STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145875	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Barr Lincoln Park	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop a comprehensive and individualized care plan for a Stage IV pressure for one (R3) of four residents reviewed for improper nursing care. The findings include: R3's face sheet's showed admit date on 4/18/25, with diagnoses not limited to Encounter for surgical aftercare following surgery on the skin and subcutaneous tissue, Pressure ulcer of sacral region stage 4, Type 2 diabetes mellitus, Essential (primary) hypertension, Disorder of prostate, Unspecified dementia. R3's health record showed discharge date on 8/1/25. MDS (Minimum Data Set), dated 7/7/2025, showed R3's cognition was intact. He needed Substantial / maximal assistance with eating, oral and personal hygiene; Dependent with toileting hygiene, shower / bathe self, upper and lower body dressing, chair / bed transfer. R3 was always Incontinent of bowel and bladder. MDS showed 1 Stage IV pressure ulcer that was present upon admission / entry.On 9/26/25 at 10:01 AM, V7 (Wound Care Coordinator, LPN / Licensed Practical Nurse) stated she has been working in the facility for almost a year. V7 stated R3 had no skin breakdown upon initial admission. V7 said R3 went to the hospital several times and came back to the facility with Stage IV pressure ulcer on sacral area. SR3 was followed up by wound Nurse Practitioner/NP. V7 said skin breakdown / pressure ulcer should be care planned. The care plan is a document that needs to be known for the resident so staff would be able to know how to care for the resident. V7 said care plan will show what needs to be done or it is the plan of the care of the resident that would include goals and interventions. She said she is responsible in doing the care plan for skin impairment.Survey resumed on 11/14/25 due to Federal Government Shutdown that began on 10/1/25.On 11/14/25 At 12:41pm, V2 (DON / Director of Nursing) stated care plan should be person centered and individualized. It includes problem / concerns, goals, and interventions. V2 said plan of care would direct staff on how to care for the resident. Surveyor reviewed R3's care plan with V2; no care plan found for R3's stage IV pressure on Sacrum. She said there should be a care plan for Stage IV pressure ulcer done by wound care nurse. On 11/14/25 At 12:51pm, V7 (Wound Care Coordinator) stated Care plan should be done for residents with skin impairment including pressure ulcer. She said care plan should be individualized and includes concern/ comorbidities, type of wound and stage of pressure ulcer, goals and interventions. V7 said care plan is the plan of care of the resident that would direct staff what to do. Surveyor reviewed R3's care plan with V7, no care plan found for R3's stage IV pressure ulcer to sacrum.V26 (Wound Nurse Practitioner / NP) notes, dated 7/28/25, showed: R3 with Stage 4 pressure ulcer on sacral. Wound size: 8cm x 12.5cm x 1.3cm. Wound base: 60% granulation, 40% slough. Exposed tissues: Subcutaneous, muscle / fascia, tendon/ligament, Bone. Exudate: Heavy amount of serous. R3's skin / wound evaluation, dated 7/5/25, showed: Community acquired Stage IV pressure ulcer to sacrum. Measurement: 10.5 x 6.5 x 1.6cm. R3's POS (Physician Order Sheet), order date 7/29/25, showed: Clean sacrum with normal saline pat dry apply Betadine-soaked gauze cover with dry dressing secure with a border dressing daily and PRNR3's hospital records, dated 8/1/25, showed: R3 presented on 8/1/25 with sacral ulcer. During this admission, ID (Infectious Doctor) and general surgery were consulted for stage IV sacral wound infection. R3 underwent sacral bone debridement with bone biopsy on 8/6/25 and the bone biopsy (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	culture grew polymicrobial. His AMS (Altered Mental Status) has been improved, which is likely secondary to UTI (Urinary Tract Infection) and sacral wound infection given significant improvement after starting antibiotic and surgery.R3's TAR (Treatment Administration Record) for the month of July reviewed with no concern.R3's care plan reviewed on 9/24/25, 9/26/25, 9/30/35, and 11/14/25; no care plan found for Stage IV pressure ulcer to sacrum. On 11/17/25, facility provided R3's care plan that showed care plan for skin impairment with information and documentation that was not present on the previous care plan records provided to and reviewed by surveyor with V2 and V7. Facility's care plan policy, dated 6/30/25, showed: It is the facility of the facility to ensure that all care plan 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 7days.