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 _____	C 07/24/2024

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

(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 Surveys: #2494062 / IL173531 #2494073 / IL173542 #2494603 / IL174237 #2495545 / IL175584	S 000		
S9999	Final Observations Statement of Licensure Violations: ONE OF TWO 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the	S9999		

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 _____	C 07/24/2024

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

(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		

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.

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:

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.

These requirements were not met as evidenced by:

Based on observation, interview, and record

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 _____	C 07/24/2024

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

(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		

review, the facility failed to recognize an acute change in condition for a resident. This failure applied to one (R5) of three residents reviewed for nursing care and resulted in a delay in care for R5 who was hospitalized for respiratory failure.

Findings include:

R5 is 77 years old and admitted to the facility on 6/21/24 and has diagnoses that include hydrocephalus, g-tube placement, communication deficit weakness and lack of coordination.

Minimum data set (6/28/24) indicates R5 to have severe cognitive impairment and unable to make needs known to staff. The assessment data also includes that R5 is incontinent of bowel and bladder and totally dependent on staff for turning, repositioning and all other activities of daily living.

On 7/15/24 at 12:51PM R5 was in the facility, observed by the Surveyor to be in bed, and appearing to be in respiratory distress. R5 was visibly and audibly gasping for air and respirations were counted at 47 breaths per minute. At 12:55PM V7 Registered Nurse said that R5 "has been breathing like that all morning. It's baseline." V7 said that vital signs were taken about 15 minutes prior and documented as: blood Pressure 111/44, Temperature 97.4F, Pulse 100 beats per minute, Respirations 24 breaths per minute and Oxygen 94% on room air.
At 12:58PM V7 and V8 LPN (licensed practical nurse) went to the bedside of R5 at request of the Surveyor. V8 was orienting with V7 on this day and while at the bedside, V7 and V8 agreed that R5's presentation and assessment was unchanged since earlier that morning around 9AM. Surveyor requested an immediate set of

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 _____	C 07/24/2024

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

(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		

vital signs which V7 and V8 obtained. The pulse oximeter measured a pulse of 110 beats per minute and an oxygen saturation fluctuating between 80% and 97% on room air. V9 Registered Nurse entered the room at 1:07PM physically assessed R5 and agreed that R5's presentation was normal for their baseline, and that R5 "periodically gets like this." At 1:08PM V7 was asked for a respiration count and said it was 28 breaths per minute. V7 said that a normal respiration count should be between 12 and 25 breaths per minute. Surveyor requested to count again together out loud, and the result was 40 breaths per minute. V7 left the room to call the medical provider for further orders.
At 1:33PM, R5 was observed in bed, condition unchanged. V7 said that the provider was notified that R5 has a rate of 40 respirations and did not give any further orders. At 1:58PM V2 Director of Nursing said that a respiration rate of 40 would not be considered normal, however co-morbidities should be considered overall. V2 said, that R5's family refused hospice services upon recommendation and R5 remained full code at the moment, meaning that all measures should be taken to sustain life. V2 went to personally assess R5 and follow up with V7.

Emergency Paramedics were observed on site in the facility at 2:30PM. V7 said that they called 911 due to R5 experiencing a further increase of breathing and decreased blood pressure to 89/50. R5 was transferred via Fire Department to the hospital emergency room and admitted to the neurological intensive care unit for respiratory failure and treated for sepsis.

The medical group representing R5's physician and Nurse Practitioner refused an opportunity to interview R5's providers during this investigation.

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 _____	C 07/24/2024

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

(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		

The facility provided "Notification for Change of Condition" policy revised 6/6/24 which states in part: Policy Statement: The facility will provide care to residents and provide notification of resident change in status.
Procedures 1. The facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is: b. A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); c. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or d. A decision to transfer or discharge the resident from the facility as specified in §483.15 (c) (1) (ii) as in the continued presence of the resident poses a threat to the safety and health of the resident and other individuals in the facility.

(A)

TWO OF TWO

300.610a)
300.1210b)
300.1210d)5)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and

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 _____	C 07/24/2024

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

(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		

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.

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

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 _____	C 07/24/2024

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

(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		

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

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to implement turning and repositioning to prevent the development of new pressure injuries and complete treatment orders. This failure affected two residents (R4 and R5) who were at high risk of developing pressure ulcers and resulted in R4 and R5 developing deep tissue injuries to the sacrum.

Findings include:

R4 is 87 years old and admitted to the facility on 3/12/24 with diagnoses that included Protein-calorie Malnutrition, Heart failure, and metabolic encephalopathy. According to Skin Evaluation Assessment of 3/13/24, R4 was assessed to have one pressure ulcer of the right heel.

Minimum Data Set (3/25/24) indicated R4 was cognitively impaired, incontinent of bowel and bladder and dependent on staff for turning, repositioning and toileting. R4 used a manual wheelchair, to which they were dependent on staff to transfer and maneuvers. R4 was able to feed self with set-up assistance from the staff.

The mobility task for R4 was reviewed for March 2024. Turning and bed mobility were not documented night shift 3/17 and morning shift 3/18. According to nursing progress notes on 3/18 at 3:30PM, an "open wound [was] noticed to the sacrum" A significant change was noted on 3/19/24 and R4 was assessed to have a sacral

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 _____	C 07/24/2024

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

(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 7	S9999		

deep tissue injury measuring 7cm (centimeters) length by 10cm width. The wound nurse practitioner assessed and treated R4 on 3/19 and orders were placed to cleanse with normal saline and apply bordered foam every three days. The Treatment Administration Record of March 2024 did not contain any signatures that this treatment was completed 3/22, 3/25 or 3/28. R4 was discharged from the facility on 4/1/24.

R5 is 77 years old and admitted to the facility on 6/21/24 and has diagnoses that include hydrocephalus, g-tube placement, communication deficit weakness and lack of coordination.

Minimum data set (6/28/24) indicates R5 to have severe cognitive impairment and unable to make needs known to staff. The assessment data also includes that R5 is incontinent of bowel and bladder and totally dependent on staff for turning, repositioning and all other activities of daily living.

According to Skin Evaluation (6/22/24) R5 admitted to the facility with staple to a surgical scalp laceration and without any pressure ulcers. During assessment by the nurse practitioner on 7/10/24, R5 was noted with a sacral deep tissue injury (pressure wound) measuring 5cm length and 6.5cm width. Orders were placed to cleanse with normal saline and apply medical grade honey and silver alginate (for debridement) and secure with a hydrocolloid bandage every other day and as needed. Review of the Treatment Administration Record July 2024 indicated that this treatment was not signed as completed 7/14/24.

On 7/15/24 R5 was in the facility, observed by the Surveyor to be in bed, and appearing to be in

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 _____	C 07/24/2024

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

(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 8	S9999		

respiratory distress. Facility staff was notified, and R5 was transferred to the hospital emergency room and admitted to the neurological intensive care unit due to respiratory failure.

A care plan for skin integrity was initiated 6/21/24 and included an intervention to check skin every shift and report abnormalities to the nurse. A skin observation report was requested from the facility and not provided.

On 7/16/24 at 3:24PM V13 Wound Care Nurse was interviewed and said, the wound care team was alerted to R5's sacral wound after the nurse placed a wound consult. The nurses and CNA's are responsible for checking skin of high risk residents every shift and during incontinence care. R5 was high risk due to immobility, use of g-tube and general unresponsive presentation. Because of this, we ordered R5 to be on an alternating pressure relieving mattress to assist with prevention of skin breakdown, however it does not replace the need for turning, repositioning and routine skin care. By the time the wound care team assessed the sacral wound, it was a deep tissue injury with leathery eschar (dead tissue). V13 was unable to determine for certain how long the wound had developed but said that it was likely a full thickness wound under the dead tissues. V13 was not able to recall any information regarding R4's admission to the facility.

Facility Policy "Skin Care Regimen and Treatment Formulary" revised 1/24/24 states in part: It is the policy of this facility to ensure prompt identification, documentation and to obtain appropriate treatment for residents with skin breakdown.
Procedures

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 _____	C 07/24/2024

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

(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 9 1. Charge nurses must document in the Electronic Health Record any skin breakdown upon assessment and identification. Furthermore, treatment must be obtained from the patient's physician. 2. Routine daily wound care treatment/ dressing change is administered by the wound care nurse or designee daily unless otherwise indicated by the patient's attending physician. a) Pressure Injuries/ Vascular Wounds (Stasis/ Arterial/ Diabetic) b) Surgical Wounds c) Other Skin Conditions 4. TAR [Treatment Administration Record] Nursing Documentation includes: a) Routine wound care completed by wound care nurse or designee. b) Ostomy care completed by the wound care nurse or designated nurse. 5. Refer any skin breakdown to the skin care team and physician including wound physician/NP (nurse pracitioner) for further review and management as indicated. 6. Residents who are not able to turn and reposition themselves will be turned and repositioned at least every 2 hours unless otherwise specified by the physician. (B)	S9999		