(X6) DATE

(X3) DATE SURVEY

Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	LETED
		IL6005177	B. WING		05/0	3/2024
	PROVIDER OR SUPPLIER	7200 NOR	DRESS, CITY, S TH SHERIDA , IL 60626	STATE, ZIP CODE AN ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Annual Licensure S	urvey				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	1 of 3					
	300.610 a) 300.615 e) 300.615 f) 300.615 g)					
	a) The facility sprocedures governing facility. The written be formulated by a Committee consisting administrator, the amedical advisory conformities shall complete written policies the facility and shall by this committee, conformittee, co	dvisory physician or the ommittee, and representatives in services in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least annually documented by written, signed				
	Screening and Requesters Record Information Act for a Record Information Record Information Act for a Record Information Infor	uest for Resident Criminal				
Illinois Donor	Information Act for a	all persons 18 or older seeking				

(X2) MULTIPLE CONSTRUCTION

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

05/22/24 **Electronically Signed** 

TITLE

Illinois Department of Public Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.			
		IL6005177	B. WING		05/0	3/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
APERIO	N CARE LAKESHORE		TH SHERID. , IL 60626	AN ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	check was initiated Hospital Licensing be based on the reand other identifiers Department of Stat of the Act) f) The facility sname on the Illinois website at www.isp Department of Compage at www.idoc.sindividual is listed a g) If the result inconclusive, the fafingerprint-based of check is waived by based on verification resident is completed resident meets other existence of a smedical, or mental potential risk prese 2-201.5(b) of the Act a fingerprint-based a waiver from the Executiving inconclus background check background check days after receiving name-based check.  These requirement Based on record refailed to obtain Crin Response Process hours of admission R79, R118) in the total state of the requirement of the R118 of t	by a hospital pursuant to the Act. Background checks shall sident's name, date of birth, as a required by the e Police. (Section 2-201.5(b) shall check for the individual's Sex Offender Registration state.il.us and the Illinois rections sex registrant search state.il.us to determine if the is a registered sex offender. So of the background check are cility shall initiate a neck, unless the fingerprint the Director of Public Health on by the facility that the ely immobile or that the er criteria related to the lack of potential risk, such as severe, debilitating physical, condition that nullifies any inted by the resident. (Section of the Condition of the Condit	\$9999			

Illinois Department of Public Health

STATE FORM BM1T11 If continuation sheet 2 of 17

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	
		IL6005177	B. WING		05/03/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
APERIO	N CARE LAKESHORE		TH SHERIDA , IL 60626	AN ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
\$9999	Illinois Sex Offender (R50, R118, R621) sample; and failed to National Sex Offender (R50, R118) out of sample. For one rescriminal sexual assumants and care plan had runable to provide a documentation to service of 3/13/2018. V1 (A (Director Social Services) proceed to the completed 7/22/2013 documentation from Registry. National Section of 3/4/2024. V1 (Ad Social Services) proceed to the completed of 3/4/2024. V1 (Ad Social Services) proceed to the complete of 12/13/2017. V1 (Services Director) proceed to the complete of 12/13/2017. V1 (Services Direc	er Registry for three residents out of eleven residents in the to complete assessment of the der Registry for two residents eleven residents in the sident (R16) with history or ault, facility documentation resident at "low risk" but was riminal analysis or other upport a risk level of low.  Documents an admission date administrator) and V23 rvices) presented CHIRP was 19 with "HIT" result. No in the Illinois Sex Offender Sex Offender Registry (27/2022.  Documents an admission date aministrator) and V23 (Director esented documentation that eted with no date provided and administrator) and V23 (Director esented documentation that eted 2/5/2024 with "HIT" result.  Idocuments an admission date Administrator) and V23 (Social presented documentation that eted 8/13/2019. Illinois Sex documentation was 8/15/2019 ional Sex Offender Registry	S9999			

6899

Illinois Department of Public Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		IL6005177	B. WING		05/	03/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ADEDIO	N CADE LAVESHORE	7200 NOR	TH SHERID	AN ROAD		
APERIO	N CARE LAKESHORE	CHICAGO	, IL 60626			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 3	S9999			
	of 4/20/2024. V1 (A Services Director) p CHIRP was in prog Sex Offender Regis presented. On 5/2/2024 at 9:24 V23 (Director of So	documents an admission date dministrator) and V23 (Social presented records that a ress on 4/22/2024. No Illinois stry documentation was  AAM, V1 (Administrator) and chall Services) stated The				
	process for resident admission relative to identified offender assessment is as follows: The facility runs a background check, completes an Illinois and National sex offender check, checks with the Illinois Department of Corrections to determine if the resident has been incarcerated. Based on the background check, the "HITs" are reviewed. If the resident is an identified offender, the facility then submits for fingerprinting. If there is anything in the fingerprinting, Illinois state police are called to gather information and send for a Once the criminal analysis is returned, the facility determines the level of risk and care plans					
	accordingly. Reside offenders are deter low risk. This deterring the criminal analysis. Toffenders through the IDPH list to know discussed that document that every resident within 72 hours of Chave been checked Sex Offender Registen submitted to I (Director of Social Soff. Excuse me. Thi (Administrator) statt Services) is new and	ents who are identified mined to be high, medium or mination comes from the he facility reports identified				

Illinois Department of Public Health

STATE FORM BM1T11 If continuation sheet 4 of 17

Illinois Department of Public Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6005177	B. WING		05/0	3/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
APERIO	N CARE LAKESHORE	7200 NOR CHICAGO	TH SHERIDA , IL 60626	AN 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	documentation pro- Social Services) for includes State of III criminal sexual ass of age. Date of birth Identified Offender V1 (Administrator) determined to be a (Administrator) stat on criminal analysis produce criminal ar requests. Care plar Identified Offender: behavior. I have de admission screening	g process and does not				
	behavior. I have demonstrated stability during the admission screening process and does not appear to present at risk, fits criteria for an "identified offender". "Interventions: Low risk: observe for behavior changes."  Review of policy titled Admission of Identified Offender- Illinois, dated 11/28/2012 and revised 1/24/2018, stated: Guidelines:  1. Screened on Sex Offender websites.  2. Criminal history record information requested.  4. Facility must review screenings and all supporting documentation to determine if the placement is appropriate.  6. Information compiled must be disseminated to law enforcement, the parole officer, the division of Long-Term Care Filed Operations in the Department's Office of Health Car Regulation and other facilities licensed or regulated by the Department and the Illinois Department of Healthcare and family Services or the Illinois Department of Human Services.  8. No person who is an identified offender shall					

Illinois Department of Public Health

STATE FORM BM1T11 If continuation sheet 5 of 17

NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   T200 NORTH SHERIDAN ROAD   CHICAGO, IL 60626	STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
APERION CARE LAKESHORE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE DATE DATE DATE DATE DATE D			IL6005177	B. WING		05/0	3/2024
CHICAGO, IL 60626   CHICAGO, IL 60626     CK4)   ID   PROVIDER'S PLAN OF CORRECTION (CACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREGULATORY OR LSC IDENTIFYING INFORMATION)   PEPETIX TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAJI   D   SUMMARY STATEMENT OF DEFICIENCIES   D   PROVIDERS PLAN OF CORRECTION   PRETIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   PRETIX   TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   PRETIX   TAG   (EACH CORRECTION CATTON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	APERIO	N CARE LAKESHORE			AN ROAD		
requirements listed above are met.  16. (e) Facilities must maintain written documentation of compliance with these rules.  (C)  2 of 3  300.610 a) 300.625 c)2) 300.625 g)  Section 300.610 Resident Care Policies and procedures governing all services provided by the facility. The 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 300.625 Identified Offenders c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the	PRÉFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident.  The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and	\$9999	requirements listed 16. (e) Facilities mudocumentation of concentration of	above are met.  ust maintain written ompliance with these rules.  esident Care Policies shall have written policies and ing all services provided by the policies and procedures shall Resident Care Policy ng of at least the idvisory physician or the ommittee, and representatives or services in the facility. The ly with the Act and this Part. Is shall be followed in operating I be reviewed at least annually documented by written, signed of the meeting.  entified Offenders of a resident's criminal check reveal that the resident inder as defined in Section in the facility shall do the  72 hours, arrange for a riminal history record inquiry to the identified offender resident. The based on the subject's name,	S9999	DETIGIENCT)		

Illinois Department of Public Health

STATE FORM BM1T11 If continuation sheet 6 of 17

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6005177	B. WING		05/03/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
APERIO	N CARE LAKESHORE		TH SHERIDA , IL 60626	AN ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	State Police. The inthrough the files of Police and the Fedelocate any criminal may exist regarding Bureau of Investigat Department of Statinquiry under this shistory record information of Composition	inquiry shall be processed the Department of State eral Bureau of Investigation to history record information that the subject. The Federal tion shall furnish to the eral Police, pursuant to an subsection (c)(2), any criminal mation contained in its files. all maintain written compliance with Section eral maintain written compliance with Section eral History Information (CHIRP) for nine residents	S9999			

Illinois Department of Public Health

of 7/6/2023. V1 (Administrator) and V23 (Social

STATE FORM BM1T11 If continuation sheet 7 of 17

ILEGOS177  MAME OF PROVIDER OR SUPPLIER  APERION CARE LAKESHORE  T20 NORTH SHERIDAN ROAD  CHICAGO, IL 6028  PROVIDERS PLAN OF CORRECTION (BACK) IL 6028  PROVIDERS PLAN OF CORRECTION (BACK) IL 6028  SUMMARY STATEMENT OF DEPICIENCIES TAG  SUMMARY STATEMENT OF DEPICE OF DEPICE TAG  SUMMARY STATEMENT OF DEPICE TAG  SAMPLE SAMPARY  SAMP		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
APERION CARE LAKESHORE    CHICAGO, IL 60628   CHICAGO, IL 60628     CHICAGO, IL 60628   CHICAGO, IL 60628   CHICAGO, IL 60628     CHICAGO, IL 60628   CHICAGO, IL 60628   CHICAGO, IL 60628     CHICAGO, IL 60628   CHICAGO, IL 60628   CHICAGO, IL 60628     CHICAGO, IL 60628   CHICAGO, IL 60628   CHICAGO, IL 60628     CHICAGO, IL 60628   CHICAGO, IL 60628   CHICAGO, IL 60628     CHICAGO, IL 60628   CHICAGO, IL 60628   CHICAGO, IL 60628     CHICAGO, IL 60628   CHICAGO, IL 60628   CHICAGO, IL 60628     CHICAGO, IL 60628   CHICAGO, IL 60628   CHICAGO, IL 60628     CHICAGO, IL 60628   CHICAGO, IL 60628   CHICAGO, IL 60628     CHICAGO, IL 60628   CHICAGO, IL 60628   CHICAGO, IL 60628   CHICAGO, IL 60628     CHICAGO, IL 60628   CHICAG			IL6005177	B. WING		05/0	3/2024
CHICAGO, IL 60626   CHIC	NAME OF F	PROVIDER OR SUPPLIER			,		
PRÉFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 7  Services Director) presented records of a CHIRP in process on 777/2023 and completed 9/5/2023. Fingerprinting was requested 10/23/2023. R21 has not been submitted to the IDPH IO program.  R41's face sheet documents an admission date of 5/5/2023. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP in process on 5/6/2023 and completed 5/5/2023. R41 has not been submitted to the IDPH IO program.  R50's face sheet documents an admission date of 3/13/2018. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP in process on 5/6/2023 and completed 5/24/2023. Fingerprinting was requested 6/5/2023. R41 has not been submitted to the IDPH IO program.  R50's face sheet documents an admission date of 3/13/2018. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 7/22/2019. Fingerprinting was requested 5/25/2022. R50 has not been submitted to the IDPH IO program.  R68's face sheet documents an admission date of 3/4/2024. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed with to date. No fingerprinting documentation was provided by the facility. R68 has not been submitted to the IDPH IO program.  R79's face sheet documents an admission date of 2/2/2024. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 3/13/2024. R79 has not been submitted to the IDPH IO program.  R118's face sheet documents an admission date of 12/13/2017. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 3/13/2019. R118 has not been submitted to the IDPH IO program.	APERIO	N CARE LAKESHORE	•		AN ROAD		
Services Director) presented records of a CHIRP in process on 7/7/2023 and completed 9/5/2023. Fingerprinting was requested 10/23/2023. R21 has not been submitted to the IDPH IO program.  R41's face sheet documents an admission date of 5/5/2023. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP in process on 5/6/2023 and completed 5/24/2023. Fingerprinting was requested 6/5/2023. R41 has not been submitted to the IDPH IO program.  R50's face sheet documents an admission date of 3/13/2018. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 7/22/2019. Fingerprinting was requested 5/25/2022. R50 has not been submitted to the IDPH IO program.  R68's face sheet documents an admission date of 3/4/2024. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed With no date. No fingerprinting was requested solved with no date. No fingerprinting documentation was provided by the facility. R68 has not been submitted to the IDPH IO program.  R79's face sheet documents an admission date of 2/2/2024. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 2/5/2024. Fingerprinting was requested 3/13/2024. R7 has not been submitted to the IDPH IO program.  R118's face sheet documents an admission date of 12/13/2017. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 8/13/2019. R118 has not been submitted to the IDPH IO program.	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETE
R143's face sheet documents and admission	\$9999	Services Director) prin process on 7/7/2 Fingerprinting was has not been submited of 5/5/2023. V1 (Add Services Director) prin process on 5/6/2 Fingerprinting was not been submitted R50's face sheet dof 3/13/2018. V1 (Add Services Director) processed 5/25/202 submitted to the ID R68's face sheet dof 3/4/2024. V1 (Add Services Director) prompleted with not documentation was has not been submitted to the ID R79's face sheet dof 2/2/2024. V1 (Add Services Director) prompleted 2/5/2024 requested 3/13/2024 requested 3/13/2025 submitted to the ID R118's face sheet dof 12/13/2017. V1 (Services Director) prompleted 8/13/2025 submitted to the ID R118's face sheet dof 12/13/2017. V1 (Services Director) prompleted 8/13/2025 submitted to the ID sub	presented records of a CHIRP 023 and completed 9/5/2023. requested 10/23/2023. R21 itted to the IDPH IO program.  Documents an admission date deministrator) and V23 (Social presented records of a CHIRP 023 and completed 5/24/2023. requested 6/5/2023. R41 has 1 to the IDPH IO program.  Documents an admission date administrator) and V23 (Social presented records of a CHIRP 19. Fingerprinting was 12. R50 has not been PH IO program.  Documents an admission date deministrator) and V23 (Social presented records of a CHIRP date. No fingerprinting is provided by the facility. R68 ditted to the IDPH IO program.  Documents an admission date deministrator) and V23 (Social presented records of a CHIRP date. No fingerprinting is provided by the facility. R68 ditted to the IDPH IO program.  Documents an admission date deministrator and V23 (Social presented records of a CHIRP 4. Fingerprinting was 14. R79 has not been PH IO program.  Documents an admission date documents an admission date Administrator) and V23 (Social presented records of a CHIRP 19. R118 has not been PH IO program.	S9999			

Illinois Department of Public Health

STATE FORM BM1T11 If continuation sheet 8 of 17

Illinois Department of Public Health

TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  S9999  Continued From page 8  date of 8/22/2023. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 8/24/2023. Fingerprinting was requested 10/23/2023. R143 has not been submitted to the IDPH IO program.  R189's face sheet documents an admission date of 5/3/2023. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 5/5/2023. Fingerprinting was requested 5/10/2023. R189 has not been	STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
APERION CARE LAKESHORE  T200 NORTH SHERIDAN ROAD CHICAGO, IL 60626  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 8  date of 8/22/2023. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 8/24/2023. Fingerprinting was requested 10/23/2023. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 8/24/2023. Fingerprinting was requested 10/23/2023. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 5/5/2023. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 5/5/2023. Fingerprinting was requested 5/5/2023. Fingerprinting was requested 5/5/2023. Fingerprinting was requested 5/5/2023. R189 has not been			IL6005177	B. WING		05/0	3/2024
APERION CARE LAKESHORE  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 8  date of 8/22/2023. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 8/24/2023. Fingerprinting was requested 10/23/2023. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 8/24/2023. Fingerprinting was requested 5/3/2023. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 5/5/2023. Fingerprinting was requested 5/5/2023. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 5/5/2023. Fingerprinting was requested 5/5/2023. Fingerprinting was requested 5/10/2023. R189 has not been	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	APERIO	N CARE LAKESHORE			AN ROAD		
date of 8/22/2023. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 8/24/2023. Fingerprinting was requested 10/23/2023. R143 has not been submitted to the IDPH IO program.  R189's face sheet documents an admission date of 5/3/2023. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 5/5/2023. Fingerprinting was requested 5/10/2023. R189 has not been	PREFIX	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE	
submitted to the IDPH IO program.  R212's face sheet documents an admission date of 1/18/2024. V1 (Administrator) and V23 (Social Services Director) presented records of a CHIRP completed 1/19/2024. Fingerprinting was requested 3/13/2024. R212 has not been submitted to the IDPH IO program.  On 5/2/2024 at 9:24 AM, V1 (Administrator) and V23 (Director of Social Services) stated the process for resident admission relative to identified offender assessment is as follows: The facility runs a background check, completes an Illinois check with the Illinois Department of Corrections to determine if the resident has been incarcerated. Based on the background check, the "HITs" are reviewed. If the resident is an identified offender, the facility then submits for fingerprinting. If there is anything in the fingerprinting, Illinois state police are called to gather information and send for a Once the criminal analysis is returned, the facility determines the level of risk and care plans accordingly. Residents who are identified offenders are determined to be high, medium or low risk. This determination comes from the criminal analysis. The facility reports identified offenders through the IDPH portal. V1	\$9999	date of 8/22/2023. (Social Services Dir CHIRP completed 8 requested 10/23/20 submitted to the ID R189's face sheet of 5/3/2023. V1 (Ad Services Director) prompleted 5/5/2023 requested 5/10/202 submitted to the ID R212's face sheet of 1/18/2024. V1 (A Services Director) prompleted 1/19/202 requested 3/13/202 submitted to the ID On 5/2/2024 at 9:24 V23 (Director of Soprocess for residentified offender a facility runs a backgullinois check with the Corrections to detein carcerated. Based the "HITs" are reviewed identified offender, fingerprinting, Illinoing gather information acriminal analysis is determines the level accordingly. Residoffenders are deter low risk. This determinal analysis. T	V1 (Administrator) and V23 rector) presented records of a 8/24/2023. Fingerprinting was 023. R143 has not been PH IO program.  documents an admission date diministrator) and V23 (Social presented records of a CHIRP 3. Fingerprinting was 023. R189 has not been PH IO program.  documents an admission date administrator) and V23 (Social presented records of a CHIRP 024. Fingerprinting was 024. R212 has not been PH IO program.  4 AM, V1 (Administrator) and ocial Services) stated the of admission relative to cassessment is as follows: The ground check, completes an of elllinois Department of ormine if the resident has been of on the background check, weed. If the resident is an of the facility then submits for ore is anything in the ore is state police are called to of and send for a Once the ore returned, the facility ore of risk and care plans ore of the facility ore of risk and care plans ore of the facility reports identified ore of the facility reports identified ore of the facility reports identified	S9999	DETICIENCY)		

Illinois Department of Public Health

STATE FORM BM1T11 If continuation sheet 9 of 17

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		IL6005177	B. WING		05/	03/2024
	PROVIDER OR SUPPLIER N CARE LAKESHORE	7200 NOR	DRESS, CITY, S TH SHERIDA , IL 60626	TATE, ZIP CODE AN ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
\$9999	(Administrator) statt the IDPH list to know discussed that door that every resident within 72 hours of Chave been checked Offender Registry a submitted to IDPH Social Services) stame. This should ha (Administrator) statt Services) is new an (Administrator) statt Services) is new an (Administrator) statt Review of policy titl Offender- Illinois, di 1/24/2018, stated: Guidelines:  2. Facility must resupporting docume placement is appro 7. The facility shallong-term care field department's Office within 48 hours after that Illinois state po	ed that he has not looked at a who is on it. Surveyor umentation does not support has had fingerprinting ordered CHIRP receipt, not all residents I against the Illinois Sex and residents have not been IO program. V23 (Director of ated, "I am pi\$\$ed off. Excuse we been done." V1 ed V23 (Director Social ad expert in this area. V1 ed, "We will get this fixed." ed Admission of Identified ated 11/28/2012 and revised eview screenings and all intation to determine if the priate. Ill inform the division of	S9999			
	a) The facility	esident Care Policies shall have written policies and ing all services provided by the				

Illinois Department of Public Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		IL6005177	B. WING		05/0	3/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
APERIO	N CARE LAKESHORE	•	RTH SHERIDA , IL 60626	AN ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
\$9999	facility. The written be formulated by a Committee consisti administrator, the a medical advisory co of nursing and othe policies shall complicies shall complicies the facility and shall by this committee, cand dated minutes  Section 300.1210 (Nursing and Person b) The facility scare and services to practicable physical well-being of the releach resident's complan. Adequate and care and personal cresident to meet the care needs of the resident services to must be a supported to resident to meet the care needs of the res	policies and procedures shall Resident Care Policy ng of at least the dvisory physician or the ammittee, and representatives a services in the facility. The ly with the Act and this Part. I shall be followed in operating I be reviewed at least annually documented by written, signed of the meeting.  General Requirements for hall Care shall provide the necessary of attain or maintain the highest I, mental, and psychological sident, in accordance with apprehensive resident care I properly supervised nursing care shall be provided to each et total nursing and personal	S9999			

Illinois Department of Public Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6005177	B. WING		05/0	3/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	-	
APERIO	N CARE LAKESHORE		RTH SHERID <i>A</i> D, IL 60626	AN ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	urinary catheter, an urinalysis results in in R52 experiencing was left untreated.  The findings included 1. R52's Progress of PM, by V40 (Nurse The progress note of dysuria. R52 reports Repeat urinalysis woral antibiotics received on 4/30/2024 at 9:3 medical record inclus Nitrofurantoin Macrom MG, which was ordediscontinued 4/16/2001 (Nitrofurantoin MC, which was ordediscontinued 4/16/2001 (Nitrofurantoin MC, which was ordediscontinued 4/16/2001 (Nitrofurantoin MC, which was ordediscontinued 4/16/2001 (N	d failed to address R52's a sample of 35. This resulted burning with urination, which be:  note, dated 4/19/2024 at 12 Practitioner) was reviewed. Stated R52 complained of ed burning upon urination. The as ordered. R52 completed ontly.  B1 AM, review of the electronic uded an order for ocrystal Oral Capsule 100 ered on 4/9/2024 and 024.  PM, review of the urinalysis at 7:40 PM and resulted on AM, was positive for a small oudy clarity, the presence of stals, moderate leukocytes, WBC clumps were present, tein, many bacteria and white than 100.  B3 AM, V15 (Licensed N) was interviewed. Laboratory ectations to provider were N) stated the nurse receives and notifies the provider "in the N) entered the electronic (15 (LPN) reviewed the on 4/20/2024 and results on	\$9999	DEFICIENCY)		
	4/22/2024. V15 (LP the nurse notify the	on 4/20/2024 and results on N) stated the expectation is Nurse Practitioner of the reviewed the electronic health				

Illinois Department of Public Health

STATE FORM BM1T11 If continuation sheet 12 of 17

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		IL6005177	B. WING		05/0	3/2024		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
APERION CARE LAKESHORE			TH SHERIDA , IL 60626	AN ROAD				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
S9999	record and could not the urinalysis res (Director of Nursing process when labo the floor nurse comprovider of the result in the electronic he Nurse) was brough (DON), because V3 new. V25 (Wound health record and sersults to the provide occurred.  R52's progress not entered by V25 (Wellow "Relayed labs to NI UA and urine cultur collect urine."  On 5/2/2023 at 10:0 burning when she weeks. R52 stated burning came back urine sample today  On 5/02/24 at 10:0 reach V39 (Nurse Follow) (Nu	ot locate provider notification sults. V15 (LPN) contacted V3 g/DON). V3 (DON) stated the ratory results are received, is tacts the provider, notifies the ults, and enters that notification alth record. V25 (Wound t into the discussion by V3 g (DON) stated that she was Nurse) reviewed the electronic stated notification of urinalysis der was not documented if it  e, dated 5/1/2024 at 10:45 AM, ound Nurse). It stated: P/PPHR new order for repeat re. Notified nurse on duty to	S9999					

Illinois Department of Public Health

STATE FORM BM1T11 If continuation sheet 13 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
IL6005177		B. WING		05/03/2024	
NAME OF PROVIDER OR SUPPL	IER STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
APERION CARE LAKESH	)RF	RTH SHERIDA ), IL 60626	AN ROAD		
PREFIX (EACH DEFICI	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	/E ACTION SHOULD BE COM D TO THE APPROPRIATE DA	
facility today. V trying to get hol phone so that so Practitioner). V one that covers she is not availated a copy 4/22/2024 at 132 "Reviewed by V 4/22/2024 at 12 On 5/3/224 at 12 Was interviewed V39 (Nurse Practition was take (Administrator) (Nurse Practition on the culture a reviewed the unaction was take (Administrator) (Nurse Practition of the culture a reviewed the unaction was take (Administrator) (Nurse Practition of the culture a reviewed the unaction was take (Administrator) (Nurse Practition of the practitioner) stawas not that I woversight that the ordered." V39 (quality of care for two different processes of policic Notification - Cl 10/1/2015 and 11/13/2018, stamedical care processes of the processe	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13 facility today. V1 (Administrator) stated he is trying to get hold of V39 (Nurse Practitioner) by phone so that surveyor can speak to V39 (Nurse Practitioner). V1 (Administrator) stated there is no one that covers for V39 (Nurse Practitioner) when she is not available.  On 5/3/2024 at 10:10 AM V1 (Administrator) provided a copy of a document titled: Laboratory: 4/22/2024 11:39 Urinalysis. It documented "Reviewed by V39 (Nurse Practitioner) on 4/22/2024 at 12:23".  On 5/3/224 at 11:49 AM, V39 (Nurse Practitioner) was interviewed with V1 (Administrator) present. V39 (Nurse Practitioner) stated she was waiting on the culture and sensitivity results after she reviewed the urinalysis on 4/22/2024 before any action was taken on the urinalysis results. V1 (Administrator) reviewed the medical orders. V39 (Nurse Practitioner) and V1 (Administrator) confirmed no urine culture and sensitive was ordered until 5/2/2023, when V25 (Wound Nurse) contacted the nurse practitioner. V39 (Nurse Practitioner) stated, "I see what you are seeing. It was not that I wasn't seeing her, but it was an oversight that the culture and sensitivity wasn't ordered." V39 (Nurse Practitioner) stated, "The quality of care fell through because there were two different providers involved."  Review of policy titled Physician-Family Notification - Change in Condition, dated 10/1/2015 and updated 11/17/2017 and 11/13/2018, stated: Purpose: to ensure that medical care problems are communicated to the attending physician or authorized designee and				

IL6005177 B. WING 05/03/202	05/03/2024		A. BUILDING:	IDENTIFICATION NUMBER:	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			
		B. WING		IL6005177				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		STATE, ZIP CODE	DRESS, CITY, S	NAME OF PROVIDER OR SUPPLIER STREET ADD				
APERION CARE LAKESHORE 7200 NORTH SHERIDAN ROAD CHICAGO, IL 60626		AN ROAD		APERION CARE I AKESHORE				
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	N SHOULD BE COMPLETE DATE	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES	PREFIX	/ MUST BE PRECEDED BY FULL	(EACH DEFICIENC)	PRÉFIX		
S9999  Continued From page 14  2. R145's health record documented admission date on 11/13/2020, with diagnoses not limited to Chronic ischemic heart disease, Transient cerebral ischemic attack, Hyperlipidemia, Heart disease, Retention of urine, Unspecified open wound of right forearm, Major depressive disorder, Bipotar disorder, Unspecified atrial fibrillation, Elevated prostate specific antigen, Personal history of covid-19, Insomnia, and Acute ischemic heart disease.  Minimum Data Set (MDS), dated 4/4/24, showed R145's cognition was intact. He needed supervision or touching assistance with oral, tolieting and personal hygiene, upper and lower body dressing, chair/bed and toliet transfer; Partial/moderate assistance with shower/bathe self. MDS indicated R145 was continent of bowel and bladder.  Bladder function assessment, dated 3/6/24, showed R145 had no catheter.  On 4/30/24 at 11:01 AM, R145 was very agitated, screaming/yelling, showing his leg bag with yellow colored urine, and stating remove this (pointing to his urinary bag). 'Il don't need this, I can pee to the bathroom' in a very loud voice.  On 5/1/24 at 1:28 PM, V3 (Director of Nursing / DON) said, "For a resident with indwelling urinary catheter, a bladder function assessment should be done upon admission/readmission, quarterly, and as needed. Assessment is done to know the appropriate care or needs of the resident, justification of indwelling urinary catheter use, as resident will be put at risk for infection. Care plan should be developed as well for urinary catheter use. Care plan is like a road map of needs of the				cord documented admission with diagnoses not limited to eart disease, Transient attack, Hyperlipidemia, Heart of urine, Unspecified open arm, Major depressive sorder, Unspecified atrial I prostate specific antigen, covid-19, Insomnia, and Acute asse.  (MDS), dated 4/4/24, showed as intact. He needed hing assistance with oral, hal hygiene, upper and lower ir/bed and toilet transfer; asistance with shower/bathe d R145 was continent of bowel assesment, dated 3/6/24, no catheter.  If AM, R145 was very agitated, showing his leg bag with yellow stating remove this (pointing to don't need this, I can pee to very loud voice.  PM, V3 (Director of Nursing / resident with indwelling urinary function assessment should ission/readmission, quarterly, seessment is done to know the needs of the resident, elling urinary catheter use, as at risk for infection. Care planed as well for urinary catheter	2. R145's health redate on 11/13/2020 Chronic ischemic herebral ischemic adisease, Retention wound of right foreadisorder, Bipolar disfibrillation, Elevated Personal history of ischemic heart dise.  Minimum Data Set R145's cognition was supervision or touch toileting and person body dressing, chair Partial/moderate as self. MDS indicated and bladder.  Bladder function as showed R145 had in the bathroom of the b	\$9999		

Illinois Department of Public Health

resident to identify the concern and problem, put

IL6005177 B. WING 05/03/20	2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
APERION CARE LAKESHORE 7200 NORTH SHERIDAN ROAD CHICAGO, IL 60626	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRECTION (EACH CORRECTION SHOULD BE CORRECTION SHOULD BE CORRECTION (EACH CORRECTION SHOULD BE CORRECTION SHOULD BE CORRECTION (EACH CORRECTION SHOULD BE CORRECTION SHO	(X5) COMPLETE DATE
interventions appropriate for the resident, a plan of treatment based on the needs of the resident." Reviewed R145's electronic health record, no bladder function assessment completed, and no care plan found for urinary catheter use.  Facility's policy for bowel and bladder assessment dated 1/16/18 documented in part:  - A bowel and bladder assessment will be completed by a licensed nurse: Admission, quarterly and with significant resident changes, and as needed.  - The resident's plan of care will be developed to address the issue(s), goals and appropriate interventions for elimination program, using an interdisciplinary team approach.  3. On 4/30/24 at 11:33 AM, R39 was resting in bed alert and able to verbalize needs. R39 was noted with an indwelling urinary catheter.  On 5/01/24 at 9:52 AM, R39 was noted still with an indwelling urinary catheter. R39 stated it was inserted to help with R39's wound healing.  R39's Minimum Data Set (MDS), dated 3/14/24, shows R39 is cognitively intact. R39's physician orders with active orders as of 4/30/24 shows an order of: "Foley Catheter: 18 French 30 ML Balloon to Gravity Drainage. To promote wound healing." R39's electronic health records do not show a comprehensive lateder function assessment was completed related to the use of indwelling urinary catheter. R39's comprehensive care plan does not address the use of the indwelling urinary catheter.  On 5/01/24 at 2:58 PM, V32 (MDS/Care Plan Coordinator) stated all services provided to the residents should be addressed in the care plan	

6899

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6005177	B. WING		05/0	3/2024
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  7200 NORTH SHERIDAN ROAD  CHICAGO, IL 60626					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDSHOUND THE APPROVIDER OF THE APPROVIDER O	JLD BE	(X5) COMPLETE DATE
S9999	for the staff to know based on the care parties the use of indwelling addressed in the result of the facility's policy Plan", dated 11/17/develop and implementation of the staff of the st	what to do for the residents plan interventions. V32 stated g urinary catheter should be	\$9999			

6899