STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145899	A. Building B. Wing	03/22/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31327 44387 Based on observation, interview, and record review, the facility failed to assess residents for self-administration of medications, and failed to obtain physician order for resident to self-administer medications and to have medications stored in resident rooms. This applies to 5 of 5 residents (R3, R10, R17, R123 and R388) reviewed for medications in a sample of 34. The findings include: 1. On 3/19/24 at 11:19 AM, there was bottle of Tums Calcium Carbonate 1000mg Antacid on R10's bedside dresser. On 3/21/24 at 1:05 PM, R10 said, The gas medicine is mine, I use it ever so often, once in a while, when I get heartburn. R10's current Physician Order Sheet (POS) was reviewed. R10 did not have an order for Tums Calcium Carbonate, to self-administer medications, or to have medications stored at the bedside. R10's care current care plan was reviewed; R10 was not care planned for self-administration of medication. 2. On 3/19/24 at 11:29 AM, there was tube of Sooth and Cool Antifungal cream Miconazole Nitrate 2% and a bottle of Antifungal Powder Miconazole Nitrate 2% on R13's bedside cabinet. On 3/21/24 at 10:29 AM, there was a tube of Clotrimazole and Betamethasone Dipropionate Cream 1%/0.05% on R13's bedside table. At 1:04 PM, R13 said the Clotrimazole cream and the antifungal cream and powder were his; he said, I use them for my toes and feet; the Clotrimazole does not work, but the antifungal cream works for me. R13's current Physician Order Sheet (POS) was reviewed. R13 did not have an order for Antifungal Cream, Antifungal powder, or Clotrimazole cream. R13 did not have an order to self-administer medications or to have medications stored at the bedside. R13's care current care plan was reviewed. R13 was not care planned for self-administration of medication. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 3/19/24 at 12:03 PM, on R17's bedside cabinet, there was a bottle of Nystatin Powder 100,000 unit/gram, lubricant eye drops Carboxymethyl Cellulose Sodium 0.5%, and Chloraseptic fast acting sore throat spray. R17 said they were all hers; she uses the Nystatin powder for rash that was under her breast, the eye drops because her eyes get dry, and the Chloraseptic sore throat spray because her throat gets dry. On 3/20/24 at 10:19 AM, there was a medicine cup that had two round white pills on R17's bedside table. R17 said she was dosing off when the nurse gave them to her. At 10:33 AM, V23 (Wound care LPN/Licensed Practical Nurse) came in to R17's room; V23 said medications should not be left on the resident's bedside table, and he was not the nurse assigned to R17. V23 left the room to get R17's nurse. At 10:25 AM, V24 (Agency LPN) came in to R17's room. V24 said she was the nurse assigned to R17, and does not know who left the medications on R17's bedside table. V24 asked R17 who left the medications. R17 said the nurse did; V24 said she gave R17 her medications earlier and threw away the medicine cup after. R17 still had the Nystatin Powder, the lubricant eye drops and the Chloraseptic sore throat spray in her room. On 3/21/24 at 10:31 AM, the Nystatin Powder, the lubricant eye drops, and the Chloraseptic sore throat spray were in her room. R17's current Physician Order Sheet (POS) was reviewed. R17 had on order to apply antifungal powder to bilateral breast twice a day for MASD (Moisture Associated Skin Disease), order for drops Carboxymethyl Cellulose Sodium 0.5% 1 drop both eyes three times a day. R17 did not have an order for Chloraseptic sore throat spray. R17 did not have an order to self-administer medications, or to have medications stored at the bedside. R17's care current care plan was reviewed. R17 was not care planned for self-administration of medication. On 3/21/24 at 8:53 AM, V1 (Administrator) said medications should not be left at residents bedside; the nurse needs to observe the resident take their medications to ensure it is properly administered. At 12:41 AM, V1 said residents are to be assessed for self-administration of medication to see if they are cognitively able to self-administer medications. After the assessment, there needs to be an order for self-administration and to have medications stored in resident rooms. On 3/21/24 at 9:42 AM, V2 (DON/Director of Nursing) provided list of residents that can self-administer medications and have medications stored in their rooms; R3, R10, and R17 were not on the list. The facility's Self-Administration of Medication policy (revised 7/28/23) documents, The IDT (Interdisciplinary Team) will assign a staff to evaluate resident's ability to safely administer medications. A self-administration evaluation will be filled out to determine capability. The resident may store the medication at bedside if there is a physician order to keep it at bedside. 4. R123's face sheet shows diagnoses of major depressive disorder, weakness, and generalized anxiety disorder. R123's POS (Physician Order Sheet) shows an order of Fluticasone Propionate Suspension 50 MCG (Micrograms)/ACT-1 spray in each nostril one time a day for allergies/congestion that was ordered on 2/27/24. R123's MDS (Minimum Data Set), dated 2/28/24, shows a BIMS (Brief Interview for Mental Status) score of 11, which means he is moderately impaired in cognition. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/24 at 11:19 AM, R123 was sleeping in his wheelchair and in the presence of V41 (R1's son) and daughter. On his end table, there was a bottle of Fluticasone Propionate Nasal Spray. V41 stated, Those are (R123)'s nasal drops. They (Facility) never have them in stock. I brought it last week and it's kept in his room. He takes it by himself. On 3/20/24 at 9:31 AM, V2 (DON-Director of Nursing) stated, We only have one resident that can self-administer medications and it's not R123. When families bring medications from home, they are supposed to show the nurse and it has to be in the medication cart. If the resident is using it in his room, there should be an order from the doctor and medication self-administration form. Review of R123's electronic medical record shows there was no order by the physician for the medication to be at the bedside. There was also no self-administration of medication assessment form completed. Facility policy titled Self-Administration of Medication (7/28/23) shows: Procedures: 1. The IDT (Interdisciplinary Team) will assign a staff to evaluate resident's ability to safely administer medication. A self-administration evaluation will be filled out to determine capability. A return demonstration will be done to accurately evaluate resident's ability after the health teaching. 2. The resident may store the medication at bedside if there is a physician's order to keep it at bedside. 3. The nurse on duty will document administration of medication in the MAR (Medication Administration Record). 5. The resident's ability to self-administer medication will be assessed regularly by the facility to coincide with the MDS assessment or any notable change in status. 46003 5. R388 is a [AGE] year-old male admitted on [DATE] with diagnoses that includes wedge compression fracture of first lumbar vertebra, subsequent encounter for fracture with routine healing, Chronic Obstructive pulmonary disease, chronic kidney disease, and atrial fibrillation. According to R388's MDS (Minimum Data Set), dated 2/8/24, he is cognitively intact. On 3/19/24 at 1:01 PM, R388 was observed to have a budesonide / glycopyrrolate formoterol fumarate 160mcg/9mcg/4.8mcg inhaler on his bedside table. R388 stated he's had the inhaler the entire time he's been at the facility because the staff was not bringing it to him. R388 stated staff would get the medication off the table and hand it to him to use. On 3/19/24 at 1:21 PM, V36, RN (Registered Nurse) assigned to R388, stated she did not have any residents with assessments or orders to keep medications at the bedside to self-administer. On 3/22/24 at 8:52 AM, V2, DON (Director of Nursing), stated R388's inhaler was started on 2/8/24. The assessment and order for R388 to keep the inhaler at the bedside for self-administration was obtained on 3/19/24. V2, DON, stated he completed the assessment when V40, Nurse Manager, made him aware the inhaler was being left at the bedside. V2, DON, stated the assessment and Physician's order should have been obtained prior to nursing staff leaving the inhaler at the bedside. The assessment is required to assure (R388) was safely administering the medication and taking the correct dose. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R388's care plan, physician orders and assessment for self- administration of inhaler were reviewed. R388 has an order for budesonide / glycopyrrolate formoterol fumarate inhaler; start date was 2/8/24. R388's care plan, physician orders, and assessment for self- administration of inhaler were completed on 3/19/24.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44387 Based on observation, interview, and record review, the facility failed to have call lights accessible to dependent residents. This applies to 4 of 4 residents (R8, R21, R77 and R147) reviewed for accommodation of needs in a sample of 34. The findings include: 1. R21's EMR (Electronic Medical Record) shows the following diagnoses of respiratory failure, asthma, weakness, unsteadiness on feet and need for assistance with personal care. R21's MDS (Minimum Data Set) of 1/15/24 shows R21's cognition is moderately impaired and needs partial to moderate assistance with toileting, shower and bathing. R21's care plan (initiated 7/15/22) shows R21 is at risk for falls with interventions to keep call light within reach when in bedroom or bathroom. On 3/19/24 at 12:20 PM, V28 (Agency CNA/Certified Nurse Assistant) was completing bed bath on R21. R21 requested for some ice water. V28 left the room to get the water. R21 had oxygen concentrator in the room, but did not have her oxygen on during care. After V28 left, R21 appeared short of breath, and asked surveyor for her oxygen to be placed on her. R21's call light pad was on her bed side table which was not within reach; the table was pushed away from her bedside. At 12:27 PM, surveyor pushed the call light; at 12:29 PM, V29 (Restorative Aide) came in the room and placed the nasal cannula on R21, and moved the call light pad and placed it next to R21. 46409 2. R8's face sheet showed R8 was admitted to the facility with diagnoses including hemiplegia and hemiparesis affecting left non-dominant side, hypertension, malnutrition, epilepsy, restlessness and agitation, and adult failure to thrive. R8's MDS (Minimum Data Set), dated 2/23/24 showed R8 had moderate cognitive impairment. R8 required moderate assistance for eating and was dependent on staff for oral hygiene, toileting hygiene, shower/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. R8's ADL (Activities of Daily Living) care plan dated 9/21/21 showed to keep call lights within reach when in bedroom or bathroom. On 3/19/24 at 12:06 PM, R8 was lying in bed. His call light was not visible on his bed, and was out of reach. At 2:53 PM, R8's call light was still not visible or within reach of the resident. On 3/20/24 at 09:44 AM, R8's call light was not visible and not within reach of the resident. At 09:46 AM, V4 (CNA/Certified Nurse Assistant) and V14 (LPN/Licensed Practical Nurse) entered R8's room and repositioned R8. V14 gave R8 his television remote and left the room. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/20/24 at 3:21 PM, R8's call light was out of reach of the resident. On 3/21/24 at 09:36 AM, R8's room call light was on. V19 (CNA) said R8's roommate had pressed the call light, but R8 had requested V19 to pick up his television remote and room phone he had dropped on the ground. V19 said R8 was able to eat by himself. R8's call light was not within reach. R8 said he was able to use the call light, and the staff do not give him the call light. R8 then asked where the call light was, and said it was a round ball. At 09:40 AM, V19 said before she leaves the room, she should make sure the resident had the call light. V19 brought the call light within reach, and R8 was able to press the adaptive call light. 3. R77's face sheet showed diagnoses including cerebral infarction, non-Hodgkin lymphoma, chronic kidney disease, polyneuropathy, type 2 diabetes mellitus, and history of falling. R77's MDS, dated [DATE], showed R77 had severe cognitive impairment and was dependent on staff for all activities of daily living. R77's ADL care plan, dated 7/22/22, showed to place call light within accessible reach. R77's high risk for falls care plan, dated 8/19/22, showed to, Ensure that I will be able to use the call light. If the light is difficult to press, consider giving me a foam pad call light or other adaptive call lights. Please make sure that my call light is within my reach and encourage me to use it for assistance as needed. On 3/20/24 at 2:37 PM, R77 was in bed, and V15 (CNA) was providing care. At 2:39 PM, V15 completed providing care, and asked R77 if she needed anything else and exited the room. R77's call light was not within reach of the resident. At 2:42 PM, R77 said she used a squeeze button to call for help. R77 said if the call light was out of reach, then she was out of luck. 4. R147's face sheet showed diagnoses including Parkinson's disease, muscle wasting, need for assistance with personal care, and a history of falling. R147's MDS, dated [DATE], showed R147 had moderate cognitive impairment. R147 required moderate assistance for toileting hygiene and personal hygiene, substantial assistance for oral hygiene, and was dependent on staff for eating, shower/bathing, upper and lower body dressing, and putting on/taking off footwear. R147's risk for alteration of bowel and bladder functioning care plan, dated 2/7/23, showed to keep call light within reach. On 3/19/24 at 2:46 PM, R147's call light was on the ground on the right side. R147's call light was not within reach of the resident. On 3/21/24 at 8:51 AM, V1 (Administrator) said call light should be within reach so residents can call for assistance when needed. The facility's Call Light Policy (reviewed 7/27/23) states to be sure call lights are placed with reach of residents who are able to use it at all times.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on observation, interview, and record review, the facility failed to ensure two residents were free from physical restraints. This applies to 2 of 2 residents (R77, R86) reviewed for restraints in a sample of 34. The findings include: 1. R77's face sheet showed diagnoses including cerebral infarction, non-Hodgkin lymphoma, chronic kidney disease, polyneuropathy, type 2 diabetes mellitus, and history of falling. R77's MDS (Minimum Data Set), dated 3/4/24, showed R77 had severe cognitive impairment and was dependent on staff for all activities of daily living. R77's Restorative Side Rail/Other Devices Evaluation, dated 3/13/24, showed, Indicate the type of Side Rail used: 2 half rails. On 3/19/24 at 12:31 PM, R77's full length side rails were both up. On 3/20/24 at 2:29 PM, R77's full length side rails were both up. At 2:29 PM, V15 (CNA/Certified Nurse Assistant) entered R77's room to assist R77 with changing her gown. V15 lowered R77's left full length side rail, and removed R77's blankets and changed her gown and linen. At 2:34 PM, R77 said she was given the bed with the full-length side rails. At 2:39 PM, V15 raised the left full length side rail and went to the right side of the bed. V15 did not lower the side rail on the right while providing care, and exited R77's room with both side rails up. At 2:59 PM, R77's side rails were both up. On 2/20/24 at 2:46 PM, V15 said she kept both side rails up just in case, so R77 did not fall. On 3/20/2/4 at 2:49 PM, V16 (LPN/Licensed Practical Nurse) said R77's side rails were full length side rails, and both were supposed to be up. V16 said she got the bed with these side rails from hospice. On 3/20/24 at 3:09 PM, V2 (DON/Director of Nursing) said full length side rails are side rails that are the length of the bed. V2 said the restorative staff do assessments to figure out the use of side rails. V2 said if both full-length side rails are up, it is a restraint. V2 said the resident could try to climb over the side rail to get out of bed and fall from a greater height. 2. R386 was admitted to the facility on [DATE], with diagnoses that include idiopathic peripheral autonomic neuropathy, diabetes, right below the knee amputation depression and anxiety. R386's MDS (minimum Data Set), dated 3/13/24, shows she is cognitively intact with a BIMS (Brief Interview for Mental Status) Score of 15. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R386's admission assessment, completed on 3/12/24, documented elopement interventions of frequent monitoring and bed alarms. On 3/19/24 at 12:16 PM, R386 was observed with a position change alarm on her bed and chair. R386 stated the bed alarm was aggravating. She was told the alarm is mandatory in the facility. R386 stated she did not know why she needed an alarm. R386 stated she puts her prosthesis on independently and can walk by herself. R386 stated she will not move or get from the bed because she knows it will set the alarm off. On 3/19/24 at 12:25 PM, V11, CNA (Certified Nursing Assistant), stated R386 has a bed and chair alarm in use. V11, CNA, stated the alarms are a part of R386's plan of care. On 3/20/24 at 3:39 PM, R386 stated she had previously told staff she did not want the alarms in place, but was told when she's laying down the alarm turns off. R386 stated she would call them for assistance and had not attempted to get out of bed independently. On 3/20/24 at 4:01 PM, V39, COTA (Certified Occupational Therapy Assistant), stated R386's was independent with ambulation and transfers, but required staff supervision/stand by assistance for longer distances. On 3/20/24 at 4:13 PM, V38, RN (Registered Nurse), stated R386 bed and chair alarms were not discontinued. V38 stated R386 reoriented well and could follow directions. V38 stated a physician's order was not required for position change (mobility) alarms, it was a nursing judgement. On 3/21/24 at 9:42 AM, V2, DON (Director of Nursing), stated the use of a position change alarm was determined by an assessment. On 3/21/24 at 1:16 PM, V2, DON, stated, (R386) did not have an assessment or care plan completed for the use of a bed alarm. The admitting nurse may have put it in place. The purpose of the alarm is to alert the staff is the residents attempting to transfer independently. The alarm the alarm may also alert the resident to stay and await assistance. On 3/21/24 at 3:24 PM, V2, DON, stated R386 was decisional, and was not an elopement risk because she could leave the facility anytime she wanted. V2 stated a mobility alarm could be a restraint if it ultimately keeps them from moving. R386's EMR (Electronic Medical Record) was reviewed. No physicians' orders, care plan, or restraint or alarm assessments were in place for the use of mobility alarms. The facility's Side Rail policy reviewed on 7/28/23 showed, It is the facility's policy to comply with the federal requirements on the use of side rails. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Restraints policy reviewed on 7/28/23 showed, It is the facility's policy to ensure that each resident is not restrained for the purposes of discipline or convenience .Physical Restraint is defined as any manual method, physical or mechanical device, equipment or material that meets ALL of the following criteria: . B) that the individual cannot intentionally remove easily, and C) restricts freedom of movement or normal access to one's body .Any device including mobility alarms that may have a restraining effect on a resident should be assessed and evaluated to determine it is a restraint or an enabler. In the event the resident's condition warrants the use of restraint, a restraint device assessment will be done to determine if the device is appropriate for the resident. Once the assessment determines that the device or intervention is a restraint a physician order will be obtained indicating the type of device to be used. The order may be accompanied by the indication / reason for the device, the duration of use and how often it is supposed to be released. If this information is not reflected in the POS (Physician Order Sheet), these should be specified in the device assessment, in the progress notes or in the care plan. Any device including mobility alarms that may have a restraining effect on a resident should be assessed and evaluated to determine if it is a restraint or an enabler. 46409

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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. 45906 Based on interview and record review, the facility failed to administer medications timely as per the physician's orders. This applies to 1 resident (R82) in a sample of 34 residents reviewed for medication pass timing. R82's MDS (Minimum Data Set), dated 2/14/24, shows her cognition is intact. R82's POS (Physician Order Sheet) shows order, dated 3/14/24: Maintain at all times: Strict contact isolation precautions due to an active infection (ESBL urine) single room. R82's Care Plan, dated 3/14/24, shows resident is on contact isolation precautions related to positive ESBL in urine. Interventions include provide antibiotic therapy per the physician's orders. On 3/19/24 at 3:27 PM, R82 said she had been at the facility for 5-6 weeks, and on 2 occasions, the staff did not bring her medications. R82 said the most recent occasion was on 3/15/24, when she was moved into an isolation room after being diagnosed with a contagious bladder infection. R82 said she arrived into her new room at 4pm on 3/15/24. R82 said around 6pm, she asked her CNA (Certified Nurse Assistant) to ask her nurse why she had not received her medications, and no one came back. R82 said finally at 10pm on 3/15/24, the head nurse came into her room and R82 told her she never received her evening medications, and that nurse walked out and never came back. R82 said that was her fourth request of staff for her evening medications, and the medications were not brought in until right before midnight on 3/15/24. R82 said the medications that were due were antibiotics, blood thinners, about nine different pills that I take between 6 and 7 PM. R82 said she is taking oral antibiotics for her bladder infections, and that was one of the pills that she was given late. R82 said, They move me over here because I have a bladder infection, and then they don't bring me my antibiotic. On 3/21/24 at 1:41, V2 (DON/Director of Nursing) said nurses have one hour before and one hour after the time a medication is scheduled to pass the medications to residents. V2 said it is not appropriate to give insulins, antibiotics, heart rhythm pills, blood pressure pills, cholesterol pills, blood thinners, etc. late unless the doctor is notified and is okay with it. V2 said giving these medications late can cause issues because either they are being doubled up too soon (given too close to the next dose) or are being given too late. V2 said medications are scheduled at specific times for a reason. V2 said insulin is important to give when scheduled because the patient's blood sugar can drop or become uncontrollably high. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145899	A. Building B. Wing	03/22/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R82's Medication Administration Audit Report shows on 3/15/24, she received 12 medications scheduled for 5PM late, and 4 medications scheduled for 9PM late. All of these medication, 16 total, were not given until 11:55-11:56 PM. The medication due at 5 PM, and their indication were as follows: Insulin Lispro for Diabetes, Metoprolol for blood pressure, Lactulose for constipation, Amiodarone for heart rhythm, Atorvastatin for cholesterol, Eliquis for thinning blood, Gabapentin for anticonvulsant, Entresto for heart failure, Lactobacillus for probiotic, magnesium oxide for antacid, Senna-Plus for laxative, and Nystatin powder for antifungal. These 12 medication were given six hours late, accounting for the one hour after window for medication pass timing. The medications due at 9 PM and their indication were as follows: melatonin for sleep, macrobid for Klebsiella urinary tract infection with ESBL in the urine, Humulin 70/30 insulin for Diabetes, and Insulin Lispro for Diabetes. These four medications were given 2 hours late, accounting for the one hour after window for medication pass timing. R82's Progress Notes and POS do not show R82's doctor was notified and/or okay with her receiving medications late on 3/15/24. The facility's policy titled, Medication Pass last reviewed 7/28/23 states, Policy Statement: It is the policy of the facility to adhere to all Federal and State regulations with medication pass procedures .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on observation, interview, and record review, the facility failed adjust the mattress and bed frame so the exposed metal frame was not a hazard. This applies to 1 resident R63 reviewed for accidents hazards in a sample of 34. Findings include: R63 was admitted to the facility on [DATE], with diagnoses that include cord compression, weakness, dementia, cerebral ischemia, rhabdomyolysis, cervical disc degeneration, and abnormality of gait and mobility. R63's MDS (Minimum Data Set), dated 2/29/24, shows he is cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 1. R63 is staff dependent for transfers and requires partial / moderate staff assistance to reposition in the bed. R63's care plan for memory deficit, poor safety awareness and difficulty understanding others, dated 2/29/24, sets the goal of resident being free of any injury related to accidents with interventions that include keeping environment uncluttered and any potentially harmful items out of reach. On 3/19/24 at 12:34 PM, R63 was observed lying in bed. The metal bed frame was exposed on the right side of his bed and at the foot of his bed where it was not covered by the mattress. On 3/20/24 at 4:30 PM, R63's metal bed frame was still exposed. On 3/21/24 at 10:54 AM, R63's was in bed being assisted by V39, COTA (Certified Occupational Therapist). The right middle section of the bed frame was exposed and sticking out not covered by the mattress. Surveyor asked V39 if that section of the bed was adjustable. V39 repositioned the exposed middle section of the bed frame so that it was positioned under the mattress and no longer exposed. On 3/21/24 at 1:58 PM, V37, Director of Maintenance, stated, Anyone can adjust the bed frame. There are clips on either side of the bed to adjust the frame. If they were having difficulty, they could contact maintenance for assistance. On 3/21/24 at 1:38 PM, V2, DON (Director of Nursing), stated metal parts of the bed frame sticking out are a potential hazard because R63 could bump it and cause a skin tear. The facility policy Hazards, dated 7/28/23, states it is the facility's policy to ensure the safety of each resident in the building and remove hazardous items and correct situations to prevent accidents.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48526 Based on observation, interview, and record review, the facility failed to maintain resident nutritional status and monitor weights as ordered. These failures resulted in R33 experiencing a significant weight loss. This applies to 1 resident (R33) reviewed for weight loss in a sample of 34. The findings include: R33 was admitted originally admitted to the facility on [DATE]. R33 was readmitted on [DATE] per the Face Sheet. R33's MDS (Minimum Data Set), dated 03/13/24, showed no BIMS score for R33, but showed R33's cognitive skills for daily decision making were severely impaired. The same MDS showed R33 was dependent upon staff for most ADL's (Activities of Daily Living). The same MDS showed R33 received nutrition through a feeding tube. The facility's Weights and Vitals Summary showed R33 had a -10% change [comparison weight 10/15/23, 94. 6 pounds, -10.1%, -9.6 pounds]. R33's recorded weight on 10/15/23 was 94.6 pounds. R33's recorded weight on 03/19/24 was 85 pounds. R33's enteral feed orders were flush Gtube with 120 ml of water every six hours, every day shift total volume infused in 24 hours (feeding: 1260 ml, flush 480 ml), every shift tube feeding Jevity 1.2 via Gtube continuous @70 ml/hr to total volume of 1260 ml, one time a day turn on tube feeding at 5 PM daily. R33 had orders for daily weights written 11/24/23. The Weights and Vitals Summary showed multiple dates where no weights were obtained. R33's Enteral Feeding care plans, dated 10/16/23, showed R33 receives enteral feedings as the primary source of nutrition due to malnutrition and weight loss. Interventions included enteral nutrition prescription as ordered and monitor weights. R33's tube feeding care plan, dated 10/30/23, showed weight loss. Interventions included R33 is dependent with tube feeding and water flushes, see MD (Medical Doctor) orders for current feeding orders. Weight will be obtained as ordered by MD. R33's progress notes from 10/15/23 through 03/22/24 were reviewed. R33 had one episode of vomiting on 11/17/24, and was admitted to the hospital. No other episodes of vomiting were documented. Registered Dietitian's notes, dated 12/24/23, was reviewed. Dietitian stated, nursing reports resident tolerating tube feeding well, no vomiting reported. The same note showed an increase in the tube feeding to 65 ml/hr and the total volume to be infused was 1040 ml in a 24-hour period. The Dietitian's note, dated 01/18/24, showed a trigger for significant weight loss of 8.2% in one month. The tube feeding was increased to 70 ml/hr, with a total volume to be infused was 1260 ml in a 24-hour period. (continued on next page)

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	145899	A. Building B. Wing	03/22/2024

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 03/19/24 at 11:53 AM, R33 was not in R33's room. R33's tube feeding pump was in the room, next to the bed. R33's tube feeding pump did not have any formula hanging. On 03/20/24 at 10:09 AM, R33 was sitting in her wheelchair, awake and alert, but confused. R33's tube feeding pump was in her room, with no feeding hanging. On 03/20/24 at 5:07 PM, R33 was in bed. V33 (Licensed Practical Nurse) was in R33's room preparing for her Gtube (Gastrostomy tube) feeding and water flushes. R33's pump was set for Jevity 1.2 @70 ml/hr. with 120 ml of water for flush. R33's Gtube placement was verified, and the tube feeding was started. R33 tolerated the Gtube feeding without difficulty. On 03/21/24 at 8:43 AM, R33 was in the bed. R33's Gtube feeding of Jevity 1.2 @70 ml/hr continued to infuse. The tube feeding pump showed 1208 ml total volume had already infused. 1000 ml of Jevity was left in the bag. The tube feeding pump showed the water flush of 120 ml every six hours. 800 ml of water was left in the bag. On 03/21/24 at 8:56 AM, V34 (RN, Unit Supervisor) said there is no set time for R33's feeding to be turned off. V34 said the feeding is completed once the total volume is infused. V34 said R33 received the Gtube in October 2023, and became NPO (nothing by mouth) in October 2023. On 03/21/24 at 12:33 PM, V35 (Dietitian) said if residents tube feeding orders are for 70 ml/hr to infuse 1260 ml, the resident should be receiving the feedings for 18 hours. V35 said if residents are not receiving the feedings as ordered, it can lead to weight loss or a decrease in nutritional status. V35 said the weight loss R33 has had could be from her not getting the full amount of the tube feeding. V35 said she was not aware of R33 having an order for daily weights. V35 said she did not know there were any missing weights for R33. On 03/21/24 at 12:38 PM, V2 (Director of Nursing) said, (R33) should be receiving the tube feeding starting at 5 PM and ending at 11 AM, or 18 hours. (R33) is at risk for weight loss if she is not receiving the tube feeding for the correct amount of time. V2 said he does not know why R33's feeding was turned off before 11 AM. V2 said nurses should follow the orders as written. V2 said he was not aware of R33 having orders for daily weights, and the weights were not being done daily. On 03/22/24 at 3:21 PM, V44 (Palliative Nurse Practitioner) said he visits R33 every week or every other week. V44 said R33 has esophageal stricture. V44 said R33 used to have vomiting when she was eating by mouth. V44 said since R33 receives tube feedings and is NPO, she has not had any vomiting. V44 said he was not aware of R33 not getting the correct amount of feeding. V44 said he had documented in his notes the weight loss R33 had. V44 said his expectation is that the resident receives the correct amount of feeding that is ordered. V44 said if R33 is not getting the feeding as ordered, and she is not receiving oral foods, she can lose weight.

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	145899	A. Building B. Wing	03/22/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46409 Based on interview and record review, the facility failed to evaluate for gradual dose reductions (GDR) for a resident receiving psychotropic medications. This applies to 1 of 1 resident (R68) reviewed for antipsychotic medications in a sample of 34. The findings include: R68's face sheet showed she was admitted to the facility on [DATE], with diagnoses including dementia and depression. R68's face sheet showed R68 was not being followed by a psychiatrist. R68's MDS (Minimum Data Set), dated 1/1/24, showed R68 had severe cognitive impairment, required substantial assistance from staff for eating, oral hygiene, toileting hygiene, upper body dressing, and personal hygiene, and was dependent on staff for shower/bathing, lower body dressing, and putting on/taking off footwear. R68's POS (Physician Order Sheet) showed R68 was prescribed Prozac 10 milligrams at bedtime for anti-depressant and trazadone hydrochloride 50 milligrams at bedtime for insomnia. On 3/21/24 at 3:01 PM, V2 (DON/Director of Nursing) said a GDR was not done for R68 since her admission to the facility on [DATE]. At 3:08 PM, V2 said there were no specific notes written by a psychiatrist, and she was overdue for a GDR. At 3:24 PM, V2 said the residents on antipsychotic medications do not need a psychiatrist, and the medical doctor could make recommendations for the resident's antipsychotic usage. On 3/22/24 at 10:35 AM, V42 (Nurse Practitioner) said R68's primary care physician would be responsible for the GDR. V42 said the GDR should be completed every six months, and this was important for residents on antipsychotics to evaluate whether the medication was necessary or not. V42 also said the nursing staff should be documenting the resident's behaviors to evaluate for the effectiveness of the medication. V42 said without monitoring the behaviors, the medical staff would not know whether the resident needed an increase or decrease of the medication, or additional medications to treat the behaviors. The facility's Psychotropic Medications policy reviewed on July 24, 2023 showed, Check that all antipsychotics and antidepressants have gradual dose reduction (GDR) within the 1st year or after initiation of initial dose in 2 quarters within the 1st year. If no reduction was done, there should be a psychiatric note why GDR is contraindicated specifically saying that the GDR is contraindicated because it increased the target behavior or that the psychiatrist had documented the rationale that GDR is likely to impair resident's function and increase the distress behavior. Make sure that there is an annual GDR after the 1st year.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 45906 Based on observation, interview, and record review, the facility failed to administer medications in the appropriate form and as ordered per physician. There were 29 opportunities with 3 errors, resulting in a 10. 34% error rate. This applies to 2 (R47 and R121) of the 5 residents observed in medication pass. 1. On 3/20/24 at 9:15 AM, V24 (Agency LPN/Licensed Practical Nurse) administered Norco 5/325 mg to R47. When V24 told R47 she was giving her Norco, R47 said, I already had Norco, didn't I? to which V24 replied, That was yesterday. V24 did not go check the computer to look at the doctor's order or see what time R47 last received Norco. R47 then swallowed the Norco pill. R47's POS (Physician Order Sheet) shows order: Norco oral tablet 5/325 mg give 1 tablet by mouth three times a day for pain. R47's MAR (Medication Administration Record) shows the Norco is scheduled at 6AM, 2PM, and 10PM. There is no dose scheduled when V24 administered Norco to R47. R47's POS does not show an order for PRN Norco. R47's MAR shows a PRN order, dated 8/4/23: May give pain medication Norco oral tablet 5/325 mg 30-60 minutes prior to wound care. V24 did not document administration for the 9:15 AM dose that she gave under either the scheduled Norco or the PRN Norco before wound care on the MAR. On 3/20/24 at 2:45 PM, V24 (Agency LPN) said the Norco order she saw for R47 was the PRN order for prior to wound care. R47 then said, I can't tell you what time or when she got wound care. On 3/20/24 at 3:37 PM, V26 (Wound Care Coordinator) said he did not do wound care on R47 today. On 3/20/24 at 4:10 PM, V26 said R47 had a skin tear to her right forearm that the dressing was last changed for on 3/18/24, but it is now healed so he is going to discontinue the wound care orders. V26 confirmed again, the dressing change/wound care was not done today for R47. V26 said that was the only wound that R47 had, and it is now healed. 2. On 3/20/24 at 9:39 AM, V25 (Agency LPN) removed a Metoprolol 50mg ER (Extended Release) tablet and a Potassium Chloride 20 meq (milliequivalents) ER tablet from her medication cart in preparation to give R121. V25 crushed these medications and mixed them with some apple sauce in a medication cup and administered them to R121. R121's POS shows and order: May crush appropriate medication and mix with food or liquid as needed. There is no physician order allowing the crushing of extended release medications. On 3/20/24 at 2:45 PM, V24 (LPN) said you cannot crush extended release medications because the medication is supposed to break down inside the body, not outside the body. On 3/20/24 at 3:08 PM, V27 (RN/Registered Nurse) said you cannot crush extended release medications because the patient can have a reaction to the medication and the medication will not work the right way. (continued on next page)

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	145899	A. Building B. Wing	03/22/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/21/24 at 1:41 PM, V2 (DON/Director of Nursing) said extended release medications cannot be crushed because it can interfere with the absorption of the medication and cause interactions. V2 said the nurse should check before administering Norco to see when the previous dose was given to make sure the narcotic is being given within the appropriate time period. V2 said is Norco is scheduled to be given at 6AM, 2PM, and 10PM, a dose should not be given at 9AM unless there is a PRN order. V2 said if the PRN order states before wound care, the nurse would need to call the doctor and clarify if it could be given PRN in other cases of pain and not just prior to wound care. V2 said V24 should have called and spoken with the doctor and obtained a PRN Norco order for breakthrough pain prior to administering Norco to R47. The facility's undated, ISMP Do Not Crush List shows both Potassium Chloride and Metoprolol ER are medications that are not to be crushed. The facility's policy titled, Medication Pass last reviewed on 7/28/23 shows, Policy Statement: It is the policy of the facility to adhere to all Federal and State regulations with medication pass procedures. Procedures: .2. Crushed Meds: .b. Makes sure to check before crushing meds. Some meds should not be crushed (extended release meds, K-dur, etc.) .7. PO meds: .e. After medication is administered to each resident, sign MAR that it was given .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on observation, interview, and record review, the facility failed to provide food services in a manner that prevents food borne illness. This applies to all 166 residents that receive food services from the facility. Findings include: On [DATE] at 10:29 AM, the kitchen tour was conducted with V7 (Assistant Dietary Manager) On [DATE] at 10:33 AM, the dry storage was observed. A storage bin with contents identified as oatmeal by V7 was not labeled with contents and had a date of [DATE]. V7 stated the bin should be labeled with the contents, in date and expiration date sot that staff are not serving outdated food items. An open box 25 LB (pounds) containing a clear plastic bag of instant food thickener was open to air. V7 stated the bag should have been sealed to protect it from contamination. V7 stated she had taken a food certification course. Items should be labeled with contents in date and expiration date. It is important so that we don't serve expired food items to residents. Using expired food can cause food borne illness. Bag of navy beans volume not observed open to air. V7 stated dry goods are good for three months. The use by date should be followed. Dry goods can develop mold or grow weevils when they are kept too long. Bin identified by V7 as brown sugar was not labeled with contents open on or use by date. On [DATE] at 10:56 AM, the walk-in freezer was observed. A 20 LB box of unbaked chocolate chip cookies was open to air and without a use by date. V7 stated residents can get sick if they eat freezer burned food. A silver pan of facility prepared mostaccioli, dated ,d+[DATE], sealed with plastic wrap was covered with frost and freezer burn. A silver pan of barbeque ribs, dated ,d+[DATE], covered with plastic wrap was covered with freezer burn and frost. Frozen pancakes 10.8 LB was open to air. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hamburger patties 10 LB box was open to air. Cauliflower 20LB box was open to air and covered in frost. On [DATE] at 11:05 AM, the walk in cooler #1 was observed. Chunky white cheese was identified by V7 as shredded mozzarella did not have an opened on or use by date. The bag was loosely wrapped in plastic and had a red substance in the bag. V7 stated it looks like they left it sitting out and it melted. Yellow cheese slices were in a zippered bag open to air. Six hot dogs with white specks on them were in an open plastic bag and leaking on to other packages of hotdogs. Metal pan of cooked cream of wheat with a use by date of [DATE]. On [DATE] at 11:24 AM, walk in cooler #2 was observed. A metal pan with pureed mandarin orange is expired ,d+[DATE]. Flour tortillas in plastic wrapping was open and exposed to air. Meat in a metal pan identified by V7 as three ham roasts butts were gray, dated ,d+[DATE]. Pan labeled Sandia. V7 stated Sandia means watermelon in Spanish. The watermelon was cut in to chunks that appeared mushy and were sitting in a cloudy liquid. 16 cups identified by V7 as fortified pudding had lids that did not fit and were falling into the pudding. 14 Green peppers that had a gray furry growth and blackened soft spots. Personal food contained with a spaghetti pasta in white sauce with specks of green and a red substance on top did not have a label or date. A chocolate cup type pastry in factory wrapper did not have a label or date. On [DATE] at 11:48 AM, The microwave had food splatters and crusty inside and had grease smears on the outside. Red sanitization bucket #2 in use with disinfectant tested at 500 ppm (Parts Per Million). Red sanitization bucket #3 was changed by V10 (Dietary Cook). V10 was observed to pour disinfectant into bucket without measuring it. V10 tested disinfectant level which measured at 500 ppm in front of surveyor and V7. V10 took sanitization bucket #3 to the food prep area. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 11:48 AM, V10 (Dietary Cook) stated she changes the sanitization buckets every two hours. V10 stated sanitization bucket #3 was ready to use. V10 stated the disinfectant dispenser on the wall was not operational. V10 stated she stirred the bucket but did not measure out the disinfectant. V10 the disinfectant should be at 200 ppm. On [DATE] at 11:50 AM, V7 stated kitchen staff should be using the wall unit not pouring in the disinfecting solution. V7 stated she was not informed the dispenser was broken. V7 stated using too much disinfectant can make someone sick and contaminate the food. On [DATE] at 4:50 PM, V8 (Dietary Aide) walked into the kitchen and directly the food preparation line without washing his hands. On [DATE] at 4:55 PM, V9 (Dietary Aide) touched her hair and was not wearing a hair net while preparing food trays. On [DATE] at 11:50 AM, V7 tested the sanitization level for the sanitization side of the three-compartment sink that was in use. The disinfectant was 0 ppm. On [DATE] at 11:57 AM V10 dropped the oven mitt on the floor and used it to remove a pan from the oven. On [DATE] at 10:16 AM, V14, LPN (Licensed Practical Nurse), inspected 2nd floor pantry with surveyor. There was no thermometer or temperature log. V14 stated housekeeping is supposed to maintain the unit refrigerator and discard items that are undated or expired. The refrigerators contain residents and staff food items. The freezer section of the small refrigerator was filled with ice buildup. A bag with a white Styrofoam bowl labeled chicken soup had a dried yellow substance on the lid and did not have a date or name. A container with apple pie was dated [DATE]. A takeout container with brown sliced meat, baked beans with ground meat, spaghetti with meat, green beans, mac and cheese had no name or date. A clear bowl with wilted mix salad in white dressing labeled rm 203 was undated. On [DATE] at 10:22 AM, V14 LPN (Licensed Practical Nurse) inspected 2nd floor Servery refrigerator. A container with had broccoli, green beans, large cut of bacon and a white and brown substance. The food was covered with a furry substance. The container did not have a date. A container with two and ,d+[DATE] pieces of partially eaten chicken parts with a creamy substance had no name or date. (continued on next page)

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	145899	A. Building B. Wing	03/22/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A facility prepared egg sandwich expired on ,d+[DATE]. A takeout container with four chunks of fried boneless wings covered in a reddish-brown glaze had not name or date. A pizza box without a name or date had two slices of pepperoni pizza and two slices of sausage and green pepper pizza slices that were dried out. On [DATE] at 2:55 PM, V6 (Dietary Manager) stated, Food items are identified when they come in, and are placed in the appropriates storage area. The food items are labeled with the date they come in using a marker or stamping gun. Newer items are rotated to the back. Staff know how long to keep food items by the use by or manufactures date. Fresh fruits and produce are monitored daily and before we reorder, twice per week. Using outdated food can cause food poisoning and illness if it is improperly maintained or stored. Food not properly sealed can become contaminated. It can be exposed to pests and loose it's freshness. The outcome of consuming those foods can cause sickness, especially when you are dealing with an elderly population that has compromised immune systems. Food with frost and frost burn will lose its quality, throw off the flavor and texture. Foods should be labeled in English so that everyone know what the product is. Moldy food should be tossed out every day. Staff should not store personal food in the facility kitchen because of cross contamination. We don't know what they have in their homes or what it touched. We don't want that coming in contact with the residents' food. The appropriate range for the sanitization is 200 ppm to 400ppm, with a max of 75 degrees water temperature. It is the same for the three compartments sink as we use the same disinfectant. If the disinfectant level is too low, it will not disinfect the food contact surfaces. If the disinfectant is too high, it becomes a chemical poisoning and will also cause illness. Staff should wash their hands frequently every time they change gloves, if their hands become soiled, if they go the restroom or if they leave the immediate work area and return. If they don't wash their hands they can spread germs, pathogens, compromise residents and possibly infect their coworkers when they touch high touch surfaces. Staff should have their hair covered because it can have dirt, grease, germs and contaminate the food. They should not be touching their face, body or hair while preparing foods. The process is still the same they would need to wash their hands before continuing to handle food to prevent food contamination. If an oven mitt hits the floor it needs to be washed. The floor is disgusting and there are a lot of germs on the floor, and you don't want to take a chance and contaminate the food. The facility did not provide temperature logs for the 2nd floor unit refirgerators. The facility did not provide product concentration information for their their quat sanitizer or directions for their testing strips. Email confirmation of the number of residents served by dietary services received from V1 (Administrator) on [DATE] at 10:57 AM. The facility policy Kitchen, dated [DATE], states the facility will comply with state and federal regulations in operating facility's kitchen. Refrigerated foods should be covered, dated, labeled. Open containers or potentially hazardous food o leftovers should be dated and used within ,d+[DATE] days in the refrigerator. Dry storage large bulk items like rice flour etc. are labeled. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hair restraint is required except for those who are bald. Staff will wash hands prior to handling food for , d+[DATE] seconds. Before using kitchen rages on food prep surfaces, the sanitizer bucket level will be checked for proper level of sanitizer present. The kitchen staff will not use rags from sanitizer bucket unless the sanitizer is at the right level. Food brought by the resident's family will be labelled to identify the date the food from outside was brought in by the representative. Perishable food items brought in by the resident's representative will be discarded in ,d+[DATE] days after brought in and refrigerated in the resident's room. The facility Food Handling Policy, dated [DATE], states food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31327 Based on observation, interview, and record review, the facility failed to have thermometers and complete temperature logs for residents' personal refrigerators. They facility also failed to remove expired items, label food, and clean refrigerators. This applies to 5 of 5 residents (R1, R2, R53, R62, R94) reviewed for refrigerators in a sample of 34. The findings include: 1. On [DATE] at 10:55 AM, during initial tour, R62 was not in his room. Inside R62's fridge, there was no thermometer. Inside, there were also 2 sandwiches with no date as to when they were prepared. There was orange juice, cola, and drinks with electrolytes. The fridge and freezer had orange stains from drinks inside. 2. On [DATE] at 11:02 AM, inside R53's fridge, there was no thermometer. Inside there was cream cheese, milk, apple sauce, bars of chocolate, crackers, and a bag of slices of bread with mold, with a sell through date of [DATE]. R53 was asked by surveyor if the facility staff is taking temperatures of his fridge and if he had any concerns with his fridge. R53 couldn't understand surveyor because his primary language was Polish. R53 just stated, Everything ok, everything is ok. On [DATE] at 9:31 AM, V2 (DON-Director of Nursing) stated, I believe you are supposed to have resident temperature logs and thermometers in resident refrigerators. I wanna say it's housekeeping job to check the fridges. When housekeeping or the CNAs (Certified Nursing Assistants) clean the residents' rooms, they should also remove expired food. On [DATE] at 9:39 AM, V1 (Administrator) stated, Housekeeping and nursing is responsible for removing expired items and clean the fridge. Each fridge should have a thermometer and temp log. On [DATE] at 11:41 AM, V18 (Housekeeping Director) stated, Me and the housekeepers are responsible for checking the fridge. We are to remove expired items and there should be thermometers in the fridge. If it's stained,we would clean them. I'm not done with the March temperature logs. At 11:52 AM, V18 brought in a second binder and he did not have the March refrigerator temperature logs for R53 and R62. 44387 3. On [DATE] at 10:51 AM, R94 was in bed resting in her room. R94 had a personal refrigeration in the room. There were 6 cans of Pepsi, chicken salad, unlabeled half of sandwich in a clear zip lock bag. There was no thermometer in the refrigerator, and there was no temperature log. R94 said that her daughter takes care of refrigerator. 4. On [DATE] at 11:07 AM, R2 was in bed in his room; R2 had personal refrigerator in the room. There were 2 cans of Pepsi, 2 cans of Coca Cola, and 1 loaf of sliced bread that expired on [DATE]; the bread was hard. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On [DATE] at 11:36 AM, R1 was in bed resting; R1 had a personal refrigerator in the room. R1 had 6 Actvia yoghurts in the refrigerator, 2 of which expired on [DATE]. R1 said her daughter brings in the food for her. On [DATE] at 8:54 AM, V1 (Administrator) said that housekeeping staff keeps the temperature log for personal refrigerators, and nursing staff and housekeeping staff were responsible for taking care of resident's personal refrigerator. On [DATE] at 1:20 PM, V18 (Housekeeping Supervisor) said he could not find the temperature log for R94's personal refrigerator, he said the temperature log was not done. R18 was able to provide temperature logs for R1 and R2 personal refrigerator. Facility's policy titled Refrigerator and Resident Appliance Maintenance Service ([DATE]) shows: Procedures: 1. The maintenance department or facility designee is responsible for maintaining that resident appliance e.g. refrigerators are safe, clean and operable at all times. A. Refrigerator in resident room. 2. The facility will perform the following refrigerator checks: a. Refrigerator in resident room. 2. The facility will perform the following refrigerator checks: b. Monitor that refrigerators are utilized for storage of resident food and supplements are intended exclusively for resident use. c. Temperature is maintained below 41 degrees Fahrenheit and above 32 degrees Fahrenheit using a thermometer with + -3 degrees temperature variance. d. Proper labeling, storage, and disposition of food items. e. Ensure proper dating and disposition of outdated food items including food brought by family and resident from the outside. Facility's policy titled Food from the Outside Policy ([DATE]) shows: Procedures: 1.) All food brought by visitors and family members from the outside of the facility will be labeled with the date it was brought to the facility. 3. After ,d+[DATE] days, these food items will be discarded. 4. All undated food items will be discarded to ensure safety of the residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46409 Based on observation, interview, and record review, the facility failed to apply PPE (Personal Protective Equipment) and perform handwashing for a resident who was on contact isolation for C. Diff. (Clostridium Difficile). The facility also failed to This applies to 2 of 2 residents (R21, R147) reviewed for infection control in a sample of 34. The findings include: 1. R147's face sheet showed diagnoses including Parkinson's disease, muscle wasting, need for assistance with personal care, and a history of falling. R147's MDS (Minimum Data Set), dated 2/7/24, showed R147 had moderate cognitive impairment. R147 required moderate assistance for toileting hygiene and personal hygiene, substantial assistance for oral hygiene, and was dependent on staff for eating, shower/bathing, upper and lower body dressing, and putting on/taking off footwear. R147's POS (Physician Order Sheet) showed, Strict Contact Isolation (C.Diff). R147's care plan, dated 3/13/24, showed, Resident requires strict Contact Precautions related to: C. diff. with interventions including, Observe isolation precautions as clinically indicated, use appropriate protective equipment, and utilize proper hand washing technique. On 3/20/24 at 09:27 AM, V4 (CNA/Certified Nurse Assistant) was in R147's room. R147's room door had signage posted for contact isolation PPE to be worn when in R147's room. V4 exited R147's room and went to another resident's room without performing hand hygiene after leaving R147's room, or before entering the next resident's room. At 09:58 AM, V4 provided incontinence care for R147. V4 removed R147's dirty incontinence brief and flat sheet, and applied the clean incontinence brief and flat sheet without changing gloves or performing hand hygiene. At 10:16 AM, V4 said R147 was on contact isolation for C. Diff. V4 said she should have worn a gown, gloves, and mask if needed. V4 said PPE was worn any time you went into R147's room, and staff should wash or sanitize hands after removing PPE so that there was no cross contamination. On 3/21/24 at 09:24 AM, V18 (Director of Housekeeping) was in R147's room without any PPE on. V18 touched R147's fridge and then walked out of the room, without performing hand hygiene. V18 said R147 had C. Diff. and was on contact precautions. V18 said staff can spread C. Diff, and he should wear a gown and gloves in the room. On 3/21/24 at 09:42 AM, V21 (Wound Care Tech) and V22 (Wound Care Tech) were in R147's room without any PPE on. V22 said R147 had C. Diff., and she was supposed to wear a gown and gloves. V21 said she should sanitize her hands and a gown and gloves should be worn any time you need to enter the room. V22 said the staff need to wash their hands with soap and water. V21 said the PPE and handwashing was done so as not to transfer the infection to themselves, staff, or other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/21/24 at 10:36 AM, V23 (Wound Care LPN/Licensed Practical Nurse) was assisting V26 (Wound Care Coordinator) with providing wound care for R147. V23 and V26 were wearing a gown and gloves. V23 removed his gown and gloves after assisting V26, performed hand hygiene only using alcohol-based hand sanitizer, and left R147's room to gather supplies. At 10:42 AM, V20 (CNA) entered R147's room with the gown and gloves on and was carrying linen and an incontinence brief. At 10:43 AM, V20 removed her gown and gloves and left R147's room, without washing her hands with soap and water. On 3/20/24 at 4:14 PM, V2 (DON/Director of Nursing) said the staff should wear a gown, gloves, and a mask in R147's room. V2 also said hand hygiene should be done before and after residents are given any kind of care. V2 said staff should be washing their hands with soap and water as they are at risk for spreading the infection to themselves or other residents. 44387 2. R21's EMR (Electronic Medical Record) shows the following diagnoses of respiratory failure, asthma, weakness, unsteadiness on feet and need for assistance with personal care. R21's current Physician Order Sheet (POS) shows the following orders for continuous oxygen at 3 liters per minute via nasal cannula. On 3/19/24 at 12:20 PM, V28 (Agency CNA/Certified Nurse Assistant) was completing bed bath on R21. R21 requested for some ice water, V28 left the room to get the water. R21 had oxygen concentrator and the nasal cannula was on the floor; R21 did not have her oxygen on during care. After V28 left, R21 appeared short of breath, and asked surveyor for her oxygen to be placed on her. R21's call light pad was on her bed side table, which was not within reach. At 12:27 PM, surveyor pushed the call light, at 12:29 PM, V29 (Restorative Aide) came in the room, and picked up the nasal cannula from the floor and placed the nasal cannula on R21. On 3/21/24 at 8:51 AM, V1 (Administrator) said nasal cannula should be placed inside a bag to keep it clean as a preventative measure for infection control. The facility's Infection Prevention and Control policy, revised on 10/23/23, showed, Hand hygiene will be performed by staff before and after direct patient contact and after each situation that necessitates hand hygiene. Alcohol-based hand rubs or hand washing x 20 seconds will be used . Contact Precautions- Intended to prevent transmission of infectious agents spread by direct or indirect contact with patient or the environment. Examples of infectious organisms requiring contact precautions are C. Difficile . Use of gown and gloves is necessary prior to room entry. Face protection may be necessary if performing activity with risk of splashing or spraying (Standard Precaution).