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	08/27/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on records review and interview the facility failed to provide an individualized or person-centered care plan for a resident who has an order for restraints due to pulling out of tracheostomy care. This failure applies to 1 out of 4 residents (R1) reviewed for plan of care. This failure has affected 1 resident (R1) by pulling his tracheostomy the second time. Findings include: R1 was initially admitted on [DATE] in the facility. Discharge record from the hospital dated 8/6/2024 documents that R1 uses tracheostomy that was providing oxygen at 28 percent. R1's medical diagnosis related to need for tracheostomy with 28 percent oxygen was respiratory failure. R1 had an order for soft restraints on both wrists dated 8/6/2024 upon admission due to pulling out his tracheostomy. On 8/7/2024 the day after R1 was admitted , V10 (RN/Supervisor) in her progress notes documented that she was notified by her Certified Nursing Assistant that R1 pulled out his tracheostomy. V11 (Respiratory Therapist) was notified. Per V11 progress notes, V11 documented that she tried to reinsert the tracheostomy in R1 but was unsuccessful. R1 was given non-rebreather oxygen and was transferred to the hospital. Progress notes of V5 (Licensed Practical Nurse) dated 8/10/2024 documented that R1 was sent again to the hospital emergency room for pulling out his tracheostomy. Per notes R1 had broken soft restraints and was able to maneuver R1's hand to remove the tracheostomy by himself. Hospital record dated 8/10/2024 documents that R1 developed pulmonary edema or swelling in the lung area. Review of R1's plan of care from the incident on 8/7/2024 when R1 pulled out his tracheostomy the first time; pulling out the tracheostomy was not addressed until R1 pulled it out on 8/10/2024 . When restorative noted in R1's care plan that due to R1 pulling out his tracheostomy soft restraints will be changed to apply double strap sheep skin limb holders to R1's left upper extremity. Although the care plan instructed to change soft restraint to double strap sheep skin there was no physician order documented until 8/16/2024. Care plan also does not document any intervention change after two (2) incidents of pulling out his tracheostomy. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/2024 at 9:27 AM, V9 (Restorative Nurse/Supervisor) stated that he is the facility staff that is in charge of restraints. V9 stated that R1 came in the facility from the hospital with restraints and R1 initially used soft restraints which means a restraint with soft strap. V9 said that he did the initial assessment because when he called the family he was informed that R1 needs to have restraints. V9 stated that R1 was strong and vigorous, R1 moves a lot and is restless. V9 stated that he used the soft restraint because it was least restrictive. Once R1 got decannulated (removal of dislodging of tracheostomy) V9 used the stronger restraints which were the double strap restraints. V9 was asked when did he start using the double strap restraints? V9 stated that after R1 removed his tracheostomy on 8/10/2024 he applied the double strap restraints because the facility has them in stock available. Surveyot pointed out to V9 that the physician order for double strap restraints was not placed until 8/16/2024 and by placing the double strap restraints, the facility was using restraints without an order by a physician. V9 retracted his statement, V9 said, Double strap was not in stock, so I have to place the order on 8/16/2024. I have to wait for double strap restraints to come and it was on the 16th of August. V9 stated that double strap restraints should have been implemented on 8/10/2024 but was not done until 8/16/2024. V9 stated that placing double strap restraints on 8/10/2024 in the care plan was his only intervention. V9 was asked since double strap restraints did not come until 8/16/2024, was there any other intervention done until the double straps were available? V9 stated, it was only double strap restraints, nothing else. Care Plan policy dated 7/26/2024, reads: It is the policy of the facility to ensure all care plans including baseline care plans are in conjunction with the federal regulations. The facility will put in place person-centered care plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on record reviews, interviews, and observation the facility fails as follows: to provide respiratory care as per physician's order; to provide interventions for plan of care that would help prevent tracheostomy dislodgement; to provide close monitoring of tracheostomy for a resident with history of multiple incidents of decannulation or dislodgement by following physician's order and/or plan of care. These failures apply to 1 out of 4 residents (R1) reviewed for respiratory care via tracheostomy. These failures that include not closely monitoring, not following physician orders and/or care plan interventions resulted in facility staff not being aware of decannulation or dislodgement of tracheostomy that provides oxygenation essential for 1 resident's (R1) airway. R1 was found expired with tracheotomy dislodgement. Findings include: R1 was initially admitted on [DATE] in the facility. The discharge record from the hospital dated [DATE] documents that R1 uses tracheostomy that was providing oxygen at 28 percent. R1's medical diagnosis related to need for tracheostomy with 28 percent oxygen was respiratory failure. R1 had an order for soft restraints on both wrists dated [DATE] upon admission due to R1 pulling out his tracheostomy. On [DATE] the day after R1 was admitted , V10 (RN/Supervisor) in her progress notes, documented that she was notified by her Certified Nursing Assistant that R1 pulled out his tracheostomy. V11 (Respiratory Therapist) was notified. Per V11 progress notes, V11 documented that she tried to reinsert the tracheostomy to R1 but was unsuccessful. R1 was given non-rebreather oxygen and was transferred to the hospital. Per progress notes of V5 (Licensed Practical Nurse) dated [DATE] it was documented that R1 was sent again to the hospital emergency room for pulling out his tracheostomy. Per notes R1 had broken soft restraint and was able to maneuver R1's hand to removed tracheostomy by himself. Hospital record dated [DATE] documents that R1 developed pulmonary edema or swelling in the lung area. During review of R1's plan of care, the incident on [DATE] when R1 pulled out his tracheostomy the first time was not addressed until the reoccurrence of pulling his tracheostomy on [DATE]. When restorative noted in R1's care plan that due to R1 pulling out his tracheostomy soft restraint will be changed to apply double strap sheep skin limb holder to left upper extremity. Although the care plan instructed to change soft restraint to double strap sheep skin there was no physician order documented until [DATE]. The Care plan also does not document any intervention change after two (2) incidents of pulling out his tracheostomy. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 9:27 AM, V9 (Restorative Nurse/Supervisor) stated that he is the facility staff that is in charge of restraints. V9 stated that R1 came in the facility from the hospital with restraint. And R1 initially uses soft restraints which means a restraint with soft strap. V9 said that he did the initial assessment because when he called the family, he (V9) was informed that R1 needs to have restraints. V9 stated that R1 was strong and vigorous, R1 moves a lot and is restless. V9 stated that he used the soft restraint because it was least restrictive. Once R1 got decannulated (removal of dislodging of tracheostomy) I used the stronger restraint which was the double strap restraint. V9 was asked when did he start using double strap restraint? V9 stated that after R1 removed his tracheostomy on [DATE] he applied double strap restraint because facility has in stock available. Surveyor pointed out to V9 that physician order for double strap restraint was not placed until [DATE] and by placing the double strap restraint, the facility was using restraint without an order by a physician. V9 retracted his statement, V9 said, Double strap was not in stock, so I have to place the order on [DATE]. I have to wait for double strap restraint to come and it was on the 16th of August. V9 stated that double strap restraint should have been implemented on [DATE] but was not done until [DATE]. V9 stated that placing double strap restraint on [DATE] in the care plan was his only intervention. V9 was asked since double strap restraint did not come until [DATE], was there any other intervention done until double strap was available. V9 stated it was only double strap restraint, nothing else. On [DATE] at 2:59 PM, V13 (Certified Nursing Assistant) stated that at around 9:30 PM, with another certified nursing assistant they cleaned up R1. V13 took off the restraint before cleaning R1 and placed back the restraint after cleaning R1. V13 stated that R1 was a little restless during the time he was cleaned up. After that the next time he (V13) saw R1 was around the time nursing staff was performing code blue. On [DATE] at 11:59 AM, V4 (Registered Nurse Agency) stated that V3 informed her that R1 was unresponsive. V4 stated that she saw the left wrist restraint was in place, but the tracheostomy cannula was dislodged when she went to the room after being informed by V3. V4 stated, I have no clue what happened and why it was dislodged. At 2:14 PM, V4 stated that when the aide (V13 Certified Nursing Assistant) did bedside care for R1 around 9:30 PM she did not know that restraint was removed prior to care and was placed back after care. V4 stated I was not with them (V13 and the other certified nursing assistant) when they did bedside care. V4 said, They did not tell me they removed the restraint. V4 stated that it is normal practice for certified nursing assistant to manage restraint in providing care. V4 stated that restraint on R1's left wrist was in place during CPR (cardiopulmonary resuscitation). (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 12:29 PM, V3 (Respiratory Therapist) stated that about 10:00 PM, when she walked into the room of R1. V3 noticed that R1's chest was not rising. V3 stated that she called a code blue and informed the nurse on duty (V4/Agency Registered Nurse). V3 stated that it was only when she lifted the neck of R1 that she saw that the tracheostomy was decannulated. V3 stated that the whole tracheostomy was out or not inserted in the stoma (A tracheostomy is a surgically created hole (stoma) in your windpipe (trachea) that provides an alternative airway for breathing). V3 stated that she reinserted the tracheostomy and started cardiopulmonary resuscitation (CPR) and continue until 911 paramedics came. V3 stated that when she checked R1's oxygen saturation, there was no result seen on the oximeter equipment. V3 stated that she did not recall if the restraint was in place during that time. V3 stated that she started her shift at 7:00 PM and it was the only time she saw R1 when R1 was unresponsive around 10:00 PM. V3 stated that like nurses on the floor, respiratory therapist needs to see residents that need respiratory care at the beginning of the shift (7:00 PM). But that particular day she (V3) needed to see three (3) residents on the other side of the hallway (pointing to the opposite hallway) right away. When V3 was asked how the tracheostomy became decannulated? (when out of the stoma). V3 said, I really can't say. On [DATE] at 12:30 PM, V3 reiterated that she did not work on bedside respiratory care on R1 until 10:00 PM. V3 again reiterated that it was not only the cannula inside the tracheostomy that was dislodged but the entire trach. At 1:58 PM, R3 was seen at the bedside. According to V3, R3's tracheostomy is similar to R1's. R3 has Velcro around his neck that holds the tracheostomy collar. A tracheostomy collar was connected to the oxygen concentrator at the opening of the tracheostomy that provides oxygen to R3. V3 removed the mask (tracheostomy collar) that immediately made R3 respond by coughing and displaying difficulty of breathing. V3 stated that R1 was large in build, that was the reason that the tracheostomy was not easily seen dislodged. V3 presented a tracheostomy that was in an unopened package. The tube inside the transparent plastic that was inserted into the stoma or opening in the throat area (trachea) was around two (2) to three (3) inches. Physician orders for R1 were as follows: Dated [DATE] - Vital signs every shift. Per Medication Administration Review (MAR) last vital sign was checked in day shift of [DATE]. On [DATE] at 9:19 AM, V3 stated that all respiratory therapist documentation was in the point click care (PCC) under Respiratory Therapy Daily Flow sheet. And suctioning of R1 was scheduled the same as other residents which is every six (6) hours and as needed. V3 was asked that under Respiratory Therapy Daily Flow sheet dated [DATE] there was no care documented from 1:17 PM to 10:01 PM (around 9 hours) and was there respiratory care was done for R1? V3 stated, As I told you before, I needed to see 3 residents first. R1 was seen for respiratory care around 10:00 PM. Per Physician Order dated [DATE] - Suctioning of tracheostomy was scheduled every four (4) hours not every 6 hours. Per respiratory administration record documentation, R1 was not suctioned on [DATE] at 8:00 PM as ordered by the physician. Per hospital records dated [DATE] (initial admission of R1) documents R1 requires a lot of suctioning for copious secretions. Review of all Respiratory Therapy Daily Flow Sheets dated [DATE] are as follows: Time 1:00 AM by V17 (Respiratory Therapist Agency) documents, R1 on humidified tracheostomy collar 28%, suction and trach care given, resident emergency equipment at bedside. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Time 7:38 AM by V18 (Respiratory Therapist) documents, R1 received an aerosol trach collar 30% fraction of inspired oxygen. Emergency equipment is at the bedside, respiratory equipment is properly plugged into the emergency red outlet. I will continue to monitor R1 throughout the shift. Time 1:17 PM by V18 documents the same notes as above. Time 10:01 PM by V3 (Respiratory Therapist) documents, observed R1 unresponsive and decannulated. The nurse was notified. CPR was started, 911 was called. On [DATE] at 10:04 AM, V2 (Director of Nursing) stated that compared to nursing staff, the task of respiratory therapist was to provide respiratory care. Respiratory care includes suctioning of the tracheostomy. Ventilators and tracheostomies are primary duty of a respiratory therapist in the facility. V2 stated that restraints are handled by nursing staff. V2 stated that R1 was sent out to the hospital for CT scan on [DATE] due to fall. When asked how can a resident with restraint fall? V2 stated that she was not present during the time R1 fell , she (V2) would not know. Per V2 full sets of vital signs are done by nursing staff. And R1 vital signs was not documented between 3:00 PM to 11:00 PM because R1 expired on that day. Clarificatory question was asked, since R1 was found unresponsive around 10:00 PM almost the end of the shift which is 11:00 PM. Why was there no full set of vital signs recorded? V2 stated, I don't know. I will check if there is vital signs. Physician order of R1 on vital signs dated [DATE] documents that R1 needs vital signs every shift. Per Medication Administration Review (MAR) last vital sign was checked in day shift of [DATE] which was 7:00 AM to 3:00 PM and no vital signs documented for evening shift 3:00 PM to 11:00 PM. V2 was informed that there was no documentation between 1:17 PM to 10:01 PM (around 9 hours) that respiratory care was done. V2 stated that best practice is to have respiratory care done between 1:00 PM to 10:00 PM to check the resident. V2 stated that R1 was restless and agitated, it can be seen in R1's record. V2 stated that tracheostomy may have dislodged because of R1's agitation and being restless. V2 was asked would frequent monitoring and tracheostomy care per physician orders help in making sure that it was in place? V2 stated that nursing staff does not do tracheostomy care because it is being done by respiratory therapist. V2 said, Nurses just look at the trach but do not do actual care. Because respiratory therapist are the one who do actual care of trach and ventilator. V2 was informed that on V4's documentation dated [DATE] at 9:30 PM, it was documented that restraint and tracheostomy were in place. But V4 stated that she was not present when the 2 certified nursing assistants were cleaning R1. In fact, V4 stated that she was not informed by V13 (Certified Nursing Assistant) that he took the restraint off prior to care and placed it back after the care. V2 stated that, documentation in the progress notes dated [DATE] at 9:30 PM are statements coming from certified nursing assistant to the nurse. V4 was just informed by the certified nursing assistant who did the bedside care. V2 stated that best practice is for respiratory therapist to monitors residents often, ensuring that tracheostomy of all residents are in place. V2 pointed out that respiratory therapist has separate documentation related to complying with physician's order. Upon reviewing respiratory administration record, R1 ordered to be suction related to his tracheostomy every four (4) hours dated [DATE] at 8:00 PM was documented as NN (see Progress Notes). R1's progress notes does not have any documentation on suctioning on [DATE] at 8:00 PM. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R1's plan of care dated [DATE] on tracheostomy sows, risk for ineffective airway clearance, impaired breathing mechanics due to respiratory failure. Intervention includes ensure that tracheostomy ties are secured at all times. Tracheostomy Dislodgement article prepared by the Department of Surgical Education, at [NAME] Regional Medical Center Surgical Critical Care Evidence-Based Medicine Guidelines Committee dated [DATE], reads: Tracheostomy tube dislodgement is associated with multiple potential complications including loss of airway, subcutaneous emphysema, pneumothorax, pseudotract formation, stomal stenosis, sternoclavicular osteomyelitis, and trachea-innominate fistula. The most devastating complication of tube dislodgement is anoxic brain injury and patient death. Facility policy on Suctioning dated [DATE], reads: It is the facility's policy to provide care for residents with suctioning needs. After request of V1 (Administrator) for policies related to tracheostomy care and monitoring. None was provided.