STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145632	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Barr South Loop	1725 South Wabash Chicago, IL 60616

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 15301 Based on interviews and record reviews, facility failed to follow their policy to investigate an allegation of abuse for one of three residents (R4) in the sample of four. Findings include: On 11/17/2024, at 10:26 AM via telephone, V3 (R4's sister) said R4 was hit in the face in the morning of 11/6/2024, prior to R4's discharge from the facility. V3 said she reported the incident that day to a male ADON (V4-Assistant Director of Nursing) who said he would look into it. V3 said she also spoke with the V2 (Director of Nursing) who said she would look into it. V3 said I have not heard anything. On 11/17/2024, at 1:38 PM, V4 (Assistant Director of Nursing) said he was informed of alleged staff to resident abuse involving R4 and staff. V4 said I immediately reported it to the V1 (Administrator). V4 said I don't remember the details; I think I spoke with the resident's sister V3. On 11/17/2024, at 1:44 PM V2 (Director of Nursing) I never heard about any concern regarding R4. V2 said staff are supposed to notify the V1 (Administrator) immediately (of any allegation of abuse). On 11/17/2024, at 2:07 PM V1 (Administrator) said that he was not informed of the alleged staff to resident physical abuse by V4. Abuse and Neglect Policy (Revised 7/12/2024) documents in part: Policy Statement: The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations . Reporting/Response: All allegations and/or suspicions of abuse must be reported to the Administrator immediately. A final investigation report will be submitted to IDPH (Illinois Department of Public Health) within 5 working days.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49666 Based on interview and record review, the facility failed to properly identify/assess a resident (R1) for the source of an injury in a timely manner and failed to recognize and/or assess risk factors placing the resident at risk for specific conditions and/or problems. This failure was for one (R1) resident out of three residents reviewed for injury of unknown origin in the sample of four. Findings include: R1's hospital record dated 11/13/2024, documents in part, multiple wounds/burns. pt-patient (R1) has significant burn marks/bruising on R (right) side, stated hot water was spilled on her at facility. APS (adult protective service) called. Wound care. On 11/17/2024, 12:45 PM, R1 stated that she accidentally spilled hot water on herself. R1 stated it happened during mealtime about 2-3 weeks ago. R1 is not able to remember the exact date. R1 stated that she denies reporting it to staff when it happened. R1 stated that she denies any staff hurting her and denies any staff spilling hot water on her. R1 stated that she likes hot water, and she had gotten it before the incident. R1's current face sheet documents that R1 is an [AGE] year-old female with diagnoses not limited to: burn of third degree of chest wall, subsequent encounter, weakness, encounter for other specified aftercare, osteomyelitis of vertebra, sacral and sacrococcygeal region. R1's MDS/Minimum Data Set Section C dated 10/08/2024, documents that R1 has a BIMS/Brief Interview for Mental Status score of 12/15, indicating that R1 is moderately cognitively impaired. R1's MDS/Minimum Data Set section GG dated 10/8/2024, documents that R1 requires setup and or clean-up assistance for eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident). On 11/17/2024, 2:55 PM, V2 (Director of Nursing) stated that V15 (Wound Care Nurse) just went on vacation this morning. Will get contact information. On 11/17/24, 3:27 PM, V10 (Licensed Practical Nurse) stated I don't know any incidents that happened. If I did, I would have documented it in the progress notes. V10 stated that she usually works on the set where R1's room was located. V10 stated I know when I readmitted her the other night, I was writing extra wounds that I didn't see, then I saw a right burn to the right side and around her abdominal area, I did a head-to-toe assessment. V10 stated that she denies any nursing staff reporting to her that R1 was noted with any burns. V10 stated I would have reported it right away to the Director of Nursing and administration, because that could be a sign of abuse. V10 stated that when R1 returned from the hospital, she did not ask R1 what happened to the areas. V10 stated during report from the hospital, I was informed from them that she had burns. I readmitted her. I think she is cognitively intact to be able to say what happened. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/17/24, 5:24 PM, V2 (DON-Director of Nursing) stated our wound care coordinator noted her to have a blister on her right back of her right arm. I don't know what date it was. I believe it was on the 3rd. She developed a blister on the back of her arm. Wound care picked it up. V2 stated that V14 (Nurse Practitioner) assessed her on Tuesday, during her rounds. V2 stated that V14 noticed the right breast with blisters. V2 stated that V15 (Wound Care Nurse) questioned the resident (R1) what happened, and the resident didn't know how it got there. On 11/17/24, 4:28 PM, via telephone V12 (Certified Nursing Assistant) stated that she worked on 11/3/2024, and she works for the facility full-time. V12 stated that she is familiar with R1. V12 stated she (R1) normally needs to be changed, she is very alert, and she knows English, but she chooses who she speaks to. She doesn't talk much unless she likes you. V12 stated I wasn't there for two weeks before November 3rd, 2024. V12 stated that she does not remember R1 having any skin issues when she worked with her that day. V12 stated I didn't notice anything on her skin because I didn't give her a bed bath or shower, I don't just look at her breast. V12 stated that R1 was not acting any different than her usual. V12 stated she was normal, she was on the phone. I gave her hot water and her tray, she uses hot water, because she told me that Asian women like hot water for their hands and teeth. On 11/18/24, 12:09 PM, via telephone V14 (Nurse Practitioner) stated I was consulted to see her (R1) for a new blister to her right upper arm and her breast on 11/5/24, from my understanding, they did a whole investigation. V14 stated when I went in with the nursing wound care team, she does have a language barrier and she also has dementia. When I asked her what happened, she said hot water. Again, I don't know what's true and not true. V14 stated that for the blisters located in the breast area, there were a few still scattered fluid filled blisters on the breast. V14 stated that the blisters were superficially opened, which showed superficial broken skin. V14 stated that the location of the injury was essential around the areola, below the right breast on the right abdomen area/rib cage area. V14 stated that R1 did have slight facial grimacing when wound care applied treatment. V14 stated that R1 has very thin skin which puts her at high risk for skin breakdown. V14 stated one of the medications that she is receiving is for cancer treatment, and has a side effect, potentially that could have caused it. V14 stated in regard, to the hot water, I don't know for sure if that was a cause, because of the internal, she doesn't receive hot water. V14 stated that blisters can be a sign of a burn. V14 stated my assumption was that V2 (DON) was made aware when it first happened. On 11/18/24, 12:49 PM, V17 (Registered Nurse) stated she was the nurse that called and gave report to the charge nurse at the emergency department. Surveyor questioned what information was given in the report, and she stated, I gave her the reason she (R1) was being transferred out, her latest vital signs, mental status at the time of transfer, her age, past medical history, and the ordering doctor that is sending her out. She stated that she was working the evening shift. She stated that she did not receive any calls from the ER (emergency room) department regarding this resident. She stated that she was made aware that R1 had some skin issues which were already addressed in the morning. She stated, her skin was intact, but I think she had blister on her chest. She stated that she didn't report anything about her skin, just the reason she was being transferred to the hospital for low hemoglobin. V17 stated that I didn't think it was relevant, because that was not the reason she was being sent out. They did not call me and ask me about the blisters. R1's Skin/Wound Evaluation dated 11/03/2024, documents in part, right post. (posterior/back) of arm, blister, serous (clear fluid) filled blister measure 6.5 centimeters x 4.0 centimeters. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's skin summary note included in R1's skin/wound evaluation dated 11/03/2024, no documentation noted if resident explained source of injury and/or if abuse was ruled out. R1's Skin/Wound Evaluation dated 11/04/2024, documents in part, right breast blister, serous (clear fluid) filled blister measure 0.0 centimeters x 0.0 centimeters. R1's skin summary note included in R1's skin/wound evaluation dated 11/04/2024, no documentation noted if resident explained source of injury and/or if abuse was ruled out. R1's Skin/Wound Evaluation dated 11/15/2024, documents in part, abdomen, burn, measure 11.0 centimeters x 5.0 centimeters. R1's Skin/Wound Evaluation dated 11/15/2024, documents in part, right breast, burn, measure 3.5 centimeters x 5.5 centimeters. R1's Skin/Wound Evaluation dated 11/15/2024 documents in part, right post arm, burn, measure 7.5 centimeters x 6.0 centimeters. R1's skin and wound note dated 11/5/2024, documents in part, new wounds noted to the right breast/ribcage and right upper arm - Patient states she spilled hot water on her arm and breast - large fluid filled blister to her right upper arm remains intact, blisters to the right breast broken. After further review by bedside nursing and DON, patient does not receive hot water or hot coffee with her meals and patient can sometimes be confused at baseline. R1's current care plan does not address R1's preference for hot water and risk and safety interventions in place. On 11/18/24, 2:54 PM, V2 stated that she did initiate an investigation after R1's grandson visited R1 the day after R1 returned from the hospital. V2 stated that no staff informed her that hot water was involved. V2 stated that she asked R1 both days, on 11/3/24 and on 11/4/24 if she knew what happened. V2 stated that R1 responded that she did not know. V2 stated that V15 assessed the wounds and V2 stated that they thought it was related to pressure and friction.