

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  01/29/2025
NAME OF PROVIDER OR SUPPLIER  Warren Barr Buffalo Grove		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>45540</p> <p>Based on observation, interview, and record review the facility failed to assist residents with feeding in a dignified manner. This applies to 5 of 30 (R6, R53, R17, R69, R81) residents reviewed for dignity in the sample of 30.</p> <p>The findings include:</p> <p>On 1/26/2025 at 12:43PM, general dining observations were made. At 12:43PM, V21 Activity Director was observed standing over R6 while assisting her with feeding her lunch. At 12:43PM, V20 CNA (Certified Nursing Assistant) was observed standing over R53 while assisting her with feeding her lunch. At 12:44PM, V22 CNA was observed standing over R17 while feeding him his lunch. At 12:45PM, V23 CNA was observed standing over R69 while feeding her lunch. At 12:48PM, V24 LPN (Licensed Practical Nurse) was observed leaning against the window standing over R81 while feeding him his lunch.</p> <p>On 1/26/2025 at 12:48PM, V2 DON (Director of Nursing) said staff should be seated when feeding residents. V2 said it is more comfortable for the resident if the staff sit next to them while they are being fed and it is also a dignity concern.</p> <p>The facility provided list of residents requiring feeding assistance lists [R53] as one person assist, [R6] as one person assist, [R69] as supervision, [R17] as one person assist, and [R81] as one person assist.</p> <p>The facility provided Privacy and Dignity policy dated 8/16/2024 states, it is the facility's policy to ensure that resident's privacy and dignity is respected by the staff at all times.</p>

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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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34506</p> <p>Based on observation, interview, and record review, the facility failed to provided residents with privacy during personal cares for two of 30 residents (R81, R121) reviewed for privacy in the sample of 30.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>R81's Admission Record dated January 26, 2025 shows R81 was admitted to the facility on [DATE] with diagnoses including antistrophic lateral sclerosis, anemia, restlessness and agitation, and adult failure to thrive.</li> </ol> <p>On January 26, 2025 at 1:13 PM, V13 CNA (Certified Nursing Assistant) provided incontinence care for R81. R81's door was opened and R81 was visible from the hallway. V13 removed R81's incontinence brief leaving R81's perineal area exposed to the hallway while being turned from side to side.</p> <ol style="list-style-type: none"> <li>R121's Admission Record dated January 29, 2025 shows she was admitted to the facility on [DATE] with diagnoses including major depressive disorder, pressure injury of sacral region, and peripheral vascular disease.</li> </ol> <p>On January 26, 2025 at 10:44 AM, V12 CNA was providing incontinence care to R121. R121's roommate got up from his bed and looked around the curtain prior to walking to the bathroom. R121's curtain was not pulled all around R121's bed. R121's buttocks was exposed.</p> <p>On January 28, 2025 at 2:07 PM, V18 CNA said the residents doors should be closes and the curtain should be pulled all the way closed to provide privacy to the residents.</p> <p>The facility's Privacy and Dignity policy dated August 16, 2024 shows, It is the facility's policy to ensure that resident's privacy and dignity is respected by the staff at all all times. During care that requires privacy such as incontinence care, the resident will be placed in bed and the privacy curtain will be drawn to provide full visual privacy if the privacy curtain is not sufficient to provide full visual privacy, the combination of the privacy curtain and privacy screen will be used.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>45540</p> <p>Based on interview, and record review the facility failed to request a level II PASSAR (Preadmission Screening and Resident Review) screening for residents with a psychiatric/mood disorder which was added after the resident was admitted to the facility. This applies to 2 of 5 (R99, R119) residents reviewed for PASSAR in the sample of 30.</p> <p>The findings include:</p> <p>R99's PASSAR level 1 screening dated 11/11/2023 shows a determination of No Level II Required.</p> <p>R99's MDS (Minimum Data Set) section I dated 11/11/2024 under psychiatric/mood disorder I5950 Psychotic Disorder (other than schizophrenia) is checked for R99.</p> <p>R119's PASSAR level 1 screening dated 2/1/2023 shows a determination of No Level II Required.</p> <p>R119's MDS (Minimum Data Set) section I dated 11/1/2024 under psychiatric/mood disorder I5950 Psychotic Disorder (other than schizophrenia) is checked for R119.</p> <p>On 1/28/2025 at 1:29PM, V19 Admissions said PASSARs are completed prior to admission to make sure we provide the services the residents needs while they are at the facility. V19 said she was unsure if the PASSAR should be re-run if additional psychiatric diagnosis gets added but will check on that.</p> <p>On 1/28/2025 at 1:59PM, V19 said both [R99] and [R119] should have been rescreened. V19 said the facility will be running those now.</p> <p>The facility provided PASSAR Screening of Residents with Mental Disorder or Intellectual Disability revised 8/16/2024 fails to address residents being rescreened in the event additional psychiatric diagnoses are added during the resident's stay at the facility.</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35119</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident was screened prior to admission for 1 of 5 residents (R96) reviewed for preadmission screenings (PASARR) in the sample of 30.</p> <p>The findings include:</p> <p>On 01/27/25 at 10:03 AM, R96 was sitting up in a reclining chair in his room sleeping.</p> <p>On 01/28/25 at 12:00 PM, V1 Administrator said there was no PASARR done for R96. V1 said he has not left the facility since he was admitted . V1 said admissions is doing a screening now.</p> <p>R96's Face Sheet shows R96 was admitted to the facility on [DATE] with a diagnoses of unspecified dementia and schizophrenia.</p> <p>The facility's PASSAR Screening of Residents with Mental Disorder or Intellectual Disability dated 8/16/24 shows The facility will not allow admission form the hospital without a preadmission screening which includes PASSAR screening for those with mental or intellectual disorder.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34506</p> <p>Based on observation, interview, and record review the facility failed to provide ADL (Activities of Daily Living) assistance for residents that are dependent on staff for two of 30 residents (R25, R1) reviewed for ADLs assistance in the sample of 30.</p> <p>The findings include:</p> <p>1. R25's Admission Record dated January 26, 2025 shows she was admitted to the facility on [DATE] with diagnoses including dysphagia, history of Covid-19, mid cognitive impairment, scoliosis, pain, and history of falling.</p> <p>R25's Care Plan initiated August 21, 2020 shows, [R25] is incontinent of bowel and bladder, check resident every two hours and assist in toileting as needed. Provide incontinence care after each incontinence episode. The resident requires extensive one staff participation with personal hygiene and oral care.</p> <p>On January 26, 2025 at 9:39 AM, V12 CNA (Certified Nursing Assistant) provided incontinence care for R25. R25's incontinence brief was saturated with dark urine and soft stool. There was creases in R25's buttocks. V12 said R25 was last changed during the night shift.</p> <p>On January 28, 2025 at 2:07 PM, V18 CNA said that residents should be checked and changed at least every two hours.</p> <p>The facility's Incontinent and Perineal Care policy revised July 31, 2024 shows, 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. Do rounds at least every two hours to check for incontinence during shift.</p> <p>2. R1's Admission Record dated January 27, 2025 shows she was admitted to the facility on [DATE] with diagnoses including dementia, renal dialysis, adjustment disorder, anxiety disorder, and morbid obesity.</p> <p>R1's Care Plan dated January 26, 2025 shows, R1 has an ADL Self Care Performance deficit and Impaired Mobility. R1 requires weight bearing assistance with personal hygiene and oral care.</p> <p>R1's MDS (Minimum Data Set) dated January 15, 2025 shows R1 is cognitively intact, is dependent on staff for showering and bathing, and is always incontinent of bowel and bladder.</p> <p>On January 26, 2025 at 10:25 AM, R1 said she hasn't gotten a bed bath. R1 said she doesn't get in the shower, but staff give her a bed bath. R1 said she asked staff about her bed bath yesterday (January 25, 2025) but facility staff told R1 there was not enough staff. R1 said she is supposed to get two showers per week.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On January 26, 2025 at 11:03 AM, V13 CNA (Certified Nursing Assistant) was finishing up changing R1 incontinence brief and V13 said R1 was supposed to get a bad bath yesterday, (January 25, 2025) but V13 did not know if R1 did.</p> <p>R1's shower/bathing and skin monitoring shows she has received three showers in the last 14 days.</p> <p>R1's showering/bathing and skin monitoring task documentation shows R1 did not receive a bed bath on January 23-28, 2025.</p> <p>On January 28, 2025 at 2:07 PM, V18 CNA said residents should get at least two showers/bed baths per week. V18 said she doesn't remember the last time R1 got a bed bath.</p> <p>The facility's Shower and Hygiene policy revised August 19, 2024 shows, It is the policy of this facility to ensure that resident shower/hygienic care is provided by the nursing staff to promote cleanliness, provide comfort to the resident and observed the condition of the resident's skin.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34506</p> <p>Based on observation, interview, and record review, the facility failed to obtain daily weights on a resident with a history of fluid overload and failed to ensure protective arm sleeves were applied as ordered for two of 39 residents (R37, R70) reviewed for quality of care in the sample of 30.</p> <p>The findings include:</p> <p>1. R37's Admission Record dated January 27, 2025 shows she was admitted to the facility on [DATE] with diagnoses including reduced mobility, need for assistance with personal care, prosthetic heart valve, pleural effusion, acute respiratory failure with hypoxia, pulmonary hypertension, chronic diastolic congestive heart failure, and stage four chronic kidney disease.</p> <p>R37's Order Review Report dated January 27, 2025 shows an order was entered on January 9, 2025 for daily weight due to diagnosis of congestive heart failure, notify doctor with patient gains three pounds in one day or five pounds in one week, in the morning.</p> <p>R37's Care Plan shows potential for fluid overload. Weight will be obtained as ordered by the doctor.</p> <p>R37's Progress Notes dated December 28, 2024 shows, Spoke with [registered nurse] from [local hospital] who stated resident is being admitted for hypervolemia (fluid overload) and renal failure.</p> <p>R37's Physician Progress Note dated January 9, 2025 shows, Patient is seen after returning from [local hospital]. She went to the hospital because of shortness of breath, hypoxia (low oxygen), and lethargy. She was fluid overloaded.</p> <p>On January 27, 2025 at 10:06 AM, R37 said she is supposed to be weighed daily because she retains fluid. R37 said staff do not always weigh her every day.</p> <p>R37's Weights and Vital Signs summary shows her weight was not obtain on January 18, 19, 23, and 25, 2025.</p> <p>On January 28, 2025 at 2:01 PM, V16 RN (Registered Nurse) said R37 is daily weight because she is a congestive heart failure resident. V16 said daily weights are obtain to watch for weight gain and fluid overload.</p> <p>The facility's Weights policy revised August 19, 2024 shows, It is the facility's policy to obtain resident's monthly weight unless otherwise ordered differently by the physician.</p> <p>34490</p> <p>2. R70's Physician's Order Sheet (POS) printed on 1/28/25 shows an order dated 6/16/24 for: Tubigrip (protective arm sleeve) on both arms in the morning.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/26/25 at 10:43 AM, R70 had a large brown/black discoloration and multiple small areas of discoloration on his right lower arm just below his elbow. R70 had multiple areas of discoloration to his left lower arm. R70 did not have any protective arm sleeves on. On 1/27/25 at 2:07 PM, V18, Certified Nursing Assistant (CNA) provided incontinence care to R70. R70 did not have protective arm sleeves on. On 1/28/25 at 12:10 PM, R70 did not have protective arm sleeves on. A pair of protective arm sleeves were on R70's night stand.</p> <p>On 1/28/25 at 2:15 PM, V18 (CNA) said that R70 is supposed to wear covers on his arms to prevent bruising but she did not put them on yesterday (1/27/25). V18 said that he is supposed to wear them throughout the day.</p> <p>R70's Care Plan shows, Alteration in musculoskeletal status r/t (related to) history of right hand amputation . 5/28/24 right elbow contusion 2/2 (secondary to) ASA (Aspirin)/plavix (blood thinner) and advanced age, fragile skin .Tubigrip both arms.</p> <p>The facility's Physician Orders Policy revised on 8/16/24 shows, 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. The facility shall ensure to follow physician orders as it is written in the POS.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>35119</p> <p>Based on observation, interview, and record review the facility failed to ensure a palm protector was in place for a resident with a contracture and failed to ensure restorative assessments were done for 4 of 5 residents (R38, R62, R65, R57) reviewed for restorative services in the sample of 30.</p> <p>The findings include:</p> <p>1. 01/27/25 at 10:18 AM, R38 was sitting up in a chair at the bedside. R38's fingers of his left hand were contracted into his fist. There was nothing observed in R38's left hand. R38 said they usually put something in his hand.</p> <p>On 01/28/25 at 9:18 AM, R38 was up in a chair at the bedside. R38's left hand did not have a palm protector or other device.</p> <p>On 01/28/25 at 10:54 AM, V26 Restorative Nurse said R38 has a left hand contracture and a palm protector should be in on at all times except for hand hygiene and passive range of motion. V26 said the palm protector is to makes sure there is no further decline in R38's contracture and to maintain skin integrity.</p> <p>R38's most recent Restorative UDA Form is dated 12/5/23.</p> <p>R38's Care Plan dated 2/6/20 shows R38 requires restorative program for passive range of motion due to contracture of left hand with an intervention of palm protector on left hand to post range of motion exercises and check skin integrity to left hand daily post palm protector removal.</p> <p>On 01/28/25 at 12:30 PM, V26 said contracture assessment are on the Restorative UDA form and are supposed to be done quarterly. V26 said she has not able to do quarterly restorative assessments since 2023. V26 said there is no assessment for R38 for all of 2024, the last assessment was done 12/5/2023 for R38's contracture.</p> <p>2. On 01/27/25 at 09:59 AM, R62 was in bed on her right side on an air mattress. R62 said staff help her turn and position in bed.</p> <p>R62's most recent Restorative UDA form is dated 9/11/23 and shows R62 requires extensive assistance with activities of daily living and is on a passive range of motion program.</p> <p>On 01/28/25 at 12:30 PM, V26 said contracture assessment are on the Restorative UDA form and are supposed to be done quarterly. V26 said she has not able to do quarterly restorative assessments since 2023. V26 said there is no assessment for R62 for all of 2024, the last assessment was done 9/11/23.</p> <p>45540</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. The facility provided Restorative assessment for R65 shows the resident had an assessment last completed on 12/31/2023. The facility failed to provide a more current Restorative assessment for R65.</p> <p>On 1/28/2025 at 11:45AM, V26 Restorative Nurse said she started on 1/4/2024. V26 said she has been doing the quarterly assessments but has not been documenting them.</p> <p>4. The facility provided Restorative assessment for R57 shows the resident had an assessment last completed on 12/13/2023. The facility failed to provide a more current Restorative assessment for R57.</p> <p>On 1/28/2025 at 11:45AM, V26 Restorative Nurse said she started on 1/4/2024. V26 said she has been doing the quarterly assessments but has not been documenting them.</p> <p>The facility provided Restorative Nursing Program revised 8/19/2024 states, . nursing and restorative services may include the following: splint/orthotic management. evaluation as to the need of adaptive equipment/enabling devices to help accommodate the resident's needs, promote optimal functioning and self-sufficiency in ADL's may be referred to the Therapy Department. for the most appropriate device/s recommendations. the restorative programs shall be evaluated on a quarterly basis.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>34490</p> <p>Based on observation, interview and record review the facility failed to ensure fall interventions were in place for a resident that is at high risk for falls. This applies to 1 of 30 residents (R39) reviewed for safety in the sample of 30.</p> <p>The findings include:</p> <p>R39's Face Sheet shows diagnoses of: parkinson's disease with dyskinesia, lack of coordination, unsteadiness of feet and history of falling.</p> <p>On 1/26/25 at 11:22 AM, R39 was in the common area. R39 had a wheelchair pressure sensor alarm attached to his wheelchair. R39 lifted his buttocks off of the seat of the wheelchair multiple times and the alarm did not sound. The In Use light on the alarm box was not on. At 2:16 PM, V29 (Certified Nursing Assistant) had R39 stand from his wheelchair. R39's alarm did not sound when he stood up. V29 turned the alarm box on and it sounded and there was a green light on the alarm box that was blinking In Use.</p> <p>On 1/27/25 at 2:07 PM, V18 (CNA) said that R39 is at fall risk. V18 said that R39 will try and stand on his own but he is not stable and that is why he has an alarm. V18 said that the alarm should be on when he is in his wheelchair.</p> <p>R39's Care Plan shows, [R39] is at high risk for falls related to history of falling, parkinson's, unsteady feet, unspecified lack of coordination, CHF (congestive heart failure), HTN (hypertension) .Interventions: Bed alarm and chair alarm to alert staff when resident attempts to get out of bed or wheelchair unassisted, so staff can assist resident.</p> <p>The facility's Fall Occurrence Policy revised on 7/26/24 shows, It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and interventions are reevaluated and revised as necessary .</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35119</p> <p>Based on observation, interview, and record review the facility failed to maintain a nephrostomy and urinary drainage bag below the level of the bladder for 2 of 7 residents (R67, R121) in the sample of 30.</p> <p>The findings include:</p> <p>1. On 01/27/25 at 09:47 AM, R67 was in bed with her nephrostomy drainage bag containing urine laying on the bed. R67's foot of the bed was elevated making the urine pool at the opening of the nephrostomy drainage bag, and up into the nephrostomy tubing. The urine in the tubing unable to drain into the bag.</p> <p>On 01/27/25 at 12:26 PM, R67's nephrostomy drainage bag remained on the bed in the same position, with the urine unable to drain into the bag.</p> <p>On 01/27/25 at 3:00 PM. R67's nephrostomy drainage bag remained in the same position, with urine backing up into the nephrostomy tubing.</p> <p>On 01/29/25 at 09:31 AM, V2 Director of Nursing said you should position the nephrostomy drainage bag so the flow of urine can go into the bag to prevent infection. V2 said care is provided the same way as an indwelling urinary catheter.</p> <p>R67's Care Plan shows R67 has left side nephrostomy due to acute kidney injury and renal calculi.</p> <p>The facility's Urinary Catheter Care Policy dated 8/19/24 shows The purpose of this procedure is to prevent catheter-associated urinary tract infections. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent urine in the tubing and drainage bag from flowing back into the urinary bladder.</p> <p>34506</p> <p>2. R121's Admission Record shows he was admitted to the facility on [DATE] with diagnoses including major depressive disorder, pressure injury of the sacral region, and other mechanical complication of other urinary devises and implants.</p> <p>R121's Care Plan initiated November 26, 2023 shows, Please position catheter bag and tubing below the level of the bladder and away from entrance room door.</p> <p>On January 26, 2025 at 10:44 AM, V12 CNA (Certified Nursing Assistant) performed peri care on R121. R121's urinary drainage bag had about 200-300 milliliters in it. The tubing was filled with amber colored urine. V12 lifted R121's urinary drainage bag above the level of R121's bladder when V12 was repositioning R121. V12 then set the urinary drainage bag on R121's bed at R121's feet.</p> <p>(continued on next page)</p>		

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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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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On January 28, 2025 at 2:07 PM, V18 CNA said urinary drainage bags should be kept below the level of the residents' bladder.</p> <p>The facility's Urinary Catheter Care policy revised August 19, 2024 shows, The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34490</p> <p>Based on observation, interview, and record review that facility failed to ensure placement of a gastrostomy tube was checked prior to administering medication for 1 of 4 residents (R39) reviewed for enteral nutrition in the sample of 30.</p> <p>The findings include:</p> <p>R39's Face Sheet shows that he readmitted to the facility on [DATE] with a new diagnosis of gastrostomy.</p> <p>On 1/26/25 at 10:00 AM, V14 (Licensed Practical Nurse) went into R39's room to administer his medications. At that time, R39 said that it is sometimes painful when things are put into his tube. V14 assessed the area and told R39 that she would go slow and then administered his medications. V14 did not check the placement of R39's gastrostomy tube before administering his medications.</p> <p>On 1/28/25 at 1:53 PM, V16 (Registered Nurse) said that the type of gastrostomy tube that R39 had does not have a line to check for placement. V16 showed the gastrostomy tube insertion site and there was no line present. V16 said that placement is always checked before administering any tube feeding or medications by aspirating gastric content.</p> <p>R39's Physician's Order Sheet printed on 1/16/25 shows an order dated 1/26/25 for: Enteral feeding-Check G-tube placement by checking for marking at the insertion site every shift and or per policy .</p> <p>The facility's Medication Pass Policy revised on 8/16/24 shows, G-Tube medications .Check placement of G-tube by checking if the marker of the actual enteral tube is still located at the G-tube insertion site If the marker cannot be located or had become too light to see, the nurse will aspirate the gastric content and confirm the ph of the aspirated material</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>34490</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident's oxygen tubing and bubble humidifier bottle was changed as ordered and failed to ensure a resident's oxygen humidifier bottle was kept filled for 1 of 8 residents (R32) reviewed for oxygen administration in the sample of 30.</p> <p>The findings include:</p> <p>On 1/26/25 at 11:30 AM, R32 was laying in bed with oxygen being administered via nasal cannula. R32's oxygen tubing and bubble humidifier bottle was labeled 12/13/24. R32's bubble humidifier bottle was empty. On 1/27/25 (Monday) at 12:23 PM, the tubing and bottle were still labeled 12/13/24 and the humidifier bottle was still empty.</p> <p>On 1/126/25 at 11:30 AM, R32 said that she does frequently get sinus pain and a dry nose.</p> <p>On 1/27/25 at 1:37 PM, V28 (Licensed Practical Nurse) said that oxygen tubing and bubblers are changed weekly. V28 said that the bubbler humidifier bottle should be filled before it is empty.</p> <p>R32's Physician's Order Sheet printed on 1/27/25 shows an order dated 9/23/24 for, Change oxygen tubing/bubblers weekly and PRN (as needed) and every night shift every Sun (Sunday).</p> <p>The facility was unable to provide an oxygen administration policy.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>34490</p> <p>Based on observation, interview, and record review, the facility failed to administer medications according to standard of practice for a resident receiving medications through a gastrostomy tube. There were 25 opportunities with 5 errors resulting in a 20% error rate. This applies to 1 of 7 residents (R39) observed in the medication pass.</p> <p>The findings include:</p> <p>R39's January Medication Administration Record shows that he receives aspirin 81 mg (milligrams) chewable, omeprazole 20 mg, multiple vitamin with minerals, tramadol 25 mg, vitamin D3 25 mcg (micrograms)-2 tablets and carbidopa-levodopa 25-100 mg-2 tablets via G-tube at 9:00 AM.</p> <p>R39's Physician's Order Sheet does not document that all medications can be given at the same time.</p> <p>On 1/26/25 at 10:00 AM, V14 (Licensed Practical Nurse) prepared R39's morning medications. V14 put R39's aspirin, multivitamin, vitamin D3 and carbidopa-levodopa into a pill crusher pouch, crushed the medications and place them into a medication cup. V14 then opened the omeprazole capsule and placed the contents into the same cup. V14 then went into R39's room and mixed approximately 20 ml (milliliters) of water into the cup and administered the medications via gastrostomy tube to R39.</p> <p>On 1/27/25 at 2:20 PM, V34 (Registered Nurse) said that all medications should be crushed and given individually if administering through a gastrostomy tube to prevent interactions. V34 said that 10-30 mls of water should be given in between each medication.</p> <p>The facility's Medication Pass Policy revised on 8/16/24 shows, Separate each medication in med cup and flush between each med with at least 5 ml of water.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>34490</p> <p>Based on observation, interview and record review the facility failed to ensure a resident's medication was stored in a secure manner for 1 of 30 residents (R54) reviewed for medication storage in the sample of 30.</p> <p>The findings include:</p> <p>On 1/26/25 (Sunday) at 10:32 AM, there was a blue and white capsule in a medication cup on R54's bedside table. R54 said that she was not sure what it was but she thinks that it is something she was supposed to take at breakfast. At 11:11 AM, V14 (Licensed Practical Nurse) brought R54 her medications. V14 said that she was unsure what the medication on her bedside table was.</p> <p>On 1/26/25 at 11:20 AM, V14 verified that the blue and white capsule was PhosLo 667 mg (milligrams). V14 said that medications should never be left at the resident's bedside. V14 said that the resident could forget to take the medication or another resident could take it.</p> <p>R54's Physician's Order Sheet (POS) printed on 1/27/25 shows an order for, PhosLo Oral Capsule 667 MG-Give 3 capsules by mouth with meals for end stage renal disease give at 6 am on HD (Hemodialysis) days. R54's POS shows that she receives dialysis on Monday, Wednesday and Fridays.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>33760</p> <p>Based on observation, interview, and record review, the facility failed to ensure the dishwasher reached the desired temperature to sanitize dishes to prevent the spread of food borne illness, failed to ensure meat products were covered, dated, and labeled, failed to ensure staff wore beard coverings in the kitchen to prevent cross contamination and failed to ensure the kitchen was maintained in sanitary conditions. This failure has the potential to affect all residents residing at the facility.</p> <p>Findings include:</p> <p>The CMS 671 dated 1/26/25 show there were 153 residents residing at the facility.</p> <p>1. On 1/26/25 at 9:10 AM, V5 (Dietary Manager-DM) was in the dishwashing area loading dish racks eight (8) times . V5 said he had to run the dish machine (dishwasher) at least five cycles so the final temperature (temp) reaches at 160 degrees Fahrenheit. (F). After V5 ran the dish machine eight (8) times, the final rinse noted at the dishwasher remained at 130F. V5 said it should be at least 160F. It was important to reach the desired temperature to kill the bacteria in the soiled dishes.</p> <p>At 9:20 AM, V7 and V8 (both Dietary Aides-DA) were in the dishwasher area loading the soiled dishes coming from the floors after breakfast. V11 (Dietary Aide) was scraping the food debris from the soiled plates, cups, glasses, spoons, and forks used at breakfast. V7 (DA) was loading the soiled dishes in the dirty area of the dishwasher and running the soiled dishes through the dishwasher. V8 (DA) was at the other end of the dishwasher, in the clean area removing the dishware from the dishwasher and placing them in the metal rack to dry. The final rinse in the dish machine was staying at 130F. At 9:45 AM, 10 AM, and at 10:30AM while V7 continued to load soiled dishes and V8 continued to remove the clean dishes and placing the dishes to the metal rack to dry, the final rinse stayed at 130F. V7 said the final rinse should be at least 135F. V8 said she does not pay attention to the temperatures of the dishwasher and does not know what the final rinse temperature should be.</p> <p>At 11:30 AM during lunch service, V5 (DM) said he was aware that the final rinse was at the 130's F. Lunch will be served using paper products (Styrofoam). Staff still used the regular silverware that was washed in the dishwasher earlier. Staff also used some regular cups and plates to serve salads, sandwiches, and dessert. V5 said the evening meal will be completely served with paper products.</p> <p>At 12:50 PM, V10 (Dishwashing Vendor Company Head) said the facility has a high temp dishwasher. They were at the facility a couple of weeks ago servicing the facility dishwasher which was a high temp. V10 said on a high temp dishwasher, the final rinse should be within 160-180F.</p> <p>At 2PM, V9 (Technician Dishwashing Vendor) was at the facility at this time fixing the dishwasher. V9 said he had fixed the dishwasher and the final rinse was now able to reach at 180F. V9 said he also fixed the wash cycle since when it reaches 150F it stops, it was now at 160F.</p> <p>Review of the facility dishwashing log dated 1/2025 show final rinse ranges from 160 to 180F except for the 20th which was 150F.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The facility policy entitled Cleaning and Sanitation Warewashing (undated) states, check to make sure the machine is meeting the correct wash and rinse temperature .160F.</p> <p>2. During the tour in the kitchen at 10:45 AM, with V5 (DM) the walk in freezer had boxes of frozen hamburgers, frozen breaded pork, and chicken patties that were all open to air, unlabelled, and not dated. V5 said it should be stored tightly to prevent freezer burn and growth of bacteria.</p> <p>The facility policy entitled Kitchen dated 8/16/24 show, all food products should be covered, dated and labeled.</p> <p>3. On 1/26/25 from 9:02 AM to 10:30 AM, V6 (Cook) who had a thick beard had no facial hair covering while handling food throughout the kitchen. V5 said V6 should wear a facial hair covering to prevent contaminating the residents food.</p> <p>The facility policy entitled Kitchen dated 8/16/24 show, a. Hair restraints is required for those with facial hair that might fall on food.</p> <p>4. During the lunch service at 11 AM, on the wall next to the ice machine is a bin where the ice scooper sits. Inside the bin where the ice scooper sits was covered with dust and whitish debris. There was a hanging rack above the meal service assembly where meal tickets were clipped that was covered with grayish dust. V5 said this was unacceptable and cleaning will be done. Kitchen should be kept clean and sanitary.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34490</p> <p>Based on observation, interview, and record review the facility failed to ensure multi-use resident equipment was cleaned after being used by a resident on contact isolation, failed to ensure incontinence care was performed in a manner to prevent the spread of infections, failed to ensure staff removed their gloves and washed their hands to prevent to spread of infection and failed to ensure a resident with an indwelling medical device was placed on enhanced barrier precautions. This applies to 6 of 30 residents (R54, R70, R45, R25, R67 and R121) reviewed for infection control in the sample of 30.</p> <p>The findings include:</p> <p>1. R54's Physician's Order Sheet printed on 1/27/25 shows an order dated 1/23/25 for, Strict contact isolation for Norovirus.</p> <p>On 1/27/25 at 10:49 AM, V18, Certified Nursing Assistant (CNA) wheeled R54 down the hallway in a dialysis chair to her room. V18 stopped before entering R54's room and took R54's blankets off of her and placed them in the soiled linen cart that was down the hallway. While carrying the soiled linens, they were touching her scrub top. V18 then placed R54's electronic tablet on a table that was in the hallway. V18 then placed R54's personal blanket and pillow onto a chair in the hallway. R54 stood up from her wheelchair and held onto the hallway grab bar and was assisted to sit down in her wheelchair. V18 then wrapped R54's blanket around her and gave her her tablet. V18 then brought the dialysis chair into the shower room and left. V18 did not sanitize the dialysis chair, table, chair or grab bar.</p> <p>On 1/28/25 at 2:08 PM, V27 (CNA) said that all shared equipment should be disinfected with a disinfecting wipe after being used on a resident who is on isolation for infection control reasons. V27 said that used linens should not be placed on a public surface without cleaning the surface afterwards.</p> <p>2. On 1/27/25 at 2:07 PM, V18 (CNA) provided care to R70. V18 removed R70's soiled sheets and placed them onto the floor. V18 then started providing incontinence care. V18 cleaned R70's front perineal area and then turned him to the left side. V18 cleaned stool from R70's buttock. V18 then took the soiled incontinence brief off and placed it on the floor. V18 then took the soiled incontinence pad off and placed it on the floor. With the same gloves on, V18 adjusted R70's shirt, used the bed control, put new sheets on and applied R70's positioning bolster.</p> <p>On 1/28/25 at 2:08 PM, V27 (CNA) said that when providing incontinence care soiled linen should be placed in a bag and soiled gloves and incontinence briefs should be placed in another bag. V27 said that they should not be placed on the floor for infection control reason. V27 said that gloves should be changed and hands sanitized after cleaning stool and before touching any other objects for infection control reasons.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility Incontinent and Perineal Care Policy revised on 7/31/24 shows, Discard disposable items into designated containers/plastic bag. Remove gloves and dispose to designated plastic bag. Wash hands. Put on new set of clean gloves to put on clean briefs/incontinence pads, to make resident comfortable, groom and change clothing. The facility's Hand Hygiene Policy revised on 7/30/24 shows, Hand Hygiene using alcohol-based hand rub is recommended during the following situations: .Before moving from a soiled body site to a clean body site on the same resident. After contact with blood, body fluids or surface contaminated with blood and body fluids.</p> <p>34506</p> <p>3. R45's Admission Record dated January 26, 2025 shows she was admitted to the facility on [DATE] with diagnoses including cellulitis, history of covid 19, and history of falling.</p> <p>R45's Care Plan initiated May 17, 2024 shows R45 has had a urinary tract infection.</p> <p>On January 26, 2025 at 9:52 AM, V12 CNA performed perineal care on R45. V12 folded the front of R45's incontinence brief in between R45's legs while R45 was lying on her back. V12 wiped R45's front peri area and touched R45's body to help her turn onto her side. V12 then wiped the stool from R45's buttocks, placed a clean pad and clean brief under R45, touched R45's shirt, and then turned R45 back onto her back. V12 then pulled R45 up in bed and touched R45's pillows and blankets. V12 did not wash his hands nor change his gloves when going from clean to dirty items.</p> <p>4. R25's Admission Record dated January 26, 2025 shows she was admitted to the facility on [DATE] with diagnoses including dysphagia, history of Covid-19, mid cognitive impairment, scoliosis, pain, and history of falling.</p> <p>R25's Care Plan initiated August 21, 2020 shows, [R25] is incontinent of bowel and bladder, check resident every two hours and assist in toileting as needed.</p> <p>On January 26, 2025 at 9:39 AM, V12 CNA provided peri care for R25. V12 folded R25's incontinence brief in between her legs while she was lying on her back. V12 wiped R25's front peri area, touched R25's body when he help her turn onto her side, then wiped the large soft stool from R25's buttocks. V12 placed a clean incontinence pad under R25 and placed a clean brief under R25 and helped R25 to turn. V12 then touched R25's shirt to fix the placement. V12 did not change his gloves nor perform hand hygiene when going from touching dirty surfaces to clean surfaces.</p> <p>5. R121's Admission Record shows he was admitted to the facility on [DATE] with diagnoses including major depressive disorder, pressure injury of the sacral region, and other mechanical complication of other urinary devises and implants.</p> <p>On January 26, 2025 at 10:44 AM, V12 performed peri care for R121. R121 had a urinary catheter in place and a pressure injury to his buttocks. R121 removed R121's incontinence brief, wiped R121's front peri area, turn R121 onto his side, and wiped his buttocks. V12 placed cream onto R121's buttocks, placed a new incontinence pad and brief under R121, and then helped R121 to turn back onto his back. V12 did not change his glove nor perform hand hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On January 28, 2025 at 1:38 PM, V17 CNA said she changes her gloves and performs hand hygiene before entering residents room and before leaving residents rooms. At 2:07 PM, V18 CNA said she changes her gloves and performs hand hygiene before entering residents rooms and before leaving. Neither CNA stated that they change their gloves and perform hand hygiene when going from dirty to clean items.</p> <p>35119</p> <p>6. On 01/27/25 at 09:47 AM, R67 was in bed with her urine drainage bag (from her nephrostomy) laying on the bed. There was no signage for isolation precautions outside of R67's room.</p> <p>On 1/28/25 at 9:15 AM, R67 did not have isolation precaution signage on R67's door.</p> <p>On 01/29/25 at 9:45 AM, V4 Infection Control Registered Nurse said if a resident has a nephrostomy they should be on Enhanced Barrier Precautions (EBP). V4 said R67 should be on EBP.</p> <p>The facility's Enhanced Barrier Precaution Policy dated 7/26/24 shows The facility will use EBP to reduce the transmission of multi-drug resistant organisms in the nursing home. EBP will be used for any resident in the facility: has indwelling medical devices (e.g. central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of Novel or Targeted Multidrug-Resistant Organisms colonization status.</p>