

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6014963</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/23/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WARREN BARR NORTH SHORE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2773 SKOKIE VALLEY ROAD HIGHLAND PARK, IL 60035</b>
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S 000 Initial Comments  
  
Facility Reported Incident/April 11, 2019/111318  
Complaint investigation surveys:  
#1912867/IL111482  
#1912849/IL111463

S 000

S9999 Final Observations  
  
Licensure Violations  
300.610a)  
300.1210b)5)  
300.1210d)4)A)B)6)  
300.1230d)1)  
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 300.1210 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

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**Attachment A**  
**Statement of Licensure Violations**

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>05/04/19</b>
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S9999	<p>Continued From page 1</p> <p>resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:</p> <p>5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.</p> <p>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:</p> <p>4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:</p> <p>A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene</p> <p>B) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene.</p> <p>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.</p> <p>Section 300.1230 Direct Care Staffing</p> <p>d) Each facility shall provide minimum direct care staff by:</p> <p>1) Determining the amount of direct care</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>staffing needed to meet the needs of its residents</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>Based on observation, interview and record review the facility failed to provide sufficient staffing to meet resident needs. This failure resulted in R1 falling and sustaining a right wrist fracture. The facility failed to provide showers due to lack of staffing.</p> <p>This applies to 27 of 33 residents (R1, R3, R5-R14, R16-R30) reviewed for staffing in the sample of 33.</p> <p>The findings include:</p> <p>1.R1's Physician Order Sheet Assessment dated April 2019 shows R1 has diagnoses of Parkinson's, Diabetes and Hypertension.</p> <p>R1's Minimum Data Set Assessment dated March 6, 2019 shows R1 has no cognitive impairment.</p> <p>R1's care plan dated January 28, 2019 shows R1 is at high risk for falls</p> <p>The Facility's Incident Report dated April 11, 2019 shows R1 was observed in a crawling position on the hallway. R1 had an abrasion on the forehead with slight bleeding. R1 was sent to a local hospital and was found to have a fracture of his right wrist.</p> <p>R1's Radiology report dated April 12, 2019 shows R1 has a non-displaced fracture of R1's right wrist</p>	S9999		
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On April 22, 2019 at 9:30 AM, R1 was in bed. R1's right hand was elevated with a pillow. R1 said he fell more than a week ago. R1 said it was around past ten at night. R1 said the facility was short of help. R1 said he had his call light on and was needing assistance from staff to get up. R1 said his back was bothering him so he was also needing the nurse. R1 said he waited for staff to come to his room. R1 said no one answered his call light for almost an hour. R1 said he got up and decided to walk towards the nurse's station to look for a staff. R1 said before he made it to the nurse's station, his legs buckled. R1 said he tried to use his right hand to balance himself, but he ended on the floor. R1 said he was so weak to get up, he ended up crawling until someone helped him from the floor. R1 said if the staff would have only answered his call light promptly he would have not fallen.

On April 22, 2019 at 10:30 AM, V7 (CNA) said she was the only CNA working today on North wing. V7 said there were supposed to be 4 CNAs. V7 said she was doing the best she could. V7 said it was not safe for the residents to only have 1 CNA for the whole wing. V7 said she needs help to take care of all these residents. V7 unable to answer call light on time and unable to give scheduled showers. V7 said it was impossible to do her job.

On April 22, 2019 at 10:40 AM, V5 (License Practical Nurse-LPN) said she has 1 CNA for the whole wing. V5 said the quality of care suffers if there is not enough staff to take care of all the residents.

On April 22, 2019 at 12:00 PM, V4 (Registered Nurse-RN) said they were short of staff that night.

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(April 11, 2019) V4 said there were supposed to be 4 CNAS (Certified Nursing Assistants) on 1st floor (Long Term and Dementia Unit) but there were only 2 CNAs working that night. V4 said she was so busy that night that she cannot remember if R1 had his call light on. V4 said she saw R1 crawling towards the nurse's station. V4 said she saw R1's forehead was bleeding. R1 was sent to the local hospital for evaluation.

The facility nursing schedule dated April 11, 2019 shows there were 2 CNAs working instead of 4 CNAs on the first floor.

On April 23, 2019 at 10:30 AM, V11 (concierge) said she was only on the floor to pass ice water and collect room trays. She has no direct care staff responsibilities.

On April 23, 2019 at 11:30 AM, (confidential interviews from staff) "we work with 1 CNA on each wing most of the time. It is impossible to perform our job by being alone, unable to answer call lights on time, unable to turn and reposition residents, unable to give bath, feed, etc... we feel sorry for the residents, if they need help and we are not there, then they get up on their own just like what happened which resulted with the resident falling and hurting himself."

On April 23, 2019, at 11:45 AM, V10 (License Practical Nurse) said "we work with 2 CNAs instead of 4. When we are short of staff, it limits the time we care for the residents. Most of the residents need extensive assist to go to the bathroom, get up from bed to their wheelchair or assist during feeding. We were unable to answer call lights timely."

On April 23, 2019 at 2:00 PM, V2 (Director of

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S9999	<p>Continued From page 5</p> <p>Nursing) stated "we never denied we are short of staff. There were supposed to be 2 Nurses and 4 CNAs working on each floor and we are not meeting that."</p> <p>The facility Nursing Schedule shows there was 1 CNA on each wing in each floor scheduled on April 22, 2019. A concierge staff was helping on each floor.</p> <p>The Facility Resident Council Minutes for January- March 2019 shows residents requesting more CNAs.</p> <p>The facility policy entitled Staffing dated February 17, 2017 shows "It is the policy to provide adequate staff to meet the needs of the residents which is the requirement under the federal regulations."</p> <p>2. On April 23, 2019 at 10:45AM, R5 was in a wheel chair sitting in the hallway by her room.</p> <p>On April 23, 2019 at 11:00AM, R3 was in a wheel chair sitting in the hallway by the nurse's station.</p> <p>On April 23, 2019 at 10:45AM, R5 said, "I was told I got taken off the shower schedule. I went five weeks without a shower."</p> <p>On April 23, 2019 at 11:00AM, R3 said, "I did not get my bath on Saturday. I usually get my bath Saturday morning. I asked the CNA-Certified Nursing Assistant the reason why I did not get my bath and I was told they were too busy. Everyone thinks I do not have a good memory, but I know when I do not get a bath. It has been over ten days from the time I received a bath. "</p> <p>On April 23, 2019 at 11:21AM, V7 CNA-Certified</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>Nursing Assistant said, "Yesterday I was the only CNA on the third floor. I was only able to bath one resident. This job is very hard, too impossible to do with only one CNA on the floor."</p> <p>On April 23, 2019 at 2:15PM, V3 provided Shower Record/Skin Audit forms dated April 19, 2019 for R15 and April 22, 2019 for R31, R32, and R33. V3 said, this is all I have. We are calling staff to check if the other residents received their showers.</p> <p>On April 23, 2019 at 2:30PM, V2 DON-Director of Nursing said, residents are scheduled to have showers twice a week. The nurses monitor when the resident gets a shower. The Shower Record/Skin Audit form is filled out by the CNA during every shower. The nurse signs off that it has been reviewed. The shower record is a part of our wound care program.</p> <p>On April 23, 2019 V3 ADON-Assistant Director of Nursing was asked for Shower Record/Skin Audit forms for R3, R5, and R6-R33, based on the shower schedules for April 19, 2019, April 20, 2019, and April 22, 2019.</p> <p>The facility Shower Schedule dated December 21, 2018 shows R3 is scheduled for showers twice a week on Wednesday and Saturday morning.</p> <p>The facility's CNA Daily Assignment book shows, R3's last bath was received Saturday April 13, 2019 (10 days ago) by V8 CNA.</p> <p>(B)</p>	S9999		
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