

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 08/20/2025
NAME OF PROVIDER OR SUPPLIER Warren Barr North Shore		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. Based on observation, interview and record review the facility failed to ensure a qualified staff member operated a resident's enteral feeding pump for 1 of 30 residents (R4) reviewed for qualified persons/staff in the sample of 30. The findings include: R4's admission Record dated 7/24/25 showed R4 was admitted to the facility with diagnoses of respiratory failure and dementia. R4 was admitted with a gastrostomy tube (G-tube) in place for enteral feedings. R4's current care plan showed R4 required enteral feedings as the primary source of nutrition. On 8/18/25 at 10:25 AM, V8 Certified Nursing Assistant (CNA) entered R4's room to provide cares. R4 was in bed with his enteral feeding infusing via an enteral feeding pump at R4's bedside. V8 CNA reached over and paused R4's feeding pump as she began repositioning R4. At 10:29 AM, V8 CNA left R4's room to get additional staff to help provide cares to R4. At 10:38 AM, V8 CNA returned to R4's room and paused R4's enteral feeding pump again to allow V8 CNA and V7 Wound Nurse to provide cares to R4. On 8/19/25 at 11:03 AM, V3 Director of Nursing stated CNAs are not allowed to operate a resident's enteral feeding pump because CNAs are not licensed to do so and have not been trained to operate a feeding pump.		

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide feeding assistance and incontinence care to residents that require staff assistance to complete these activities of daily living for 3 of 30 residents (R4, R6, R61) reviewed for activities of daily living (ADLs) in the sample of 30. The findings include: 1. R4's admission Record dated 7/24/25 showed R4 was admitted to the facility with diagnoses of respiratory failure and dementia. R4 was admitted with a tracheostomy and gastrostomy in place. R4's current care plan showed R4 was cognitively impaired and completely dependent on staff for all cares, including toileting/incontinence care. On 8/18/25 at 10:01 AM, R4 was in bed. An odor of stool was noted in R4's room. On 8/18/25 at 10:24 AM, R4 remained in bed. An odor of stool remained in R4's room. At 10:25 AM, V8 Certified Nursing Assistant (CNA) was asked when she last did incontinence care on V4. V8 stated she had yet to provide incontinence care to V4 that morning. V8 stated, He was last changed on nights (before 7 AM). I haven't changed him yet today. I am waiting on wound care to come see him and I will change him then. At 10:36 AM, V8 CNA and V7 Wound Nurse entered R4's room to provide cares. V8 pulled down R4's brief. R4's brief was saturated with urine and a contained a large amount of mushy stool that had leaked out of the side's of R4's brief, onto the bed. R4's groin and buttocks were red. The bottom half of a large, rectangular adhesive dressing was no longer secured in place over R4's sacral wound. Stool was noted under the dressing, in R4's sacral wound. 2. R6's current care plan showed R6 was dependent on staff for toileting/incontinence care. R6 was incontinent of bowel and bladder. On 8/18/25 at 9:25 AM, V6 CNA entered R6's room to provide cares. V6 CNA stated he had yet to provide incontinence care to R6 that morning. R6 stated his incontinence brief was last changed around 6 AM this morning. As V6 CNA pulled back R6's brief, liquid stool leaked out of R6's brief. R6's brief contained a large amount of urine and liquid stool. Dried stool was also noted on R6's buttocks. R6's buttocks and groin appeared bright red. On 8/19/25 at 11:03 AM, V3 Director of Nursing stated incontinence care and/or toileting should be offered and/or provided to residents every two hours by staff. The facility's Incontinence and Perineal Care policy dated 6/30/25 showed, It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition. Do rounds at least every 2 hours to check for incontinence during shift. 3. R61's Face Sheet dated 8/16/25 shows that R61 is a [AGE] year old Spanish speaking resident with diagnoses including Metabolic Encephalopathy and End Stage Renal Disease. On 8/18/25 at 12:20PM R61 was lying in bed with her head elevated to about 20 degrees, turned partially on her left side. R61 summoned (waved for) Surveyor to come into her room. R61's empty meal tray was propped on the tray table and resting on her bed and her plate of food was sitting on (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the side of the bed. R61 was eating her mechanical soft diet with her hands. R61 had food all over the bed, her silverware, tray lid and cookie were on the floor under the bed. R61 was coughing. Surveyor left the room to find staff. V16 Licensed Practical Nurse (LPN) was at the nurse's station at the other end of the hall. Surveyor reported R61's condition to V16 and V16 came to assist R61 after she found V15 (CNA) in the room next to R61. V16 picked up the items off of the floor and assisted V15 to reposition R61 to an upright position with her tray table and plate in front of her. V16 left the room and returned with a new set of silverware but did not bring in a new cookie. V15 then stated that R61 usually eats with her hands because she is unable to hold a spoon. V16 handed R61 a spoon and R61 finished every bite of food on her plate with the spoon. Per V15, R61 stated the food is good in Spanish. R61's care plan dated 1/30/25 states, Instruct resident to eat in a n upright position, to eat slowly and to chew each bite thoroughly, Keep head of bed elevated 45 degrees during meal and thirty minutes afterwards, Observe the resident during mealtimes for any signs and symptoms of aspiration, coughing, throat clearing, drooling, holding food in mouth (pocketing), prolonged swallowing time, repeated swallows per bite or difficulty swallowing. R61's Dietary Note dated 7/7/25 states, CCHO/renal diet (Constant Carbohydrate), mech(anical) soft texture, thin liquids. NKFA (No known food allergies). 1:1 feeding assistance or set-up and orient Pt to plate r/t blindness. Intake good most meals. Baseline intake fair-good, consistent with current intake per staff on unit. Does not eat fish. ABT may affect appetite, monitor. Intervention: therapeutic, mechanically altered diet as tolerated, Nepro QD, Prostat SF AWC 30 ml QD, fortified pudding QD with dinner for additional calories/protein for weight maintenance with HD (Hemodialysis). Use same method of weighing/time of day for consistency. Provide feeding assistance PRN. Encourage continued good intake, adequate hydration. Goal: stable dry weight, PO intake >65%. Monitor intake, appetite, weights, skin integrity, labs as available.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide wound treatments to a resident with a pressure injury. The facility failed to provide pressure relieving interventions to residents with pressure injuries and to residents at risk for pressure injuries for 3 of 8 residents (R4, R2, R6) reviewed for pressure injuries in the sample of 30. The findings include: 1. R4's admission Record dated 7/24/25 showed R4 was admitted to the facility with diagnoses of respiratory failure and dementia. R4 was admitted with a tracheostomy and gastrostomy in place. R4's Skin and Wound Note dated 8/4/25 showed R4 was admitted to the facility with a Stage 4 pressure injury to his sacrum. The note showed R4's wound currently measured 12.5 cm (centimeters) x 13.9 cm x 3.8 cm. The note showed R4 was incontinent of bowel and bladder. Staff were to provide thorough skin care to R4 after each incontinence episode. A physician order for R4, dated 8/1/25, showed R4 was to have a urinary condom catheter in place. R4's current care plan identified R4's Stage 4 sacral pressure injury. The plan showed, Apply wound treatment as ordered by the physician. keep wounds clean and dry. The plan showed R4 wore a urinary condom catheter related to his urinary incontinence. The plan showed R4 was cognitively impaired and completely dependent on staff for all cares. On 8/18/25 at 10:01 AM, R4 was in bed. An odor of stool was noted in R4's room. On 8/18/25 at 10:24 AM, R4 remained in bed. An odor of stool remained in R4's room. At 10:25 AM, V8 Certified Nursing Assistant (CNA) was asked when she last did incontinence care on V4. V8 stated she had yet to provide incontinence care to V4 that morning. V8 stated, He was last changed on nights (before 7 AM). I haven't changed him yet today. I am waiting on wound care to come see him and I will change him then. At 10:36 AM, V8 CNA and V7 Wound Nurse entered R4's room to provide cares. V8 pulled down R4's brief. R4's brief was saturated with urine and a contained a large amount of mushy stool that had leaked out of the side's of R4's brief, onto the bed. R4's groin and buttocks were red. The bottom half of a large, rectangular adhesive dressing was no longer secured in place over R4's sacral wound. Stool was noted under R4's dressing. Stool was noted in R4's sacral wound. The skin noted around V4's sacral wound was red and excoriated with a moderate amount of bleeding noted from the skin around the wound. No condom catheter was noted on R4's penis or in R4's brief. V7 Wound Nurse stated R4 is really someone who needs to be monitored every two hours for incontinence because of his wound. We need to keep it clean and dry to prevent infection. V7 stated R4's sacral pressure dressing should be changed as soon as possible if found soiled. V7 stated any nurse can provide wound care treatments and dressings. On 8/19/25 at 10:24 AM, V7 Wound Nurse stated V4, has an order to wear a condom catheter to keep him dry and help his wound heal. He does try to pull it (catheter) off, but we need to try to keep applying it. He needs it. 2. R2's Skin and Wound Note dated 8/14/25 showed R4 had a Stage 2 pressure injury to his left heel, measuring 3.5 cm x 3 cm x 0 cm. The note showed a bordered foam adhesive dressing was to be in place, covering R2's left heel pressure injury, at all times. A physician order dated 6/24/25 showed R2 was to have a low air loss mattress in place as a pressure treatment intervention for R2. R2's weight record dated 8/11/25 showed R2 weighed 168.2 pounds (lbs). On 8/18/25 at 11:42 AM, R2 was in bed, lying on a low air loss mattress. R2's low air loss mattress was inflated however the mattress settings showed the mattress was programmed for a resident weighing 200 lbs, not 168 lbs. R2 wore no socks on either foot. No pressure injury dressing was noted to R2's left heel. On 8/18/25 at 1:25 PM, R2 was asleep in bed with no dressing noted to his left heel. On 8/19/25 at 8:31 AM, R2 was in bed. R2's low air loss mattress was still programmed for a resident weighing 200 lbs. A small band-aid was noted to R2's posterior left heel. When R2 was asked about the band-aid to his heel, R2 stated, They just put that on there this morning. I didn't have anything (dressing) on my (left) heel yesterday. On 8/19/25 at 10:24 AM, V7 Wound Nurse stated a low air loss mattress should be programmed to support an accurate weight of the resident because if the weight is off, the mattress could be too hard or soft. That won't help wounds heal or help prevent (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them. V7 stated R2 should have an adhesive dressing covering his left heel pressure wound at all times, not a band-aid. 3.R6's pressure injury risk assessment dated [DATE] showed R6 was at a high risk for developing pressure injuries. R6's current care plan showed pressure injury prevention interventions for R6 included for him to have a low air loss mattress and to offload his heels in bed with either a pillow or heel boots. R6's weight record dated 8/11/25 showed R6 weighed 196 lbs. On 8/18/25 at 9:25 AM, R6 was in bed on a low air loss mattress. R6's low air loss mattress was inflated however the mattress settings showed the mattress was programmed for a resident weighing 250 lbs, not 196 lbs. R6's heels rested directly on the mattress. No pillow was noted under his heels. Heel boots were noted on the window ledge in R6's room. On 8/19/25 at 8:24 AM, R6 was in bed. R6's low air loss mattress was still programmed for a resident weighing 250 lbs. R6's heels rested directly on the mattress. Heel boots were noted on a chair in R6's room. The facility's Skin Care Regimen and Treatment Formulary policy dated 7/3/25 showed, It is the policy of this facility to ensure prompt identification, documentation and to obtain appropriate treatment for residents with skin breakdown. Routine daily wound care treatment/dressing change is administered by the wound care nurse or designee daily. Residents with Stage III and IV pressure injuries will be placed on specialized air mattresses like Low Air Loss Mattress.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review the facility failed to ensure a urinary catheter bag was maintained below the level of the bladder and failed to apply a condom catheter as ordered to 2 of 11 residents (R42, R4) reviewed for catheters in the sample of 30. The findings include: 1. On 8/18/25 at 11:10 AM, R42 was in bed. V12 (Wound NP) and V7 (Wound Nurse) were in the room to perform R42's wound care. R42 was incontinent of stool. V17 and V19 both Certified Nursing Assistants (CNAs) were in the room to provide incontinence care. V19 (CNA) unhooked the catheter and handed the catheter over to V17 who was at the opposite side of the bed. V17 (CNA) then placed the catheter in bed beside R42 at hip level higher than the bladder. Both V17 and V19 then provided incontinence care while the catheter bag kept in bed at hip level. The catheter was half full of urine with urine backflow was noted. After incontinence care, V12 (Wound NP) performed wound assessments showing this surveyor R42's different wounds while catheter was still in bed hip level. On 8/19/25 9:30 AM, V7 Wound Nurse said the catheter bag should be placed below the level of the bladder for gravity and to prevent UTI. R42's care plan dated 7/22/25 under catheter shows, (R42) has indwelling catheter. Please Position catheter bag and tubing below the level of the bladder. The facility policy on Indwelling Catheter dated 6/30/25 documents, 7. Indwelling catheter bag will be positioned below the bladder region to prevent backflow. 2. R4's admission Record dated 7/24/25 showed R4 was admitted to the facility with diagnoses of respiratory failure and dementia. R4 was admitted with a tracheostomy and gastrostomy in place. A physician order for R4, dated 8/1/25, showed R4 was to have a urinary condom catheter in place. R4's current care plan identified R4's Stage 4 sacral pressure injury. The plan showed, Apply wound treatment as ordered by the physician. keep wounds clean and dry. The plan showed R4 wore a urinary condom catheter related to his urinary incontinence. The plan showed R4 was cognitively impaired and completely dependent on staff for all cares. On 8/18/25 at 10:36 AM, V8 CNA and V7 Wound Nurse entered R4's room to provide cares. V8 pulled down R4's brief. R4's brief was saturated with urine and a contained a large amount of mushy stool that had leaked out of the sides of R4's brief, onto the bed. R4's groin and buttocks were red. The bottom half of a large, rectangular adhesive dressing was no longer secured in place over R4's sacral wound. Stool was noted under the wound dressing. Stool was noted in R4's sacral wound. The skin noted around V4's sacral wound was red and excoriated with a moderate amount of bleeding noted from the skin around the wound. No condom catheter was noted on R4 or in R4's brief. On 8/19/25 at 9:26 AM V9 Certified Nursing Assistant (CNA) stated R4 did not have a condom catheter on. On 8/19/25 at 10:24 AM, V7 Wound Nurse stated V4, has an order to wear a condom catheter to keep him dry and help his wound heal. He does try to pull it (catheter) off, but we need to try to keep applying it. He needs it. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's External Condom Urinary Catheterization policy dated 1/14/25 showed, The facility will observe and implement the following procedures in the nursing management of a resident on condom catheterization in order to prevent urinary tract infection and skin breakdown for an incontinent episode. Nurse shall review that there is a physician's order in the resident's clinical record indicating placement of external urinary catheter.		

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on observation, interview and record review the facility failed to provide colostomy care to a resident as ordered and as per the resident's preference for 1 of 1 residents (R54) reviewed for colostomy care in the sample of 30. The findings include: R54's admission Record dated 7/9/25 showed R54 was admitted to the facility with a colostomy in place. R54's current care plan showed R54 had a colostomy in place due to an alteration in bowel. The plan showed, Perform ostomy care daily and as needed per physician's order. The plan showed R54 was cognitively intact. A physician order dated 8/9/25 showed R54's colostomy bag was to be changed by staff every 3 days. R54's August 2025 Treatment Administration Record (TAR) showed R54's colostomy bag was changed on 8/9/25. The TAR showed documentation that R54's colostomy bag was changed by V5 Licensed Practical Nurse (LPN) on 8/12/25. The TAR showed documentation that on 8/15/25, R54 refused to have her colostomy bag changed. On 8/18/25 at 9:49 AM, R54 was seated in a chair in her room with colostomy bag intact to her abdomen. R54 stated, My only issue is that I need to have my (colostomy) bag changed. It hasn't been done since I got back from the hospital (8/9/25). The skin around it is starting to itch and get irritated. It's gets emptied every day, but the bag and appliance should be changed every 3 or 4 days. I don't want it to leak. R54 stated she had never refused to allow staff to change her colostomy bag. On 8/19/25 at 1:03 PM, V5 LPN stated he never changed R54's colostomy bag on 8/12/25. When V5 LPN was asked why R54's 8/12/25 TAR showed documentation that he changed R54's colostomy bag, V5 LPN stated, I don't know. The facility's Colostomy Care policy dated 6/30/25 showed, It is the policy of this facility to perform proper ostomy care in order to prevent exposure of the resident's skin/stoma sites from fecal manner. The facility's Physician Orders policy dated 7/3/25 showed, It is the policy of this facility to ensure that all resident/patient medications, treatment and plan of care must be in accordance to the licensed physician's orders.		

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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. Based on observation, interview and record review the facility failed to ensure the required volume of enteral feeding was administered for a resident with insidious weight loss for 1 of 8 residents (R10) reviewed for nutrition in the sample of 30. The findings include: R10's face sheet shows she has diagnoses including Alzheimer's Disease, moderate protein-calorie malnutrition, and gastrostomy placement. R10's Enteral Feeding care plan initiated on 7/20/23 shows she requires enteral feedings via a Gastrostomy tube as her sole source of nutrition. R10's Weight Summary shows the following: On 4/3/25 she weighed 121 lbs. Additional monthly weights show she began to have trending weight loss as follows: On 5/4/25 she weighed 119.8, on 6/5/25 she weighed 117.6, on 7/7/25 she weighed 115.8. A Dietary note completed by V11 (Registered Dietician) on 4/3/25 shows that R10 has had weight loss after a desired weight gain. V11's note also shows R10's Jevity 1.5 (enteral feeding) should be increased from a total volume of 560 ml. to a total volume of 630 ml. (milliliters) at a rate of 35 ml. per hour until the total volume has infused. R10's Physicians Order Summary (POS) and Medication Administration Summary (MAR) both show active orders for Jevity 1.5 at a rate of 35 ml/hr. start at 7:30 PM and infuse until 560 ml total volume is reached per day turn off during ADLs PRN (as needed). The most recent order dated 4/3/25 shows Jevity 1.5 rate 35 ml/hr. infuse until 630 ml. total volume has infused turn off for feedings and during ADL's and PRN. R10's MARs from April through August 2025 show both of the Jevity orders were still being signed off as being given. On 8/19/2025 at 9:50 AM, V11 said she did increase R10's enteral feedings in April 2025 to a total volume of 630 ml. On 8/19/25 at 11:10 AM, V10 (Nurse Practitioner) said a resident on tube feeding should not lose weight if the required tube feeding amounts are administered. On 8/20/25 at 8:27 AM, R10's tube feeding was hanging at her bedside infusing at 35 ml/hr. The mechanical pump showed that 430 ml. had infused and 130 remained to be infused. The tube feeding bag showed the Jevity was hung at 7:30 PM on 8/19/25. On 8/20/2025 at 8:29 AM V3 (Director of Nursing) went into R10's room with this surveyor and verified that the amount administered was 430 ml and the remaining amount to be administered was 130 making the total 560 ml. On 8/20/25 at 10:50 AM, V3 said when the new order for R10's Jevity was received the old order should have been discontinued and they should only follow the current Jevity order (630 ml.).		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to ensure medications were supervised a resident during medication administration. This applies to 1 of 30 (R26) in the sample of 30 reviewed for medications at the bedside. The findings include: On 8/18/2025 at 9:37AM, R26 had a medication cup on her bedside table in front of her with multiple unknown medications in the cup. On 8/18/2025 at 9:37AM, R26 stated staff leave medications on my table when I'm sleeping. On 8/18/2025 at 9:39AM, V20 Licensed Practical Nurse (LPN) said nurses stay with the residents every time to make sure the resident takes the medication and for safety reasons like choking. V20 said none of her residents can self-administer medications. V20 said she is [R26's] nurse. V20 said she doesn't know where the medications came from, and she didn't pass medications to [R26] yet. V20 said they could be medications from night shift. R26's current Care Plan dated 7/29/2025 doesn't list R26 as being able to self-administer medications. R26's Order Summary Report active orders as of 8/18/2025 does not list R26 as being able to self-administer medications.		