STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9016273	A. BUILDING: _____ B. WING _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT BARTLETT	829 CARILLON DRIVE BARTLETT, IL 60103

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S 000	Initial Comments First Probationary Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations(1 of 3) 300.696d)2) Section 300.696 Infection Prevention and Control d) Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health Administration (see Section 300.340): 2) Guideline for Hand Hygiene in Health-Care Settings This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff changed their gloves and performed hand hygiene before cleaning a wound after handling soiled wound materials for 1 of 1 residents (R5) in the sample of 11 reviewed for hand hygiene during wound care. The findings include: R5's Admission Record dated 4/15/25 shows he was admitted to the facility on 4/3/25 with necrotizing fasciitis.	S9999		

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On 4/14/25 at 10:31 AM, V4, Wound Care Nurse, was changing R5's right groin wound dressing/wound vac. With gloved hands, V4 removed the foam packing and placed in the biohazard bag. The foam was saturated with blood and other fluids. With the same gloved hands, V4 proceeded to wash out and remove blood clots from R5's wound with normal saline and 4 by 4 gauze.

On 4/15/25 at 9:15 AM, V2, Director of Nursing (DON), said when performing a dressing change, the nurse should remove their gloves after removing the dirty materials, wash their hands, and don new gloves because it could be an infection risk. V2 said you don't want to introduce any harmful bacteria from the dirty to the clean.

The facility's Wound Care Policy/Procedure (not dated) shows exam gloves should be worn to loosen the tape and remove the dressing, then the dressing materials should be discarded along with the gloves. The nurse should wash and dry their hands thoroughly and put on clean gloves, then proceed with the ordered wound cleaning/treatment.
(C)
(2 of 2)

300.1620a)

Section 300.1620 Compliance with Licensed Prescriber's Orders

a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section

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300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.

This REQUIREMENTS were not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure medications were administered at designated times. The facility also failed to ensure insulin pens were primed prior to administration. This applies to 4 of 5 residents (R6, R9, R10 & R11) reviewed for medication administration in the sample of 11.

The findings include:

1. R9's medication administration record (MAR) for April 2025 shows, a physician prescribed order for "insulin glargine (long acting insulin) solostar subcutaneous solution pen-injector 300 unit/ml [milliliter], inject 15 unit subcutaneously two times a day for diabetes."

On April 14, 2025 at 10:16 AM, V5 Registered Nurse (RN) was preparing R9's morning medications. V5 applied a needle to R9's insulin glargine pen. He turned the dial to 15 units. He did not prime the needle with 2 units prior to turning the dial to 15 units. He stated, he doesn't ever prime the insulin pen needles prior to giving insulin.

On April 15, 2025 at 8:45 AM, V2 Director of Nursing (DON) confirmed, insulin pens should be primed prior to administrating to the residents.

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The manufacturer's guidelines for insulin glargine injection pens provided by the facility on April 15, 2025 shows, "How to use your lantus (insulin glargine) solostar pen in 6 steps: ...Step 2: Attach the needle... Step 3: Perform a safety test: dial a test dose of 2 units...."

The facility's insulin pen administration policy dated August 2017 shows, "Steps in procedure: ...9. Attach the needle to the end of the pen and prime pen. 10. Prime pen by dialing the dose knob to select 2 units...."

2. On April 14, 2025 V5 RN was observed administering morning medications from 10:16 AM until 10:55 AM. At 10:16 AM, he administered R9's medications (16 minutes late). At 10:32 AM, he administered R10's medications (32 minutes late). At 10:48 AM, he administered R11's medications (48 minutes late).

R9's MAR for April 2025 shows, physician prescribed orders for carvedilol 12.5 mg (milligrams), give 1 tablet by mouth two times a day for HTN (hypertension), Eliquis oral tablet 5 mg, give 1 tablet by mouth two times a day for AFIB (atrial fibrillation) and insulin glargine (long acting insulin) solostar subcutaneous solution pen-injector 300 unit/ml, inject 15 unit subcutaneously two times a day for diabetes. All three medications were scheduled at 9:00 AM and 5:00 PM.

R10's MAR for April 2025 shows, physician prescribed order for amoxicillin oral capsule 500 mg give 1 capsule by mouth two times a day for UTI (urinary tract infection), carvedilol oral tablet 6.25 mg give 1 tablet by mouth two times a day for HTN, doxycycline hyclate oral tablet 100 mg give 1 tablet by mouth two times a day for

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osteomyelitis left 5th toe, furosemide table 40 mg give 1 tablet by mouth two times a day for fluid retention and vancocin oral capsule 250 mg give 1 capsule by mouth four times a day for c-diff (scheduled at 9:00AM, 1:00 PM, 5:00 PM, 9:00 PM). The rest of the medications were scheduled for 9:00 AM and 5:00 PM.

R11's MAR for April 2025 shows, physician prescribed order for bethanechol chloride tablet 25 mg give 1 tablet by mouth two times a day for urinary retention, carvedilol tablet 6.25 mg give 1 tablet by mouth two times a day for HTN and eliquis oral tablet 5 mg give 1 tablet by mouth times a day for afib. All four medications were scheduled at 9:00 AM and 5:00 PM.

3. On 4/14/25 from 10:05 AM to 10:30 AM V3 was observed while administering morning medications to residents. The medications were scheduled for 8:00 AM and 9:00 AM.

At 10:15 AM V3 was asked why medications are being given late. V3 stated, "The other side (Hall) was just busy." V3 then confirmed that he had 24 residents on his assignment to administer medications to.

At 10:30 AM R6 was given Carvedilol 12.5mg , Eliquis 5 mg, and Hydralazine 25 mg.

R6's Medication Administration Record for April 2025 shows orders for Carvedilol 12.5mg twice a day (Antihypertensive), Eliquis 5 mg twice a day (Anticoagulant) and Hydralazine 25 mg twice a day (antihypertensive). All of these medications are scheduled for 9:00 AM.

The undated facility policy entitled Administering Medications states, "Medications are

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S9999	Continued From page 5 administered in accordance with prescriber orders, including any required time frame." and "Medications are administered within 1 hour of their prescribed time, unless otherwise specified ..." (B) (3 of 3) 300.2100 Section 300.2100 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Code." This REQUIREMENTS were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure open food items were labeled and ice scoops were stored properly. This applies to all 55 residents residing in the facility. The findings include: The facility data sheet dated April 14, 2025 shows, 55 residents currently residing in the facility. On April 14, 2025 during the initial tour of the kitchen, multiple food items were opened/prepped and not labeled with dates. The cooler had an open package with a raw burger patty, a container of cut up fruit (cantaloupe, grapes, melons), cooked corn bread, lettuce, tomatoes, onions and carrots. The prep cooler had sheets of raw bacon on a rack with no label. There were also sheets of diced up carrots, onions and celery. The refrigerator on the third	S9999		

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floor, in the kitchenette had a plastic bag with some type of gray substance in it. Both ice machines on the third floor had the scoops laying in the ice and not placed in the designated holder.

On April 15, 2025 at 8:45 AM, V6 Certified Dietary Manager stated, all opened food items/prepped items should be labeled. V2 Director of Nursing (DON) confirmed that the ice scoops should not be laying in the ice.

The facility's record of meeting attendance for ice scooper storage (no date) shows, "Ice scooper must be placed in the designated spot inside the ice machine. Do not leave the scooper sitting freely over the ice, always store it appropriately."

The facility's labeling, dating, and storage of received and prepared foods policy dated January 2, 2023 shows, "a. Any packages opened for food production will be labeled with an open date and sealed air tight prior to being placed back into food storage bin. 4. Any food items prepared in house will be labeled with food name and date of preparation. Prepared foods will be sealed air tight and placed in appropriate food storage areas.
(C)