STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145923	A. BUILDING _____ B. WING _____	**07/30/2020**

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

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide care in a safe manner for a resident at risk for falls to avoid injury. This applies to one (R3) of three residents reviewed for falls with injury. This failure contributed to R3 falling out of bed and fracturing her right ankle on March 23, 2020. The findings include: R3's Admission Record printed on July 27, 2020 showed R3 to be a [AGE] year old female with [DIAGNOSES REDACTED]. R3's Facility assessment dated [DATE] showed R3 to be cognitively intact, needing extensive/dependent 2 person assistance with bed mobility, transferring, dressing, and toileting. R3's Care Plan dated July 22, 2020 showed R3 is a high risk for falls due to limited range of motion [MEDICAL CONDITION] activity, stroke, impaired balance, inability to bear weight on bilateral lower extremities, and needs 2 people assistance with changing and repositioning. On July 27, 2020 at 10:30 AM, V17 Wound Nurse and V20 Wound Tech had to position R3's legs to complete a dressing change. R3 was asked to move her legs. R3 could not lift her legs, and only slightly shake her feet back and forth. R3's Nurses Notes (Incident Summary) dated March 25, 2020, showed R3 was guided to the floor with no open wounds noted. An X-ray was of right foot was ordered per resident request. On July 27, 2020 at 12:15 PM, V14 Licensed Practical Nurse (LPN) reviewed the fall incident report of March 25, 2020. V14 stated V19 Certified Nursing Assistant (CNA) told her R3 was on the floor. V14 said she was getting R3 cleaned up when she started sliding off the bed. V19 said she guided R3 to the floor. V14 stated V19 was the only CNA in the room, and they had to get another CNA to help with the mechanical lift to get her back into bed. V14 stated R3 needs 2 person assist with turning and toileting. On July 27, 2020 at 12:25 AM, V24 CNA was starting R3's incontinence care. V24 was alone and attempted to turn R3 on her right side. R3 yelled where is my rail. I don't want to fall again! at that time V24 walked around the bed, locked the quarter bedrail in place, and attempted to turn R3 on her right side again. At this time this surveyor stopped V24 to get assistance. On July 27, 2020 at 2:00 PM, V24 stated she had not worked with R3 before. She could have asked another CNA or checked the mobility sheet at the nurse's station. V24 stated she did not check the sheets at the desk before going to provide care for R3. The undated Weekly Bed Mobility Report, at the 1st floor nurses station, showed R3 on the list of residents needing 2 person assist. On July 27, 2020 at 12:40 PM, V2 Director of Nursing stated, during the investigation of R3's March 25, 2020 fall, the only CNA getting R3 cleaned up was V19 at the time of the fall. V2 stated R3, is currently and at the time of her fall, an extensive assist of 2 people at the time of the fall. The Hospital Discharge summary dated March 31, 2020 showed R3 to weigh 300 pounds while in the hospital and included R3's Cat scan impressions. The Cat scan Impression lists 4 fractures within the right ankle and localized area. On July 29, 2020 at 11:20 AM, V26 Orthopedic Surgeon stated confirmed he reviewed R3's Cat scan and medical records. V26 stated The fractures for (R3) were acute in nature. She had soft tissue swelling to her right ankle when I examined her which is consistent with a traumatic (impact) injury. Due to (R3's) Osteopenia, the impact which caused the injuries could even have been low energy/impact in nature.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to label resident medication and store resident medication in a locked compartment until administered to the resident. This applies to two of three residents (R5, R3) reviewed for medications. The findings include: 1.On July 28, 2020 at 9:30AM, R5 was sleeping in her bed. R5's breakfast tray was sitting at the bedside. On the tray was a small cup without a label. In the cup was seven unidentified tablets. R5 did not respond to verbal stimulation. At 10:08AM, R5 was awake in her bed and eating breakfast. The small cup without a label was empty. On July 28, 2020 at 10:08AM, R5 said, I prefer my medication to be handed to me by the nurse, not just left on a table. R5's current Care Plan on July 27, 2020 did not show, R5 was Care Planned for Self-Administration of medications in the facility. R5's current Physicians Orders on July 27, 2020 did not show, R5 had a Physicians Order for Self-Administration of medication in the facility. 2. On July 28, 2020 at 9:25 AM, R3 was in bed with the bedside table across her lap eating breakfast. A medication cup with 9 unidentified pills were on her table. R3 stated she just started taking her morning medications with breakfast. R3 finished taking the medications during the interview. On July 27, 2020 at 12:05 PM, V8 Registered Nurse stated medication should not be left at the bedside. Residents should be watched while taking oral medications to make sure they take them all, and the resident gets them down without any problems. After a resident has taken the medications you chart given in the MAR-Medication Administration Record. On July 27, 2020 at 12:40 PM, V2 Director of Nursing stated, residents should be monitored while taking their medications. Medications should not left on the bedside table. The nurse giving the medications should chart the medication was given on the MAR after the medications have been given. R3's Care Plan dated July 22, 2020 does not show R3 to be care planned to take medications by herself. R3's Admission Record printed on July 27, 2020 showed R3 to be a [AGE] year old female with [DIAGNOSES REDACTED]. R3's Medication Administration Record (MAR) printed on July 27, 2020 showed R3's 9 AM oral medications include: [MEDICATION NAME] extended release 5 milligrams (mg), Cranberry Tablet 300 mg, [MEDICATION NAME] tablet 54 mg, [MEDICATION NAME] tablet 40 mg, Potassium Chloride 10 Milliequivelants, Spirolactone tablet 25 mg, [MEDICATION NAME] extended release 25 mg, Calcium [MEDICATION NAME] plus Vitamin D 500/200 mg, [MEDICATION NAME] extended capsule 300 mg, [MEDICATION NAME] Di-potassium 7.5 mg, and [MEDICATION NAME] tablet 250 mg. The facility's Medication Pass policy dated September 5, 2019 shows, after medication is administered to each resident, sign the Medication Administration Record that it was given.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.