

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145875	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Warren Barr Lincoln Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2732 North Hampden Court Chicago, IL 60614	

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30279</p> <p>Based on interview and record review, the facility failed to protect the residents right to be free from physical abuse by staff. This failure affected one resident (R1) who was handled roughly and was hit on the arm and the back by a facility CNA (Certified Nursing Assistant) as she attempted to redirect R1.</p> <p>This was identified as an Immediate Jeopardy which began on 06/30/24 when V20, Certified Nursing Assistant, physically abused R1. The immediacy was removed on 07/22/24.</p> <p>On 07/17/24, V1 (Administrator) was informed of the Immediate Jeopardy and the Immediate Jeopardy template was presented on 07/17/24 at 2:41pm.</p> <p>The facility provided an acceptable removal plan on 07/22/34 at 5:34pm.</p> <p>On 07/23/24, through onsite observation, interviews, and record reviews, the surveyor confirmed the implementation of facility's removal plan.</p> <p>Although the immediacy was removed and the removal plan accepted, the deficiency remains at the second level of harm until the facility can determine the effectiveness of the implementation of removal.</p> <p>Findings include:</p> <p>R1's medical record documented R1 was admitted [DATE], with diagnoses that includes but not limited to Dementia in other diseases classified elsewhere mild with agitation, insomnia due to medical condition, essential hypertension, and chronic obstructive pulmonary disease.</p> <p>R1's plan of care for potential to demonstrate verbally and physically aggressive behaviors related to dementia, with initial date 08/11/2022, listed interventions including but not limited to when R1 becomes agitated, staff should walk calmly away, and approach later.</p> <p>R1's plan of care for presence of abuse and neglect factors, initiated 05/18/2024, has goals that include R1 will be treated with respect, dignity and reside in the facility free of mistreatment (abuse/neglect).</p> <p>(continued on next page)</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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 07/10/24 at 10:34am, R1 was noted in the dining area, which is also used for activity with peers. R1 does not speak English, but is able to understand greetings in English language. At 12:25pm, V14 (Activity Director) stated R1 speaks Chinese; R1 was unable to recollect or speak of any abuse incident.</p> <p>On 7/10/24 at 12:26pm, V4 (Registered Nurse) and V5 (Registered Nurse) assessed R1's body, which showed bruising to the right antecubital area, which V4 attributed to R1's visitation to ER (emergency room) on 07/08/24. V4 stated the bruising might be from possible IV insertion site at the hospital ER (emergency room).</p> <p>On 07/10/24 at 3:00pm, V20, CNA (Certified Nursing Assistant), stated, I (V20) will tell you the truth. It happened about two weeks ago, and the whole thing was in the hallway where the video camera can pick it up (see it). Another staff, (V21, CNA) was also present when the incident occurred. V20 checked the calendar for the day she worked, and stated the incident happened on 06/30/24. V20 stated, (R1) was trying to sit on the floor. (R1) usually does this, and I was trying to grab (R1) quickly to get (R1) seated in the chair to avoid sitting on the floor. (R1) hit me with the elbow on the same spot I have being having pain. To be honest with you, I hit (R1) on the right hand. V20 was asked whether hitting a resident is a form of abuse, and whether V20 reported it to V1 (Administrator). V20 stated, Yes it is a form of abuse, but I never saw it as an abuse. When V20 was asked about the facility abuse policy and prevention of abuse and what V20 will do if she witnesses a resident being abused by staff, peers, or family member, V20 stated, I will report it immediately within 2 hours.</p> <p>On 07/10/24 3:13pm, V1, Administrator, stated the camera is reviewed daily and only 7 days of recording is stored. The only video camera recording history was from 07/01/24 to 07/10/24. V1 stated, The history from 06/30/24 has been wiped off. V1 was asked about the facility policy, and whether it is appropriate for staff to hit any of the residents. V1 stated, Abuse is a willful act that causes harm. V1 was asked under what situation/condition it is appropriate for your staff to hit a resident? V1 stated, Under no condition. V1 was asked whether hitting is a form of abuse, and V1 stated, Yes.</p> <p>On 07/11/24 at 4:05pm, V21 (CNA), whom V20 stated was present and witnessed the incident at the time of alleged abuse, stated, (R1) has dementia and can be combative at times, but that does not mean that the staff should abuse him). I was in the dining area, and I saw (V20) hitting (R1) multiple times on the back, hands, and grabbing (R1) roughly on the arm. I told (V20) not to hit (R1), and (V20) said that (R1) hit her first, and 'I am not going to let (R1) hit me.' I told (V20) that she should have handled it in a better way that does not involve hitting (R1), which will not be abusive. No staff should hit any of the residents or handle them roughly, even with their bad behavior. V21 stated R1 has dementia and does not speak English. V21 stated, (R1) was crying and shouting, and that was why I looked in their direction. I reported it to the nurse (on duty) (V10), and nothing was done until you (referring to the surveyor) came here (facility). V21 was asked when would you report any alleged abuse. V21 stated, Immediately as soon as you see it. I reported it to the nurse on duty (V10) and they did nothing. She did it in front of the camera, it's not like she was hiding it. Even when I told her that it is not right, (V20) was confrontational about it. (V20) retaliated by hitting (R1) and that is wrong.</p> <p>On 07/11/24 at 4:30pm, V2, Director of Nursing (DON), stated, It is not appropriate for any of the staff to hit or handle any of the resident roughly. It should be reported when that happens.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>According to facility investigation, the facility concluded the allegation of abuse cannot be substantiated.</p> <p>On 07/23/24 at 2:09pm, V27 (Facility Medical Director) was asked whether hitting a resident is a form of abuse in V27's professional opinion. V27 stated, In this case, we (facility) think it is a form of self-defense. Residents should not be touched (physically abused). We protect them at all costs. They (staff) have the right to defend themselves. V27 stated the staff should defend themselves without aggressively attacking the resident and de-escalate the situation. V27 was asked whether staff should be correcting residents' aggressive behavior by hitting or slapping a resident. V27 stated, Of course not, no one should hit anyone. De-escalate. Protect your face, move away, and ask for help.</p> <p>On 7/23/24 at 2:26pm, V28 (Social Services Director) stated, (R1) has dementia and that was why (R1) was discharged to a memory care unit at a long-term care yesterday (07/22/24). (R1) has wandering behavior. Cognitively is severely impaired. Some behavior problems with history of verbal and physical aggression. V28 was asked whether V28 was informed of R1 being physically hit by staff. V28 stated, Yes, by (V1) when (V1) was informed (07/10/24). V28 stated staff hitting a resident is a form of physical abuse. V28 stated, It is never appropriate to hit a resident. Staff should de-escalate a resident's aggressive behavior, separate, get help, and make sure the resident is safe. V28 stated the Abuse Coordinator (V1), the Administrator, must be informed of any alleged abuse incident.</p> <p>On 7/23/24 at 3:09pm, V1 (Administrator) was asked whether it is appropriate for staff to hit a resident to de-escalate aggressive behavior. V1 stated, No, it is not appropriate. At no time is it appropriate for staff to hit a resident. V1 was asked how about in self-defense. V1 stated, It is not appropriate to hit a resident. It is a form of abuse.</p> <p>The facility policy titled Abuse and Neglect, with revised date of 06/06/24, documented it is the policy of the facility to provide professional care and services in an environment that is free from abuse, corporal punishment, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation. Abuse is defined as willful infliction mistreatment that includes punishment.</p> <p>The policy documented examples of physical abuse that includes but not limited to hitting, slapping, grabbing, and roughly handling. Potential aggressors listed include but not limited to facility staff.</p> <p>The policy listed 7 steps in abuse prevention including reporting/response. Listed procedure includes all allegations and/or suspicion of abuse must be reported to the administrator immediately.</p> <p>The facility Behavior Monitoring of Residents presented, with revised date of 06/06/24, documented policy statement it is the facility's policy to ensure that the residents with aggressive behavior are monitored. Listed procedure includes but not limited to if the resident's aggressive behavior is monitored anytime.</p> <p>On 07/23/24, the surveyor through observations, interviews, and record review, confirmed the following removal plan by the facility:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> 1. V20 suspended 07/10/14. 2. R1 is no longer residing at the facility. R1 has been discharged to another Long-Term Care on 07/11/24 3. R1 full skin assessment conducted 07/10/24. 4. R1 seen by psychotherapist on 07/10/24. 5. R1 evaluated by Physiatrist. 6. R1 screened for abuse/neglect 07/10/24. 7. V21 was suspended on 07/11/24 for not reporting to V1, pending investigation. 8. Staff are being educated on Abuse, initiated 07/10/24, with quiz to monitor effectiveness. 9. Abuse in-service completed 07/16/24. 10. Abuse in-service on Handling Aggressive Behaviors with quiz for 5 staff members three times per week for 12 weeks on-going. 11. Social Work outside consultation group initiated monthly in-service on de-escalation techniques and handling aggressive residents, initiated 07/19/24. 12. Staff training on facility code gray for aggressive behavior/violence, initiated and completed 07/22/24. 13. QA (Quality Assurance) audit on 3 times weekly times 12 weeks to ensure direct staff care staff (Nurses and CNA's), initiated 07/15/24. 14. Thirteen residents R1, R7, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, and R22, were reviewed for abuse and aggressive behaviors. List of residents with behaviors provided and posted at the nurse's station inside a closed cupboard. 15. V27 (Medical Director) interviewed and was aware of the removal plan with V27's approval. 16. Staff interviewed: V4, V33, V40, RN (Registered Nurse), V14 (Activity Director), V29, V38 (Activity Aides), V22, HR (Human Resources), V28, SSD (Social Services Director), V31 (restorative aide), V37 (Certified Nurse's Aide Supervisor), V30, V32, V36 CNAs (Certified Nurse's Aides), V24, V26, V34 and V39 LPNs (Licensed Practical Nurses) were interviewed. No concerns identified.

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30279</p> <p>Based on interview and record review, the facility failed to immediately report to IDPH (Illinois Department of Public Health) within required time, the allegation of abuse of one of four residents (R1) reviewed for abuse. This failure affected R1 who was handled roughly and was hit on the arm and back by a facility staff as an attempt to redirect R1.</p> <p>Findings include:</p> <p>R1's medical record documented R1 was admitted on [DATE], with diagnoses that includes but not limited to Dementia in other diseases classified elsewhere mild with agitation, insomnia due to medical condition, essential hypertension, and chronic obstructive pulmonary disease.</p> <p>On 07/10/24 at 3:00pm, V20, CNA (Certified Nursing Assistant), stated, I will tell you the truth, it happened about two weeks ago, and the whole thing was in the hallway where the video camera can pick it up (see it). V20 checked the calendar of the day she worked and stated the incident happened on 06/30/24. V20 stated, (R1) was trying to sit on the floor. (R1) usually does this, and when I was trying to grab (R1) quickly to get (R1) seated in the chair to avoid sitting on the floor, (R1) hit me with the elbow on the same spot have being having pain. To be honest with you, I hit (R1) on the right hand. V20 was asked whether hitting a resident is a form of abuse and whether V20 reported it to V1 (Administrator). V20 stated, Yes, it is but I never saw it as an abuse. V20 was asked about the facility abuse policy and prevention of abuse and what V20 will do if she witnesses a resident being abused by staff, peers, or family member. V20 stated, I will report it immediately within 2 hours.</p> <p>On 07/11/24 at 4:05pm, V21 (CNA), who V20 stated was present and witnessed the incident at the time of alleged abuse, stated, (R1) has dementia and can be combative at times, but that does not mean that the staff should abuse (R1). I was in the dining area, and I saw (V20) hitting (R1) multiple times on the back and hands, and grabbing (R1) roughly on the arm. I told (V20) not to hit (R1), and (V20) said (R1) hit her first, and she said she was not going to let (R1) hit her. I told (V20) that she should have handled it in a better way that does not involve hitting (R1), which will not be abusive. No staff should hit any of the residents or handle them roughly, even with their bad behavior. (R1) has dementia and does not speak English. (R1) was crying and shouting and that was why I looked in their direction. I reported it to the nurse (on duty), and nothing was done until you (surveyor) came here (facility). V21 was asked when any alleged abuse should be reported. V21 stated, Immediately as soon as you see it. I did report it to the nurse on duty and they did nothing. She (V20) did it in front of the camera, is not like she was hiding it. Even when I told her that it is not right, (V20) was confrontational about it. (V20) retaliated by hitting (R1) and that is wrong.</p> <p>On 07/23/24 at 2:12pm, V28, SSD (Social Services Director), stated all alleged abuse incidents must be reported to V1 (Administrator), who is the Abuse Coordinator, and must be reported initially to IDPH (Illinois Department of Public Health). V28 stated, Always inform the Abuse Coordinator (V1), the Administrator, of any abuse incident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Abuse and Neglect, with revised date of 06/06/24, documented it is the policy of the facility to provide professional care and services in an environment that is free from abuse, corporal punishment, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation. Abuse is defined as willful infliction mistreatment that includes punishment. The policy documented examples of physical abuse that includes but not limited to hitting, slapping, grabbing, and roughly handling. Potential aggressors listed include but not limited to facility staff. The policy listed 7 steps in abuse prevention that includes but not limited to reporting/response. The listed procedures include that all allegations and/or suspicion of abuse must be reported to the administrator immediately.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30279</p> <p>Based on interview and record review, the facility failed to immediately initiate an investigation into an alleged physical abuse for one of four residents (R1) in the sample reviewed for physical abuse. This failure affected R1 who was handled roughly and was physically hit in the arm and back by a staff to redirect R1.</p> <p>Findings include:</p> <p>R1's medical record documented R1 was admitted [DATE], with diagnoses that includes but not limited to dementia in other diseases classified elsewhere mild with agitation, insomnia due to medical condition, essential hypertension, and chronic obstructive pulmonary disease.</p> <p>On 07/10/24 at 2:50pm, V20, CNA (Certified Nursing Assistant), stated, I will tell you the truth. It happened about two weeks ago, and the whole thing was in the hallway where the video camera can pick it up (see it). V20 checked the calendar for the day she worked and stated the incident happened on 06/30/24. (R1) was trying to sit on the floor. (R1) usually does this, and when I was trying to grab (R1) quickly to get (R1) seated in the chair to avoid sitting on the floor, (R1) hit me with the elbow on the same spot I have being having pain. To be honest with you, I hit (R1) on the right hand. V20 was asked whether hitting a resident a form of abuse. V20 stated, Yes. V20 was asked whether it was reported to V1 (Administrator), who is the Abuse Coordinator. V20 stated, I did not report it because I did not think it was abuse. And it happened in the hallway. Maybe when V1, Administrator, looks at the camera they would have seen it and ask V20. This resulted in the facility not initiating an investigation into allegation of abuse until 07/10/24.</p> <p>On 07/11/24 at 4:05pm, V21 (CNA), who V20 stated was present and witnessed the incident at the time of alleged abuse, stated, (R1) has dementia and can be combative at times, but that does not mean that the staff should abuse (R1). I was in the dining area, and I saw (V20) hitting (R1) multiple times on the back and hands and grabbing (R1) roughly on the arm. I told (V20) not to hit (R1), and (V20) said (R1) hit her (V20) first, and V20 said 'I am not going to let R1 hit' her. I told (V20) that she should have handled it in a better way that does not involve hitting (R1), which will not be abusive. No staff should hit any of the resident or handle them roughly even with their bad behavior. (R1) has dementia and does not speak English. R1 was crying and shouting and that was why I looked in their direction. I reported it to the nurse (on duty), and nothing was done until you (referring to the surveyor) came here (facility). V21 was asked about when to report any alleged abuse. V21 stated, Immediately as soon as you see it. V21 stated, I reported it to the nurse on duty (V10) and they did nothing. She did it in front of the camera, it is not like she was hiding it. Even when I told her that it is not right, (V20) was confrontational about it. (V20) retaliated by hitting R1 and that is wrong.</p> <p>On 07/23/24 at 2:12pm, V28, SSD (Social Services Director), stated all alleged abuse incident must be reported to V1 (Administrator), who is the Abuse Coordinator and must be investigated.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Abuse and Neglect, with revised date of 06/06/24, documented it is the policy of the facility to provide professional care and services in an environment that is free from abuse, corporal punishment, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation. Abuse is defined as willful infliction mistreatment that includes punishment. The policy documented examples of physical abuse that includes but not limited to hitting, slapping, grabbing, and roughly handling. Potential aggressors listed include but not limited to facility staff. The policy listed 7 steps in abuse prevention that includes but not limited to investigation and protection of the resident.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>30279</p> <p>Based on observation, interview, and record review, the facility failed to ensure that medication was locked up safely when not in visual proximity of the licensed nurses and not in use to prevent tampering and accidental hazard. This failure has the potential to affect all the residents residing on the 2nd and 3rd floor of the facility.</p> <p>Findings include:</p> <p>On 07/10/24 at 11:29am, the treatment cart was observed in the hallway on the 3rd floor, not in visual proximity of the nurse, and was unlocked. V16, RN (Registered Nurse) was asked about the facility policy/protocol on treatment carts storage and medication storage. V16 stated the medications are to be locked in a cart when not in use and not in visual proximity of a nurse. V16 stated, I did not put it there so I was not watching to see whether it is locked or not. You will have to ask the treatment nurse (referring to V18 (Wound Care Nurse) why the cart was left unlocked.</p> <p>On 7/10/24 at 11:31am, V18, LPN (Licensed Practical Nurse) Wound Care Nurse, stated, The wound care cart (treatment cart) should be locked because the treatment medications are stored in it and so it should be locked preventing any of the resident to get into the cart.</p> <p>On 7/10/24 at 1:35am, V3, ADON (Assistant Director of Nursing), stated, Treatment cart or general medication cart should be locked and placed within the visual proximity of the nurse to prevent either the resident or unauthorized staff/ visitor to get into it.</p> <p>On 07/11/24 at 11:28am, on the 2nd floor, the medication cart observed in the hallway, unlocked, and not in visual proximity of V24, LPN (Licensed Practical Nurse). V24 stated it is supposed to be locked when the nurse is not visually able to see the cart so no one can get into it (tamper). V24 stated, I just went into the dining room to give a resident medicine; I did not know I did not lock it.</p> <p>The facility policy presented titled Hazards, with a revised date of 06/06/24, documented it is the facility's policy to ensure the safety of each resident in the building and remove hazardous items and correct situations to prevent accidents. Listed procedures include but not limited to ensuring that residents have no access to medications, sharps and chemicals that would be hazardous to them.</p> <p>Facility policy on Medication Pass, with revised date 06/06/24, documented it is the policy of the facility to adhere to all Federal and State regulations with medication pass procedure.</p> <p>The facility policy on Medication storage, Labelling, and Disposal presented, with revised date of 06/06/24, documented it is the facility's policy to comply with federal regulations in storage, labelling and disposal of medications. Procedures listed includes but not limited to medications will be secured in locked storage area.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30279</p> <p>Based on observation, interview, and record review, the facility failed to ensure medication is administered as ordered for one resident (R3) for residents reviewed for medication administration.</p> <p>Findings include:</p> <p>R3's MAR (Medication Administration Record) and POS (Physician Order Sheet) showed an order for Potassium chloride crys ER 20 meq tablet extended release give 20 [NAME] by mouth one time a day every Monday, Wednesday, Friday for supplement. The MAR showed R3 was administered this medication on 07/10/24, a Wednesday, and should not have been given any potassium on 07/11/24.</p> <p>On 07/11/24 at 11:45am, R3 was observed in bed, with two plastic medication cups on the over bed table. One had a big whitish pill and the second cup had six medications. R3 asked the surveyor to identify the pills. R3 stated, I am stressed because I have been calling the nurse and the nurse will not help me. I don't know what this big pill is. V16, RN (Registered Nurse) stated they were R3's morning scheduled medications, and was not aware R3 did not take the medication. V16 stated, (R3) must have spit it out; R3 stated, I was waiting for you to tell me what this big medicine is. V16 replied to R3, I told you what medication you are taking before giving them to you this morning. V16 identify the big pill as potassium. V16 stated the medications were scheduled for 9:00am, and proceeded to administer the medications to R3 including the potassium.</p> <p>When the surveyor asked about facility policy on medication pass and the professional standard regarding medication administration, V16 stated, The medications are to be given to the resident, and walked away from the surveyor and continued to talk to R3. V16 stated R1 was not on self-administration program. V16 refused to talk with surveyor stating, Lady (referring to the surveyor), I did what I'm supposed to do. I gave the medications period.</p> <p>On 7/11/24 at 11:55am, V2, DON (Director of Nursing) stated all medications should be administered as ordered.</p> <p>On 7/11/24 at 12:45pm, V2, DON (Director of Nursing), stated medication should not be left at the bedside of the resident unless ordered and assessed that the resident can administer the medication safely. Medications as ordered, right route, right medication, right dose, right patient, and right time.</p> <p>The facility was unable to provide any documentation where the physician was notified of the medication error and V16 did not document that potassium was administered at 11:50am instead of 9:00am. V16 signed all the scheduled medication as given at 9:00am.</p> <p>Facility policy on Medication Pass, with revised date 06/06/24, documented it is the policy of the facility to adhere to all Federal and State regulations with medication pass procedure.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145875	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Warren Barr Lincoln Park		STREET ADDRESS, CITY, STATE, ZIP CODE 2732 North Hampden Court Chicago, IL 60614	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy on Physician orders with revised date of 06/06/24 documented that it is the policy of the facility to ensure that all resident/patient medications, treatment, and plan of care must be in accordance with the licensed physician's orders. the facility shall ensure to follow physician orders as it is written in the POS (Physician Order Sheet).</p> <p>The facility job description for RN (Registered Nurse) Floor Nurse documented summary/objective in keeping with our organization's goal of improving the lives of the Guests we serve; the RN plays a critical role in providing superior customer service and nursing care to all Guest and guests. The RN provides supervision of staff and will safeguard the health, safety, and welfare of all Guests under their care by following applicable laws, regulations, and established nursing policies and procedures.</p>		