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 _____	04/09/2015

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 Annual Licensure Survey.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210a) 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to .... use speech, language, or other functional communication systems. 300.1210 a) 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and / or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. 300.1020 Communicable Disease Policies a) The facility shall comply with the Control of Communicable Diseases Code (77 Ill. Adm. Code 690). b) A resident who is suspected of or diagnosed as having any communicable, contagious or infectious disease, as defined in the Control of Communicable Diseases Code, shall be placed in isolation, if required, in accordance with the Control of Communicable Diseases Code. These requirements are not met:	S9999		

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S9999	Continued From page 1 Based on observation, record review and interview the facility failed to ensure: the nurse call light was accessible and answered the nurse call lights to promote effective communication for a residents who has tracheostomy; the staff provide incontinence care and handled indwelling urinary catheter to promote clearing of R4's urinary tract infection (UTI); the staff used personal protective equipment (PPE) consistently when in contact with a resident who has Klebsiella Pneumoniae Carbapenemase (KPC) in the sputum and Extended Spectrum Beta-Lactimase) ESBL in urine. This is for one of seven residents (R4) in the sample evaluated for urinary tract infection, tracheostomy, urinary indwelling catheter and communicable diseases. Findings include: I. On 4/7/15 at 11:50 am R4 was in his bed calling for staff attention with a loud moaning. R4 has a tracheostomy and was in isolation for KPC in sputum and ESBL in the urine. R4 also has a indwelling urinary catheter. R4 has the ability to initiate nurse call light, but the nurse call light cord was not reachable for R4 to initiate. The cord was on the floor three feet away from bed. E10 (Nurse) and E9 (Nurse Supervisor) passed the room, but did not respond to R4's moaning. When the surveyor called E9's attention to R4's calling, E9 went to get help, but did not return until 12:25 pm to find what R4's need was. When E9 and E10 responded R4 wanted him to be repositioned and he was incontinent of stool. On 4/8/15 at 12:15 pm R4's nurse call light cord was on the floor, hanging over Oxygen concentrator. At 2:15 pm R4's nurse call cord was	S9999		

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still in the same place as it was at 12:15 pm. At this time surveyor called the attention of E8 (Nurse) who verified the nurse call cord switch was on the floor three feet away from the bed. E8 verified R4's humidity bag was leaking, he needs to be repositioned, but R4 could not initiate nurse call light.
R4's 3/27/15 Minimum Data Set (MDS) showed he needs extensive assistance for all his activities of daily living, also has communication difficulty.
R4's 1/16/15 communication plan of care interventions are generalized, not specific to his understanding or the ability to use communication devices including communication boards, cards, use of nurse call lights.

II. On 4/7/15 at 11:50 am R4 was in his bed calling for staff attention with a loud moaning voice. R4 has a tracheostomy, and in isolation for KPC in sputum and ESBL in urine. R4 also has a indwelling urinary catheter. At 12:25 pm E9 came along with E10 to assist R4 and found he needs to be repositioned and was incontinent of stool. E9 and E10 had gloves and gown. Neither E9 nor E10 had mask on as precaution for KPC in sputum. E9 stated R4 is in contact isolation and contact isolation do not require a mask.
R4's current physician orders showed, R4 was placed in isolation for KPC in sputum and ESBL in urine.
At 2:15 pm surveyor called the attention of E8 (Nurse), E8 verified R4's humidity bag was on the mattress, leaking, he needs to be repositioned. E8 had gloves, gown and mask. E8 called two Certified Nurses (CNAs - E6 and E7) to assist R4. E6 and E7 had gloves, gown, and mask. R4's humidifier bag leaked and his buttocks area was wet with fluid from humidity bag. R4's both buttocks area was excoriated. E6 wiped his buttocks with wet wipe once, applied A&D

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ointment, removed top sheet on the mattress and placed a clean sheet. Through out the process E6 did not wash hands or changed gloves between touching soiled and clean surface. E8 contaminated clean linen with soiled gloves, threw soiled linen on the floor. During the process of the care, E7 lifted R4's indwelling urinary catheter urine bag with 350 cc urine in it over R4's bed. The urine from the bag flew back and forth from the bag to resident. R4 is currently being treated for ESBL infection in his urine.

R4's 3/31/15 isolation precaution plan of care interventions are not specific for KPC in sputum. When the surveyor brought the concern to the attention of the facility administration staff (Director of Nurse and Assistant Director of Nurses) on 4/8/15, the facility revised plan of care on 4/9/15.

The facility policy and procedure for contact isolation showed mask is not required when caring for residents in contact isolation. The policy did not address the concern related to Droplet and Respiratory isolation.

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Section 300.1210 a) The facility must 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 residents comprehensive assessment and plan of care. 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

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S9999	Continued From page 4 minimum the following procedures: 300.1210 a)4) All nursing personnel shall assist and encourage residents so that a residents abilities in activities of daily living do not diminish unless circumstances of the individuals clinical condition demonstrates that diminution was unavoidable. This includes the residents abilities to bathe, dress and groom; transfer and ambulate; toilet; eat; and use speech, language or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming and personal hygiene. 300.1210 b)3) Objective observation of changes in a residents 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 residents medical record. These requirements are not met. Based on Interview and record review the facility failed to meet the nutritional requirements, failed to conduct an ongoing assessment of nutritional status to prevent undesirable weight loss. This applies to one (R9) of one resident evaluated for weight changes. The findings include: R9 had a documented weights starting with admission of :	S9999		

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1/13/15 = 156 lbs.
2/17/15 = 146 lbs
2/18/15 = 145.5 lbs
2/22/15 = 144.2 lbs.
3/2/15 = 137.8 lbs
3/4/15 = 136.4 lbs
4/1/15 = 138.4 lbs

(All weights were done with the bed scale except 4/1/15 was documented done with a wheelchair scale.)

R9 also has a documented height of 56 inches. This gives R9 a significant weight loss of 11% in less than three months.

R9's April 2015 Physician order sheet (POS) documents R9 to be on a cardiac diet with thin liquids.

On 1/12/15 E4 (Registered Dietician, RD) did an initial comprehensive evaluation on R9 and documented R9 to have been slightly overweight, had lost approximately 50 pounds over the past year due to a kidney infection and a nutritional drink supplement was added to R9's dietary orders to supplement and meet nutritional needs.

There is no documentation whether the R9 drinks the ensure twice a day or not. There are no physician orders for any supplemental drink or change in diet.

On 3/7/15 at 1:30 PM, R9 stated, "The food here is horrible, I don't like it at all. I have lost about 25 pounds since coming here."

On 3/9/15 at 11:15 AM E4 (RD) stated, " I assessed R9 initially and she was eating 50-75 percent of the food and I added a supplemental

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drink twice a day." E4 stated he had spoken to R9's physician about the weight loss but had not documented it anywhere. There are no physician notes related to R9's weight loss. E4 stated it has been a challenge getting through all the weights and trying to determine all the weights. E4 stated the facility does not have a policy on weight gain or weight loss. E4 stated the weight change is notable and was not a desirable or planned weight loss.

E4 (RD) had documented on R9's weight loss on three separate occasions. On 2/16/15 E4 stated R9 had a 12 pound weight gain in one month (This is actually a documented weight loss not gain). E4 stated he suspected it was from weight record accuracy and will have nursing re-weigh. R9 has a documented weight of 146.2 lbs. on 2/17/15 and 145.5 lbs. on 2/18/15. Even though the re-weigh was done and R9 was shown to have a significant weight loss there is no follow-up from E4 until 10 days later on 2/26/15 when E4 documented "...Recent weight loss may simply be related to controlled eating environment and management of primary medical history as opposed acute changes in nutrition status. Stable weight status, current diet orders remain appropriate and will be continued. On 3/11/15 E4 documented R9 had "some"weight loss over the past month. The documented weight loss between February and March is documented as eight pounds. E4 also documented R9 has a good appetite. E4 again stated the weight loss was a combination of a controlled eating environment as well as weight record accuracy. Current diet orders are appropriate and continued. There is no further assessment of R9's weight loss and no documentation to support the physician was aware of the weight loss.

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