| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145899 | A. Building<br>B. Wing | 06/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Warren Barr Orland Park | 14601 South John Humphrey Dr<br>Orland Park, IL 60462 |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain confidentiality of resident's record by failing to ensure that resident's medications were secured at the facility and not sent home with another resident. This failure affected one (R172) of two residents reviewed for confidentiality of records.Findings include:R172 is [AGE] years old and resided at the facility from 4/21/2026 to 6/5/2026. R172's face sheet listed the following medical history: Cerebral ischemia, anemia in chronic kidney disease, hyperlipidemia, essential primary hypertension, atherosclerosis of coronary artery bypass graft (s) without angina pectoris, andchronic diastolic (congestive) heart failure.MDS (Minimum Data Set) assessment, dated 4/22/2026, scored R172 with a BIMS (Brief Interview for Mental Status) score of 13. Section gg (functional status) documented R172 is dependent on staff for transfers, toileting hygiene and lower body dressing, requires maximal/substantial assistance to partial/moderate assistance for other ADL (activities of daily living) care needs.On 5/10/2026, R236 was discharged from the facility. Staff inadvertently supplied the incorrect medications to a resident who was discharging. The following medications belonging to R172 were sent home with R236 Amlodipine 10mg, Carvedilol 6.25mg, Clonidine 0.1mg, Furosemide 20mg, Hydralazine 100mg, Trazadone 50mg and Zofran 4mg. As stated in the variance form, dated 5/12/2026, the nurse did not complete proper medication reconciliation with R236 prior to discharging resident. On 6/9/2026 at 3:29PM, V23 (Registered Nurse/RN) said the following day, she realized R172 did not have her medications. V23 volunteered to go the discharged resident's house to switch the medications, notified the Director of Nursing (DON), who authorized her to go to the discharged resident's house and retrieve R172's medications. V23 brought medication back and medications were put back in the medication cart and were administered to R172. Review of R172's medical record did not show any documentation R172 or her daughter were notified of the medication variance; her physician or pharmacy were not notified either.On 6/10/2026 at 9:30AM, V45 (RN) said she recalls R172. V23 brought the medications from the discharged resident's house (R236) and gave them to her around 10:00AM. V45 added she put the medications back in the medication cart, R172 had her morning medications at that time, resident had extra medications in the cart. V45 was not told why V23 brought the medications or where they came from, she just continued to use the medications that were brought back.On 6/9/2026 at 3:29PM, V2 (DON) said R236 discharged from the facility on 5/10/2026; they realized the mistake and went and swapped the medications. V2 added the physicians for both residents and the pharmacy were not notified, R172 or her daughter were not notified. The swapped medications were placed back in the medication cart and continued to be administered to R172.On 6/10/2026 at 1:40PM, V43 (Consultant Pharmacist) said once medication is sent out, facility should notify pharmacy and order new medications. V43 added the facility should make sure the medication is complete, set them aside and order new medications. V43 was asked if the medications that left facility ground exposed resident's protected health information and she said, Yes, residents' information is on the bingo card, exposing that information to another resident is definitely a health insurance portability and accountability act (HIPAA) violation.On 6/11/2026 at 10:46AM, V39 (Social worker) said she recalls R236; R236 lives at home by herself and gets home (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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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | care from the Department of Aging. V39 said she set R236 up with a home health care agency. R236 is alert but gets home health nurses 2 or 3 times a week.On 6/11/2026 at 12:08PM, V1 (Administrator) said R172's daughter was involved in her care, neither the resident nor her daughter was informed that her medication was sent home with another resident. V1 said the resident and her daughter could have been informed after the investigation. V1 is not sure if the physicians were notified either, stating that he is not clinical; the Director of Nursing will be in a better position to answer that question. V1 was asked what the impact would be for a resident whose information was exposed to the community, and he said, The bingo card does not contain sensitive information, just the resident's name and the name of the medication. A bingo card was reviewed with V1 and V47 (LPN/Licensed Practical Nurse/unit manager) and noted it contains the following:Resident's name, medication name, prescription number, pharmacy name and an inscription that says: prohibits transfer of medications to other persons. A bingo card from the narcotic locked box was reviewed and noted it contains resident's date of birth .Surveyor attempted to contact R172 on 6/11/2026 at 2:17PM but resident did not answer, and her mailbox was full.Privacy and dignity policy, revised 7/3/2025, stated:Policy statement: It is the facility's policy to ensure that residents' privacy and dignity is respected by the staff at all times.Procedures #6. Resident's health information will not be shared by anyone who is not involved in resident's care and to anyone whom the alert and oriented resident does not wish to share his/her information with. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff conducted appropriate discharge instruction prior to discharging a resident and failed to ensure a resident was discharged home with the right medications. This failure affected one (R236) of one resident reviewed for discharge.Findings include:R236 is [AGE] years old admitted to the facility on [DATE]. R236's face sheet listed the following past medical history: Diverticulosis of large intestine, without perforation, specified disorders of the muscle, other symptoms and signs involving the musculoskeletal system, personal history of malignant neoplasm of breast, chronic kidney disease stage 3, secondary attack (TIA), and cerebral infarction without residual deficits, hyperlipidemia, essential primary hypertension etc.Minimum Data Set (MDS) assessment, dated 5/9/2026, section C0100 (cognitive pattern) documented a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident is somewhat cognitively intact. Functional abilities section GG0100 documented the resident needed partial assistance from another person to complete activities; functional cognition documented R236 needed assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury. Section GG0130 (self-care assessment) indicated R236 is dependent on staff for toileting hygiene, chair to bed transfer and toilet transfer, substantial/moderate assistance for walking 50 feet, sit to stand, lying to sitting, putting or removing footwear and lower/upper body dressing.Medication variance form, dated 5/12/2026, completed by V2 (Director of Nursing/DON) documented: Type wrong drug. Summary: R236 was discharged from the facility, additional information regarding variance states: On 5/10/2026 staff inadvertently supplied the incorrect medications to a resident who was discharging. Staff stated that as she was preparing the medications, she set the stacks down and then when she picked it back, she accidentally grabbed another resident R172's medication.Follow up/facility notified date/time: Staff realized the error on 5/11/2026 and reported to the Director of Nursing. The resident was called and notified and the resident stated she had not taken any of the medications because she still had some of her own at home. On 5/12/2026, the correct medications were delivered to R236 and swapped out with the incorrect medications.Additional monitoring/labs/procedures needed related to the error: N/A, resident discharged , she was encouraged to follow up with her primary care physician for further review. There was no mention of the resident whose medication was wrongly sent home with another resident in the variance form.Part C factors contributing to variance: Other: Lack of medication review.How could this error have been prevented: Closer review of medications upon discharge and medication reconciliation with residents prior to discharge.The following wrong medications were sent home with R236:Amilodipine 10mg, Carvedilol 6.25mg, Clonidine 0.1mg, Furosemide 20mg, Hydralazine 100mg, Trazadone 50mg and Zofran 4mg. Review of physician order for R236 shows the only medication like the ones sent home with R236 is Amlodipine 5mg tablet, take one tablet by mouth one time a day.Surveyor attempted to reach R236 at the number listed in her face sheet several times on 6/9/2026 at 12:24PM, 6/10/2026 at 10:18AM, and 6/11/2026 at 2:15PM, but resident did not answer or return calls. R172's MDS assessment, dated 4/22/2026, scored R172 with a BIMs score of 13. Section GG (functional status) of the same assessment documented R172 is dependent on staff for transfers, toileting hygiene and lower body dressing, requires maximal/substantial assistance to partial/moderate assistance for other ADL care needs.Physician order summary for R172 shows the above medications were ordered for the resident; there was no documentation in resident's medical record that she or her representative were notified of the medication variance, no documentation her physician or pharmacy were notified,Surveyor attempted to contact R172 on 6/11/2026 at 2:17PM but resident did not answer, and her mailbox was full.On 6/9/2026 at 3:29PM, V23 (Registered Nurse/RN) said she pulled resident's medication from the medication cart and set it aside, then pulled resident's<br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Tramadol from the narcotics box and mistakenly put it in front of another resident's medication. When the resident was leaving, V23 pulled the tramadol with other bingo cards that belonged to another resident. V23 realized the mistake the following day; she realized the other resident that is still at the facility did not have her medications. V23 volunteered to go the discharged resident's house to switch the medications. V23 said R236 was discharged on Sunday around 12:00PM; she called the resident the following day around 8 or 9:00AM and she said that she has not used any of the medications from the facility, she still has her own home medication. V23 said V2 (DON) was notified, and he authorized her to go and switch the medications. V23 dropped the correct medications at the resident's house and brought back the medications for R172.On 6/10/ 2026 at 9:27am, V23 (RN) was interviewed again and said the day she brought medications back from R236, she gave them to the assigned nurse for R172 because V23 was off work that day. V23 said she volunteered to go and get the medications though it was her off day.On 6/10/2026 at 9:30AM, V45 (RN) said she recalls R172. V23 brought the medication from the discharged resident's house (R236) and gave them to her around 10:00AM. V45 added she put the medications back in the medication cart. R127 had her morning medications at that time; resident had extra medications in the cart. V45 was not told why V23 brought the medications or where they came from, she just continued to use the medications that were brought back.On 6/10/2026 at 1:40PM, V43 (Consultant Pharmacist) said for someone already on a blood pressure medication, taking additional hypertensive medications can drop the blood pressure too low. V43 was asked what the potential harm could be if someone takes a lot cardiac and hypertensive medications that are not prescribed for them and she said, drop in blood pressure and heart rate, syncope and fainting can occur depending on how many doses the person have taken.V43 was asked if the facility should take medications back after leaving the facility grounds for more than 24 hours and she said, No, once medication is sent out, facility should notify pharmacy and order new medications. The facility should make sure the medications returned from the community is complete, set them aside, and order new medications. On 6/9/2026 at 3:29PM, V2 (DON) said R236 discharged from the facility on 5/10/2026. They realized the mistake and went and swapped the medications. V2 was asked why the nurse did not do a medication reconciliation before discharging resident and he said that the nurse did; she went over the medication list. V2 was asked if that was the expectation for appropriate medication reconciliation during discharge and he said, I guess she should have gone over the medications physically. V2 added the physicians for both residents and the pharmacy were not notified, R172 or her daughter were not notified, the swapped medications were placed back in the medication cart and continued to be administered to R172. On 6/10/2026 at 12:14PM, V44 (Quality Assurance Manager/Pharmacist) said accepting medication back after it has left the facility grounds for more than 24 hours depends on the facility; it is not a pharmacy policy once the medication leaves the pharmacy and changes hands with the facility. V44 said that the integrity of the medication could have been affected after it left the facility; they could have contacted their pharmacy and reordered those medications.On 6/10/2026 at 12:36PM, V14 (Medical Director) said accepting medications after it has left the facility grounds is not typical; the facility could have gotten new medications for the resident, that would have been the best practice. V14 added the prescribing physicians should have been notified. V14 was not sure if he was notified; could have been but he does not recall and cannot say it did not happen. V14 was asked if he would consider the discharge process as inappropriate and he said, maybe an erroneous discharge.On 6/11/2026 at 10:46AM, V39 (Social worker) said she recalls R236; she was previously at another facility and came to the facility from the hospital. R236 lives at home by herself and gets home care from the Aging Department. V39 said she set R236 up with a home health care agency. R236 is alert but gets home health nurse 2 or 3 times a week. R236 was picked up by her friend when she was discharged .On 6/11/2026 at 12:08PM, V1 (Administrator) said a resident's medication were given to another resident who was discharged , the nurse notified the Director of Nursing and reached out to the resident, the nurse then went to the discharged resident's home to get the wrong medications that belong to a resident still at the facility. V1 was<br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | asked what could have been the impact of sending the resident home with the wrong medications and he said, The resident could have taken the wrong medication, the resident that was still at the facility did not miss any medication, nurses administered her medications to her. V1 was asked if it is a normal practice for the facility to allow a nurse who was off duty to go and collect medications from a discharged resident's house and bring it back to the facility and he said, I am not sure it is allowed or not, I have to look at the schedule to determine if the nurse was off duty that day. V1 added that R172's daughter was involved in her care, neither the resident nor her daughter was informed that her medication was sent home with another resident. V1 said the resident and her daughter could have been informed after the investigation. V1 is not sure if the physicians were notified either, stating he is not clinical; the Director of Nursing will be in a better position to answer that question. Pharm script discharge with medication policy #5.2 stated:Medications may be sent with the resident upon discharge from the facility only under conditions that protect the residents and ensure compliance with applicable state laws.Procedures:1. Medications may be sent with the resident on discharge if ordered by the prescriber. The prescribershould list the medications to be released upon discharge.2. The labels on discharged medications are verified for completeness and accuracy by reconciling them against the most recent physician orders.3. Directions for use are reviewed with the residents and/or the party responsible. If current directions for use are not the same as those on a prescription label, the medication name, strength, and the correct directions for use are written on a separate piece of paper. The correct directions are given to the resident and/or responsible party, not affixed to the container .Facility discharge planning and instructions policy, revised 6/30/2025, documented:Policy statement: It is the policy of this facility to conduct proper discharge planning for all residents and provide appropriate discharge instructions in preparation for discharge on ce a discharge order is obtained from the resident's attending physician.Procedure: 9. Medications will be sent with resident being discharged to the community. For Medicaid residents, residents on commercial insurance that does not do consolidated billing, and Part D prescription plan residents, all medications had been previously paid for, so the medications belong to the resident, therefore should be sent with the resident upon discharge except for narcotic pain medications. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have a five percent (5%) or lower medication error rate. There were 2 medication errors out of 30 medication opportunities resulting in a 6.67% medication error rate. This failure affected one (R195) of three residents reviewed for medication administration. R195's face sheet documents R195 is an [AGE] year-old resident admitted on [DATE] with diagnoses including but not limited to Type 2 diabetes mellitus without complications, supraventricular tachycardia, and acute gastroenteropathy due to Norwalk agent, and Alzheimer's disease with late onset.R195's Minimum Data Set documents a Brief Interview of Mental Status (BIMS) summary score of 5, indicating R195 has severe cognitive impairment.On 06/09/2026 at 9:05 AM, the surveyor observed V21 (Licensed Practical Nurse/LPN) administer R195 scheduled 8:30 AM morning medications. Two medications (Metformin HCL Oral Tablet500 mg 1 tablet by mouth two times a day for diabetes and Eliquis Oral Tablet 5 mg. 1 tablet by mouth two times a day for A-Fib) were not available for administration because the medication cart ran out of stock and medications were not reordered. V21 stated, This is my first time on this cart. I will reorder. The medications should be re-ordered when there are three doses of medications left. V21 obtained the Metformin and Eliquis from the automated medication dispensing machine after she completed all her scheduled 8:30 AM medication passes. R195 was administered Metformin and Eliquis and administration of these medications were documented on 06/09/2026 at 10:20 AM. V21 stated medications administration timeframes are one hour before or one hour after the scheduled administration time. Review of Ordering and Receiving Non-Controlled Medications Policy#3.3, with no date, documents, Reorder medication based on the reorder date on the Pharmacy Rx label, to assure an adequate supply is on hand. The facility did not comply with its reordering policy. |