

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145632	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER Warren Barr South Loop		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observations interviews, and record reviews, facility failed to follow their policy to ensure residents have a homelike environment for 3 (R1, R8, R9) out 5 residents reviewed for homelike environment in a sample of 11. Findings include: On 09/09/2025, surveyor observed R1's room had a broken thermostat with no temperatures indicating the temperature in the room. R1's dresser also had a missing handle with drawers that would not close. R1's dresser was also dirty with hardened paste all over it. R8's thermostat was also broken thermostat with no indication of the temperature. R9's thermostat had no temperatures marking on it. R1, R8 and R9's thermostat's analog dial did not have any markings on it to indicate if the thermostat was set to cool or hot. On 09/09/2025 at 10:30 AM, V7 (R1's POA) stated that R1's thermostat is broken and there is no way for us to know what temperature is being set in the room. V7 also pointed to R1's dresser and showed the hardened paste all over the dresser. V7 stated that some drawers would not even close. On 09/09/2025 at 1:14 PM, V3 (Maintenance Director) stated he over looks all the physical plant problem in the facility. V3 stated that there is a thermostat in every patient room which helps resident control the temperatures. The thermostat is an analog thermostat which says what the temperature is set at. V7 stated that every thermometer should have numbered temperatures indicating what the temperatures in the room are set at. Surveyor then asked V3 to join him in R1, R8 and R9's rooms. Surveyor pointed to R1, R8 and R9's thermometer and asked V3 if he knew what the temperature was set at. V3 stated that he doesn't know. V3 stated that this is not what a homelike environment for residents should be. Surveyor also showed V3, R1's dresser. V3 had to take out a wrench from his pocket to fix the drawers on R1's dresser as well as scrape the hardened paste on the dresser. V3 stated that he will get housekeeping right away to clean the dresser and the room. On 09/11/2025, V1 (administrator) stated that all the thermostats are being replace and fixed. V1 stated that V3 is communicating with an outside company on the quotes for this repair. Facility's Resident's rights policy (undated) documents in part: The facility must be safe, clean, comfortable and homelike. Facility's Maintenance policy (07/2025) documents in part: All resident building environment with be maintained by the maintenance department. Any staff who is made aware of a malfunctioning equipment will report the issue to the maintenance department. Cleaning will be done daily while being used by the resident by the housekeeping staff.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145632
		If continuation sheet Page 1 of 1