

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Warren Barr Oak Lawn		STREET ADDRESS, CITY, STATE, ZIP CODE 9401 South Kostner Avenue Oak Lawn, IL 60453	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41156 Based on interviews and record reviews, the facility failed to notify attending doctor of an outside consultant order/recommendations. This deficient practice affects one resident (R18) of three residents reviewed for physician notification. Findings Include: R18 is a [AGE] year old with diagnoses but not limited to: Acute Diastolic Congestive Heart Failure, Arteriosclerotic Heart Disease of Native Coronary Artery, Multiple Sub segmental Pulmonary Emboli, Acute Embolism and Thrombosis Deep Vein of Right Lower Extremity. R18 hospitalized on [DATE] for chest tightness and was diagnosed with bilateral proximal pulmonary artery emboli with right heart strain, underwent thrombectomy. Returned in the facility on 1/23/23, and was place on anticoagulant medication. R18 went to see Cardiologist on 6/1/23 and returned with an order of: May discontinue Eliquis (Anticoagulant) medication on 7/18/23 and follow up with cardiologist in 6 months. Nurse notes dated 6/1/23, reads in part: R18 returned from cardiologist. New orders to discontinue Eliquis on 7/18/23. Follow up appointment needs to be scheduled in 6 months. Orders carried out. Physician Order Sheet reviewed and on 6/1/23, the order was carried out and entered by V34 (RN). V34 did not document that Attending MD (V46) was informed and the family of R18 was informed. V34 no longer an employee of the facility and was not able to reach for an interview. On 3/8/24 at 9:40 AM, V2 (Director of Nursing) stated that upon return of any residents from outside appointment, my expectation is for the staff to notify attending physician for any new orders or recommendations and to enter the orders in the resident's chart. Staff to also document in resident's chart the attending doctor and family were informed of the changes. On 3/8/24 at 12:30 PM, V46 (Attending Physician) stated V46 does not recall if V46 was informed by staff with the medication discontinuation upon returned from cardiologist appointment on 6/1/23, and stated that usually the facility staff informs V46 for any outside consultant recommendation and V46 would then agree with the orders. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 145363	Facility ID: 145363 If continuation sheet Page 1 of 7

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notification for Change in Condition policy is the policy provided by V2 (Director of Nursing) stating that this is the policy that the staff follows as their practice to notification and calling physician with any changes in their residents, such as fall incidents and change in medication upon return in the facility. Notification for Change in Condition Policy with a revised date of 12/17/23, reads in part: The facility will provide care to residents and provide notification of resident change in status. The facility will 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: 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).		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 39340 Based on interview and record review the facility failed to follow physician orders by not applying an antifungal cream to one resident. This affected one of three residents (R3) reviewed for medication. Findings include: R3 readmission hospital paperwork dated 9/15/23 documents orders for: antifungal cream apply three times daily. R3's physician order dated 9/15/23 with start date of 9/16/23 for antifungal ointment apply to affected area three times a day for fungal infection R3 medication administration record for September 2023 documents: antifungal ointment apply to affected area three times a day (0600, 1400, 2100) for fungal infection with start date of 9/16/23 and discontinued on 9/19/23. The 0600 dose on 9/16/23- 9/19/23 documents NN (nurses notes) which indicates to see nursing notes. R3's nursing notes dated 9/16/23 documents: antifungal cream on order. R3's nursing notes dated 9/17/23 documents: medication unavailable. R3's nursing notes dated 9/18/23 documents order with no other documentation. R3's nursing notes dated 9/19/23 documents: medication unavailable. On 3/1/24 at 2:08PM, V13(Pharmacy tech) said R3's medicated ointment was never delivered to the facility due to needing clarification. The clarification was never received. On 3/1/24 at 12:44PM, V10 (MDS) said, R3 had an ordered for medicated ointment without a stop date on 9/16/23. V10 said, she canceled the existing order and input the order with a stop date. R3 had medical ointment ordered on 9/19/23 which was changed to an antifungal power on 9/20/23. On 3/1/24 at 1:44PM, V12 (Treatment nurse) said, during rounds R3 requested her medicated ointment be changed to an anti-fungal power. The anti-fungal power was a house stock that we need a doctor's order to implement. R3's anti-fungal powered was stated on 9/21/23. On 3/12/24 at 4:00PM, V2 (DON-Director of Nursing) said all residents readmitted from hospital will have their orders verified by nurse, one other nurse and nurse manger to ensure accuracy. The pharmacy will email nurse managers (DON, ADON, Restorative nurse) for any medication recommendation, clarifications or whatever the question. The DON or ADON would be responsible to ensure whatever the concern is addressed or changed at time email is received or within a day. V2 said all residents should have medication on hand to be administrated by staff. R3 physician order dated 9/20/23 with start date 9/21/23 documents: cleanse bilateral breasts with soap and water. Dust with house stock anti-fungal powder twice a day and as needed. Facility policy Following physician orders dated 05/2021 documents to correctly and safely receive and transcribe physician orders so correct order is followed and administrated.		

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 34072 Based on interviews and record reviews, the facility failed to notify the attending physician of one resident's urine culture and sensitivity results noting the antibiotic the resident was receiving for UTI (urinary tract infection) was ineffective in treating resident's UTI. This affected one of three residents (R10) reviewed abnormal labs on the sample list of 49. Findings include: On 3/12/24 at 1:07 PM, V51 (attending physician) stated that typically V51 will order macrobid (antibiotic medication) for UTI (urinary tract infection) until the urine culture and sensitivity results are known. V51 stated that it takes 3-4 days for culture results and V51 does not want to wait to start treatment. V51 stated that macrobid treats most UTIs. V51 stated that V51 expects the nurse to call him with the urine culture and sensitivity results once results are known so antibiotic can be changed if the current antibiotic is not effective in treating UTI. V51 stated that V51 does not recall R10. V51 was informed that R10 had urine for a urinalysis collected on 9/21/23 with results noting UTI on 9/21/23. V51 was notified of results and started on macrobid by mouth for 7 days. On 9/24/23 at 9:14 AM R10's urine culture and sensitivity results were reported to this facility. These results were not reviewed by nurse until 9/25/23 at 12:17 PM. On 9/29/23, V52 (former infection prevention nurse) notified V51 that R10 completed macrobid and urine culture does not note macrobid effective in treating R10's pseudomonas aeruginosa UTI. R10 was started on ciprofloxacin (antibiotic) by mouth x 7 days at that time. V51 stated that the nurse should have notified V51 on 9/24/23 so macrobid could have been discontinued and R10 started on appropriate antibiotic to treat UTI. On 3/8/24 at 1:55 PM, V21 IP nurse (Infection Prevention nurse) stated that the IP nurse is expected to review the resident's antibiotic after the third day as well as review culture and sensitivity results to ensure resident is receiving an effective antibiotic to treat the infection. On 3/8/24 at 2:49 PM, V47 RN (Registered nurse) stated that the nurse is expected to call the physician and relay all laboratory results and obtain new orders if needed. V47 stated that the nurse is expected to check and review laboratory results daily. V47 stated that the nurse reports to the oncoming nurse laboratory tests resulted and if orders were obtained and any pending laboratory results. V47 stated that the nurse marks the laboratory result(s) has been reviewed and the computer system notes name, date, and time result(s) reviewed. V47 stated that the nurse reviewing the results is responsible for contacting the physician and relaying results, and documenting in the resident's progress notes that physician notified and any orders received. R10's urine culture and sensitivity results were reviewed with V47. V47 acknowledged that V47's name appears at the top of this report with the date and time result was reviewed. There is no documentation found in R10's medical record noting V47 notified V51 of R10's urine culture and sensitivity results on 9/25/23 after V47 reviewed results. On 3/12/24 at 3:00 PM, V1 (Administrator) stated that this facility does not have a policy specific to notifying physician of laboratory results. V1 stated that this facility follows its notification for change in condition policy. (continued on next page)		

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10's medical record, dated 9/21/23, V52 (former Infection Prevention nurse) noted urinalysis with culture and sensitivity ordered for R10's complaints of dysuria (painful or difficult urination) with indwelling catheter, elevated white blood cell count result on 9/18/23. Urinalysis result called to V51 (attending physician), V51 aware culture pending. Orders recieved for macrobid 100mg (milligrams) by mouth twice daily x 7 days. 9/21, Macrobid Oral Capsule 100 MG Give 1 capsule by mouth every 12 hours for UTI for 7 Days. On 9/29/23, V52 noted report called to infectious disease nurse practitioner and V51 regarding treatment for urine culture reported on 9/24/23. R10 finished Macrobid treatment on 9/28/23 but Macrobid was not included on sensitivity culture report. V51 orders received for ciprofloxacin (antibiotic) 500mg by mouth twice daily for 7 days. There is no documentation found in R10's medical record noting V51 was informed of R10's urine culture and sensitivity results prior to 9/29/23. This facility's notification for change in condition policy, revised 12/27/23, notes the facility must immediately inform the resident, the resident's physician, and resident's family member when there is a need to alter treatment significantly (need to discontinue an existing treatment or commence a new form of treatment). The Merck manual, reviewed/revised 05/2022, notes pseudomonas species are resistant to macrobid. According to the FDA (food and drug administration) noted macrobid has no activity against Pseudomonas species.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review, the facility failed to follow their covid 19 testing policy by not testing residents and staff following a covid 19 outbreak on 9/8/23 which had the potentially to affect all the 103 residents. In addition, the facility failed to test residents and staff for covid 19 for 14 days with no new positives during an outbreak that started on 2/5/24 which had the potential to affect all 96 residents at the facility reviewed for infection control. Findings include: Facility staff covid line list dated August 1st until September 30 2023 documents: V48 (Speech) tested positive for covid 19 on 9/11/23. V49 (nurse) tested positive for covid 19 on 9/8/23. V48 (Speech) time punches document last day worked prior to positive testing was 9/7/23 8:38AM to 4:03PM. V48 provided speech services to 13 residents on 9/7/23 per daily labor report dated 9/7/23. On 3/12/24 at 12:02PM, V48 (speech) said on 9/10/23 he was symptomatic while at home and tested positive for covid using a rapid test. He informed facility on 9/11/23 of covid positive test. V49 (nurse) time punches document last day worked prior to positive testing was 9/5/23 11:00PM- 8:30AM. Facility covid line list for residents September 2023 documents: R3 tested positive for covid 19 on 9/13/23. On 3/12/24 at 330pm, V21 (Infection Preventionist nurse) said contact tracing would be tracked up to 72 hours prior to symptoms developing. Anyone who had contact would be tested for covid on day 1, 3 and 5 for contact tracing. On 3/8/24 at 3:06PM, V21(Infection Preventionist nurse) said the facility was unable to provide any contact tracing or resident testing for September. An outbreak of covid is one positive case in the facility for staff or resident. Facility census dated 9/5/23 documents: 103 residents. Facility resident covid line list documents: R48 covid positive on 2/11/24. Facility resident covid testing September 1, 2023 to March 1, 2024 documents resident testing conducted on 2/5/24 and 2/9/24. There was no other tests documented. Facility staff covid testing sheets was conducted on 2/6/24, 2/12/24 and 2/19/24 with no other testing conducted after 2/19/24 for staff. On 3/7/24 at 12:47PM, V21 (Infection Preventionist nurse) said residents were tested on [DATE], 2/9/24 and 2/16/24 with no positives test results. Staff were tested on [DATE], 2/12/24 and 2/19/24 with no positive test results. Testing was conducted for 14 days with no new positives. (continued on next page)		

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