

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/26/2025
NAME OF PROVIDER OR SUPPLIER Warren Barr Oak Lawn		STREET ADDRESS, CITY, STATE, ZIP CODE 9401 South Kostner Avenue Oak Lawn, IL 60453	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility failed to follow its fall occurrence policy by not conducting a post-fall investigation to determine the reasonable cause of the fall and reviewing the fall care plan with new interventions. This applies to one of three residents (R2) reviewed for falls in a sample of 14. The findings include: R2 was a [AGE] year-old male admitted on [DATE] with an admitting diagnosis including dementia, hemiplegia, hemiparesis, heart failure, and urinary tract infection (UTI). A review of the fall log and nursing progress notes documented that the two falls occurred to R2 on 10/30/25 and 11/7/25. On 12/24/25 at 12:25 PM, V2 (Director of Nursing/Fall coordinator) stated, I am the one investigating after a resident fall and then revising the fall care plan with new interventions. I don't have the post-fall investigation completed for R2 for the falls on 10/30 and 11/7. I know I am supposed to investigate and update the fall care plan with new interventions based on the root cause of the fall. A review of R2's fall care plan indicates any revisions with new interventions to prevent further falls following the falls on 10/30/25 and 11/7/25. A review of the facility presented the Fall Occurrence policy reviewed on 6/30/25 document:5. The fall coordinator will review the incident report and may conduct his/her own fall investigation to determine the reasonable cause of the fall. The fall coordinator will add the interventions to the resident's care plan.</p>

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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