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 07/30/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint: 2012521/IL121623-F689	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: 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	S9999	Attachment A Statement of Licensure Violations	

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 07/30/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

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) resident 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 67 year old female with diagnoses which include: seizures, anxiety, and history of falling, cerebrovascular disease, and sequellae of unspecified cerebrovascular disease.

R3's Facility Assessment dated July 8, 2020 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 seizure activity, stroke, impaired balance, inability to bear weight on bilateral lower extremities, and needs 2 people assistance with changing and repositioning.

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 07/30/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

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

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 07/30/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3 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." (B)	S9999		