STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145923	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35119 Based on observation, interview and record review the facility failed to ensure residents were provided comfortable medical equipment for 2 of 29 residents (R99, R24) in the sample of 29. The findings include: 1. On 10/07/24 at 10:04 AM, R99 was in bed finishing breakfast. R99 stated I have my own chair, but it isn't comfortable. They know my chair is uncomfortable, but they say it won't happen when I ask to get another one. On at 10/09/24 at 9:35 AM, V4 (Registered Nurse) said R99 had not mentioned anything to her about her wheelchair, but V6 (Restorative Director) might know about it. V4 said V5 (Central Supply) has wheelchairs and would get her one. V4 said if her wheelchair was uncomfortable, we could get her a new one. On 10/09/24 at 9:39 AM, R99 said she has complained about her wheelchair a number of times to the nurses and aides, and she was told they couldn't do anything until her kids removed her old one. R99 said my feet don't touch the ground in mine so it makes sitting uncomfortable. R99's wheelchair was in the bathroom, with clothes draped over it. On 10/09/24 at 9:45 AM, V5 (Central Supply) said this is the first time hearing about R99's wheelchair. V5 said usually nursing will tell me. V5 said she has wheelchairs in the store room she could give R99. On 10/09/24 at 9:50 AM, V6 (Restorative Director) said she didn't know anything about R99's wheelchair, nursing had not reported to her. R99's Minimum Data Set, dated dated dated [DATE] shows R99 is cognitively intact and is dependent on staff for transfers from the bed to chair. The Resident Rights for People in Long-Term Care Facilities (from State of Illinois Department on Aging) pamphlet shows your facility must provide services to keep your physical and mental health, at their highest practical levels. 34506 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145923	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R24's Admission Record dated October 8, 2024 shows she was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, malnutrition, dementia, Alzheimer's disease, rheumatoid arthritis, anxiety disorder, and major depressive disorder. On October 7, 2024 at 12:03 PM, V25 and V26 CNAs (Certified Nursing Assistants) provided ADL (Activities of Daily Living) care for R24. R24 was laying crooked in bed. The foot of R24's bed was elevated and V26 could not get it to go down. V26 said (R24's) bed is not working. On October 8, 2024 at 10:51 AM, V28 (CNA) provided ADL care to R24. R24 was laying in bed crooked again. R24's foot of the bed was still stuck elevated. On October 9, 2024 at 10:45 AM, V29 (Maintenance Director) said if residents' items are not working, the staff can call maintenance, page them, or use an app. V29 said that maintenance constantly walks around the facility. V29 said there are three maintenance personnel. V29 said he was not aware that R24's beds was not working. V29 said that any staff can report issues with equipment and it should be reported right away. V29 said he is on call 24/7.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 35119 Based on observation, interview, and record review the facility failed to set up a physician's appointment for 1 of 29 residents (R107) reviewed for quality of care in the sample of 29. The findings include: On 10/07/24 at 10:56 AM, R107 said she went to the hospital in January of this year and then came here. R107 said she has been in and out of the hospital with multiple medical issues going on. R107 said one of ongoing treatments is injections in her eyes. R107 said she missed an appointment because she was in the hospital last month and they were supposed to re-schedule it for her. R107 said she is not sure if they scheduled it yet. R107 was upset and stated there is no follow through here! They say they will take care of it and then I never hear anything. I have to either call myself or keep on telling them, but when I leave messages no one gets back to me. It's very frustrating. R107's Physician Orders dated (9/23/24) shows Appointment: Ophthalmologist, ASAP (as soon as possible), [Name of facility], Patient would like appointment scheduled on Monday or Friday. R107's Physician Progress Note dated 9/23/24 shows R107 seen in her room today and examined. Asking about appointments for ortho and ophthalmologist. On 10/09/24 at 9:55 AM, V7 (Ward Clerk/Scheduler) said she had not scheduled R107's appointment for the Ophthalmologist yet, it was on her to do list for today (16 days after physician order). On 10/09/24 at 10:05 AM, V8 (Receptionist for R107's Ophthalmologist office) said there has been no appointment scheduled for R107 and there are no notes that the facility has called. V8 said R107's appointment could be scheduled right away, R107 just needs a follow up appointment since she missed the last few appointments due to hospitalization . On 10/09/24 at 10:13 AM, V2 (Assistant Administrator) said the expectations is for appointments to be scheduled within a few days of the order.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 33760 Based on observation, interview and record review the facility failed to ensure a resident was transferred in a safe manner to 1 of 29 residents (R95) reviewed for safety in the sample of 29. The findings include: R95's Physician order sheet dated 10/24 show R95 has diagnoses that include right sided paralysis due to stroke and chronic end stage renal disease receiving hemodialysis. On 10/7/24 at 10:15 AM, R95 was sitting in his reclined chair being brought to his room after dialysis treatment. V13 and V14 (both Certified Nursing Assistants-CNAs) applied gait belt around R95's waist and used the gait belt to pull R95 in a standing position. R95 was hunched over and was noted to be leaning towards his right side. R95 could not hold himself up in a standing position. V13 and V14 (CNAs) then placed their hands under R95's armpits and lifted him to transfer him to his bed. R95 was not able to bear weight and unable to pivot during the transfer. V13 (CNA) said the stand lift would be a better way to transfer R95. R95's latest careplan with date initiation of 1/26/24 showed, hemiplegia and hemiparesis following cerebral infarction (Stroke) affecting right side. Transfer: (R95) require(s) Mechanical Aid (Sling) for transfers. (R95) has an ADL Self Care Performance Deficit and Impaired Mobility r/t (related to) CVA/TIA/Stroke, Musculoskeletal impairment . Chronic Kidney Disease) and Impaired balance. (R95) is high risk for falls related to recent fall, .Cerebrovascular Accident (CVA)/stroke. Decline in functional status . Difficulty maintaining standing position, Hemiplegia & Hemiparesis affecting Right side, Muscle weakness. On 10/8/24 at 2:00 PM V16 (Physical Therapist) said all residents should be transferred correctly for their safety.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on observation, interview, and record review, the facility failed to ensure a resident with a history of weight loss was served an ordered supplement for one of ten residents (R24) reviewed for weight loss in the sample of 29. The findings include: R24's Admission Record dated October 8, 2024 shows she was admitted to the facility on [DATE] with diagnoses including moderate protein calorie malnutrition, Alzheimer's disease, anemia, and major depressive disorder. R24's Order Summary Report dated October 8, 2024 shows an order for fortified pudding two times a day with lunch and dinner dated October 19, 2023. R24's Meal ticket shows magic cup and fortified pudding for lunch and dinner. R24's Dietary Evaluation dated February 28, 2024 shows, Conclusion: Order for fortified pudding twice daily, magic cup twice daily, and ensure plus daily as ordered. Recommend discontinue magic cup due to unavailability in house. Registered dietitian to follow up as needed. R24's Dietary Evaluation dated May 22, 2024 shows, Conclusion: Order for fortified pudding twice daily and ensure plus daily as ordered. Registered dietitian to follow up as needed. R24's Dietary Evaluation dated August 14, 2024 shows, Conclusion: Order for fortified pudding twice daily and ensure plus daily as ordered. Registered dietitian to follow up as needed. R24's weights summaries show on September 7, 2024, R24 weighed 149.4 lbs. On October 1, 2024, R24 weighed 145 pounds which is a -2.95 % Loss. On July 2, 2024, R24 weighed 155 lbs. On October 1, 2024 R24 weighed 145 pounds which is a -6.45 % Loss. On April 3, 2024 R24 weighed 160.4 lbs. On October 1, 2024 R24 weighed 145 pounds which is a -9.60 % Loss. On October 8, 2024 at 12:11 PM, R24 was in bed attempting to feed herself the lunch meal. R24 had lemonade, small chicken chunks, pasta, broccoli, and mandarin oranges on her tray. There was no fortified pudding on her lunch tray. On October 8, 2024 at 12:20 PM, V24 (Dietitian) said she last saw R24 on August 14, 2024 for a quarterly assessment. V24 said R24 is on fortified pudding for lunch and dinner, and ensure with the noon meal. V24 said the house supplement and fortified foods are given by the dietary staff. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R24's Nutrition Note dated October 8, 2024 at 4:05 PM by V24 shows, Noting insidious weight loss from previous 155 pounds, possible multifactorial due to sleeping during the day and not easily aroused to be interested in eating at meal time, fluid shift with diuretic and congestive heart failure. Per staff, patient often sleeps between meals and is not easily aroused to wake for a meal. For nutrition interventions for additional calories/protein for weight maintenance, orders for ensure plus daily and fortified pudding twice daily. Due to sleeping between meals, recommend offering a snack when patient is most alert/awake; bedtime snack due to patient wakes up at night. Offer ensure in addition to bedtime snack and as needed to supplement intake. Provide interventions as above and continue to monitor meal intake. R24's Care Plan intitiated September 17, 2023 shows R24 experienced weight loss and she is at risk for continued weight loss. Dietary health supplements as ordered. The facility's Weights policy revised August 19, 2024 does not include information regarding insidious weight loss.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on observation, interview, and record review, the facility failed to perform an assessment on a resident with complaints of pain for one of 29 residents (R24) reviewed for pain in the sample of 29. The findings include: R24's Admission Record dated October 8, 2024 shows she was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, malnutrition, dementia, Alzheimer's disease, rheumatoid arthritis, anxiety disorder, and major depressive disorder. R24's Care Plan initiated November 17, 2020 shows R24 is at risk for pain/discomfort related to disease process. Monitor [R24] and record/report to nurse any signs/symptoms of non verbal pain, nurse know the pain characteristics as needed, such as: quality, severity, anatomical location; onset; duration; aggravating factors; relieving factors. Staff to observe any behavior changes in usual routine, sleep patterns, decrease in functional abilities, decrease range of motion, withdrawal or resistance to care. On October 7, 2024 at 12:03 PM, V25 and V26 CNAs (Certified Nursing Assistants) attempted to perform incontinence care to R24. R24 complained of left hip pain. R24 would not let V25 and V26 change R24's incontinence brief due to pain. R24 rated her pain to her left hip at 7/8 on a scale of 0-10 pain with 10 being the worse pain. V25 went out of R24's room and told V27 (Registered Nurse/RN) that R24 was having pain. At 12:12 PM, V27 (RN) came into R24's room and gave her a Norco (narcotic pain medication). V27 did not ask R24 about her pain, what it was rated, or where it was located. V27 did not do a skin assessment or range of motion assessment prior to leaving R24's room. V25 and V26 attempted to clean R24's peri area right after R24 received her pain medication. R24 was unable to turn side to side due to the pain. R24 said she did not want to get dressed because of her pain. At 1:08 PM, staff removed R24's untouched lunch tray. R24's Medication Administration Record shows R24 received Norco for pain rated a 6 at 12:10 PM. On October 8, 2024 at 11:00 AM, V28 (CNA) attempted to perform incontinence care to R24. V28 wiped R24's front peri area, R24 said Oh your hurting me. R24 was holding her left hip area. V28 was attempting to turn R24 in bed using the incontinence pad and R24 was saying my leg is killing me Ow! V28 went into the hall and got V10 (Licensed Practical Nurse/LPN) to help with repositioning R24. At 12:11 PM, staff were in R24's room with the door closed. R24 was heard in the hallway with the door closed saying My back and my hip bone. I beg you please take it off me. Its very painful. V10 (LPN) went into R24's room and administered a Tylenol to R24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 8, 2024 at 2:28 PM, V3 (Director of Nursing/DON) said she was in R24's room at 12:11 PM. V3 said that R24 was talking about the sheet when R24 was heard saying take it off . V3 said that V10 (LPN) was with her and they pulled R24 up in bed using the incontinence pad and put a pillow on R24's left side. V3 said if a CNA sees a resident complaining of pain, then the cna should tell the nurse. V3 said the nurse should perform an assessment on the resident to determine what kind of pain, perform a skin assessment, range of motion, and if its a new pain, the nurse practitioner should be notified. R24's progress note dated October 8, 2024 at 3:59 PM and entered by V3 shows, Around 12:00 PM while doing rounds, resident seen laying in bed, alert and oriented x 1, confused and forgetful at baseline. Resident complained to this writer about lower back pain, resident repositioned in the bed with the help of the CNA, stating she is more comfortable after being repositioned. Around 3:00 PM, per nurse on duty, resident complained of left hip pain. Head to toe assessment done and range of motion within normal limits per resident's baseline. Nurse on duty said that she reached out to doctor and order for STAT [immediate] xray of left hip was received and ordered. As needed pain medication was administered by nurse on duty. The facility's Pain Policy revised August 16, 2024 shows, It is the policy of the facility to ensure that all residents are assessed for pain in every situation where there is a potential for pain. During treatment procedure, the resident will be assessed for pain.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35119 Based on observation, interview, and record review the facility failed to ensure medications were stored according to manufacturer's guidelines for 4 of 29 residents (R9, R12, R123, R132) reviewed for medications in the sample of 29. The findings include: 1. On 10/08/24 at 9:37 AM, this surveyor with V10 (Licensed Practical Nurse/LPN) opened the locked narcotic box on the first floor dementia unit medication cart. Inside the locked box contained boxes of liquid lorazepam. The boxes shows Store in Refrigerator. R12's box containing liquid lorazepam had a new and unopened bottle with a received date of 7/30/24. R9's box containing liquid lorazepam had an opened, used bottle with approximately 29 ml (milliliters) and had a received date of 8/20/24 and an opened date of 8/30/24. V10 (LPN) said lorazepam should be refrigerated, these boxes of lorazepam have not been kept in refrigerator, they have been stored in the cart. 2. On 10/08/24 at 9:49 AM, this surveyor with V11 (LPN) opened the locked narcotic box of the first floor medication cart. Inside the locked box contained boxes of liquid lorazepam which showed Store in refrigerator. R123's box containing liquid lorazepam had a new and unopened bottle with a received date of 6/8/24. V11 (LPN) said liquid lorazepam should be kept in the refrigerator. R12's Physician Orders dated 10/7/24 shows lorazepam oral concentrate 2 mg (milligrams)/ml Give 1.0 mg sublingually every 4 hours as needed for anxiety/restlessness for 2 weeks. R9's Physician Orders dated 10/7/24 shows lorazepam oral concentrate 2 mg/ml Give 0.25 ml by mouth every 4 hours as needed for agitation for 14 days. R123's Physician Orders dated 10/7/24 shows lorazepam oral concentrate 2 mg/ml Give 0.5 mg sublingually every 4 hours as needed for anxiety/restlessness for 14 days. 33760 3. On 10/8/24 at 10:15 AM, the Medication cart on 2nd floor was checked with V15 (Registered Nurse-RN). R132's two bottles of Lorazepam (Ativan) was noted in the narcotic box (not refrigerated.) One 30 milliliters (ml) bottle of Ativan was opened (undated) with 4 ml left, and 1 full bottle of Ativan with 30 ml. V15 (RN) said that R132's Ativan has always been stored in the Narcotic box and not in the refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R132's Lorazepam (Ativan) order shows, give 0.5 ml every 6 hours for anxiety and agitation with order date of 9/30/24 and stop date of 10/14/24. The Manufacturer's guide attached to the Ativan medication box shows, Store at a cold temperature, refrigerate 36 degrees Fahrenheit (F) to 46 degrees F. The facility policy entitled Storage of Medications (undated) show, Medications and biological are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35174 Based on observation, interview, and record review the facility failed to ensure Enhanced Barrier Precautions (EBP) was in place for a resident with an implanted medical device which applies to 1 of 29 residents (R339) reviewed for infection control in a sample of 29. The findings include: R339's Facesheet dated 10/8/24 showed R339 was admitted to the facility on [DATE] with diagnoses which included: dependence on renal dialysis and complete traumatic amputation (toes). R339's Admission Summary note dated 10/4/24 at 3:01 PM showed R339 was noted to have a peritoneal dialysis catheter and a gauze dressing on left lower foot. On 10/7/24 at 11: 35 AM, R339's room had no EBP sign or Personal Protective Equipment (PPE) cart outside the room to identify R339 needing to be on EBP. V30 (Certified Nursing Assistant/CNA) was standing at the bedside preparing to turn R339 with no PPE gown on. V30 stated R339 had a bowel movement and needed to be changed. On 10/8/24 at 10:15 AM, V16 (Infection Control Preventionist/ICP) stated when a R339 was admitted she should have been put on EBP. R339 has the peritoneal dialysis catheter and has a surgical dressing change. On 10/8/24 at 10:45 AM V17 (Registered Nurse) stated a resident with a implanted medial device should me put on isolation when they are admitted . We notify V16 about the resident. If V16 is not here the admitting nurse can put the resident on EBP. When a resident is on EBP staff needs to wear a gown and gloves when providing cares (dressing change, hygiene, etc) for the resident. R339's Physician orders printed 10/9/24 showed orders for peritoneal dialysis catheter management, daily dressing changes for left foot surgical wound, but no order for EBP. The facility's Infection Prevention and Control Policy dated 7/31/24 showed EBP involves using gloves and gowns during high contact resident care activities for residents infected or colonized with a Multidrug-Resistant Organism (MDRO), wounds, and/or indwelling medical devices.