STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145923	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042 Based on interview and record review the facility failed to provide ongoing assessments for a resident who had an injury of unknown origin on 7/3/24. R1 remained at the facility until he was sent to the emergency roiagnom on [DATE] for abnormal behavior. This failure resulted in R1 having a mildly impacted and angulated left femoral neck fracture and deep venous thrombosis for 1 of 3 residents reviewed for a change in condition in the sample of 6. The findings include: The Nursing Daily Evaluation dated 7/3/24 for R1 showed R1 was wincing when being changed. The nurse practitioner was notified. An order for an x-ray to both hips was received and completed. The Nurse Practitioner Note dated 7/3/24 at 11:12 AM for R1 showed, R1 seen and examined in his room, per nurses, he has not been at his baseline lately as he is usually seen walking in halls. Per staff, resident noted to be wincing when leg is touched. On exam, resident noted to be rubbing along his left lateral and anterior thigh. He does show some discomfort with palpation to left upper leg. Plan to order x-rays and follow up. The eMAR (electronic medication administration record) note dated 7/3/24 at 5:14 PM showed R1 was given 1000 mg of Tylenol Extra Strength. The X-ray (radiography) dated 7/3/24 for R1 showed, faintly visualized linear sclerotic opacity of the neck of the left femur - suspicious for a stress fracture in the appropriate clinical setting. Mild degenerative arthritic changes are seen in both hip joints, left greater than right. The bony mineralization and the visualized portion of the pelvis are unremarkable. The Progress Note dated 7/3/24 at 6:59 PM for R1 showed, medical doctor/nurse practitioner is aware of x-ray results to both hips. Left his is suspicious of a stress fracture. Order for orthopedic consult. Need consult as soon as possible, Tylenol PM given at 5:00 PM. R1's Progress Notes/Nurse's Notes from 7/4/24 - 7/7/24 did not show any assessments of R1's left leg. The facility did not have any Nursing Daily Evaluations for R1 from 7/4/24 - 7/7/24. The SBAR (situation background assessment and response) Note dated 7/8/24 at 11:50 AM for R1 showed, patient behavior noted not at baseline. V6 NP (Nurse Practitioner) notified of change and ordered patient to be sent out to ER (emergency room) for further evaluation. (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Progress Note dated 7/8/24 at 7:50 PM for R1 showed he was admitted to the hospital for a closed left hip fracture. The Emergency Department Doctor's Note dated 7/8/24 showed, R1 presented to the emergency department with the complaint of not being able to walk where he is usually very ambulatory. Per emergency medical services report he has been in bed for the last 4-5 days. About a week ago he had difficulty with transitions per wife, and now he has not been able to get up at all and likes to lay on his right side. The patients baseline mental status limits his ability to communicate and give an appropriate history. He does call out in pain when his left hip and knee is palpated or moved in any way. The hospital X-ray dated 7/8/24 for R1 showed, mildly impacted, and angulated left femoral neck fracture. The Orthopedic History and Physical Note dated 7/8/24 for R1 showed, found to have a left femoral neck fracture; has been bed bound for about a week. Patient lying in bed, left hip rotated, and pain to left hip. Decision made to proceed with surgery. Assessment/Plan: admit to orthopedics, bedrest until surgery, non-weight bearing to left lower extremity, pain management, venous doppler of lower extremities (prolonged bedbound, not on deep venous thrombosis prophylaxis), medical per-operation evaluation and risk stratification, and preoperative for surgery (done). The Orthopedic Surgery Note dated 7/8/24 for showed, patient (R1) seen in hospital room with wife at bedside. R1 with severe dementia, does not recognize wife or where he is. Appears anxious, scared. Unable to provide history but grimacing on attempt to passively move left leg. Assessment and Recommendations: admitted to hospital for hip pinning The Operative Report dated 7/10/24 for R1 showed he had an open reduction and internal fixation of the left femoral neck fracture. R1's Vascular Imaging Studies dated 7/9/24 showed, acute occlusive vein thrombosis of the popliteal vein, gastrocnemius vein and peroneal vein. Acute partially occlusive vein thrombosis of the mid to distal femoral vein. The Vascular Medicine Consult dated 7/11/24 for R1 showed, on 7/8/24 presented from Memory Care after staff reported that, patient usually ambulatory; but has been bed bound and moans in pain x 10 days when his leg is moved/touched. Last time the patient was seen walking was 6/28/24 of note, the patient has been living at the nursing home since 9/2023 due to his Alzheimer's, had a fall episode 2 months ago but was able to ambulate until 6/28 per wife (V4). Hip x-ray on 7/3 at the memory care reportedly showed a fracture leading to his emergency department visit on 7/8. In the emergency department, CT (computerized tomography) of the hip (7/8) showed angulated left femoral neck fracture. Subsequently, he was admitted for hip ORIF (open reduction and internal fixation) procedure, which he underwent on 7/10. On 7/9, bilateral lower extremity dopplers obtained and showed acute left lower extremity deep venous thrombosis. Vascular medicine service consulted to assist with anticoagulation management. On 7/9/24 an IVC (inferior vena cava) filter placed per vascular medicine recommendation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 7/30/24 at 11:20 AM, V5 (Licensed Practical Nurse/LPN) stated on 7/3/24 the CNAs (certified nursing assistants) were changing R1 and when they were moving him, he was wincing. V5 stated she was there to see R1, and he was uncomfortable. When they would go to turn R1 he was uncomfortable. V5 stated she talked to V6 (NP) and the doctor. V5 stated she did not document an assessment. V5 stated she should do an assessment when they see something new or different; she should at least do that. V5 stated assessments can be documented in the general progress notes. V5 stated R1 normally walked around; that day he wasn't getting up for us. That wasn't normal. V5 stated the NP wanted an orthopedic consult. V16 (Unit Secretary) schedules the appointments. V5 stated she would continue to assess r1 for pain after that and he was fine if he was still but if he was moved, he had pain. V5 stated they should do physical assessments and see if R1 was in pain. On 7/30/24 at 11:50 AM, V4 (R1's wife) stated she was with R1 on 6/25/24 and he was fine. When she saw R1 on 6/28/24 he wasn't fine. R1 was sitting in his roommate's bed, and she could not get him to his bed. V4 stated the CNA (Certified Nursing Assistant) helped her and they pushed the beds together as close as they could to get R1 into his bed. On 6/28/24 at around 6:00 PM, the CNA said R1 wouldn't walk that day. V4 stated she wasn't at the facility on 6/29/24. On 6/30/24 when she came in to see R1 he was laying on his right side and he would yell out when they would change him. R1 maintained that pattern of laying on his right side and was not eating as well. On 7/3/24 R1's x-rays came back, and the nurse said it was a hairline fracture. V4 stated she kept coming in and R1 was the same, so she doesn't know what prompted the facility to take R1 to the hospital on 7/8/24. R1 yelled in pain when rolling him and he did not get out of bed during that time from 7/3/24 - 7/8/24. At the ER (emergency room) the nurse wanted an x-ray of R1's left knee; it was swollen when he went there. They said he must have a blood clot. R1 was admitted to the hospital and was sent to another hospital where they could do orthopedic surgery. On 7/30/24 at 2:39 PM, V12 (CNA) stated she was told R1 had a stress fracture then he had another test and that said he had a hip fracture. V12 stated R1 would normally get up with one assist for activities of daily living. R1 would walk around. One day she came in for her shift and R1 was lying in bed and did not want to get up. V12 stated after 7/4/24 she noticed when they would touch his leg he would scream. On 7/8/24 R1 had pain just on touching him so her and her partner told the nurse. V12 stated R1's son and wife even said R1 did not want to be touched. That had been going on since 7/4/24, but 7/8/24 was the day they sent him out. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 7/31/24 at 9:21 AM, V6 NP (Nurse Practitioner) stated, on 7/3/24 R1 had an x-ray done because before that date he was walking and then stopped walking. V6 stated the nurse told him that the night before on 7/2/24 R1 was rubbing his leg. V6 stated he discussed it with the nurse and ordered an x-ray to be done on 7/3/24. V6 stated either on 7/3/24 or 7/5/24 the results of the x-ray came back and showed a suspected left proximal femur fracture. V6 stated he put in for an urgent orthopedic evaluation, Tylenol, and ice packs. V6 stated there weren't any fall reports. V6 stated he saw R1, and he was laying on his right side. R1 could extend his left leg partially but not fully. The orthopedic consult was put in as urgent. Usually, we put in for the consult and the facility sets up the appointment. V6 stated he did not hear any follow up with that. V6 stated he wanted it done as soon as possible. V6 stated the nurses should be checking R1's vital signs, assess his leg, and assess for pain. Vital signs should be done every shift. An assessment of the leg every shift and during the shift. V6 stated it was important to assess because of a suspected fracture, to see if there are any changes and/or increased pain. V6 stated he went to assess R1 closer on 7/8/24 and he did not look comfortable. V6 stated he felt R1 needed to be assessed further for a fracture. V6 stated he saw swelling to R1's leg and he had not received any reports from staff that R1 had swelling. V6 stated what could have been done differently would have been closer assessments and checking on R1 more often, then notify of any little changes in his assessment that the staff find. On 7/31/24 at 11:23 AM, V3 (Director of Nursing/DON) stated R1 was a resident that would normally be up walking around. On 7/1/24 R1 had a temperature, they called his wife, had lab work and urine collected. R1's lab work and urine came back normal. On 7/3/24 R1 was wincing when being changed so the NP ordered an x-ray. The results came back at 6:00 PM with a stress fracture. The nurse tried to reach the doctor who did not respond. The nurse called the NP who gave an order for an orthopedic consult. We called and the appointment was made for 7/10/24 at 9:15 AM. In the meantime, we tell the staff to monitor him. The NP said to notify him of any change in condition. V3 stated the only way to know if there is a change in condition is to assess. The nurses can document in the progress notes or an SBAR (situation background assessment and response). Take vitals at least once a day. V3 stated there wasn't any nurse's notes/assessments for R1 from 7/3/24 - 7/8/24. V3 stated she is counting on them to do assessments and document. V3 stated they must assess thoroughly. V3 stated she saw R1 had a blood clot when he went to the hospital; if staff had been assessing R1 they would have caught it. V3 stated staff must assess, document the assessment and let the doctor or NP know. The Face Sheet dated 7/31/24 for R1 showed diagnoses including fracture, osteoarthritis, acute embolism and thrombosis, depression, insomnia, dementia, dysphagia, unsteadiness on feet, metabolic encephalopathy, anxiety disorder, and Alzheimer's disease. The MDS (Minimum Data Set) dated 5/20/24 for R1 showed severe cognitive impairment; supervision or touching assistance for rolling left and right, sit to lying, lying to sitting, transfers, and walking 150 feet. The facility's Notification Procedures for Change in Resident Condition policy (1/14/24) showed, the charge nurse or nurse supervisor will notify the resident's attending physician or covering physician when there has been; a significant change in the resident's physical, emotional/mental condition. Significant change in medical treatment or plan of care. SBAR (situation background assessment and response) communication form and progress note - documentation tool that guides the licensed nurse through structured evaluation of change in condition by facilitating structured and systemic communication with the resident's attending physician. The policy did not show any procedure for ongoing assessments after a change in condition. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Facility's Incident/Accident Procedures policy (8/20/23) showed, an accident or incident report must be completed by the nurse for all incidents/accident including injuries of unknown source. Assess all accident/incident patients for signs and symptoms of injuries. Assess for pain and manage accordingly. Notify the patient's attending physician and family/next of kin or guardian of the accident or incident. Transfer patient to the hospital as medically necessary when ordered by the physician.