Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005003	A. BUILDING: _____ B. WING _____	C 10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	6125 SOUTH KENWOOD CHICAGO, IL 60637

(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 Complaint Investigation 2186899/IL138351	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)2) 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. 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 b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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 services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to provide and maintain proper wound assessments and treatments and failed to ensure appropriate bedding to prevent skin breakdown for 3 (R3, R5, R6) of residents reviewed for pressure ulcers. These failures resulted in a new wound on R3's right heel and worsening of left heel and coccyx pressure ulcers. Findings include: 1. R3's medical diagnoses include Dementia. Per	S9999		

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S9999	Continued From page 2 health record R3 was discharged from the facility on 8/10/21. R3's Braden Score dated 7/30/21 was 10 and categorized as High Risk. Weekly Wound Assessments read that R3 had 3 pressure wounds on the following sites: Right Heel, Left Heel and Coccyx. Right heel pressure ulcer had only a single assessment dated 8/4/21 categorizing the wound as unstageable. Right heel pressure wound measured 6.5 cm X 5.0 cm X Unable to Determine (UTD). Review of all Physician Orders and all Treatment Administration Records (TAR) resulted in no order found related to right heel pressure ulcer. Right heel pressure ulcer did not have any record that it was being treated. V17's (Licensed Practical Nurse/LPN) admission notes dated 7/23/21 categorized right heel as deep tissue injury (DTI), but no treatment was ordered until R3 was discharged on 8/10/21. Left heel pressure ulcer wound initial assessment dated 7/25/21 read that wound measured as follows: 3.5 cm X 2.0 cm X 0.1 cm. Wound assessment dated 7/28/21 (3 days after initial assessment) showed the wound drastically increased in size. Left heel wound measured 7.5 cm X 7.0 cm X 0.1 cm. Left heel pressure ulcer had a treatment order for gauze with Betadine and wrap dated 7/25/21. The treatment was discontinued upon R3's discharge dated 8/10/21. Treatment Administration Records (TAR) for July and August showed that treatment was not recorded as being performed on July 27th, 28th and August 4. Coccyx pressure ulcer wound assessment dated 7/25/21 read wound measured as follows: 2 cm X 1 cm X 0.1 cm. Wound assessment dated 8/4/21 (10 days later) showed the wound drastically	S9999		

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S9999	Continued From page 3 increased in size. Coccyx wound measured 6.5 cm X 5.0 cm X Unable to Determine (UTD). Coccyx pressure ulcer had a treatment order for gauze soaked with Betadine and cover with border gauze from 7/25/21 to 7/30/21. Treatment Administration Records (TAR) for July showed that treatment was not recorded as being performed on July 27, 28 and 30. Three out of six days physician order for wound treatment was not signed as being done. On 9/29/21 at 1:57 PM. V10 (Wound Coordinator/Licensed Practical Nurse/LPN) stated, "I am not sure the reason why R3's right heel does not have any order for treatment. But I agree, there must be a treatment order in place because that is an open wound and needs to be treated. We might have missed it." On 9/30/21 at 3:15 PM. V10 stated, "I do not know why R3's wounds on the coccyx and left heel drastically increased. I also do not know why that many days were not signed as being done in the treatment administration record (TAR), as treatment was performed. But I agree; if it was not documented, it was not done." On 9/30/21 at 9:57 AM. V11 (Wound Doctor) stated, "Facility nursing staff will inform me, then primary care doctor will give referral, then she will assess the resident. But the bottom line is that treatment should be done as ordered and an open wound must have physician order for treatment." 2. On 9/29/21 at 12:18 PM. R5 was on bed being assisted with eating lunch. R5 was able to answer questions but did not elaborate when asked. R5 was observed on a low air loss mattress with thick draw sheet and flat sheet underneath her on the bed. V9 (LPN) stated that she was not familiar	S9999		

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with residents on the floor who had wounds or pressure ulcers. V9 checked the sheets and linens underneath R5. V9 observed R5 was lying on a draw sheet at the bottom, flat sheet at the middle then another draw sheet. There were 3 linens placed underneath the R5. V9 stated, "This is not right, there must be only 1 sheet when using a low air loss mattress. The mattress is not effective when there are too many sheets." V9 then went to ask a Certified Nursing Assistant to take off the sheets. During bedside care, R5's sacrum was observed with cream only and no other dressing.

On 9/29/21 at 1:57 PM. V10 (Wound Coordinator/LPN) stated, "We used flat sheet; a thin one, not the one with rubber ends. We should only a flat sheet. At night a pad with no {incontinence brief}. A low air loss air mattress is not going to be effective when there are too many pads."

R5's Physician Order showed two (2) active orders for treatment of sacral wound. First order was for zinc oxide to peri-wound of the sacrum. Second order was to cleanse sacrum with normal saline and place foam adhesive dressing after patting dry. R5's Braden Score dated 9/25/20 was 12 and categorized as High Risk. R5's TAR for August showed multiple days that fell on the weekend as not recorded as being performed.

3. On 9/29/21 at 12:56 PM. R6 was observed in the dining room. R6 was alert and able to verbally express her thoughts. R6's sacral wound was seen with a dressing in place. R6 had a treatment order for collagen dated 8/31/21. R6's TAR for September read on 9/11, 9/12, 9/18, 9/19, 9/25 and 9/26 (Saturday and Sunday dates successively) indicate treatments were not done.

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S9999	Continued From page 5 Facility Wound Management Program and Policy not dated reads: The purpose of our Wound Management Program is: To ensure our residents have access to the appropriate assessment and management in prevention and treatment of pressure injuries and other wounds in accordance with clinically accepted guidelines to improve quality of life for all residents in our care. (B)	S9999		