provided employee on-boarding file shows V12 (CNA) was hired on 5/10/23. Facility provided background check search form was conducted on 7/31/23; 82 days later. The facility provided employee on-boarding file shows V14 (CNA) was hired on 4/28/23. Facility	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEALSHIRE CTR OF EXCELLENCE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(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
S9999	Continued From page 1 provided background check search form was conducted on 6/2/23; 56 days later. The facility provided employee on-boarding file shows V16 (CNA) was hired on 5/1/23. Facility provided background check search form was conducted on 6/4/23; 34 days later. The facility provided employee on-boarding file shows V15 (CNA) was hired on 5/25/23. Facility provided background check search form was conducted on 6/15/23; 21 days later. The facility provided employee on-boarding file shows V13 (CNA) was hired on 5/19/23. Facility provided background check search form was conducted on 6/2/23; 14 days later. On 8/1/23 at 10:50 AM, V7 (Chief Operating Officer) said that the former HR director fell behind during the change of ownership and is no longer with the company. V7 said the background checks should have been completed within 10 days of hire but they were not. C Finding 2 of 5 300.610a) 300.1010h) 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEALSHIRE CTR OF EXCELLENCE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(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
S9999	Continued From page 2 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to notify the physician after a resident experienced a significant weight loss. This failure affects one of three residents (R3) reviewed for weight loss on the sample list of 11. Findings include: R3's Weights and Vitals Summary report dated 7/31/23 shows R3 had an admission weight of 220.2 pounds (lbs) on 6/29/23. On 7/6/23 R3 weighed 206.3 lbs resulting in a 6.3% weight loss in seven days. R3's Progress Notes report dated 7/31/23 shows	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEALSHIRE CTR OF EXCELLENCE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(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
S9999	Continued From page 3 only one Nutrition (Dietary) note from 7/5/23 at 3:10 PM. There were no progress notes indicating reporting the significant weight loss to the Registered Dietitian (RD) or the Physician. On 8/1/23 at 9:42 AM, V3, Registered Nurse (RN) said the physician or RD should have been notified of R3's significant weight change. V3 said a nurse will enter a progress note showing that the physician or RD were notified of a significant weight change. V3 said it is important to notify the physician or RD of a significant weight change so they can order supplements as needed. Facility Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol policy revised 9/17 states, "Assessment and Recognition: ... 4. The staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake." B Finding 3 of 5 300.610a) 300.1210a) 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.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEALSHIRE CTR OF EXCELLENCE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(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
S9999	Continued From page 4 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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: 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEALSHIRE CTR OF EXCELLENCE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(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
S9999	Continued From page 5 services to promote healing, prevent infection, and prevent new pressure sores from developing. This REQUIREMENT was not met as evidence by: Based on interview and record review the facility failed to ensure a resident at risk for pressure injury with current skin wounds was put to bed in a timely manner. This failure affects one of three residents (R7) reviewed for pressure injuries on the sample list of 11. Findings include: R7's face sheet shows he has diagnoses including Spinal Stenosis, Abnormal Posture, Polyosteoarthritis, and Lack of Coordination. R7's skin breakdown care plan initiated on 3/9/23 shows R7 is at risk to develop skin breakdown due to being incontinent of bowel and bladder. R7's care plan shows R7 has fragile skin to R7's bilateral buttocks and thigh. Interventions to prevent skin breakdown include turning and repositioning every 2 hours. R7's- 6/5/23 facility assessment shows he is cognitively intact and requires extensive two person staff assistance with transfers and bed mobility.	S9999		
	R7's- 7/24/23 wound physician progress notes show his wounds on the right thigh are 6 (centimeters) cm x 1cm x 0.1cm, right hip 5cm x 5cm x 0.1cm, and his left thigh are 5cm x 5cm x 0.1cm. All wounds are described as pink in color with scant about of serous drainage. R7's- 7/25/23 skin and wound note completed by			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEALSHIRE CTR OF EXCELLENCE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(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
S9999	Continued From page 6 V18 (Wound Nurse) states, "Patient seen by wound NP (Nurse Practitioner) yesterday to follow up on the wounds, Abrasion on right posterior thigh, right hip and left posterior thigh is improved. Patient was on bed rest x 4 days. Order to continue with the same treatment and to get up on the wheelchair for 2 hours each time." On 8/1/23 at 9:32 AM, R7 said he has concerns about an incident that happened on 7/27/23 when he was left up in his wheelchair for over 3 hours and staff would not put back to bed. R7 said he was gotten up out of bed by the day shift at around 2 PM. He said he went to an activity and returned to the unit about 3:30 PM he told a Certified Nursing Assistant/CNA (V11) that his bottom was hurting and he was sliding in his wheelchair. R7 said he heard an unidentified nurse telling the CNAs they needed to do vital signs. R7 said he waited and waited and at 4:05 PM, he asked the CNA (V11) again if he could be put to bed but the CNA told him he had to do vitals for other residents first. R7 said he was not put to bed until 5:10 PM and his bottom was hurting because he has skin irritation and a wound and this made it worse. R7 said he is not supposed to be up for more than 2 hours at a time. On 8/1/23 at 10:45 AM, V9 (Wound Nurse) said due to R7 having excoriated skin he is not supposed to be up longer than 2 hours at a time and when he is they notice his skin becomes more irritated. V9 said R7 should have been put back to bed sooner than 3 hours. The facility provided Repositioning policy revised May 2013 states, "The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEALSHIRE CTR OF EXCELLENCE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(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
S9999	Continued From page 7 development of an individualized care plan for repositioning, to promote comfort for all bed- or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents ... Residents who are in in a chair should be on an every one hour Q1hour repositioning schedule." B Finding 4 of 5 300.610a) 300.1620a) 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 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEALSHIRE CTR OF EXCELLENCE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(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
S9999	Continued From page 8 shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review the facility failed to administer prescribed medication at the prescribed time. This failure affects three of three residents (R5, R10, R11) reviewed for medication administration on the sample list of 11. The findings include: 1. On 7/31/23 at 9:25 AM, V5 (Nurse Supervisor) was observed during medication administration for R5. V5 did not administer R5's prescribed Insulin 15 units, Metoprolol 25 mg (milligrams), cranberry tablet and nasal spray. V5 said "I don't have the insulin yet; it was re-ordered on 7/27/23." R5's blood sugar was 147. V5 said, I can't find the cranberry stock medication, they split the medication cart I don't know what happened, maybe it's on the other med cart. V5 said she was holding to give the Metoprolol, because she did not have R5's blood pressure yet. R5's Medication Administration Record (MAR) for July 2023 shows orders for Fluticasone Propionate (Glucocorticoid) Nasal Suspension 50 MCG (micrograms)/ACT (actuator) 1 spray in both nostrils one time a day Insulin Glargine inject 15 units subcutaneous one time a day for diabetes at 8:00 AM.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEALSHIRE CTR OF EXCELLENCE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(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
S9999	Continued From page 9 Cranberry tablet 450 mg give one tablet twice a day. Metoprolol (Beta Blocker Antihypertensive) 25 mg give 0.5 tablet by mouth two times a day for hypertension hold if systolic blood pressure less than 100 or heart rate less than 60. R5's July MAR on 7/31/23 shows the Insulin Glargine 15 units at 8:00 AM and Fluticasone Nasal Spray to be given at 9:00 AM was not administered and documented "unavailable." 2. On 7/31/23 at 9:43 AM, V5 was observed during medication administration for R11. V5 did not administer the prescribed Fexofenadine-Pseudoephedrine (Antihistamine/Decongestant) extended release 12-hour, 60-120 mg for nasal congestion. V5 said to R11, I do not have your allergy medication. I need to re-order the medication, R11 stated, "Again, I need my allergy pill." R11's Medication Administration Record for July 2023 shows orders for Fexofenadine-Pseudoephedrine extended release 60-120mg give one tablet twice a day for nasal congestion. R11's MAR shows the Fexofenadine-Pseudoephedrine extended release 60-120 mg was not administered and documented "unavailable." 3. On 7/31/23 at 9:49 AM, V5 was preparing R10's morning medications. She prepared three oral tablets and R10's Insulin Lispro 5 units. V5 entered R10's room and handed R10 the medication cup with three pills in it. R10 said, where's the rest of my medications. "I usually get more than this." V5 said this is it. R10 said "oh	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEALSHIRE CTR OF EXCELLENCE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(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
S9999	Continued From page 10	S9999		

there's more." V5 left the room and to check R10's Electronic Medication Administration Record and clicked on the next page and there was two more pages of medications to be administered. V5 prepared R10's medications and counted a total of thirteen oral tablets. V5 did not administer R5's Amlodipine 5 mg and Potassium 20 MEQ (milliequivalents). V5 said "I'm only missing the Potassium."

R10's Medication Administration Record (MAR) for July 2023 shows orders for:
Potassium Chloride (Supplement) tablet ER (extended release) 20 MEQ give two tablets by mouth one time a day. The MAR shows the Potassium was not administered on 7/31/23 and documented "unavailable."
Insulin Lispro inject 5 units subcutaneous with meals for diabetes scheduled at 8:00 AM.

On 7/31/23 at 12:50 PM, R10 said it makes me upset when my medications are late, and the nurses don't know us. "They always give them too late."

On 7/31/23 at 12:53 PM, V5 said medications should be given at the scheduled time. If the medication is not here the staff should get the medication re-ordered, call pharmacy, and check the stock med.

The facility's Medication and Treatment Orders Policy revised 2016 states, "Orders for medications and treatments will be consistent with principles of safe and effective order writing. Medications shall be administered only upon the written order of a person licensed and authorized to prescribe medications ..."

B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEALSHIRE CTR OF EXCELLENCE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(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
S9999	Continued From page 11 Finding 5 or 5 300.3220 f) Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to perform daily weights on a resident per physician orders. This failure affects one of three residents (R6) reviewed for physician orders on the sample list of 11. The findings include: R6's Face sheet dated 8/1/23 shows the following diagnoses: Cholelithiasis with obstruction, anemia, Hypo-osmolality, Acute Cholecystitis, Urinary Tract Infection, Osteoarthritis of the right knee, Hyperlipidemia, Benign Paroxysmal Vertigo, Fracture of Sacrum, History of Transient Ischemic Attack, Fracture of Pelvis, Hypertension, Atherosclerotic Heart Disease, Congestive Heart Failure (CHF), Peripheral Vascular Disease, Chronic Kidney Disease Stage 3, Non-Rheumatic Aortic Stenosis, and Paroxysmal Atrial Fibrillation. R6's Order Summary Report dated 8/1/23 shows R6 has an active order for, "Daily Weight: Inform	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEALSHIRE CTR OF EXCELLENCE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(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
S9999	Continued From page 12 MD (medical doctor) if with weight gain of 2-3 lbs in a day or 5 lbs in a week" that was started on 7/14/23. R6's Weights and Vitals Summary report dated 8/1/23 shows R6 was last weighed on 7/14/23 with a weight of 127.7 pounds (lbs). R6 was weighed on 6/14/23 with a weight of 149 lbs. This weight triggered a significant weight loss of 14.3% in one month. On 8/1/23 at 9:42 AM, V3 (RN) said most residents who have orders for daily weights also have a diagnosis of CHF. Per V3, daily weights are important to capture any weight fluctuations due to fluid retention or loss. If weight changes are caught, the physician or dietitian can order supplements as necessary. V3 said R6's order for daily weights should have been followed. B	S9999		