IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

February 19, 2019

Illinois Corporation Service, Registered Agent
Warren Barr North Shore, LLC
801 Adlai Stevenson Drive
Springfield, Illinois 62703

RE: Complaint #: IL 107811
Survey Date: December 20, 2018
Docket #: 19-C0040
Violation Type: A Violation with Fine

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Warren Barr North Shore.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Enclosure
cc: Administrator
File
Warren Barr North Shore/December 20, 2018/19-C0040/RegAgent/kk

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: WARREN BARR NORTH SHORE COMPLAINT #: 0107811
LIC. ID #: 0052787
DATE COMPLAINT RECEIVED: 12/05/18 12:20:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1
199	OTHER	1
404	INAPPROPRIATE EMPLOYEE BEHAVIOR	2

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. WARREN BARR NORTH SHORE, LLC, D/B/A, WARREN BARR NORTH SHORE Respondent.	)))))))))	Docket No. NH 19-C0040

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE; NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF CONDITIONAL LICENSE; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint Investigation conducted by the Department on December 20, 2018 at Warren Barr North Shore, 2773 Skokie Valley Road, Highland Park, Illinois 60035. On February 14, 2019, the Department determined that such violations constitute one or more Type "A" violations of the Act and the Skilled and Intermediate Care Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in The Statement of Licensure Violations which is attached hereto and incorporated herein as Attachment A and made a part hereof.

Pursuant to Section 3-303 of the Act, the above-referenced facility is hereby ordered to abate and/or eliminate the above violation(s) immediately.

A Type "A" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF CONDITIONAL LICENSE

In accordance with Sections 3-305 and 3-311 of the Act, the Department hereby issues a Conditional License for the operation of the Facility. This license replaces the unrestricted license issued to Warren Barr North Shore, 2773 Skokie Valley Road, Highland Park, Illinois 60035 on July 1, 2018. The Facility's current license number is 0052787. The term of the conditional license shall be from March 14, 2019 to September 13, 2019. THE CONDITIONAL LICENSE SHALL FOLLOW UNDER A SEPARATE COVER LETTER. THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON MARCH 14, 2019.

The Conditional License will be withdrawn and an unrestricted license will be issued to Respondent upon the expiration of the term of the Conditional License.

During the term of the Conditional License, Respondent will retain its status as a certified provider of Medicaid services so long as Respondent's facility complies with the applicable federal regulations.

If the Respondent timely requests a hearing to protest the basis for the issuance of the Conditional License, the terms of the Conditional License shall be stayed pending the issuance of the Final Order at the conclusion of the hearing and the facility may operate in the same manner as with an unrestricted license.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$25,000.00**, as follows:

- **Type A violation** of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b), 300.1210d)6), 300.1220b)3) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)6) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department;

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license, the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation.

Plans of Correction, Hearing and Waiver Requests can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Dated this 19th day of February, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. WARREN BARR NORTH SHORE, LLC, D/B/A, WARREN BARR NORTH SHORE Respondent.	)	Docket No. NH 19-C0040

PROOF OF SERVICE

The Conditional License will follow under a separate cover letter.

The undersigned certifies that a true and correct copy of the attached Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Plan of Correction Required; Notice of Conditional License; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Illinois Corporation Service
Licensee Info:	Warren Barr North Shore, LLC
Address:	801 Adlai Stevenson Drive Springfield, Illinois 62703

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 19th day of February, 2019.

Sammye Geer

Sammye Geer
Administrative Assistant
Long Term Care- Quality Assurance
Office of Health Care Regulations

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 12/20/2018

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 Investigation #1817893 / IL107811 Statement of Licensure Violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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:
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 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Requirements were not met as evidenced by:

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Based on interview and record review the facility failed to monitor a cognitively impaired resident with a known behavior of manipulating her dialysis access site. On July 3, 2018 R2 was discovered deceased due to hemorrhage and fatal blood loss.

This applies to 1 of 3 residents (R2) reviewed for death in the sample of 3. This past noncompliance occurred on July 3, 2018.

The findings include:

R2's computerized face sheet showed R2 had diagnoses including dementia, atrial fibrillation, heart disease, and end stage renal disease. R2's Physician Order Sheet (POS) dated June 1st to July 4th 2018 showed an order for hemodialysis 3 times weekly every day shift Tuesday, Thursday, and Saturday and an AV fistula (dialysis access site) located on the left upper extremity. The POS showed an order to monitor bilateral upper extremities for signs and symptoms of infection and bleeding every shift. The POS showed an order to monitor the site for circulation, motion, and sensation of extremity distal to AV fistula every shift.

R2's POS also showed orders for aspirin 81 milligrams daily for congestive heart failure- hold if rectal bleeding occurs, and Eliquis (Apixiban) 2.5 milligrams two times daily for blood thinner. Both medications had start dates in February 2018.

R2's MDS (Minimum Data Set) dated June 11, 2018 showed R2 was severely cognitively impaired with long and short term memory problems. The MDS showed R2 required total staff assistance for transfers, locomotion, and

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toilet use. The MDS showed R2 required extensive staff assistance with bed mobility, dressing, eating and personal hygiene. The MDS also showed R2 had no upper extremity impairment.

R2's progress note dated April 4, 2018 at 21:54 (9:54 PM) stated "CNA called this writer to come see pt (patient) quickly. Upon entering room found pt lying in _____. This writer removed fistula dressing and saw fistula oozing very little. Sheets full of coagulated blood, also sheets were hardened and brownish in color (indicative of dried blood)" .....A second note on the same evening stated "called to see pt this writer went to room and pt bood (blood) moderate amounts all over sheets looked at fistula sit (site) and was bleeding from there pressure dressing applied ....."

R2's progress note dated May 21, 2018 at 21:35 (9:35 PM) LATE ENTRY stated .....called by caregiver on 5/18/18 with concern of a new wound proximal to her LUE (left upper extremity) graft. Caregiver states that AM, she found (R2) ace wrap to the LUE loosened. (R2) is known to scratch at her chest and other areas .....

R2's progress note dated July 3, 2018 at 6:06 am LATE ENTRY stated ....."around 11 pm went to resident room. Hand was relocated away from left anticubital due to scratching the site. AV fistula to left arm intact with bruit and thrill appreciated. Covered resident with warm blanket. Around midnight resident seen sleeping comfortably and covered with warm blanket. No sign of distress noted. Around 3 am, resident seen sleeping comfortably and covered with warm blanket with no signs of distress. At 4:12 am while doing round, resident was noted unresponsive with no

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vital signs and with blood on the floor, the source of blood was later noted to derive from AV fistula on left arm and scattered blood on the bed and walls behind her. At 4:17 am (V9-RN) confirmed vital signs not appreciated, pupils dilated, upper body cold to touch, not responsive to stimulus. RN continue to search for source of bleeding and vital signs until 4:20 am and then paramedics arrived and took over. Page (V10-physican) and made aware of resident's death ....."

On December 12, 2018 at 10:45 AM, V6 (dialysis registered nurse) stated R2 received dialysis at the in-house dialysis center three times per week since the time of admission to the facility (2017). V6 said R2 was alert, but confused. V6 said R2 could easily move her arms and legs. V6 said R2 would scratch and itch at her left arm and it possibly was due to the itching of the dialysis tape. At 1:30 PM, V6 said R2 was routinely scheduled for dialysis sessions before 6 AM and facility staff typically got her out of bed around 4 or 5 AM.

On December 12, 2018 at 11:30 AM, V3 (Assistant Director of Nurses) stated R2 "had an incident on the night shift and her fistula bled out". V3 said she routinely cared for R2, generally five times per week, and R2 would scratch at the fistula site.

On December 12, 2018 at 12:35 PM, V7 (Certified Nurse Aide-night) stated he remembered R2 very well and cared for her often. V7 said R2 was confused most of the time and "many times she would scratch and pull at her dialysis thing" (fistula). V7 said he was working the night shift on July 3, 2018 when an "incident" occurred. V7 said he checked in on R2 every two hours and found her sleeping soundly. V7 said

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R2's arms were covered under her blanket and he did not remove or check her body underneath the bedding during rounds. V7 said sometime in the early morning, before 5:00 AM, he heard the floor nurse calling out for help. V7 said he entered R2's room and saw blood on the bedding and the dressing that covered her left arm was off. V7 said he had no idea what caused the bleeding. V7 said R2 was found covered with blood after the floor nurse entered her room to prepare her for her scheduled 5AM dialysis session.

On December 12, 2018 at 2:20 PM, V9 (Registered Nurse-night) stated he was working the third floor night shift on July 3, 2018 when he was called to the second floor for a resident "issue". V9 stated he entered R2's room and saw blood "all over her body". V9 said R2 was "covered from head to toe in blood". V9 said R2's blanket was wet from blood and her bed sheet was completely saturated. V9 said there was blood on the floor under her bed. V9 said R2 had passed away by the time he arrived to her room.

During the course of this survey, the second floor night nurse on duty July 3, 2018 was attempted to be interviewed, but no longer works at the facility.

On December 13, 2018 at 11:15 AM, V10 (R2's physician) stated R2 was known to scratch at her fistula site and died due to prolonged bleeding at that site. V10 said something should have been done to reduce the scratching, such as increased monitoring. V10 said the fistula was a direct connection to an open artery which can bleed out within five to ten minutes, regardless of blood thinner use or not. V10 said R2's daily blood thinner use would cause longer bleeding.

R2's State of Illinois Certificate of Death

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S9999	Continued From page 6 Worksheet was reviewed and showed a date of death of July 3, 2018 and occurring at the subject facility. The death certificate showed the cause of death due to: Exsanguination (loss of blood to a degree sufficient to cause death). R2's hemodialysis care plan and end stage renal disease care plans (both initiated dated March 1, 2017) were reviewed. Both care plans showed interventions put in place on March 1, 2017 but no new interventions addressing R2's April or May 2018 AV fistula scratching. The facility's Hemodialysis Policy reviewed dated November 1, 2017 states: It is the policy of the facility to ensure that appropriate care for resident on hemodialysis is provided by facility staff. On December 20, 2018, the surveyor confirmed through observation, interview, and record review that the facility took the following actions: 1. Audits were performed twice weekly to identify dialysis residents with behaviors. 2. The Behavior Management Policy was updated on July 3, 2018 to instruction staff to respond to cognitively impaired dialysis residents displaying a behavior of scratching, picking, touching or manipulating the dialysis access site immediately. The resident will immediately be redirected and monitored. Staff will immediately report the behavior, reassessments will occur, and care plans will be updated. 3. An IDT will be involved in reporting and intervening when the behavior is identified. 4. Dialysis patients will be assessed for cognitive impairment at admission and on an ongoing basis. 5. All licensed nursing staff have been individually in-serviced on the care of	S9999		

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S9999	Continued From page 7 hemodialysis patients, behavior specific to dialysis residents manipulating access sites, and emergency response to access site bleeding. Completed July 3, 2018. (A)	S9999		