Illinois Department of Public Health (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: _ B. WING 08/18/2020 IL6009757 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7750 SOUTH SHORE DRIVE WATERFRONT TERRACE CHICAGO, IL 60649 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) S 000 S 000 Initial Comments Complaint investigation: 2084410 / IL00123629 S9999 S9999 Final Observations Statement of Licensure Violations: 300.1210 d)2) Section 300.1210 General Requirment for **Nursing and Personal Care** 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: All treatments and procedures shall 2) be administered as ordered by the physician. These regulations are not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow physician orders for wound dressing changes. This failure affects 2 residents (R1 and R2) out of 3 residents, reviewed for pressure sore treatment. Findings include: On 7/1/20 at 11:15 am, R1 was observed in with numerous wounds on him without dressings applied. V6 (Certified Nursing Assistant) said in the morning during the bath, she had V4 (Licensed Practical Nurse) come in and see that R1 had wounds; however, no dressing was applied. V6 stated V4 did see the resident, however, he left the room and did not say anything.

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois De	epartment of Public	Health	G		-	
STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		DENTIFICATION NUMBER.	A. BUILDING:		vom teles	
			D WINO		C	
		IL6009757	B. WING		1 08/18	3/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
		7750 SOU	TH SHORE D	RIVE		
WATERF	RONT TERRACE	CHICAGO	, IL 60649			
(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)	.DBE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	Nurse) said he is at the resident current placed. On 6/29/20 (Wound Doctor), he the orders were. Vadressings on the wand did not get a clawhen wound nurse are responsible for On 7/1/20 at 11:40 undated dressing daily but it wound doctor was nurse was here last dressing, but did nurse. The other nurse.	am, R2 was observed with on his buttock and left foot. R2 is supposed to change the t was only changed when the here on Monday. The wound of Monday, started the ot finish it. I told the other				
	Left foot Arterial Insaline, protect with	sufficiency Ulcer, cleanse with skin prep, apply betadine and ssing. Change daily.				
	saline, protect with	Insufficiency Ulcer, cleanse with a skin prep, apply betadine and assing. Change daily.				
	Left wrist Unstage protect with skin p with dry dressing.	able ulcer, cleanse with saline, rep, apply betadine and cover Change daily.				
	Left Trochanter St protect with skin p with dry dressing.	age 3 ulcer cleanse with saline, rep, apply betadine and cover Change daily.				
	Right Trochanter I saline, protect with	Unstageable ulcer cleanse with n skin prep, apply betadine and				

Illinois Department of Public Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	BERTH TOAT TO THOUSE TE	A. BUILDING:	 -	40 m LE 1 LO	
		II 0000757	B. WING		08/4	; B/2020
<u>-</u>		IL6009757			1 00/1	0/2020
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
WATERF	RONT TERRACE		TH SHORE D , IL 60649	DRIVE		-
. 010.15	SHIMMADY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LID BE	COMPLETE DATE
				DEFICIENCY)	_	
S9999	Continued From pa	ige 2	S9999			
	cover with dry dres	sing. Change daily.				,
	Plan of care discus	sed with facility staff.			-	
	R2's (5/21/20) phys	sician order documents:	}			
	Cleanse right inferi	or gluteus with saline protect				
		n prep, apply silver gel to				
	wound and cover with a dry dressing daily and change as needed.					:
	R2's (11/12/19) nhy	ysician orders documents: left				
	foot: cleanse with saline, pat dry, apply iodosorb					
	to wounds. Every d	lay shift.				
	On 7/1/20 at 11:50 am, V2 (Director of Nursing) stated wound doctor always rounds on Monday, and he is the one who places orders for treatment. R1 was seen on 6/29/20 and wound					
						,
	treatment. R1 was seen on 6/29/20 and wound treatment orders were placed. V2 also said the					
	facility currently do	es not have a wound nurse.				
	On 7/1/20 at 2:30 pm, V2 said doctor's orders					
	1	by nurses as soon as				
	possible.					
		am, V5 (Wound Doctor) stated				
		facility staff is to follow orders stated he was not aware the				
		ring his orders for dressing				
	changes for R1 an	_				
	Facility policy (rev	. 11/2013) "Pressure				
	Ulcers/Skin Break	down-Clinical Protocol"				
	documents in part					
		authorize pertinent orders reatments, including pressure				
	reduction surfaces	s, wound cleansing and				
		paches, dressing and	:			
	application of topic	car agents.				
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CONTECTION		A. BUILDING:			
		IL6009757	B. WING	<u> </u>	C 08/18/2020	
			ADDRESS, CITY, S	TATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER		OUTH SHORE [
WATERF	RONT TERRACE		O, IL 60649	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)	
PREFIX	(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES	D BE COMPLETE PRIATE DATE	
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