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	06/16/2024

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 0684 Level of Harm - Minimal harm or potential for 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** 41639 Based on observation, interview, and record review, the facility failed to implement physician's orders for a resident (R1) at risk for bruising. This applies to 1 of 3 residents reviewed for skin conditions in the sample of 9. The findings include: R1's electronic face sheet printed on 6/16/24 showed R1 has diagnoses including but not limited to cerebral infarction, weakness, osteoarthritis, complete traumatic amputation of right hand at wrist level, and dysphagia. R1's facility assessment dated [DATE] showed R1 has severe cognitive impairment and is dependent on staff for bed mobility. R1's care plan dated 9/27/18 showed, Potential for skin bruising related to thin/fragile skin. Use caution during ADL (activities of daily living) care. Handle gently, observe for bruises. R1's progress notes dated 5/27/24 showed, Resident was noted to have a discoloration to right elbow measuring 9x5.5x0cm (centimeters). Skin remains intact with slight bogginess felt in the center. Periwound is intact with no swelling or erythema noted. Resident does not know how it happened. Denies pain or discomfort. ROM (range of motion) with no change from baseline. Resident is [AGE] years old, has thin fragile skin and is on Plavix daily. Resident is at high risk for bruising and skin breakdown related to blood thinners, age and fragile skin. Physician informed of findings with orders noted and carried out. Placed call to daughter but she was unavailable, voicemail was left requesting a call back. Will continue to closely monitor for any changes. R1's nurse practitioner visit note dated 5/28/24 showed, RN (Registered Nurse) requested follow up of right elbow hematoma. No recent fall per staff. (R1) is resting in bed. He is a poor historian and unable to provide history. Per patient mild soreness with palpating elbow. He is able to lift and bend arm. Denies pain. Plan of care reviewed with RN. #right elbow contusion secondary to Aspirin/Plavix and advanced age, fragile skin. Monitor hematoma, call if worsens. Addendum 5/29/24 Results reviewed with daughter via phone. Daughter verbalized patient reported bumping arm on side rail during repositioning on Monday. DON (Director of Nursing) aware and will discuss with daughter. (multipurpose bandage) or skin protector to be applied to provide additional barrier for skin . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's physician's orders for June 2024 showed no physician's orders for (multipurpose bandage) or skin protectors to be applied to R1. On 6/16/24 at 10:52AM, R1 stated, I get bruising on my arms because my arms get bumped on the rails when the staff are fixing me up in bed. I don't know exactly when it happened but it has happened before. I don't remember anything else. R1 did not have any bandages or skin protectors on his arms. On 6/16/24 at 1:42PM, V3 (Registered Nurse) stated, We use (multipurpose bandages) on (R1) to protect his arms from getting bruised if he bumps them. I didn't have them on him before because they were in the wash so we were waiting to get them back from the laundry. I finally just cut new bandages and put them on his arms. He should have them on at all times because he is at high risk for bruising due to being on blood thinners. On 6/16/24 at 2:20PM, V2 (Director of Nursing) stated, I interviewed (R1) regarding the bruising to his right elbow on 5/28/24. It was the day after the nurse discovered the bruising. He told me his elbow got bumped on the side rail but never told me it occurred during care. I asked him multiple times what happened and he stated he bumped it on his own on the rail and that it didn't hurt. (R1) started to become upset with my questions and told me to leave it alone and he wasn't concerned about it. I left a message for his daughter to call me back and she never returned my call. I believe the staff are applying (multipurpose bandages) to both of his arms due to his high risk of bruising from blood thinners. We have plenty of the bandages and they come in a big roll so all we have to do is cut them and apply them to the resident. There is no reason why (R1) would not have access to bandages or wouldn't have them on. They are for protection so should be worn at all times. The facility's policy titled, Physician Orders dated 7/28/23 showed, It is the policy of this facility to ensure that all resident/patient medications, treatment and plan of care must be in accordance to the licensed physician's orders .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639 Based on observation, interview, and record review, the facility failed to ensure 4 residents (R1,R2,R3,R7) had access to their call lights. This applies to 4 of 9 residents observed and reviewed for call light accessibility in the sample of 9. The findings include: 1) R1's electronic face sheet printed on 6/16/24 showed R1 has diagnoses including but not limited to cerebral infarction, weakness, osteoarthritis, complete traumatic amputation of right hand at wrist level, and dysphagia. R1's facility assessment dated [DATE] showed R1 has severe cognitive impairment. (During interview, R1 was oriented to person, place, and situation) R1's care plan dated 6/7/23 showed, (R1) is at low risk for falls related to cerebral infarction, complete traumatic amputation of right hand at wrist level .I prefer to keep the bed in low position for safety, I would like staff to provide me a safe environment: even floors, free from spills or clutter, adequate, glare-free light; a working and reachable call light, the bed in low position at night; side rails as ordered, hand rails on wall, please make sure my call light is within my reach and encourage me to use it for assistance as needed . On 6/16/24 at 10:52AM, R1 was laying in his bed, leaning to the left side with a pillow propping his right arm up. R1's call light was wrapped around the right side rail with the button hanging down towards the floor. R1 had a right hand amputation. R1 stated he uses his call light whenever he needs assistance from staff. Surveyor asked R1 where his call light was and he was unable to find it. R1 stated there is no way he would have been able to reach his call light or operate it with his amputated hand. On 6/16/24 at 11:16AM, V5 (Certified Nursing Assistant) stated, (R1) can definitely use his call light and does use it often. Surveyor took V5 to R1's room and showed her the positioning of R1's call light. V5 stated R1 would not be able to reach his light in the current position and stated she is unsure of why it is on his right side due to his right hand amputation. V5 stated all residents should have access to their call light so they are not trying to get up on their own and call for assistance. On 6/16/24 at 2:20PM, V2 (Director of Nursing) stated, All residents that are capable of using their call light should have it placed in an area that it is accessible to them. A call light hanging off the side of the bed is not accessible to most residents. V2 stated it's not a perfect world and call lights do get misplaced but staff should be checking to make sure residents have access to them at all times. 2) R2's electronic face sheet printed on 6/16/24 showed R2 has diagnoses including but not limited to Parkinson's disease, major depressive disorder, osteoporosis, and history of falls. R2's facility assessment dated [DATE] showed R2 has moderate cognitive impairment. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's care plan dated 6/7/23 showed, (R2) is at high risk for falls related to history of falling, Parkinson's disease, lack of coordination .I would like staff to provide me a safe environment: even floors, free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Side rails as ordered, handrails on walls .please make sure that my call light is within reach and encourage me to use it for assistance as needed. I would like staff to address my needs with a prompt response to all requests for assistance . On 6/16/24 at 10:42AM, R2 was in her bed and stated, When I need help I push my button. I'm not sure where it is right now but I'm sure if I dig around I can find it. R2 was positioned on her right side, facing towards the wall. R2's call light was wrapped around her left side rail with the button hanging down towards the floor. R2 had a pillow behind her back for repositioning and was unable to turn over and find her call light. R2 had a sign above her bed stating, Daily: Please place telephone, tv remote, and call light within (R2's) reach whether in bed or wheelchair. 3) R3's electronic face sheet printed on 6/16/24 showed R3 has diagnoses including but not limited to chronic respiratory failure with hypoxia, dysphagia, CHF, dementia without behaviors, history of falling, and bipolar disorder. R3's facility assessment dated [DATE] showed R3 has moderate cognitive impairment. On 6/16/24 at 10:45AM, R3 was yelling, CNA!! (Certified Nursing Assistant) R3 stated he needs his brief changed and can't find his call light. R3's call light was wrapped around his left side rail, with the button hanging down towards the floor. R3 was unable to obtain his call light and kept yelling for help. R3's care plan dated 10/7/19 showed, (R3) has a behavior problem related to calling the police when his call light is not answered immediately (historically had issues at past facilities with getting call light answered). R3's care plan dated 10/29/19 showed, (R3) displays manipulative behaviors related to ineffective coping skills .AAAHHH I NEED HELP!!! screaming instead of using his call light. Pt stated he likes yelling for things throughout the day .behavior has improved. All staff to manage resident's behavior consistently, encourage use of call light. 4) R7's electronic face sheet printed on 6/16/24 showed R7 has diagnoses including but not limited to spondylosis, Alzheimer's disease with late onset, anxiety disorder, spinal stenosis, and history of falling. R7's facility assessment dated [DATE] showed R7 has moderate cognitive impairment. On 6/16/24 at 11:23AM, R7 was laying in her bed with her call light placed inside a basin on her bedside table out of her reach. R7's call light was a push pad call light. R7 stated if she needs staff she will yell for them because she doesn't have a button to call them. The facility's policy titled, Call light policy dated 7/27/23 showed, It is the policy of this facility to ensure that there is prompt response to the resident's call for assistance. The facility also ensures that the call system is in proper working order .5. Be sure call lights are placed within reach of residents who are able to use it at all times .