

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

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

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 07/24/2024
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44570 Based on interview and record review, the facility failed to provide timely incontinence care assistance for one of three residents (R8) reviewed for incontinence care. Findings include: R8 is [AGE] years old and admitted to the facility with diagnosis that include peritonitis, difficulty walking, shingles, COPD and heart failure. R8 was also experiencing a infection of the bowels that causes frequent loose stools. Minimum Data Set 7/10/24 noted that R8 lacks any cognitive impairment, is incontinent of bowel, has an indwelling urinary catheter and requires physical assistance from staff for activities of daily living. On 7/18/24 at 10:17AM R8 was observed in bed, alert and coherent. The call light was activated, and V11 Unit Nurse Manager was observed donning an isolation gown. V11 went in to address R8, turn the light out and left. R8 requested incontinence care. At 10:25AM, R8 was interviewed and said, that the nurse came in and said that the CNA (Certified Nursing Assistant) was busy and that they would come as soon as they were done. R8 said that the staff doesn't always come timely, and due to the bowel issue, R8 needs frequent incontinence care and needs help from staff to remain clean due to inability to move independently. R8 said, you can call, and they won't answer, or they will take their time. R8 said that after a few days of admission, R8 requested to be moved closer to the nurse's station in hopes that they would be accessible to quicker help. R8 says when they don't answer the call light, R8 calls out into the hallway, but is often ignored. R8 said, since you [Surveyor] are in the building, they will come right away. R8 pressed the call light at 10:34AM. Shortly after, V11 returned to the room, deactivated the call light, and R8 asked again to be changed. V11 firstly said that the CNA should be coming shortly. Surveyor asked if nurses were able to provide incontinence care. V11 said, yes nurses are trained to provide incontinence care, and then said they would come back to the room with supplies to provide care for R8. Surveyor left the room at 10:45AM and R8 continued to wait for staff to assist. Progress notes and census dated 7/10/24 noted that R8 requested a room change. R8 was moved from one room to another, where the nurse's station is visible from the room. Care Plan initiated 7/3/24 notes that R8 is incontinent of bowel and has an indwelling urinary catheter, however, does not incorporate associated interventions related to bowel incontinence. (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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/24 at 1:00PM V12 Infection Preventionist said that they have been working in the facility since November 2023 and it was noticed that the facility had increased trends related to urinary tract infections. V12 said, that once this was noted, V12 conducted an in-service with all of the nursing staff to ensure that proper procedures were conducted related to perineal cleaning and since, the incidents of residents developing urinary infections has decreased. We prevent UTIs from occurring by ensuring residents receive timely and proper incontinence care and increasing fluids. Facility Policy Incontinent and Perineal are revised 6/6/24 states in part: Policy Statement: It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition.		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44570 Based on observation, interview, and record 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 [AGE] years old and admitted to the facility on [DATE] 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 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. (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The medical group representing R5's physician and Nurse Practitioner refused an opportunity to interview R5's providers during this investigation. 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 S483.15 (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. Per federal definition S483.10(g)(14) , a need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., the use of any medical procedure, or therapy that has not been used on that resident before). Per federal guidance under S483.10(g)(14), physician also need to be notified if resident experiences symptoms such as chest pain, loss of consciousness, or other signs or symptoms of heart attack or stroke.		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44570 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 [AGE] years old and admitted to the facility on [DATE] 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 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 [AGE] years old and admitted to the facility on [DATE] 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 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. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	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 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 practitioner) 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.		