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	09/27/2024

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 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** 39779 Based on interview and record review, the facility failed to notify resident's Responsible Party of pressure ulcer changes for 1 (R8) of 4 (R1, R2, R3) residents reviewed for pressure ulcers. Findings Include: R8 was admitted to the facility on [DATE] with diagnosis not limited to Cardiac Arrest due to Underlying Cardiac Condition, Encephalopathy, Tracheostomy, Gastrostomy, Anoxic Brain Damage, Essential (Primary) Hypertension, Retention of Urine, Chronic Kidney Disease, Stage 3, Hyperosmolality and Hypernatremia, Adult Failure to Thrive, Dysphagia, Oral Phase, Monoclonal Gammopathy, Type 2 Diabetes Mellitus with Hyperglycemia, Specified Anemias, Abdominal Aortic Aneurysm, Multiple Myeloma, Vascular Implants and Grafts, Acute on Chronic Diastolic (Congestive) Heart Failure, Acute and Chronic Respiratory Failure with Hypoxia, Contracture, Right Hand, Contracture, Left Hand, Muscle Wasting and Atrophy, Reduced Mobility, Restlessness and Agitation. R8's Care Plan documents in part: R8 has actual impairment to skin integrity related to PMH (Past Medical History): Anoxic Brain Injury, Respiratory Failure Trach dependent, Gastric Tube, Impaired Mobility, Incontinence, and a Braden score places her at high risk for future skin impairment. Date Initiated: 08/07/24. Sacrum: Cleanse w/NSS (with normal saline) or wound cleanser and pat dry, apply Medi honey & Calcium Alginate to wound bed and cover w (with)/dry dressing once daily/PRN (as needed). Date Initiated: 08/30/24. Educate the resident and/or family/caregivers as to causes of skin breakdown, including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Date Initiated: 08/08/24 High Risk-Skin Inspection: The resident requires Skin inspection (every shift/PRN). Observe for redness, open areas, scratches, cuts, bruises, and report changes to the Nurse. Identify/document potential causative factors and eliminate/resolve where possible. Date Initiated: 08/07/24 Monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to MD (Medical Doctor). Date Initiated: 08/30/24. R8 has an ADL Self Care Performance Deficit and Impaired Mobility r/t (related to): Right- and left-hand contracture, encephalopathy, anoxic brain damage Bed Mobility: I require x2 staff participation to reposition and turn in bed. R8 is at risk for alteration of bowel and bladder functioning related to: indwelling urinary catheter (sacral wound), Anoxic brain damage, urine retention, CKD (Chronic Kidney Disease). R8 is at risk for malnutrition related to inability to meet nutritional needs orally as evidenced by NPO (Nothing by mouth) with EN (Enteral nutrition) dependence, complicated hospital course. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145632	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Warren Barr South Loop		STREET ADDRESS, CITY, STATE, ZIP CODE 1725 South Wabash Chicago, IL 60616	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Skin Evaluation dated 08/08/24 document in part: R8 is unable to reposition self-requiring total staff assistance with repositioning and ADL (Activities of Daily Living) care. No skin impairment noted, no open areas, no lacerations. R8 has a Braden score of 7 which places her at a high risk for further alterations to the skin's integrity. Skin Evaluation dated 08/30/24 document in part: Pressure Ulcer, site: Sacrum, Type: pressure, length 2.5, width 2.0, depth 0.0, Stage: III. Wound care nurse evaluated skin and noted impairment to sacrum. area of skin. Wound Assessment report dated 09/03/24 document in part: Location: Sacrum, Measurements 2.4 cm (Centimeters) x 2.2 cm x 0.1 cm. Pressure stage 3, acquired in house, date wound acquired 08/30/24, 0% epithelial, 80% granulation, 20% slough, 0% eschar, wound edges: attached, Peri wound: intact, Fragile, Exudate amount: Scant, Exudate Description: Sanguineous, Dressing change frequency: Daily and prn, Clean wound with: Cleanse with normal saline, Primary Treatment: Medical grade honey, other dressings: Bordered gauze. Wound Assessment report dated 09/10/24 document in part: Location: Sacrum, Measurements 9.5 cm (Centimeters) x 9.0 cm x 0.1 cm. Pressure stage/severity Unstageable, acquired in house, date wound acquired 08/30/24, Wound status: worsening, 50% epithelial, 30% granulation, 10% slough, 10% eschar, wound edges: attached, Peri wound: Fragile, area of DTI (Deep Tissue Injury) surrounding cluster of open wounds, Scattered fluid filled blisters, Denuded, Exudate amount: moderate, Exudate Description: Serosanguineous, Sanguineous, Dressing change frequency: Daily and prn, Clean wound with: Cleanse with normal saline, Primary Treatment: Medical grade honey, Calcium alginate, other dressings: Bordered gauze. Physician Order dated 08/30/24 document in part: Sacrum cleanse w/NSS or wound cleanser and pat dry, apply Medi honey to wound bed and cover w/dry dressing once daily/prn as needed. Order Summary Report dated 09/11/24 document in part. Sacrum cleanse w/NSS or wound cleanser and pat dry, apply Medi honey and Calcium Alginate to wound bed and cover w/dry dressing once daily/prn as needed. On 09/25/24 at 11:13 AM V15 (R8's Family Member) stated I discovered the sacral wound when I was helping the certified nurse assistant. It was a quarter size. When I saw the wound on 09/13/24 it was 10 times larger. The wound team never mentioned to me the wound had gotten worse. No one called to tell me that there were any changes in R8's wound. On 09/24/24 at 12:37 PM V4 (Licensed Practical Nurse) stated we should notify wound care, the doctor and the family if there are any new skin tears or alterations. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/25/24 at 12:31 PM V8 (Wound Care Nurse Practitioner) stated I saw R8 twice. On 09/03/24 I noted a stage 3 pressure ulcer with the surrounding tissue intact. The wound measured 2.4 x 2.2 x 0.1 depth. The debridement was done to get rid of the layer of biofilm. Biofilm is bacteria that cause an infection or the wound to deteriorate. I ordered Medi honey daily and as needed with a border gauze dressing. On 09/10/24 I saw R8 again. I reclassified R8's sacral wound as an unstageable deep tissue injury due to the formation of purple/maroonish tissue that indicate a deeper tissue injury. There was scattered wounds in the center of the intact skin purplish tissue that was likely to evolve and opened up. R8's sacral wound rapidly deteriorated within a week. The deterioration was likely due to R8's history of failure to thrive, heart failure, medicines (heparin thin blood and Lasix). Medi honey is used as a treatment, and it can macerate the wound and it could have gotten larger because of that. On 09/24/24 at 02:11 PM V3 (Wound Care Coordinator) stated R8 was admitted on [DATE]. Upon admission her skin was intact. R8 was alert and orients x 0, nonverbal, incontinent of bowel, had an indwelling urinary catheter, was a total assist, gastric tube and no skin impairment. R8's Braden score was 7 and she was high risk. R8 developed a sacral pressure injury on 08/30/24. I picked it up and the measurements were 2.5 x 2.0 with no depth. It was a stage 3 with 80% granulation and 20% slough. Treatment was started then and there, Medi honey daily and prn covered with a dry dressing. The in house wound nurse practitioner saw R8 on 09/03/24. Once the wound nurse practitioner entered, the wound was debrided and was still a stage 3 measuring 2.4 x 2.0 x 0.1 with Medi honey daily. The next assessment on 09/10/24 R8's sacral wound was 9. 5 x 9.0 x 0.1 with 30% granulation, 10% slough, 10% eschar and 50% epithelial dark maroon purplish. The surrounding area had gotten a Deep tissue injury. There was no drainage on the initial assessment. On 09/03/24 there was scant sanguineous drainage. On 09/10/24 there was moderate sanguineous drainage. On 09/24/24 at 03:41 PM V3 (Wound Care Coordinator) stated If there are any changes in the skin, we notify the medical doctor and power of attorney. The deep tissue injury was what worsen R8's wound. On 09/03/24 there was no healing tissue or bruising around R8's sacral wound. On 09/25/24 10:43 AM the surveyor asked V3 (Wound Care Coordinator) who was changing R8's wound dressing and V3 responded, it could have been myself or it could have been V11 (Wound Care Nurse/Licensed Practical Nurse). Every time the wound care is done, we sign out on the TAR (Treatment Administration Record). On 09/25/24 at 11:45 AM V11 (Wound Care Nurse) stated R8's sacral wound was cleansed, apply Medi honey and a dry dressing daily. The surveyor asked V11 when she changed R8 sacral dressing on 09/10/24 and 09/11/24 were there any changes observed to R8's sacral wound. V11 responded, the healing partner documented the wound worsened, surrounding tissue. I treated R8 wound on the 09/05/24 and I don't recall if there were any changes. I don't know if V3 notified the family of the changes in R8's sacral wound. I did not notify the family. On 09/25/24 at 02:04 PM V2 (Director of Nursing) stated my expectation of the staff if there is a difference in the wound appearance is to notify the physician to receive any new orders then notify the resident or resident representative and notify them of any changes in the appearance of the wound. It is best practice to document when the doctor, resident or resident's representative is notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of R8's medical records there was no documentation of family notification on or after 09/10/24 when R8's wound was documented as worsened with an increase in measurements, exudate, and an added treatment of Calcium Alginate. Policy titled Notification for Change of Condition: revised 08/16/24 documents 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 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). Policy titled Skin Care Regimen and Treatment reviewed 01/24/24 document in part: Policy Statement: It is the policy of this facility to ensure prompt identification, documentation and to obtain appropriate treatment for residents with skin breakdown. 7. Notify the patient family/next of kin or POA (Power of Attorney) for any new skin alteration that is identified during course of stay at the facility. Policy titled Incontinent and Perineal Care revised 07/31/24 document 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.