STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014682	A. BUILDING: _____ B. WING _____	C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR ORLAND PARK	14601 SOUTH JOHN HUMPHREY DR ORLAND PARK, IL 60462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2174421/IL135297	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1010h) 300.1210b) 300.1210d)1) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care needs of the resident. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 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 are not met as evidenced by: Based on interview and record review, the facility failed to provide narcotic pain medication to a resident as ordered by the physician. This failure resulted in R1 not receiving physician-ordered pain medication for more than 20 hours and causing R1 to experience severe pain. This failure also resulted in psychosocial harm as evidenced by R1 stating she felt great sadness, helplessness, and anxiousness due to her pain level and the lack of available pain medication. This applies to 1 of 3 residents (R1) reviewed for pain medication in the sample of 4. Findings include: The EMR (Electronic Medical Record) shows R1 was admitted to the facility on May 29, 2021 and was discharged to home on June 15, 2021. R1	S9999		

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S9999	Continued From page 2 had multiple diagnoses including, right foot bone fracture, alcohol abuse, fall, bipolar disorder, hypertension, GERD (Gastroesophageal Reflux Disease), thyroid disorder, and major depressive disorder. R1's MDS (Minimum Data Set) dated June 6, 2021 shows R1 was cognitively intact, required extensive assistance with bed mobility, limited assistance with toilet use, and supervision with personal hygiene. All other ADLs (Activities of Daily Living) either occurred only once or twice or did not occur at all during the MDS observation period. R1's MDS continues to show, during the previous 5 days, R1 had received scheduled and PRN (as needed) pain medication, frequently experienced pain that limited her day-to-day activities, and had experienced pain of 6 out of 10 (zero being no pain and ten as the worst pain imaginable). Facility documentation shows a physician order dated May 29, 2021 for Norco (Hydrocodone-Acetaminophen narcotic pain medication) 10/325 mg (milligrams) to be given orally, every 6 hours as needed for moderate to severe pain. R1's MAR (Medication Administration Record) dated June 1 to June 30, 2021 shows R1 received 10/325 mg of Norco on June 8, 2021 at 0841 (8:41 AM) for 9 out of 10 pain. The next documented dose of Norco was thirty-three hours later. R1's MAR showed Norco was administered on June 9, 2021 at 1745 (5:45 PM) for 10 out of 10 pain. The facility's Controlled Substances Proof of Use sheet dated May 30, 2021 shows a dose of R1's Norco medication was used by nursing staff on	S9999		

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S9999	Continued From page 3 June 8, 2021 at 9:00 PM. This dose of Norco was never documented on R1's MAR to show the medication was administered to R1. The Controlled Substances Proof of Use sheet shows, "Important: The nurse who signs this record must also sign the separate Medication Administration Record for each dose given." Pharmacy delivery logs shows R1's Norco order was delivered to the facility on June 10, 2021 at 1:01 AM. On June 29, 2021 at 1:28 PM, R1 said, "While I was living at the nursing home, I went over 21 hours without receiving Norco (narcotic pain medication), even though I asked for it over and over. They ran out of my pain medicine! How does a nursing home run out of pain medication? The night nurse (V4-RN Registered Nurse) gave me a Norco around 8:00 or 9:00 PM on June 8, and said it was my last pain pill until they could order more. She showed me a cardboard card with little blister packs that hold the pain pills. All the blister packs were empty. I think she was trying to prove to me that they were out of my pain medication. I was very upset. She said they could give me Tylenol until the pain medication was delivered. Tylenol does not work for me. I have a broken bone in my foot! The next morning, it was early, around 7:00 AM, and I needed some pain medication. I was told by the nurse they did not have any pain medication for me. By the time I finally received pain medication, about 21 hours had gone by since my last pill. As the hours went by and I wasn't receiving any pain medication, I told [V2] (DON-Director of Nursing) I felt like I was having a heart attack. I have very bad anxiety, and I think I was so anxious about the pain medication it gave me the feeling of having a heart attack."	S9999		

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S9999	Continued From page 4 During the interview with R1, the resident became tearful and verbally upset. R1 expressed feelings of helplessness, great sadness, and anxiety when she found out she did not have pain medication available to her and waited over 20 hours between pain medication doses. On June 29, 2021 at 10:52 AM, V2 (DON) said, "The nurses should be vigilant about reordering medications before the medication runs out. When the resident has less than three to five doses of medication, the nursing staff needs to get the medications refilled because there may be a wait for the medications. I was caring for [R1] the entire day of June 9, 2021. Around 4:00 PM, [R1] stated she was having a heart attack and she couldn't take it. I had not given her any pain medication that day. We were waiting for her Norco to be delivered from the pharmacy." On June 9, 2021 at 8:44 AM, V4 (RN) documented, "[R1] asked writer for her Norco during the night shift, writer observed that there was only 1 pill left and explained to resident about the last dose and let resident know that a new script will be needed in the AM by the MD. Resident went off writer very rudely. Verbally redirect behavior in order to calm [R1] down. [R1] not receptive to intervention. Ordered dose of Norco was given." On June 9, 2921 at 8:49 AM, V4 (RN) documented, "Alternate comfort measures offered throughout the shift [R1] refused. Endorsed to oncoming day shift nurse to F/U (Follow Up) with provider for new script for pain medication." On June 9, 2021 at 8:52 PM, V2 (DON)	S9999		

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S9999	Continued From page 5 documented, "[R1] verbalized "I feel like I am having a heart attack." When writer asked her to describe what she was feeling patient then stated to writer "Maybe it's just anxiety. I get anxiety medication and I have not had it for a while, I just feel like I am about to lose it." On June 30, 2021 at 1:30 PM, V5 (Physician) said, "I would expect the facility to have R1's Norco medication in stock and available to administer to R1 as I ordered it. When I met the resident, she did fixate on her pain and pain medication. She was very anxious about experiencing pain. The facility should have had pain medication available so the resident did not get to the point where she experienced pain at a level of 10 out of 10 pain. For her to be told the facility was out of her pain medication and then not receiving the pain medication for 15 or 20 hours could definitely cause this resident to have signs of anxiety, including stating she felt like she was having a heart attack. I was never notified by the facility the resident was out of pain medication, experiencing 10 out of 10 pain levels or complaining of feeling as if she was having a heart attack." (B)	S9999		