STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008825	A. BUILDING: _____ B. WING _____	C 11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR SOUTH LOOP	1725 SOUTH WABASH CHICAGO, IL 60616

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S 000	Initial Comments Complaint 2288564/IL152659	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c)3) 300.1210d)5) 300.1220b)2)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other	S9999		

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S9999	Continued From page 2 modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, interviews and record review, the facility failed to prevent, assess, provide timely care, and update resident's care plan related to a facility acquired pressure ulcer/wound (R1) and a change in status of a current pressure ulcer/wound (R2). These failures resulted in acquiring, deterioration or worsening of a pressure ulcer/wound for 2 residents (R1 and R2) of 3 residents reviewed for pressure ulcers/wound prevention and treatment. These failures resulted in 1 resident's (R1) deterioration of a facility acquired pressure ulcer/wound, with subsequent transfer to the hospital with diagnosis of Sepsis of the wound. Findings include: R1 is 70 years old with medical admitting diagnosis of dementia and left femur fracture. R1 was initially admitted on 9/30/2022 and was discharged after transferred to hospital on 10/19/2022.	S9999		

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S9999	Continued From page 3 On 11/9/2022 R1, V2 (R1's Daughter) stated that R1 developed a Stage 4 pressure ulcer while in the facility. V2 also stated that R1 was rushed to the hospital due to septic shock related to the pressure ulcer on 10/19/2022. Per R1's notes dated 10/19/2022 by V7 (INFECTIOUS DISEASE NURSE PRACTITIONER) documents as follows: R1 temperature was 101 degrees Fahrenheit. Per V2 (R1's Daughter) who was present at the bedside. R1's sacral wound (The sacrum is a bone that is at the back of the pelvic bones) started on Saturday (10/16/2022). V7's skin assessment of R1: Sacral wound was hot to touch, malodor (foul smelling), necrotic tissue, purulent drainage, gray drainage, edema, and erythema around peri-wound skin. Under assessment: Sepsis R1 hypotensive, febrile, more lethargic than usual. Wound and possible aspiration pneumonia believe to be source. Discussed case with wound MD (V9). Ordered R1 sent to hospital for evaluation. On 11/9/2022 at 12:44 PM, V7 (INFECTIOUS DISEASE NURSE PRACTITIONER) stated "Given how it looked and the amount of necrotic tissue infection was identified, I informed V9 (Wound Doctor) and both of us agreed that R1 needs to go to (Operating Room) OR. Just by looking, I didn't even need to do an assessment this needed an OR intervention. " Initial skin assessment provided by V10 (Wound Care Coordinator / Licensed Practical Nurse) documents as follows: R1 does not have pressure ulcer upon admission on 9/30/2022. Under notes, due to Braden score 13 and current comorbidities, R1 is at risk for skin alterations.	S9999		

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S9999	Continued From page 4 Per R1's notes dated 10/3/2022 by V13 (Physician Assistant) documents as follows: R1 high risk for developing contractures, pressure ulcers, poor healing per fall if not receiving adequate therapy and pain control. R1's notes dated 10/15/2022 by V11 (Licensed Practical Nurse) documents as follows: R1 was observed with skin alteration to his sacrum. Writer cleaned site and applied dry dressing. Medical Doctor, V1 (Director of Nursing), V12 (Assistant Director of Nursing), and wound care made aware. V2 (R1's Daughter) at the bedside. On 11/9/2022 at 1:45 PM, V10 (WOUND COORDINATOR / LPN) stated, "R1 did not have a sacral pressure ulcer when first admitted to facility on 9/30/2022. I (V10) did not know about R1's sacral pressure ulcer until 10/18/2022 when I was informed by facility staff that day. The wound had a lot of necrotic tissue and was measured 7 centimeters by 7 centimeters and was assessed as unstageable due to having a lot of slough and necrotic tissue. When I found it, it was already that size and condition. " V10 stated, "R1's notes by V11 (LICENSED PRACTICAL NURSE) sacral wound was already identified on 10/15/2022. V10 said, "Nobody informed me (V10) about R1's pressure ulcer on the sacrum. So, after reviewing R1's health records, no assessment was done. As to R1's care plan, the pressure ulcer was not addressed until I (V10) modified it today 11/9/2022. I (V10) dated 10/18/2022 because that was the time, I identified R1's sacral pressure ulcer. I should have not modified it, since R1 was already discharged." Upon review of R1's care plan history. It was documented that V10 created a care plan for R1's	S9999		

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S9999	Continued From page 5 pressure ulcer on 11/9/2022. Upon review of R1's full care plan, R1's pressure ulcer was not care planned upon initial identification dated 10/15/2022. On 11/9/2022 at 3:12 PM. V1 (DIRECTOR OF NURSING) stated that she was not sure if she was informed by V11 (LICENSED PRACTICAL NURSE) about R1's sacral wound. After checking her phone, V1 said, "It's here she (V11) texted me. I was informed by V11 about R1's pressure ulcer on the sacrum. I don't have any knowledge if any of nursing team saw R1's sacral pressure ulcer. There is only one assessment dated 10/18/2022. The next day R1's sacral wound was bad, and he (R1) was sent to the hospital. As to R1's care plan, I told V10 not to modify it. I agree it should have been care planned once the pressure ulcer was identified. " Facility Wound Assessment Details Report by V10 documents as follows: R1's Assessment 10/18/2022, facility-acquired pressure ulcer, unstageable, 10/18/2022 date identified (although notes by V11 documents that it was identified on 10/15/2022). Tissue 20% bright pink or red, 80% necrotic hard adherent. Measured in centimeters as 7.00 by 7.00 total area of 49 centimeters. R1's Minimum Data Set dated 10/7/2022 documents as follows: R1's brief interview for mental status score was 5 indicating that R1's cognitive status was impaired. R1's needs one-person extensive assist on bed mobility. R1 does not have unhealed pressure ulcer during assessment. But R1 is at risk of developing pressure ulcer. On 11/10/2022 at 1:51 PM. V11 (Licensed	S9999		

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Practical Nurse) said, "I remember R1, I first saw his pressure ulcer on 10/15/2022 on his sacrum. It was black and red around it. I don't know how to stage pressure ulcers, but it was bleeding. I cannot remember the actual size of the wound because I did not measure it. I only used 1 boarder gauze to cover it. I cleansed it with normal saline and placed a wet to dry dressing. I informed the doctor, V1 (Director of Nursing), V2 (Assistant Director of Nursing) and the wound care team. Besides my notes, I do not remember if I did any assessment. The next time I came back was on Wednesday 10/19/2022. By that time R1 was already in the hospital. "

Per R1's Physician Order dated 10/15/2022 documents: Sacrum to be cleansed with normal saline or wound cleanser. Apply gauze to wound bed cover with dry dressing.

R2 is 69 years old with medical admitting diagnosis of Cerebral infarction due to embolism. R2 was initially admitted on 9/10/2022.
On 11/9/2022 at 11:35 AM. R2 was lying in bed and V8 (R2's DAUGHTER) was at the bed side. The bed had a LAL (low air loss) mattress. There was a thick draw sheet in between the mattress and R2.

V8 said, "I don't think they are doing a good job on my mother's wound. If they are doing a good job, how did it get so bad?"

On 11/9/2022 at 1:45 PM. V10 (WOUND COORDINATOR / LPN) stated, "Yes, R2 has sacral pressure ulcer that was healed and reopened again ". Upon looking at R2's health record. V10 said, "On 9/19/2022 R2's sacral pressure ulcer was healed and reopened again

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S9999	Continued From page 7 on 10/28/2022. In the most recent assessment dated 11/3/2022 it deteriorated because R2 refused treatment. It was assessed by V9 (Wound Doctor) and was found to be deteriorating. I personally did not care plan R2's sacral pressure wound. I agree that because R2 was refusing wound treatment it needed to be care planned. If she (R2) keeps on refusing wound treatment her sacral wound will continue to deteriorate. " On 11/9/2022 at 3:12 PM V1 (DIRECTOR OF NURSING) said, "Any resident that has a pressure ulcer and is refusing treatment must be care planned. Education is needed for R2 to understand the importance of proper treatment. " On 11/10/2022 at 12:42 PM. V9 (Wound Doctor) said, "My assessment for the buttocks wound and facility's assessment for the wound is the same. R2's wound extends from sacrum to the buttocks, or midline of the buttocks. If it is on bone prominence it is pressure, but because I also see shearing, I classified it as skin tear. But since the sacral area is a bone prominent area you could classify it as pressure sore. R2 was resisting care, and it takes 3 of us to turn her (R2). Part of the problem is convincing R2 to let staff reposition her. Preventive measures to prevent the wound from deteriorating are off-loading, repositioning, and behavioral interventions. I am not familiar with the care planning the facility used. But these interventions are important. For general wound care, it depends upon the patient status. Infection can be prevented by repositioning, off-loading, maintaining clean area of the wound, dietician intervention. It is essential for planning of care. " Per R2's wound assessment by V9 dated 11/3/2022 documents as follows: Per nursing	S9999		

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S9999	Continued From page 8 report, R2 has been refusing treatment and wound has deteriorated. On exam, 2 nurses and 1 tech were at the bedside, trying to convince R2 to be repositioned and have exam and treatment done. Discussed with R2 how her non-adherence has led to deterioration of wound. Wound measures in centimeters 6 by 8 by 0.1 with surface area 48 centimeters. Wound has exudate of light serous, 20% slough, 60% granulated tissue and 20% skin. Wound deteriorated. Compared to wound assessment dated 10/27/2022 documented as follows: Wound measures in centimeters 5 by 7 by 0.1 with surface area 35 centimeters. Wound has exudate of light serous, 100% granulated tissue. Facility wound assessment also documents deterioration. Wound assessments are as follow: On 9/19/2022 sacral wound classified as pressure was healed. On 10/28/2022 wound on the sacral re-opened measuring in centimeters 5 by 7, 35 centimeters area, and 100% bright pink or red. On 11/4/2022 sacral wound measures in centimeters increase in size to 6 by 8, 48 centimeters area with 20% slough white fibrinous, 20% skin intact and 60% bright pink or red. R2's care plan does not address the sacral pressure ulcer and/or R2's behavior in refusing care as it relates to the pressure ulcer. (A)	S9999		