Illinois D	epartment of Public	Health				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6014963	B. WING		0 11/2) 6/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY. S	STATE, ZIP CODE		
		2773 SKO				
WARREN	N BARR NORTH SHO	RE HIGHLAN	D PARK, IL	60035		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Complaint Investiga 2419656/IL181569	ation:				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	300.610a) 300.1210a) 300.1210b)					
	Section 300.610 R	esident Care Policies				
	procedures governi facility. The written be formulated by a Committee consisti administrator, the a medical advisory co of nursing and othe policies shall compl The written policies the facility and shal	dvisory physician or the ommittee, and representatives r services in the facility. The ly with the Act and this Part. shall be followed in operating l be reviewed at least annually documented by written, signed				
	Section 300.1210 (Nursing and Persor	General Requirements for nal Care				
	facility, with the par the resident's guard applicable, must de comprehensive car includes measurabl meet the resident's and psychosocial n	Resident Care Plan. A ticipation of the resident and dian or representative, as evelop and implement a e plan for each resident that le objectives and timetables to medical, nursing, and mental eeds that are identified in the				
	rtment of Public Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE
Electron	ically Signed					12/09/24

If continuation sheet 1 of 6

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		Health (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 11/26/2024	
		IL6014963				
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
WARREN	N BARR NORTH SHO	RF	DKIE VALLEY ID PARK, IL 6			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	allow the resident to practicable level of provide for discharg restrictive setting ba needs. The assess the active participat resident's guardian applicable. (Section Section 300.1210 (Nursing and Person b) The facility shall and services to atta practicable physica well-being of the re each resident's com plan. Adequate and care and personal of resident to meet the care needs of the re measures shall incl following procedures These regulations we Based on interview failed to ensure a re safely. This failure intertrochanteric (the that required an option	ensive assessment, which o attain or maintain the highest independent functioning, and ge planning to the least ased on the resident's care sment shall be developed with tion of the resident and the or representative, as n 3-202.2a of the Act) General Requirements for hal Care provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with nprehensive resident care I properly supervised nursing care shall be provided to each e total nursing and personal esident. Restorative ude, at a minimum, the	\$9999			
	safety in the sample The findings include	e of 12.				
	V11 Certified Nursi	2024 at 1:08 PM, R1 stated, ng Assistant (CNA) came to her multiple times. She				

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AME OF PROVIDER OR SUPPLIER	L	DRESS, CITY, ST	ATE. ZIP CODE		
	2773 SK				
	HIGHLAN	ID PARK, IL 6			
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
S9999 Continued From pa	•	S9999			
like she was "rough changed two times, her she was going i legs over the rail ar she had pain in her (V11) would not list touch me" and "no, suffer for my hip fra might not be able to crying and gave the R1's local hospital r 2024 shows, "Gene and physical): Hist 60F (60 year old fei medial history of) G disease), OSA (obs 1, HTN/HLD (hyper asthma, hip replace (complicated by) re infection w recent d on vancomycin and pw (patient with) lef facility receiving an the staff "was too ro my diaper" and felt pain in the left hip Stated she was h heard a pop in her j total hip arthoplasty periprosthetic fractur region as described On November 23, 2 room mate) stated, problem with some	1 change her because she felt " with her. She refused to be . The third time, V11 CNA told to get changed and threw "her hd she heard a pop." After that ento nothing. Told her "don't thank you". Now, I have to acture and have surgery. I be walk again." R1 started e phone to her daughter (V3). records dated November 21, eral: Admission H&P (history ory of present illness: R1 is a male) w PMH (with a past GERD (gastroesophageal reflux structive sleep apnea), bipolar tension/hyperlipidemia), ement 8/17 with V14 c/b current prosthestic left hip join lischarge on 11/13, discharged I cefepime (both antibiotics), ft hip pain. She was at the tibiotics and stated that one of pugh with me when changing a pop in the area, reporting . Assessment & Plan: andled roughly by staff and joint. XR (x-ray): Left revision with acute comminuted ure of the left intertrochanteric d"				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014963		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		II 6014963	B. WING		- C - 11/26/2024	
					11/2	20/2024
NAME OF 1	PROVIDER OR SUPPLIER		DDRESS, CITY, ST OKIE VALLEY			
VARREN	N BARR NORTH SHO	RF	ND PARK, IL 6			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ge 3	S9999			
		/. Then she left to the der the impression she was in mally."				
	stated, she worked shift (into November she went to R1's ro stated no. She wer again. The third tin told her no, don't to	2024 at 9:05 PM, V11 CNA November 19th on the night er 20th morning). That night om to change her and R1 nt back again and told her no ne she tried to change her, R1 uch me. She denied ever uching her that night.				
	R1's task list for No was incontinent dur	wember 19, 2024 shows, she ring the night shift.				
		dition form dated November ituation: patient is complaining i move the left leg."	1			
	Physician Assistant surgery team. R1 of had surgery back ir in the hip so they pl was sent to the faci spacer placement. after and re-did x-ra When she came int claimed staff was a leg and she heard a fracture. She had s the day before (Now fracture is caused b	2024 at 11:04 AM, V13 (PA) stated, he is part of R1's priginally broke her left hip and a August. She had an infection laced a cement spacer. She lity following that cement They had followed up with her ays, there was no fracture. to the hospital this time she ggressive with her, twisted her a pop. The x-rays showed a surgery for an open reduction vember 25th) with him. The by a twisting torsion type of ty to get the fracture is by	r			
	Assistant Administr	2024 at 9:50 PM, V15 ator stated, R1 told her V11 e her 3 times where she told				

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION I		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		IL6014963	B. WING			C 26/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
WARREN	N BARR NORTH SHO	RF	OKIE VALLEY			
			ND PARK, IL 6			(1.1-)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ige 4	S9999			
	She moved her and	hird time, she changed her. d heard a pop in her leg. V11 fused to be changed three				
	dated November 20 dependent on staff	IF (skilled nursing ity) to hospital transfer form), 2024 shows, R1 is for all ADL's (activities of daily inent of bowel and bladder.	,			
	R1's minimum data cognitively intact.	set (MDS) shows, she is				
	R12's (R1's room n shows, she is cogn	nate) minimum data set (MDS itively intact.)			
	shows, "Focus: R1 Performance Defici (related too) weakn impaired balance a weight bearing assi toileting, dressing, Comorbidities inclu Arthroplasty, AKI (a Hypercalcemia, An Obesity and OSA. staff to provide gen tolerated with daily use(s) assistive dev	ated on November 14, 2024 has an ADL Self Care it and Impaired Mobility r/t ness, impaired balance, nd pain, therefore requires ist with bed mobility, transfer, locomotion and walking. de: Infected left total hip acute kidney infection), emia, Bipolar, HTN, Asthma, Interventions: I would like tle range of motion as care. BED MOBILITY: R1 vice (bed rails) to reposition DILET USE: Anita require(s) tion to use toilet."				
	month of Septembe "Nursing/CNAs: Re about CNAs profes expressed 3rd shift	nt council minutes for the er 2024 shows, sidents had some concerns sionalism. Resident is rough at times. CNAs and get out of rooms."				

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AND PLAN OF CORRECTION IDENTIFI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 11/26/2024	
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AME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	ATE, ZIP CODE		
ARREN	I BARR NORTH SHO	RF CONTRACTOR CONTRACT	OKIE VALLEY ND PARK, IL 6			
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S9999	Continued From pa	age 5	S9999			
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