Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014963	A. BUILDING: _____ B. WING _____	C 07/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR NORTH SHORE	2773 SKOKIE VALLEY ROAD HIGHLAND PARK, IL 60035

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S 000	Initial Comments Complaint Investigation #1914463/IL113220	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.690b) 300.690c) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a	S9999	**Attachment A** **Statement of Licensure Violations**	

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resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

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.

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:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

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a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to provide adequate supervision and assistance to a resident who is at risk for falls this resulted in R5 falling twice and sustaining a laceration requiring 15 stitches. Further, the facility failed to report a fall with injury to the state agency.

This applies to 1 of 3 residents (R5) reviewed for incident reporting in the sample of 9.

The findings include:

R5's Electronic Medical Record shows R5 is 103 years old with diagnoses that include Heart Failure, Abnormalities of Gait and Mobility and Osteoarthritis.

R5's Minimum Data Set Assessment dated 4/1/19 shows R5's cognition is intact. R5 requires limited assistance of one person with transfers and ambulation.

R5's Fall Risk Assessment dated 6/17/19 shows R5 is high risk for falls.

On 7/1/19 at 2:06 PM, R5 was in her room sitting in her chair. R5 was pleasant and smiling and said she was ok.
R5 had steristrips at the back of her head. V4 (R5's daughter) was in the room with R5. V4 said

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she had a concern regarding R5's falls. V4 said R5 fell twice last month. V4 said with both falls, R5 hit her head and was sent to the hospital. V4 said with the first fall, R5 received three staples and with the 2nd fall R5 received 15 stitches. V4 said both falls, R5 was walking in her room by herself. V4 said both falls happened after eight at night. V4 said she doesn't think staff are supervising or helping R5 enough at that time. V4 stated "staff need to check [R5] more often." V4 said she does not think R5 knows how to use the call light if she needed help so staff need to check her more often. R5 is not safe for her to be walking by herself in her room.

An Incident Report dated 6/17/19 at 8:11 PM, shows "resident screaming for help, writer responded to the room, found patient laying on the floor. Observed resident bleeding from the back of her head, immobilized head and applied pressure. Could not stop bleeding ...called 911 ...paramedics arrived, transferred to the hospital."

R5's Hospital Record dated 6/17/19, shows R5 had a laceration of scalp and closed head injury.

A Wound Note dated 6/18/19, shows "laceration to the back of the head with 3 staples done at the Emergency last night per report."

An Incident Report dated 6/20/19 at 8:08 PM, shows, "heard resident screaming for help, writer responded immediately. Patient laying on the floor ...observed resident bleeding from the back of her head. Applied pressure dressing and ice pack at the bleeding site, could not stop the bleeding ...called 911 for emergency transfer."

R5's Hospital Record dated 6/20/19, shows R5 had a laceration of scalp and closed head injury.

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A Wound Note dated 6/21/19 shows "laceration to the back of the head with 15 stitches. Wound size 1.5 x 8.0 x 0.1 centimeters with scant serosanguinous drainage {and] swelling."

On 7/2/19 at 10:27 AM, V7 (Registered Nurse-RN) said he was R5's nurse when the 2 falls happened. R5 said the first fall was a little after eight at night. V7 (RN) said he was at the end of the hallway passing medications when he heard R5 screaming for help. V7 said he ran to R5's room and saw R5 on the floor bleeding. V7 said R5 said she was trying to put her jacket on unassisted. V7 said there was no staff with R5 when the incident happened. V7 said there were no Certified Nursing Assistants (CNAs) around, they were busy putting other residents to bed. V7 said he had to call 911 since he could not control the bleeding. V7 said R5 was sent to a local hospital for staples. V7 said R5's 2nd fall, on 6/20/19 (3 days after) the same thing happened, V7 said it was again past eight at night. V7 said he was at the end of the hallway passing medication when he heard R5 screaming for help. V7 said CNAs were busy putting other residents to bed. R5 was found on the floor bleeding. R5 was sent to the hospital again, because the bleeding could not be controlled. V7 said R5 received stitches at the back of her head. V7 said R5 does not use the call light, R5 screams when she needs help. V7 said R5 has to be checked more often.

On 7/2/19 at 10; 07 PM, V8 (CNA) said she had worked evening shift and had been assigned to R5. V8 said R5 has a routine that she wants to go to the bathroom around 8 PM and wants to be in bed at 9 PM. V8 said R5 needs assistance due to unstable gait. Staff has to anticipate her

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needs. If there's no staff available around that time, she will ambulate herself to the bathroom.

On 7/2/19 at 10:14 PM, V9 (CNA) said R5 uses the bathroom by 8PM and wants to be in bed at 9PM. R5 is unsteady. R5 needs staff to supervise her when she is ambulating around her room or the bathroom at night.

On 7/2/19 at 11:51 AM, V10 (Nurse Practitioner) said for residents that have history of falls with injury, frequent rounding is needed for resident's safety.

R5's current care plan shows R5 is at risk for falls due to unsteady gait, weakness, impaired balance. R5's careplan interventions include staff are to offer toileting assistance between 8:00 and 9:00 PM, Anticipate and meet resident's needs.

The facility policy entitled Fall Occurrence dated 2/20/17 shows it is the policy to ensure that residents are assessed for risk for falls and interventions are put in place to prevent them from falling.

A facility incident report dated 6/20/19 shows R5 had a fall with injury. R5's back of her head was bleeding uncontrollably. 911 was called and R5 was transferred to a local hospital for treatment.

R5's hospital record shows R5 was diagnosed with laceration of scalp, closed head injury. R5 received 15 stitches to the back of her head.

A wound note dated 6/21/19 shows "laceration to the back of the head with 15 stiches. Wound size 1.5 x 8.0 x 0.1 centimeters with scant serosanguinous drainage {and] swelling."

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S9999	Continued From page 6 On 7/2/19 at 11:50 AM, V2 (Director of Nursing) said the facility did not report the above incident which was a fall with injury since this was R5's second fall. V2 said the facility already reported the first incident, a fall with injury (6/17/19). V2 said R5 reinjured her head and did not think it needed to be reported to the state agency again. The facility policy entitled Incident Reporting dated 5/5/14 shows "It is the policy of the facility to ensure that all reportable incidents as stipulated in the section 300.690 state regulations, are reported to the state agency." (B)	S9999		