STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145899	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Barr Orland Park	14601 South John Humphrey Dr Orland Park, IL 60462

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect a resident's right to be free from theft. This applies to 1 of 3 residents (R3) reviewed for abuse/theft in the sample. The findings include: R3's Face Sheet showed he was admitted to the facility on [DATE]. The Face Sheet showed his diagnoses include cerebral infarction, abnormalities of gait and mobility, need for assistance with personal care, and sepsis. On April 29, 2025, R3's 4/29/25 Minimum Data Set showed his cognition was severely impaired. The facility's 5/26/25 Abuse Report Final Form showed, On May 20, 2025 .[R3's Son] reported .that his father's debit card is missing and that he received a notification that someone tried to use the card. [R3's Son] mentioned that he brought his father's wallet on Sunday and today 5/20/2025 he received the notification that someone tried to use the card. The charge to the card was declined. The Abuse Report Final Form continued to show Interview with [V7] Orientee CNA [Certified Nursing Assistant- former]: .[V7] admitted taking the debit card, but stated none of the transactions she attempted went through. [V7] mentioned that when she went to the gas station with the debit card that attempt was declined. [V7] refused to answer any other questions from the Administrator. The Form ended with Through the investigation and collaboration with the (city) Police Department it was determined that [V7] is the perpetrator. The allegation of theft was confirmed by the (city) Police Department . On 5/29/25 at 12:55 PM, V9 (Human Resources Director) stated V7 had finished her training modules and was assigned to work on the floor on the 2 PM- 10 PM shift. V9 stated, It was [V7's] very first day on the floor when this happened she didn't even finish her first day. On 5/29/25 at 1:05 PM, V1 (Administrator) stated she interviewed V7 after the theft, and initially V7 denied the incident. V1 stated she told V7 she could see her on video, and V7 answered none of the transactions went through. V1 stated she asked V7 how she accessed R3's debit card, and V7 hung up on her. The Abuse Final Report Form showed (city) Police identified [V7] as the perpetrator through video footage from the gas station where the debit card was attempted to be used. (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Abuse Final Report Form showed, (city) Police identified [V7] as the perpetrator through video footage from the gas station where the debit card was attempted to be used. The facility's Abuse and Neglect policy (revised 7/12/2024) showed, Financial/Misappropriation of Property: Financial abuse includes, but is not limited to deliberate misplacement, misappropriation, exploitation or otherwise taking advantage of a resident's money or property temporarily or permanently

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to safely turn a resident in bed for cares. This failure resulted in R1 rolling off the bed and sustaining a right femur fracture. This applies to 1 of 3 residents (R1) reviewed for falls. The findings include: R1's Face Sheet showed she was originally admitted to the facility on [DATE]. R1's Face Sheet included diagnoses of functional quadriplegia, reduced mobility, muscle wasting and atrophy, morbid (severe) obesity, body mass index (BMI) 50-59.9, anxiety disorder, and need for personal care. R1's Activities of Daily Living (ADL) care plan focus statement (last revised 3/2023) showed R1 has an ADL Self Care Performance Deficit and Impaired Mobility [related to] impaired balance, weakness, decreased strength and endurance [due to] recent hospital stays. Needs assistance with self care and mobility; extensive assistance of 2 staff with mobility and transfers .May use full body lift machine with total assist of 2 staff .non ambulatory at this time. An intervention (last revised 10/1/2022, over two years ago) showed May require 2 staff assist with mobility and transfers depending on her level of participation and endurance. Another intervention (also not revised since 10/1/2022) showed BED MOBILITY: [R1] requires extensive assist of 1 staff participation to reposition and turn in bed, and scooting towards head of bed [due to bilateral lower extremity] weakness. A 3/20/2023 intervention showed TOILET USE: [R1] requires extensive assist of 2 staff participation with toileting needs. R1's 5/4/2025 nursing note from 9:16 AM (late entry) showed, At approximately 5:28 AM, writer responded to staff calling for nurse and resident was observed with right hand and knee on the floor, left leg was on the bed, and left arm was holding on to bed. [R1] let go of bed rail and placed left hand/leg onto floor. She then rolled onto right side, then onto her back to floor .the resident stated 'My leg slid over the bed while the CNA [Certified Nursing Assistant] was turning me and I rolled off the bed.' .resident remained on the floor .[R1] assisted to stretcher by 6 paramedics and was sent to [local] hospital. Under History of Present Illness in R1's 5/5/2025 Hospital admission note, it showed, Patient is a [AGE] year-old bedbound, non-ambulatory female with a BMI of 55 who presented after a fall from bed .she has a complex medical history, notably a severe COVID-19 infection three years ago that led to prolonged hospitalization, deconditioning, and eventual complete loss of ambulatory status. She has not stood or walked in over a year and has since experienced significant weight gain and progressive immobility. On presentation, radiographs and a CT (computed tomography) scan of the right lower extremity revealed a comminuted, supracondylar distal femur fracture with intra-articular extension into the lateral condyle . The Objective section in R1's 5/5/2025 hospital note showed R1 is 5' 9 tall and weighs 380 pounds. R1's 2/28/2025 Minimum Data Set (MDS) showed her cognition was moderately impaired. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's April/May 2025 POC Response History 30-day lookback (from 4/29/2025 forward) asks for the amount of assistance needed to Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed. Seven documented staff entries were available up to R1's fall, one showing R1 needed Substantial/maximal assistance- helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. The other six entries showed R1 was Dependent- Helper does ALL the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. R1's 2/18/2025 MDS showed R1 was also dependent for toileting hygiene. On 5/28/2025 at 8:31 AM, R1 was in her bed wearing a hospital gown. R1 was alert and in a bariatric bed with a gel overlay. R1 stated staff took her stiches out the day before, and she was told there were three screws in her right knee. On 5/28/2025 at 9:36 AM, R1 stated V4 (CNA) was changing her by herself, when R1 fell. R1 stated when V4 was going to change R1's incontinent brief, V4 was standing on the right side of R1's bed, and V4 turned R1 away from her. R1 stated she told V4 her leg is going to fall. R1 stated V4 stood there and removed the soiled brief, and her leg slid off the bed. R1 stated she fell on her knees with her butt sticking up in the air. R1 stated 6-7 people came to her room after she fell. R1 stated her left leg has arthritis, and now her right knee was broken. On 5/28/25 at 2:51 PM, V4 (CNA) stated she worked on 5/4/2025 night shift, and she was taking care of R1 when she fell. V4 stated R1 turned herself towards the door. V4 stated as R1 was turning herself, one of her legs pulled out of the bed and R1 was on the floor. V4 stated she did not touch R1. V4 stated she yelled for the nurse. V4 stated R1 became a two person assist after she fell. V4 stated R1 never told her her leg is going to fall. On 5/29/2025 at 1:45 PM, V10 (Restorative LPN- Licensed Practical Nurse) stated R1 has never been on a bed mobility program, and she believed R1 has used a full-body mechanical lift for transfers for around two years. On 5/29/2025 at 2:25 PM, V3 (Therapy Director) stated R1 had a fall from bed resulting in a fracture. V3 stated, Staff should not roll residents away from them. V3 stated, If (R1's) leg started going off the side of her bed, she couldn't have stopped it .at 380 pounds the momentum would carry her leg over. On 5/29/2025 at 3:10 PM, V8, ADON (Assistant Director of Nursing), stated she completed the investigation into R1's fall. V8 stated R1 has full ROM (Range of Motion) to her arms, but not a whole lot of ROM to her legs as R1's baseline. V8 stated, You should not push a resident away from you in bed. You have more control of the patient if you roll them toward you. V8 stated the root cause of R1's fall was Resident stated, my leg slid over the bed and I rolled off the bed. V8 stated nobody was on that opposite side of the bed. The facility's General Care policy (revised 7/30/2024) showed, Policy Statement- It is the facility's policy to provide care for every resident to meet their needs 1 Physical needs would include, but are not limited to ADL .2. The facility will assist the resident to meet those needs .