STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145219	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burgess Square Healthcare Ctr	5801 South Cass Avenue Westmont, IL 60559

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)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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

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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 0760 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer blood thinner medication as ordered by the physician. This failure resulted in R1 experiencing an elevated INR (International Normalized Ratio) blood test and requiring the administration of Vitamin K and hospitalization. This applies to 2 of 3 residents (R1, R4) reviewed for medication administration in the sample of 5.The findings include: 1. On November 17, 2025, R1 was sitting quietly. She was unable to answer questions due to her cognitive status.The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE]. The EMR continues to show R1 was sent to the local hospital on November 4, 2025 and returned to the facility on November 5, 2025. R1 has multiple diagnoses including, kidney stones, bacteremia, sepsis aftercare, asthma, ureteral stent, tachycardia, anemia, difficulty walking, and long-term use of anticoagulants. R1's MDS (Minimum Data Set), dated November 2, 2025, shows R1 has severe cognitive impairment, is able to eat independently, requires partial/moderate assistance with oral and personal hygiene, substantial/maximal assistance with showering, lower body dressing, and bed mobility, and is dependent on facility staff for toilet hygiene and transfers between surfaces. R1 is always incontinent of urine, and frequently incontinent of stool.The facility's final report to the State agency, dated November 7, 2025 shows R1 received additional doses of Warfarin (blood thinner medication) due to a previous Warfarin order not being discontinued, resulting in R1 requiring the administration of Vitamin K, and being transferred to the local hospital on November 4, 2025.The facility's Order Audit Report, dated November 19, 2025, shows R1 had an order dated October 27, 2025 for Warfarin 1 mg. (milligram) tablet by mouth one time a day every Monday, Wednesday, Friday, Saturday, and Sunday. This order was discontinued in the EMR on October 28, 2025, at 1:43 PM.On October 28, 2025, at 1:46 PM, V11 (LPN-Licensed Practical Nurse) entered the following order into the EMR for R1's Warfarin as ordered by V9 (NP-Nurse Practitioner): Warfarin Sodium oral tablet 2 mg. Give 1 tablet by mouth one time a day for Warfarin therapy. The Warfarin 2 mg. order was not discontinued until November 3, 2025 at 2:58 PM.On October 28, 2025, at 7:23 PM, V12 (LPN) entered the following order into the EMR for R1's Warfarin as ordered by V10 (Physician): Warfarin Sodium oral tablet 4 mg. Give 1 tablet by mouth one time a day for anticoagulant. Take 1 tablet for three days. V12 did not discontinue the previous Warfarin 2 mg. order.On October 30, 2025, at 4:46 PM, V7 (LPN) entered the following order into the EMR for R1's Warfarin as ordered by V10 (Physician): Warfarin Sodium oral tablet 2 mg. Give 1 tablet by mouth one time a day for anticoagulation. This order was discontinued by V9 (NP) on November 3, 2025. The EMR shows R1 received the following doses of Warfarin:October 27, 2025: 1 mg. at 6:00 PMOctober 28, 2025: 4 mg. at 8:00 PMOctober 29, 2025: 2 mg. at 8:00 PM and 4 mg. at 8:00 PM (Total 6 mg.)October 30, 2025: 2 mg. at 6:00 PM and 2 mg. at 8:00 PM (Total 4 mg.)October 31, 2025: 2 mg. at 6:00 PM and 2 mg. at 8:00 PM (Total 4 mg.)November 1, 2025: 2 mg. at 6:00 PM and 2 mg. at 8:00 PM (Total 4 mg.)November 2, 2025: 2 mg. at 6:00 PM and 2 mg. at 8:00 PM (Total 4 mg.) The EMR shows the following INR results for R1:October 28, 2025, reported to facility at 11:35 AM: INR 1.42 ratio (Normal range 2.00-3.00) The following INRs are commonly followed: Prevention of venous thrombosis 2.00 to 3.00 ratio. Treatment of mechanical heart valve 2.50 to 3.50 ratio.October 30, 2025, reported to facility at 11:28 AM: INR 2.26 ratioOctober 31, 2025, reported to facility at 12:59 PM: INR 3.73 ratioNovember 3, 2025, a critical lab value was reported to the facility at 1:26 PM: INR 10.64 ratio. The EMR shows Phytonadione (Vitamin K) 2.5 mg. was administered to R1 on November 3, 2025 at 3:13 PM.November 4, 2025, a critical lab value was reported to the facility at 1:10 PM: INR 13.10 ratioHospital documentation shows R1 was admitted to the local hospital on November 4, 2025 at 1:22 PM ,and diagnosed with a supratherapeutic INR. In the emergency department R1's INR ratio was 7.13 ratio, and another dose of Phytonadione 2.5 mg. was administered to R1.On November 18, 2025 at 3:23 PM, V12 (LPN) said, on October 28, 2025 she notified V10 (Physician) of R1's INR result of 1. 42. V12 continued to say she was not aware R1's INR result had been addressed earlier in the day by V9 (NP), or that V9 increased R1's Warfarin dose from 1 mg. to 2 mg. V12 entered the new order of Warfarin 4 mg. from V10 (Physician), without discontinuing the previous order of Warfarin 2 mg. V12 said, The doctor ordered Warfarin 4 mg. so that's what I entered into the computer.On November 17, 2025, at 12:53 PM, V2 (DON-Director of Nursing) said, R1's Warfarin 2 mg. order was never discontinued prior to each new order being obtained. This error resulted in R1 receiving an additional dose of Warfarin 2 mg. each day, on October 29, 30, 31, 2025, and November 1, and 2, 2025, with the scheduled doses of Warfarin. V2 continued