STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145632	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Barr South Loop	1725 South Wabash Chicago, IL 60616

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 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** 32819 Based on observation, interview, and record review the facility failed to follow policy procedures, failed to assess wounds timely, failed to ensure that wound care orders are transcribed as directed, failed to implement care plan interventions (monitor dressing, report loose dressing, report signs/symptoms of infection), failed to ensure that Nurse's Notes were documented - as indicated on the TAR (Treatment Administration Record) and/or failed to follow physician orders for three of three residents (R1, R2, R3) reviewed for wound care. These failures resulted in R1 sustaining Staph (Staphylococcus) Bacteremia (presence of bacteria in the bloodstream which can occur due to tissue infection) on or about 8/2/24 which was treated with Vancomycin (Antibiotic) until 8/5/24. On 8/12/24, R1's sacrum pressure ulcer developed a foul odor (indicative of infection). Findings include: On 8/1/24, IDPH (Illinois Department of Public Health) received allegations that daily wound care was not being provided as ordered. The following concerns were identified: R1 was admitted to the facility on [DATE]. On 8/14/24 at 9:32am, surveyor inquired about concerns with R1's wound care, V10 (Significant Other) stated He got a big sore on his butt, and he got one on his elbow. You can smell them, so I assume they're infected. They (staff) are supposed to change the dressings daily and when I come back days later, it's the same ones on there. R1's diagnoses include encephalopathy, malignant neoplasm of larynx, tracheostomy, and dependence on ventilator. R1's (3/21/24) care plan states resident has actual impairment to skin integrity. Intervention: apply treatment as ordered by Physician. Monitor dressing to ensure it is intact and adhering. Report loose dressing to staff/treatment Nurse. Report abnormalities, signs, and symptoms of infection to medical doctor. R1's progress notes include (8/2/24) WBC (White Blood Cell): 12.78 (high), received orders to send out to hospital. (8/8/24) Staph bacteremia treated with IV (Intravenous) Vancomycin (Antibiotic) until 8/5/24. Sacral decubitus ulcer status post debridement. Patient returned 8/8. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145632	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Barr South Loop	1725 South Wabash Chicago, IL 60616

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 0684 Level of Harm - Actual harm Residents Affected - Few	R1's (8/8/24) wound assessment reports include the following assessments and treatment orders: 1) Left elbow (unstageable) pressure etiology 1.5 x 1.4 x 0.10cm (centimeters). 25-49% granulation, 50-74% slough. Treatment: Daily and PRN (as needed). Cleanse with 0.125% Dakins solution (a topical antiseptic/antimicrobial solution used to treat/prevent skin infections). Apply Hydrogel and bordered gauze. Odor post cleansing: none. 2) Sacrum cluster (stage 4) pressure etiology 11.0 x 18.0 x 3.5cm. 90% granulation, 10% slough. Exposed tissue: muscle/fascia, adipose, subcutaneous. Treatment: Daily and PRN. Cleanse with NS (Normal Saline). Dakins moistened fluffed gauze, ABD, bordered gauze. Odor post cleansing: none. 3) Right ischium (stage 3) pressure etiology 0.5 x 2.0 x 0.1cm. 60% epithelial, 40% granulation. Treatments: 3 times per week and PRN cleanse with 0.125% Dakins solution. Apply skin prep and hydrocolloid. Odor post cleansing: none. R1's (8/8/24) POS (Physician Order Sheets) include the following treatments that were not transcribed as directed on the wound assessment reports: 1) Left elbow: cleanse with NSS (Normal Saline Solution) and pat dry [incongruent with actual order - 0.125% Dakins solution], apply Hydrogel to wound bed, cover with foam or dry dressing [incongruent with actual order - bordered gauze] daily/PRN. 2) Sacrum: cleanse with full strength Dakin and pat dry [incongruent with actual order - NS]. Apply Dakin gauze on the wound base then cover with foam/dry dressing once daily/PRN [ABD is excluded]. 3) Right ischium: cleanse with NS and pat dry [incongruent with actual order - 0.125% Dakins solution]. Apply skin prep on the wound base, cover with hydrocolloid 3 times weekly/PRN. R1's (6/24/24) functional assessment affirms resident is dependent on staff for ADL (Activities of Daily Living) care. R1's (6/24/24) BIMS (Brief Interview Mental Status) affirms resident is rarely/never understood. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145632	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Barr South Loop	1725 South Wabash Chicago, IL 60616

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 0684 Level of Harm - Actual harm Residents Affected - Few	On 8/12/24 at 2:05pm, surveyor inquired about R1's wounds. V3 (Wound Care Coordinator) stated He has quite a few, he has a sacral and left elbow pressure wound everything else is vascular. Surveyor inquired about R1's pressure wound treatments. V3 responded The left elbow is hydrogel daily and the sacrum is Dakins (full strength) daily. V3 affirmed that she was prepared to change R1's dressings at this time and subsequently entered R1's room (with surveyor), the odor was notably foul. Surveyor inquired about the smell in R1's room. V3 replied I smell an odor. R1's left elbow dressing was dated 8/8 [4 days prior however the dressing is supposed to be changed daily]. Surveyor inquired about the date on R1's left elbow dressing. V3 gasped, paused momentarily, and stated 8/8. V3 removed R1's left elbow dressing, cleansed the wound with NS [0.125% Dakins was prescribed], applied Hydrogel, gauze and border dressing. V3 subsequently turned R1 to the side, the foul odor became almost unbearable (smelled like decomposition). R1's right ischium wound was noted to be open without a treatment (hydrocolloid) in place. R1's (undated) sacrum (foam) dressing appeared to be saturated, disintegrating and not adhered to the skin, the gauze was noted to be square, flat, and appeared gray. Fluffed gauze was clearly not present (as ordered) and/or covering the large, deep, sacrum wound with muscle exposed. Surveyor inquired about the appearance of R1's sacrum dressing. V3 responded I see saturated gauze, and the dressing looks old and soiled. Surveyor inquired about the appearance of R1's sacrum wound which was large, deep and muscle exposed. V3 replied It is a stage 4, prior to that it was covered in eschar which was debrided. V3 cleaned R1's sacrum wound with full strength Dakins solution [NS was prescribed], placed Dakins soaked (kerlix) gauze in the wound and applied several large border dressings. V3 placed the (adhesive) edge of a sacral border dressing on top of R1's right ischium wound [hydrocolloid was ordered]. On 8/12/24 at 2:29pm, V2 (Director of Nursing) entered R1's room (as requested). Surveyor inquired about the odor in R1's room V2 stated I smell something, odor. I smell an odor; I don't know where it's coming from. On 8/12/24 at 2:35pm, V4 (Restorative CNA/Certified Nursing Assistant) entered R1's room (wearing a mask) and surveyor inquired about the odor in the room. V4 stated I got sinuses right now. Surveyor inquired if V4 smelled a foul odor. V4 responded Yeah, I think I do. Surveyor inquired if there were concerns with the appearance of a resident's dressing and what's the requirement. V4 replied Immediately, I tell the Nurse. On 8/12/24 at 2:47pm, V5 (CNA) affirmed that she was assigned to R1. Surveyor inquired about the smell in R1's room. V5 stated I smell poop. Surveyor inquired about the appearance of R1's sacrum dressing when changed last. V5 responded It was soiled because he had a big bowel movement around 1:30pm. Surveyor inquired if V5 told anybody about R1's soiled dressing. V5 replied No, I charted it and went to lunch. Surveyor inquired why concerns regarding the appearance of R1's dressing were not reported to the Nurse. V5 stated I know wound care was up here doing rounds. Surveyor inquired about staff requirements for identified concerns regarding skin integrity impairments and/or dressings. V5 responded, I usually notify the Nurse and chart it. R1's (August 2024) TAR (Treatment Administration Record) affirms the left elbow and sacrum treatments were documented 8/9 and 8/12 [R1's left elbow dressing was dated 8/8 and sacrum dressing was disintegrating - during 8/12 surveyor inspection], the 8/10 and 8/11 entries are blank. R1's right ischium treatment (scheduled for 8/10 administration) was also blank therefore none of the treatments were administered as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145632	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Barr South Loop	1725 South Wabash Chicago, IL 60616

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 0684 Level of Harm - Actual harm Residents Affected - Few	On 8/14/24 at 11:30am, surveyor inquired why a treatment was not on and/or administered to R1's right ischium (stage 3) wound on 8/12/24 (as ordered). V3 (Wound Care Coordinator) stated Let me double check and look up in here (reviewed the electronic medical record) and affirmed I did not place the hydrocolloid on there, you're right. Surveyor inquired what R1's left elbow and sacrum were cleansed with during (8/12/24) treatment administration. V3 responded I cleaned the elbow with normal saline and cleaned the sacrum with Dakins. [neither wound was cleaned as directed]. Surveyor inquired about R1's right ischium and left elbow physician order sheets which are incongruent with treatment orders on the (8/8/24) wound assessment reports. V3 reviewed R1's electronic medical records and affirmed Cleanse with Normal Saline was entered in the physician orders for both treatments [not Dakins 0.125% as prescribed] and stated (V11/Wound Care Nurse) put that order in. Surveyor inquired if V3 notified the physician on 8/12/24 regarding R1's sacrum wound odor [change in condition post 8/8 assessment - odor: none]. V3 replied No, I did not notify the doctor. Surveyor inquired what a blank entry on the TAR indicates. V3 stated It wasn't signed out. Surveyor inquired how R2's left elbow dressing change was documented as administered on 8/9 when the dressing was clearly dated 8/8 (on 8/12/24). V3 responded It was signed out on the 9th and the dressing was dated 8/8. Surveyor inquired why R1's (8/12/24) sacrum dressing change was documented as administered on the TAR when it was clearly not (prior to surveyor observation) because it was saturated, disintegrating, and odiferous. V3 replied I'm not sure who signed it. Surveyor inquired if treatments documented on the wound assessment reports (by the Wound Physician and/or Wound Nurse Practitioner) are orders. V3 affirmed they are and affirmed the treatment orders are subsequently entered electronically in the POS by facility staff. R2's (6/27/24) POS includes right AKA (Above Knee Amputation): monitor steri-strips, cover with ABD pad dressing every other day/PRN. R2's (July 2024) TAR affirms the right AKA dressing change was scheduled on 7/1/24, the entry is blank. R2's dressing changes were also scheduled on 7/27 and 7/31, NN was documented. On 8/13/24 at 10:05am, surveyor inquired what NN documented on the TAR indicates. V2 (Director of Nursing) stated It means see Nurses Notes. Surveyor inquired why NN was documented on R2's TAR on 7/27/24 and 7/31/24. V2 reviewed R2's Nursing progress notes and stated It says see wound care notes on the 27th. On the 31st she put the same thing, see wound care notes again. I'll have to ask her (V8/Registered Nurse) why did she do that. It should be in the progress notes. R3 was admitted to the facility on [DATE]. R3's (7/19/24) progress notes include sacral wound (stage 4) with dry dressing intact. All meds (medications) verified with doctor [actual wound assessment and/or treatment orders received are excluded]. On 8/12/24, surveyor requested R3's initial sacral wound assessment. Surveyor received R3's (7/22/24) skin evaluation [documented 3 days after admission]. R3's (7/23/24) sacrum wound assessment report states odor post cleansing: none. R3's (7/20/24) care plan states resident has actual impairment to skin. (7/26/24) Resident is on IV antibiotics related to SSTI (Skin Soft Tissue Infections) prophylaxis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145632	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Barr South Loop	1725 South Wabash Chicago, IL 60616

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 0684 Level of Harm - Actual harm Residents Affected - Few	R3's (8/8/24) sacrum wound assessment report states odor post cleansing: mild [change in condition post 7/23/24 assessment]. On 8/15/24 at 2:19pm, surveyor inquired about staff requirements for residents admitted to the facility with wounds. V12 (Wound Care Physician) stated The Nurse does the initial assessment, and the patient needs to be admitted so they contact the medical director or physician that's on call for orders. Surveyor inquired what Dakins solution is used for. V12 responded If someone thinks that there's an infection that's going on, there's bacterial overload or generally if there's inflammation. Surveyor inquired about potential harm to a resident if daily wound dressings are not administered as ordered. V12 replied It depends on the wound. Surveyor inquired if a resident has a stage 4 wound with muscle exposed and the dressing is not changed daily what's the potential harm. V12 stated There's potential for harm, I can't be specific about it. Every wound is different, if a wound has exposed structures and the dressing is not changed every day it may last another day and still be efficiently done. If it does not get done the whole week, there may be risk for infection. Surveyor inquired what wound odor is indicative of. V12 responded Most likely it would be infection that was occurring. The Skin Care Regimen policy (revised 1/24/24) states it is the policy of this facility to ensure prompt identification, documentation, and to obtain appropriate treatment for residents with skin breakdown. Charge nurses must document in the Electronic Health Record any skin breakdown upon assessment and identification. 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. TAR Nursing Documentation includes routine wound care completed by wound care nurse of designee. Refer any skin breakdown to the skin care team and physician including wound physician/NP (Nurse Practitioner) for further review and management.