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
	IL6000236	A. BUILDING: _____ B. WING _____	12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR OAK LAWN	9401 SOUTH KOSTNER AVENUE OAK LAWN, IL 60453

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S 000	Initial Comments Annual Certification and Licensure Survey Complaint Investigation #2298007 / IL151996 #2298292 / IL152347	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 Licensure 300.690b) 300.690c) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 summary of each reportable accident or incident to the Department within seven days after the occurrence. Based on interview and record review, the facility failed to report two resident incidents that resulted in serious injuries/outcomes. This failure applied to two of two residents (R103 and R554) reviewed for reporting of incidents and accidents after R103 experienced a fall that resulted in a left temporal hematoma and R554 was found unresponsive, requiring cardiopulmonary resuscitation and ultimately unexpectedly went into cardiac arrest. Incident/Accident log states in part but not limited to the following: 10/14/22 at 2:40 AM, R103, fall resulting in serious injury in patient's room. Per witness statement from V25 dated 10/14/22 states in part but not limited to the following: At 2:50 AM, V25 went into the room to check on R103 and observed him laying lying on the floor, face down between the bed and the door. The BiPap machine was not on the patient. V25 called for staff assistance. V26 (Registered Nurse) came in and they rolled the patient over noting a small laceration to the forehead with minimal serosanguinous drainage. V25 then performed a sternal rub, R103 was non-responsive, no spontaneous breaths and no palpable heartbeat. He was transferred into the bed. V25 left the room to call 911 and grab the crash cart. V26 initiated CPR with the backboard in place and the AED on. 911 came in and took over. Emergency room records dated 10/14/22 at 3:47 AM state in part but not limited to the following: History of Present Illness: 75-year-old male with history of hyperlipidemia, heart failure, dementia, COPD, pulmonary hypertension presents in	S9999		

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cardiac arrest. EMS (Emergency Medical Service) reports that they were called by nursing home for patient in cardiac arrest. Nursing home reported patient last seen approximately 25 to 30 minutes prior to being found in cardiac arrest. Patient in asystole on EMS arrival. EMS estimates approximately 15 minutes ACLS (Advanced Cardiovascular Life Support) performed since they arrive on scene upon arrive in the emergency department, patient in asystole throughout.

Death certificate obtained for R103 lists cause of death as organic cardiovascular disease.

R554 is a 75-year-old female originally admitted to the facility on 11/5/22 who later transferred to the hospital on 11/10/22 and discharged from the facility. Her medical diagnoses include but not are not limited to the following: intracerebral hemorrhage, cerebrovascular disease, dysphagia, hemiplegia, hemiparesis, A Fib, hyperlipidemia, depression, and HTN.

Record review indicates that R554 had a fall at the facility on 11/10/22.

Per nursing notes written by V36 (Licensed Practical Nurse) on 11/10/22 at 10:06PM states in part but not limited to the following: At approximately 7:15PM, R554 had an unwitnessed fall. CNA (Certified Nursing Assistant) discovered resident on floor who stated she was reaching towards the side of her bed and fell out. Resident stated she hit her head and pain level at a 3 out of 0-10 scale. Resident transferred out to emergency room via 911.

Per physician note written on 11/10/22 at 7:55PM states in part but not limited to the following:

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S9999	Continued From page 3 R554 experiences a hematoma to left side of head, fall with injury. Large hematoma about six centimeters; headaches but not nausea/vomiting, vision changes, unspecified injury of head, transfer to emergency room. R554's incident report from 11/10/22 states in part but not limited to the following: business unit action: patient's care: evaluated for injuries, none noted. However, per witness statement report taken on 11/11/22 from V36 (LPN), states in part but not limited to the following: Head to toe assessment completed and hematoma noted to left temporal area. Sent to emergency room for evaluation. On 12/20/22 at 9:50 AM, V2 (Director of Nursing) was interviewed about incident. V2 said we chose not to report this incident since it was not a fall with a major injury. We did not know that there was an injury and when following up with the resident at the hospital, the hospital gave a diagnosis of fall. Asked V2 why the physician documented large hematoma due to fall and transferred R554 to the hospital in which she said a hematoma is just a bruise and not considered a serious injury. Our residents get hematomas all the time and we do not report them. "C" 2 of 2 Licensure 300.610a) 300.1210b) 300.1210d)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and	S9999		

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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 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:
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

This regulation was NOT MET as evidenced by:

Based on interview and record review, the facility failed to accurately transcribe hospital discharge orders to ensure that a newly admitted resident received all medications needed for treatment

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S9999	Continued From page 5 and failed to prevent a medication administration error. These failures affected two residents (R504 and R73) reviewed for medication administration and resulted in one resident (R73) receiving medication that was not ordered and resulted in (R504) not receiving medication for the prevention of blood clots upon admission to the facility and then being emergently transferred to the hospital and subsequently expiring. Findings include: R504 was an 85 year old male admitted to the facility 6/18/22 with diagnoses that included cerebral infarction and hypertension. Immediately prior to transfer, R504 underwent a surgical laminectomy of the spine after sustaining a fall in the home. According to the Minimum Data Set assessment dated 6/29/22, R504 was assessed to be totally dependent on staff for all activities of daily living, requiring extensive 2 person assistance with bed mobility, turning and toileting. R504 mobilized with a wheelchair and was not ambulatory. According to nursing progress note dated 6/30/22 at approximately 1:00AM, R504 was assessed by nursing staff to have multiple episodes of yellow emesis at start of the shift. During emesis R504 was observed to have fixed stare. Nurse assessed vital signs: Blood Pressure: 67/39 Heart Rate: 89 and blood glucose: 299. The nurse on duty called 911 for transport to the nearest hospital. According to hospital records dated 6/30/22, several hours after arriving to the Emergency Department, R504 received life resuscitation measures and expired. Death Certificate dated 6/30/22 lists cause of death: Cardiopulmonary	S9999		

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S9999	Continued From page 6 Arrest and Massive Pulmonary Embolism. On 12/21/22 at 10:06AM V2 Director of Nursing said, we were made aware that R504 went to the hospital and passed away. When the hospital called, they asked for a medication list and the unit manager grabbed the chart and reconciled the notes. That is when she found that there was a discrepancy with how the admission medication orders were transcribed. It is possible that this could have contributed to blood clot development and I began an investigation based off of this concern. The medication, Heparin was missed (upon admission to the facility) and was not documented on the Physicians Order Sheet. R504 did not receive Heparin at any time while in the facility. The nurse that transcribed the orders was from an agency and was asked not to return after this incident. On 12/22/22 at 9:58AM, V30 Medical Director and primary physician of R504 said, when patients come from the hospital, we are supposed to follow all the hospital orders. I was told by the facility that the nurses have a system in place where they call the physician and go over the medication list, and then another nurse will verify that all the medications have been ordered in the system correctly according to the discharge medication list. I round at the facility, and I also will review the hospital discharge orders when I do the initial visit. I don't know how an error could have occurred with these systems in place. Heparin is used to help prevent blood clots, such as DVT (deep vein thrombosis) and pulmonary embolism. Heparin is used to help prevent blood clots of all kinds, particularly in high risk patients. It is possible that without the Heparin being given as ordered, a patient who is at risk of developing blood clots has a higher chance of developing	S9999		

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S9999	Continued From page 7 them if they are unable to walk or move on their own. V30's Physician progress note dated 6/19/22 indicated that R504 was assessed, and all hospital records were reviewed. Hospital discharge forms and Physician Order sheet reviewed for June 2022. Hospital discharge medication list included Heparin 5,000 units to be given every 8 hours which was not transcribed to the Physician Order Sheet at the time of admission to the facility. There is no record of R504 receiving this medication while in the facility at any time. Physician progress note dated 6/23/22 documented that R504 was at risk for developing DVT (deep vein thrombosis). Facility policy titled, Admission, long-term care (Revised 5/20/22) includes: Ensure that a complete list of the medications the resident was taking at home is documented in the resident's medical record. Compare this list with the resident's current medications. Reconcile and document any discrepancies in the resident's medical record to reduce the risk of transition-related adverse drug events. R73 is a 69 year old male admitted to the facility 11/19/21 with diagnoses that include End Stage Renal Disease, Diabetes, Hypertension and Spinal Stenosis. R73 is alert and oriented as assessed on 7/14/22, with a BIMS (Brief Interview of Mental Status) score of 14 (cognitively intact). On 11/24/22 V6 (RN) wrote a progress note at 4:07PM that stated, "Resident accidentally taken the wrong medication family aware and MD will	S9999		

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S9999	Continued From page 8 continually monitor resident for side effect and reaction." Facility Witness statement for the incident of 11/24/22 states that V6 (RN) pulled medications for R73 and the roommate, and entered the room with both medication cups in hand. When she set the medication in front of R73, he ingested one pill and then stated that the medications in the cup were not his meds. V6 took the remaining medicine from R73 and gave him the other prepared medications. Prior to going into the room, the medications were labeled with the resident's names. V6 (RN) could not be reached for interview during this investigation. Review of V6's Employee file reviewed and found to contain "Employee Warning Notices" that indicated V6 had received written notice of three additional medication administration related incidents since being hired in the facility in 2018. On 12/21/22 at 10:06AM V2 Director of Nursing said, I am aware that there have been multiple medication administration errors since I've been the Director of Nursing. Medication administration errors are avoidable by utilizing the "5 rights." When an incident like this occurs, the nurses are provided education in the form of an in-service that emphasizes the Rights of Medication Administration, such as right medication, right dose, right patient, right time and right route. I was not aware that V6 (RN) had a history of documented medication errors or incidents. R73 did not require any hospitalization after the incident, and the physician was called with no further orders but to monitor for any reactions.	S9999		

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S9999	Continued From page 9 Facility policy titled, Medication and Treatment Administration Guidelines, Long-Term Care (no revision date) includes: "Medications are administered in accordance with the following "rights "of medication administration or per state specific standards: Right patient, right medication, right dose, right route, right time (including duration of therapy, right documentation, right of patient to refuse, right clinical indication)." "AA"	S9999		