STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145819	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Barr Buffalo Grove	150 North Weiland Road Buffalo Grove, IL 60089

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. 20042 Based on interview and record review the facility failed to notify the doctor and power of attorney/family when a change in condition occurred for 1 of 4 residents (R1) reviewed for change in condition. The findings include: The Change in Condition note dated 2/21/24 at 1:31 PM for R1 showed: 9:00 AM - RN (Registered Nurse) checked patient's (R1's) vital signs, blood pressure 98/50, heart rate 67, oxygen saturation 98%, and respiratory rate 18. Patient took all morning meds (medication) as scheduled including midodrine. 10:50 AM - PT (Physical Therapy) and OT (Occupational Therapy) started therapy session together. Patient appeared to be short of breath at room air, therefore therapist instructed on pursed lip breathing and oxygen saturation was checked. It was initially 96% and steadily decreased to 72%. Patient then started on oxygen at 3 liters via nasal cannula, and nurse on duty was called and assessed the resident further. Oxygen saturation increased to 96% on 3 liters per nasal cannula. Nurse instructed therapist to keep the oxygen at 3 liters while doing therapy, and upon completion decrease to 2.5 liters if oxygen saturation is at least 92%. The Physician Order Summary Report dated 4/18/24 for R1 showed and order dated 2/22/24 to monitor daily: fever (temp at/above 99.6 Fahrenheit), presence of new cough, sore throat,shortness of breath, chills, headache, muscle pain, loss of taste/smell, fatigue, congestion/runny nose, nausea/vomiting, diarrhea. If noted with any of the above, place on isolation, place mask on patient if with respiratory symptom/s and if tolerated, keep patient in room, serve meals in room & do not bring patient out for group activities. If pt has O2 (oxygen) saturation of < 92%, count that as a sign of shortness of breath as well & notify doctor as soon as possible. Observe for abnormal respiratory rate/pulse rate as well. On 4/18/24 at 7:08 AM, V9 (R1's daughter/POA - Power of Attorney) stated, R1 was at the facility for 5 days. On 2/21/24 at 10:50 AM OT (Occupational Therapy) checked R1's oxygen saturation and it was at 98% and went down to 82%. R1 was placed on 3 liters of oxygen and her oxygen saturation came up. The doctor wasn't notified until 1:00 PM. V9 stated she was not notified of R1's oxygen problem, that morning. V9 stated, I think if they would have called in the AM when (R1) desaturated, maybe the doctor would have sent her out. They did not call me; I would have sent (R1) out and give her a fighting chance. Why was her oxygen level dropping and they had to put oxygen on someone that did not use oxygen permanently. (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: 145819	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER: Warren Barr Buffalo Grove		STREET ADDRESS, CITY, STATE, ZIP CODE: 150 North Weiland Road Buffalo Grove, IL 60089	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/18/24 at 11:06 AM, V3 OT (Occupational Therapist) stated when she went into R1's room, R1 was a little short of breath. V3 stated she checked R1's oxygen saturation and it was 95% at first and then went to 89%, 88% and 82% on room air. R1 had a concentrator at her bedside so she placed R1 on oxygen and got the nurse. V3 had her occupational therapy note with her and read it. The OT (Occupational Therapy) note dated 2/21/24 (no time) for R1 that V3 read during her interview showed, When patient (R1) was found, patient was breathing and it sounded labored slightly so O2 (oxygen saturation) was taken and it was 95% for the first 10 seconds and then it went down to 89%, then 88%, then 82%. Patient was given oxygen on 3 liters and patient nurse was notified. Patient nurse came into the room when OT was sitting at the end of the bed with 3 liters on and tested O2 and stated that it was 99% so she was okay to stay on 3 liters when she was on therapy and then put down to 2.5 liter when she was supine in bed. Patients nurse was told that the patients oxygen went down when she leaves the oxygen on her finger longer. The patients nurse stated to just keep oxygen on her. Patient was talking; however, was slow to respond like the previous days. On 4/18/24 at 11:19 AM, V5 RN (Registered Nurse/Nursing Supervisor) stated, a change in condition for a resident is anything different from their baseline. V5 stated if it wasn't normal for a resident to wear oxygen and then needed oxygen, that would be a change in condition. V5 stated therapy notified them that R1 was short of breath and had a decreased oxygen saturation. V5 stated the doctor should have been notified; this was a change in condition. V5 stated when the doctor is notified they would get oxygen orders and any other orders to see what is causing the oxygen to drop. V5 stated it is important to notify the doctor because we don't know what is causing the change in condition. This should have been done as soon as it was heard from therapy. V5 stated the family should be notified of the change in condition as soon as possible. On 4/18/24 at 11:45 AM, V6 RN stated, In the morning R1's vital signs were okay. R1's blood pressure was a little low so midodrine was given. V6 stated OT (Occupational Therapy) and PT (Physical Therapy were in R1's room and told her R1's oxygen saturation was dropping. V6 stated she did not see the oxygen saturation reading that OT?PT had checked. V6 stated she was told R1's oxygen was falling from high to low. V6 stated she checked R1's oxygen saturation and it was 90%. V6 stated R1 was on oxygen when she checked her and she thought R1 was on oxygen normally. V6 stated if R1 was not normally on oxygen then that would be a change in condition. V6 stated she did not notify the doctor immediately because R1's oxygen saturation was greater than 90% so that is normal blood oxygen level. V6 stated with any change in condition the doctor is to be notified first and then the family. On 4/18/24 at 12:35 PM, V8 NP (Nurse Practitioner) stated, R1's oxygen saturation dropping and the nurse having to put oxygen on would be a change in condition for the resident. V8 stated they are supposed to call him and the nurse did not call him. V8 stated the nurse did mention it when he came to the building at 12:45 PM. The Face Sheet dated 4/18/24 for R1 showed medical diagnoses including type 2 diabetes mellitus, cardiomegaly, peripheral vascular disease, diverticulosis, pressure ulcer, spinal stenosis, cellulitis of abdominal wall, end stage renal disease, hyperkalemia, morbid obesity, chronic pain, hypotension, hypothyroidism, hyperlipidemia, essential hypertension, dependence on renal dialysis, and other sequelae following unspecified cerebrovascular disease. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Notification Procedures for Change in Resident Condition policy (1/12/23) showed, the facility shall promptly notify the resident, the attending physician and representative (POA) of changes in the resident's medical/mental and physical condition and/or status using the quality improvement program. The charge nurse or nurse supervisor will notify the resident's attending physician or covering physician when there has been: e. A significant change in the resident's physical, emotional/mental condition. Unless other wise instructed by the resident, the charge nurse of nurse supervisor will notify the resident's next of kin or representative when: c. There is a significant change in the resident's physical, mental, or medical status.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042 Based on interview and record review the facility failed to ensure the information available in the resident's chart was accurate for 1 of 3 residents (R1) reviewed for medical records. The findings include: The Face Sheet dated 4/28/24 for R1 showed she was admitted to the facility on [DATE] with medical diagnoses including type 2 diabetes mellitus, cardiomegaly, peripheral vascular disease, diverticulosis, pressure ulcer, spinal stenosis, cellulitis of abdominal wall, end stage renal disease, hyperkalemia, morbid obesity, chronic pain, hypotension, hypothyroidism, hyperlipidemia, essential hypertension, dependence on renal dialysis, and other sequelae following unspecified cerebrovascular disease. The facility's Admission Packet Information for R1 was dated 1/15/24 and R1 was admitted on [DATE]. The Consent for the Use of side rails, Fall Prevention Education Material, Informed Consent for Influenza Vaccination, Informed Consent for Pneumonia Vaccination, and Informed consent for Vaccination (RSV - respiratory synctial virus), were dated 1/15/24 and signed by the resident on the same date. R1 was not admitted until 2/15/24 and these forms were part of the Admission Packet for R1. The Daily Skilled Nurse's Notes for R1 dated 2/16/24 through 2/21/24 had it marked under section a, daily evaluation section that R1 had an ostomy. The Daily Skilled Nurse's Notes for R1 showed dialysis was not marked on 2/17/24, 2/18/24, and 2/20/24. R1 did not have an ostomy and was on end stage renal dialysis. On 4/18/24 at 7:08 AM, V9 (R1's daughter/power of attorney) stated, they have poor charting. They had R1 signs documents dated 1/15/24 and she was admitted on [DATE]. They should have caught that. How are you having her sign things for when she wasn't there. You don't care enough to make sure her chart was accurate then what else don't you care about. V9 stated most R1's teeth were missing and that was not documented. V9 stated R1 had a previous ostomy but did not have one now. V9 stated R1 had dysphagia and that was not on there. V9 stated they did not document that R1 had a previous stroke and that was not in her diagnoses. On 4/18/24 at 12:23 PM, V1 (Administrator) stated, staff are expected to chart accurately. I know R1 was on dialysis and she did not have an ostomy. When R1 was here in the past she had an ostomy. It must have pulled over in the chart but the nurse's are supposed to be aware of that. V1 stated R1 was not at the facility on 1/15/24 and the papers in the admission packet should not be dated that; they should be accurate. The facility's Electronic Medical Record Policy (7/28/23) showed, it is the policy of this facility to ensure that only authorized personnel shall complete appropriate entries, insure efficient monitoring of these records, maintain integrity, confidentiality and preservation of resident clinical information.