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 03/02/2023

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WARREN BARR NORTH SHORE	2773 SKOKIE VALLEY ROAD HIGHLAND PARK, IL 60035

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S 000	Initial Comments Complaint Investigation 2311689/IL156952	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 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: 3) Objective observations of changes in a resident's 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 resident's medical record. These requirements were not met as evidenced by: Based on interview and record review the facility failed to provide ongoing assessments for a resident after an incident for 1 of 3 residents (R1) reviewed for change in condition. This failure resulted in R1 experiencing a delay in	S9999		

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S9999	Continued From page 2 acute care treatment and treatment for pain after sustaining a left hip fracture. The findings include: R1's face sheet showed he was admitted to the facility on 3/3/17 with diagnoses to include cerebral infarction, dementia, psychotic disorder, dysphagia, neuromuscular dysfunction of bladder, atherosclerotic heart disease, contracture, major depressive disorder, hemiplegia, and osteoarthritis of knee. R1's facility assessment dated 12/30/22 showed he had moderate cognitive impairment and required extensive assistance from staff for all cares. R1's February 2023 Physician Order Sheet showed a current order for "Pain Assessment: Numeric Scale (0 = No Pain; 1 to 3 = Mild Pain; 4 to 7 = Moderate Pain; 8 to 10 = Severe Pain) every shift." R1's Nursing Note dated 2/25/23 at 6:00 PM showed, "Received a call from [acute care hospital] at 5:51 PM, resident will be admitted. Diagnosis: left hip fracture..." There were no progress notes between 2/6/23 and 2/25/23 note showing R1's admission. There were no progress notes entered in R1's record indicating the reason R1 was sent to the hospital. R1's complete medical record was reviewed and showed no evidence of any nursing assessments being completed for R1 during the month of February. R1's 2/25/23 Change in Condition form completed by V8 (Licensed Practical Nurse/LPN) showed, "At around 10:00 AM, during patient care, nurse on duty went to resident room to give	S9999		

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S9999	Continued From page 3	S9999		

medications. Resident complained of pain to left groin. When tried to assess his left leg and groin, resident refused. Resident verbalized pain 8/10. Tylenol 1000 mg given. [Primary Physician] was informed at 10:21 AM and ordered to send the resident to the hospital for evaluation..."

R1's February 2023 eMAR (electronic Medication Administration Record) showed an order for "Tylenol 500 mg, Give 2 tablets by mouth every six hours as needed for pain or fever." The only dose of Tylenol given during the month of February was documented at 10:05 AM on 2/25/23.

On 3/1/23 at 1:09 PM, V8 (LPN) said, "Last Thursday (2/23/23) around 9 PM I was doing medication pass when V9 (Certified Nursing Assistant/CNA) came up to me and said they were changing [R1] when they heard something 'pop'. I went in and asked him about pain, and he told me he did not have pain. I went back at the end of my shift because I was worried about him. At the end of my shift I told the oncoming nurse what happened and asked the CNA to explain to the oncoming nurse what happened also. I did not work on Friday (2/24/23). On Saturday morning the same CNA [V9] who was working with me on Thursday came up to me and told me R1 was still in pain. I went into R1's room and he said 'don't touch me'. I asked if he was still having pain and he pointed to his leg/groin area and said his pain was an 8 (Pain scale 1-10). I contacted the doctor, and R1 was sent to the emergency room. He would not allow me to assess his leg, which is why I messaged the doctor right away."

On 3/1/23 at 2:20 PM, V9 (CNA) said she was assisting to change R1's incontinence brief when R1 became very combative. V9 said R1 flails his

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arms, curses, and calls staff names. V9 said they heard a noise, so they stopped changing his brief and went to get V8 (LPN) to check on him. V9 said she was concerned about him, so she checked on him again before she left after her shift. V9 said she explained to the nurse coming onto the shift what happened before she left. V9 said on Saturday morning (2/25/23) she went into R1's room to try and change his incontinence brief and she could not change it because he was 'getting too crazy' with her. V9 said she went and told V8 (LPN) that R1 would not allow her to change his brief. V9 said R1 is always combative verbally but they are usually able to distract him and get it done.

On 3/1/23 at 1:27 PM, V10 (CNA) said he was working Thursday (2/23/23) and was changing R1's incontinence brief with V9 (CNA). V10 said while they were changing R1's incontinence brief, R1 got combative, and they heard something crack or pop. V10 stated, "We stopped and got the nurse. It was the first time we heard something like that while changing him." V10 said he worked Friday, and he was able to change R1 but they were careful to make sure they turned him on the other side. V10 said R1 did not complain of pain to him on Friday (2/24/23) but said to leave him alone which is a normal behavior for him.

On 3/1/23 at 3:00 PM, V14 (LPN) said she worked Friday 2/24/23 starting at 7:00 AM. V14 said R1 did not express that he was having pain. V14 said she does not know much about the resident because she does not usually work on his hall. V14 said she gave him his medications and he took them. V14 said she did not assess R1 on Friday and she did not ask him if he was having pain.

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S9999	Continued From page 5 On 3/1/23 at 2:52 PM, V11 (CNA) said she worked Friday 2/24/23, and she was assigned to R1. V11 said, "He was in a lot of pain. He said he could not turn on his side because he was hurting. We could not turn him at all because he would yell out in pain. We talked to V12 (LPN) because she came in the room because he was yelling. V12 acted like it was not unusual for R1 to do this, but I have taken care of him frequently before this and this was different." On 3/2/23 at 9:00 AM, V12 (LPN) confirmed she worked on 3rd shift on Thursday night. V12 said the nurse before her told her to keep an eye on R1, but there was nothing new. V12 said it is normal to be told in report to monitor everyone because of the kind of hall it is. V12 said the only thing she knows is that R1 did not complain of pain to her and his yelling out is not new to her. When V12 was asked about entering R1's room because she heard him yelling, she stated that this "maybe happened." V12 said, "I went in to calm him down. It seemed like regular behavior. I told him if the pain is really not going away, I will send him to the hospital. He said 'no stop, don't touch me'. I'm not ignoring what he is saying but if he is saying he really has pain and wants to go to the hospital I would send him. The pain assessments I do is I go in their room and ask 'How are you doing? How's your day? Is there anything you want to say?' I have a regular conversation with them. They say nothing." On 3/2/23 at 9:34 AM, V17 (CNA) said, "I had R1 last Friday on 3rd shift. He is normally combative, but if you give him a different approach it takes his mind off of being changed. That day I did go to change him, but he was screaming that his leg hurt. I asked another CNA to come help so we	S9999		

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could roll him the other way. I think it was his left leg, because he always has that one bent. I looked at it and tried to touch it with my finger, but he kept screaming. I told him it might feel better if we straighten that leg out, but it didn't work. He was hitting us saying 'please don't'. I told the nurse [V12] that he was screaming. I let her know so she could see him. I told her he was refusing care. He does always get upset during care, but this time the screaming was different. I was just taking off the covers and he was screaming. I knew it was probably something else (not behaviors). He was screaming so loudly you could hear him outside the door, at the top of his lungs. I told V12 that R1's leg was hurting, he was refusing care, and screaming, she said 'ok, thanks for letting me know'."

On 3/1/23 at 3:41 PM, V2 (Director of Nursing/DON) said the nurse called her on Saturday morning to let her know R1 was in pain. V2 said she asked the nurse what happened, and she told her while the CNAs were doing cares on Thursday R1 started getting combative and they heard 'something.' V2 said R1 is different for the nurses than the CNAs because R1 does not like to be touched and the nurses don't have to touch him very much since they are passing his medications. V2 said the timeframe for pain assessments is not specific, but vitals are done every shift. V2 said pain is documented on the eMAR when a PRN pain medication is given. V2 said R1 is able to give a pain level if he is asked. V2 said if the nurse is notified of a resident having pain, she would expect an assessment be documented. V2 said since V12 works that hall all the time he may have assumed this was just his normal behavior.

On 3/2/23 at 3:14 PM, V18 (Nurse Practitioner)

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S9999	Continued From page 7 said, "I was not notified of R1 having anything happen with him during care. I was told he sustained a fracture and went to the hospital. They should have notified myself or the primary care physician when the resident was complaining of pain. There should have been an assessment done when the injury first occurred, and once he started complaining of pain it should have been charted and assessments completed. If I had been notified that he had an incident during care which the aides heard a "pop" and he was complaining of pain, I would have ordered diagnostic tests to be done." The facility's policy and procedure revised 7/28/22 showed, "Policy Name: Pain... Policy Statement: It is the policy of the facility to ensure that all residents are assessed for pain in every situation where there is a potential for pain, For pain complaints and for situations/incidents that might result to pain (ex: fall incident, altercation, cute, bruises, wound care, etc.) the nursing staff may document it in any part of the resident's medical record that includes nurses notes, incident report, and medication administration record... Procedures: 1. After the administration of PRN (as needed) pain medications, the resident will be assessed for the effectiveness of the pain medication. If the resident is still unrelieved of pain despite pharmacologic and nursing measures, the resident's physician will be called to refer the lack of relief..." The facility's policy and procedure revised 7/28/22 showed, "Policy Name: Notification for Change of Condition... Policy Statement: The facility will provide care to residents and provide notification of resident change in status. Procedures: The facility must immediately inform the resident; consult with the resident's physician;	S9999		

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S9999	Continued From page 8 and if known, notify the resident's legal representative or an interested family member when there is: a. An accident involving the resident which results in injury and has the potential for requiring physician intervention; b. A significant change in the resident's physical, mental, or psychosocial status..." (B)	S9999		