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
	IL6008825	A. BUILDING: ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR SOUTH LOOP	1725 SOUTH WABASH CHICAGO, IL 60616

(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 Annual Licensure and Certification Survey F686G	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c)3) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 02/24/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008825	A. BUILDING: ___ B. WING ___	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR SOUTH LOOP	1725 SOUTH WABASH CHICAGO, IL 60616

(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	S9999		

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.

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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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
	IL6008825	A. BUILDING: ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR SOUTH LOOP	1725 SOUTH WABASH CHICAGO, IL 60616

(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	S9999		

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 services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to adequately assess a resident identified at high risk for pressure ulcers, in an effort to ensure wounds are identified and treatment is implemented promptly, for 1 resident (R148), who was identified to have a facility acquired pressure ulcer to the right heel. This facility failure, resulted in a deterioration of R148's skin integrity and the development of a Stage 3 pressure ulcer to the right heel.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008825	A. BUILDING: ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR SOUTH LOOP	1725 SOUTH WABASH CHICAGO, IL 60616

(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	S9999		

Findings include:

R148 is 80 years old with diagnoses that include Osteomyelitis of Vertebra, Sacral and Sacrococcygeal Region, Major Depressive Disorder, Abrasion of Lower Back and Pelvis, Unspecified Protein-calorie Malnutrition, ST elevation Myocardial Infarction, Unspecified Lack of Coordination.

R148's Braden Scale dated 1/03/2020, documented that R148 was a moderate risk (score 13) for pressure ulcer development. R148's Minimum Data Set (MDS) dated 1/10/2020, under the section titled, "Functional Status", facility staff indicated that the resident required total dependence of two+ persons physical assist, during transfers and toileting; and extensive assistance of two+ persons for bed mobility.

On 1/3/2020, R148 was transferred to the hospital. According to the hospital records, R148 was treated for Osteomyelitis of the Sacrum. The hospital Nursing Progress Notes, Admission Summary dated 1/3/2020, on assessment, R148 was identified to have an "unstageable wound on the heel of his right foot." The hospital Consultation Note dated 1/3/2020, documented the following: "R heel Necrotic tissue; Length 4.5 cm (centimeters), Width 2.5cm; Depth 0cm." On review of the electronic health record, there was no documentation that facility staff identified the wound on R148's right heel. This wound was not identified until the resident was transferred to the hospital on 1/3/2020.

R148 was discharged from the hospital on 1/3/2020, with treatment orders and instructions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008825	A. BUILDING: ___ B. WING ___	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR SOUTH LOOP	1725 SOUTH WABASH CHICAGO, IL 60616

(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	S9999		

for facility staff, for the wound on the right heel.

R148's Wound Assessment Details Report dated 1/6/2020, documented that the facility wound care department, performed a full body assessment and noted sacrum and ischial wounds. There was no documentation of the wound to the right heel. Upon the resident's return to the facility, staff failed to assess, identify and implement treatment for the facility acquired wound to the right heel.

The wound to the right heel, was not identified by facility staff until 1/28/2020. According to the documentation, on 1/28/2020, R148's right heel measurement was recorded as- 2.20 cm X 2.10 cm X 0.10 cm (L x W x D). During an observation of the dressing change on 2/05/2020, the wound to the right heel measured - 2.00 cm X 1.00 cm X 0.10 cm (L x W x D).

Skin/Wound Note dated 1/28/2020 indicated, "Resident seen by wound MD (medical doctor) new site heel, orders placed in (facility computer program) preventative measures and tx (treatment) orders remains in place."

On 2/5/2020 at 2:52 PM, V7 (Wound Care Nurse/Licensed Practical Nurse, LPN) stated that R148's wound on right heel was discovered on 1/28/2020. V7 (LPN) stated that wound care nurses do assessments daily.

On 2/6/2020 at 10:19 AM, V8 (LPN) said that if Certified Nursing Assistants (CNA) notice anything on residents during the showers, CNA's are supposed to notify the nurses. V8 further stated, nurses will then perform a full body assessment and will notify the doctors of any findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008825	A. BUILDING: ____ B. WING ____	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR SOUTH LOOP	1725 SOUTH WABASH CHICAGO, IL 60616

(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	S9999		

On 2/6/2020 at 12:19 PM, V8 (LPN) stated that during R148's admission to the facility she noted a wound on both heels. V8 stated that when R148 arrived to facility, she (V8) needed to remove the hell protectors and the dressing in order to assess R148's lower extremities. V8 said that she notified the Wound Care Department about R148's wounds.

On 2/6/2020 at 11:00 AM, V13 (CNA) stated that she noticed the wound on R148's right heel on readmission to the facility, but she forgot to report it.

On 2/6/2020 at 10:37AM, V12 (Wound Care Nurse/LPN) stated that she performed a full body assessment on R148 upon readmission. V12 stated that she didn't notice any wound on R148's right heel. V12 said that the wound was identified on 1/28/2020 when she was doing rounds. V12 stated that skin assessment is done by wound care nurses only on the wounds have already been identified. Floor nurses do weekly skin assessments.

On 2/6/2020 at 10:51 AM, V10 (Wound Care Physician) stated, "I started taking care of him when he came in. He was admitted with wounds. I was notified that (R148) had the right heel pressure ulcer Stage 3, can't remember when. But I did see (R148's) right heel last on 02/04/2020. We are treating it with Hydrofera Blue. Daily assessment on the skin identifying wounds like these should be documented. I was notified, yes but I don't know how staff works, they are not my employees. Staff should follow the skin protocol. That is their job and in their job description. I can only assess what I see that day at that time, and the wound can develop within

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
	IL6008825	A. BUILDING: ______ B. WING ______	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR SOUTH LOOP	1725 SOUTH WABASH CHICAGO, IL 60616

(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	S9999		

hours. So, I expect - float heels on bed; air boot or heel protector and wound treatment should be implemented in order to prevent and manage pressure ulcers on the feet. These are protocols in the facility."

Facility Policy "Skin Care Treatment Regimen" Revised August 2, 2019 states "It is the policy of this facility to ensure prompt identification, documentation and to obtain appropriate topical treatment for residents with skin breakdown. Procedures: 1. Charge nurses must in the nurse's notes and/or the Wound Report form any skin breakdown upon assessment and identification. 5. Refer any skin breakdown to the skin care coordinator for further review and management as indicated."

(B)