

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145942	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2024
NAME OF PROVIDER OR SUPPLIER Oak Lawn Respiratory & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 9525 South Mayfield Oak Lawn, IL 60453	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40066</p> <p>Based on interviews and records reviewed the facility failed to follow their policy to ensure that medications were stored safely and securely. This affected one of three residents (R4) reviewed for medication storage. This failure resulted in one resident (R4) accessing the medication cart.</p> <p>The findings include:</p> <p>On 11/2/24 at 1:28PM V8, Registered Nurse (RN), said I worked on 10/20/24, on the night shift. V8 said I received in report from V11, Licensed Practical Nurse (LPN), I think that was her, that R4 got into the medication cart. V8 said I was told the CNA reported seeing R4 in the cart. V8 said R4 told me she was counting her medication in the cart, I was counting my oxy. V8 said V11 and R4 did not tell me how R4 got in the cart. V8 said I did not report to anyone because V11 told me she reported to the Director of Nursing (DON). V8 said R4's room was outside the nurses station.</p> <p>On 11/2/24 at 1:52PM V2, CNA, said R4 was loud and rude and she would go off. V2 said I never saw R4 in pain. V2 said if R4's medication comes a minute after it is due then she starts saying she is in pain. V2 said I came out of a resident room and R4 was putting the keys back in the binder on the nurses cart. V2 said I saw R4 with the nurse's keys in her hands. V2 said R4 said she was trying to see if she had 2 cards. V2 said the nurse was taking care of another resident in her room. V2 said R4 walked away to the elevator. V2 said I pushed the lock on the cart and took the nurse the keys. V2 said I handed the nurse the keys and told her R4 had the keys. V2 said I didn't know R4 would do that, but she would look at her medication and say there goes my medication. V2 said the cart was unlocked when I walked into R4.</p> <p>On 11/3/24 at 10:35AM V5, Director of Nursing (DON), said on 10/21/24 a manager reported to me the nurse reported that R4 had the key to the medications cart. V5 said I went to speak to V12, because she reported it and I called V8 and V11. V8 told me V11 said the keys were in the drawer. V5 said the CNAs never reported they saw R4 with the keys to the med cart. V5 said V11 told me she left the keys in the drawer during her wound care to another resident. V5 said I told V11 you should have the keys on you. V5 said the expectation is that they notify me. V5 said I don't know if R4 was in the cart. V5 said the expectation is that the medication cart keys are to stay on the nurses at all times. V5 said the medication that could have side effects, antihypertensives, blood thinner, and diabetics medications are stored in the cart.</p> <p>(continued on next page)</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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Attempts to reach V11 on 11/2/24 at 2:03PM and 11/3/24 at 10:12AM were unsuccessful.</p> <p>R4 diagnosis include but are not limited to Low Back Pain, Schizoaffective Disorder, Bipolar Disorder, Insomnia, Sciatica, Personal History of Traumatic Brain Injury, Cannabis Abuse, Nicotine Dependence, and Bariatric Surgery. R4 admitted to the facility on [DATE].</p> <p>Progress notes reviewed fated 10/18/24 - 10/22/24. No progress notes related to R4 being seen with the medication cart keys. On 10/20/24 R4's progress notes documents a referral to another facility. On 10/22/24 R4 was transported/discharged to another facility.</p> <p>Order Summary Report for R4 documents Psychological Services. Oxycodone -Acetaminophen tablet 5/325mg 1 tablet every 8 hours as needed for pain.</p> <p>R4's Medication Administration Record for October 2024 documents Oxycodone -Acetaminophen tablet 5/325mg administered on 10/19/24 at 1:00PM; 10/20/24 at 12:50PM; 10/20/24 8:18PM; and 10/21/24 at 12:00PM.</p> <p>R4's Preadmission Screening and Resident Review (PASRR) dated 5/11/24 documents you have attempted to end your life in the past by taking your mom's pain pills. You need help from others to make safe decisions.</p> <p>Schedule reviewed for Sunday 10/20/24 identifies V11, LPN, on 3:00PM - 11:00PM shift and V8 RN on 11:00PM - 7:00AM shift.</p> <p>R4's care plan includes interventions for socially inappropriate and maladaptive/disruptive behavior manifested by a disturbed sense of entitlement. R4 refuses to see psychotherapy professional. R4 has a history of substance abuse/chemical</p> <p>dependency related to diagnosis cannabis abuse. Smoking care plan identifies non compliance with safe smoking regulation by smoking at non designated times, begging, borrowing, stealing, selling and or trading for smoking materials.</p> <p>Expectation of Nurses documents DO NOT LEAVE KEYS TO MED CART IN A DRAWER EVER.</p> <p>Witness Statement dated 10/21/24 from V8 regarding R4 for incident date 10/21/24 documents I relieved V11 on her shift she stated to me watch out for [R4] she tried to take her keys. I endorsed behavior to oncoming nurse for 7:00 - 3:00PM shift. Interviewed by V5.</p> <p>Witness Statement dated 10/21/24 from V11 regarding R4 for incident date 10/21/24 documents I saw R4 behind the nurses' station. Interviewed V5 asked V11 where her medication cart keys were. V11 states in the nurses' station drawer. V11 said R4 did not have the key or access to the key. Nurse stated you know this women is crazy and probably looking for Norcs.</p> <p>Witness Statement dated 10/21/24 from V12 regarding R4 for incident date 10/21/24 documents I was informed by outgoing nurse (V8) that R4 was trying to get nurses' keys to get into the Norc box and watch out for the behavior.</p> <p>(continued on next page)</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>Facility policy Medication Storage in the Facility dated May 2024 states Medication and biologicals are stored safely, securely, and properly. The medication supply is accessible only to licensed nursing personal. Medication rooms, carts, and medication supplies are locked or attended by person with authorized access: Licensed Nurses, Consultant Pharmacist, Pharmacist Technician, Individual Lawfully Authorized to Administer Drugs, and Consultant Nurses. All drugs classified as schedule 2 of the Controlled Substance Act will be stored under double locks.</p> <p>Residents who have been trained in self-administration will have access only to their individual drug supply.</p>		