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	09/29/2025

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 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. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow wound care specialist's recommendation to treat a resident's pressure ulcer and failed to revise the comprehensive care plan addressing a resident's new skin alteration. These failures affected one (R1) out of three residents reviewed for wound care.Finding Include:R1's clinical records show an original admission date of 6/12/25 with included diagnoses but not limited to acute and chronic respiratory failure with hypoxia, anoxic brain damage, and encounter for attention to tracheostomy, and gastrostomy. R1's progress notes show R1 was discharged to hospital on 7/7/25, 7/11/25, 7/19/25, 8/9/25, 8/23/25, and 9/6/25. readmitted back to facility on 7/9/25, 7/15/25, 7/26/25, 8/20/25, and 8/31/25. R1's Quarterly Minimum Data Set assessment dated [DATE] shows R1 is cognitively impaired and is dependent on staff's assistance for his activities of daily living.R1's Wound Assessment Report dated 9/4/25 documented by V23 (Wound Care Nurse Practitioner) revealed R1 was observed with left lateral leg cluster pressure ulcer/injury stage 2 on 8/21/25 (present on admission). Treatment documents in part: Cleanse with normal saline; Betadine and bordered foam; daily and as needed. R1's comprehensive care plan dated 6/13/25 was not revised to address R1's left lateral leg cluster wound. R1's physician orders from 8/21/25 to 9/6/25 shows no treatment order was entered for R1's left lateral leg cluster wound. R1's August to September Treatment Administration Records (TAR) show no documentation of treatments done for R1's left lateral leg cluster wound. On 9/28/25 at 1:52 PM, V8 (Wound Care Licensed Practical Nurse) stated that R1's wounds were all acquired from the hospital and that V23 was seeing R1 weekly at the facility and writes notes weekly. V8 stated that new admissions and re-admissions are seen by the wound care nurse within 24 hours. V8 stated, We call primary doctor to notify of the wounds regardless of if it's old or new then the primary doctor will let us know to follow [V23's] recommendation. We enter treatment orders in PCC [Residents' Electronic Health Record]. All orders will generate in the TAR. Wound care nurse will document in the TAR when treatment is done. Wound care nurses make rounds with [V23] once a week and she let's us know her treatment orders. Then we enter the treatment order in PCC. Wound care will sign the TAR after treatment is done. V8 stated that she is not sure if the facility's wound care team was made aware of R1's left lateral leg cluster wound. Surveyor asked V8 if there were treatment orders in R1's electronic health records for his left lateral leg cluster wound. V8 stated she could not find any documentation. On 9/28/25 at 3:12 PM, V2 (Director of Nursing) stated that resident's who are re-admitted or newly admitted to the facility will be assessed by the admitting nurse and assessed by the wound care nurse within 24 hours for skin alterations. V2 stated that the nurse will get order from the Nurse Practitioner or doctor and then wound care will assess and contact [V23] for recommendations. V2 said that treatment orders will be obtained within 24 hours of admission/re-admission until [V23] comes in and assesses to provide further recommendation. V2 said that the facility's wound care team makes rounds with V23, and all her recommendations will be entered in the resident's electronic health records. V2 said all orders entered will show in the resident's TAR and the wound care nurse will document or sign the TAR if treatment is done. V2 said that if it's not signed off, it's not an active order. V2 further stated that skin care plan is revised as needed and if any new skin issue occurs. It needs to be revised based on the current condition of the resident. V2 said that the care plan is resident specific and individualized, and the purpose of the care plan is to make sure staff is following the plan of care of the residents. V2 stated that the resident's needs, conditions, outcomes, and interventions should all be included in the care plan.The facility's Skin Care Regimen and Treatment Formulary policy dated 7/3/25 documents in part: It is the policy of this facility to ensure prompt identification, documentation and to obtain appropriate treatment for residents with skin breakdown. Charge nurses must document in the Electronic Health Record any skin breakdown upon assessment and identification. Furthermore, treatment must be obtained from the patient's physician. TAR Nursing Documentation includes: a) Routine wound care completed by wound care nurse or designee. b) Ostomy care completed by the wound care nurse or designated nurse. Refer any skin breakdown to the skin care team and physician including wound physician/NP for further review and management as indicated.The facility's Care Plan policy dated 6/30/25 documents in part: It is the policy of the facility to ensure that all care plans including base line care plans are in conjunction with the federal regulations. After the comprehensive assessment (state/federal-required MDS) is completed, the facility will put in place person-centered care plans outlining care for the resident within 7 days. These will be periodically reviewed and revised by a team