

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0053892		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/14/2026	
NAME OF PROVIDER OR SUPPLIER WARREN BARR LINCOLN PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 2732 NORTH HAMPDEN COURT , CHICAGO, Illinois, 60614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000				
	Complaint Investigation 25812073/2689222						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)						
	300.1210c)						
	300.1210d)6)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.						
	c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to supervise a resident with a history of falls. This failure affected one resident (R2) out of 3 residents reviewed for accidents and supervision in the facility. As a result, R2 fell and sustained a laceration of the head requiring sutures. Findings Include: On 11/29/25 at 8:24 pm, an initial Facility Reported Incident was submitted to Illinois Department of Public Health (IDPH) that documented, "Around 11:25 am, a resident (R2) was observed lying on his back on the floor in the bathroom of his room. (R2's) fall was unwitnessed and resulted in (R2) having a laceration to the right forehead, that required (R2) to get two sutures. (R2) can stand and ambulate with a walker, cues, and standby assist. Resident primarily uses a wheelchair for mobility." The final report was submitted to IDPH on 12/5/25 at 3:50 pm. R2's diagnoses include but are not limited to syncope, collapse, falling, transient cerebral ischemic attack, hypertension, abnormal gait and mobility, chronic fatigue, and Alzheimer's Disease. R2's Minimum Data Set (MDS), dated 1/7/26, documents, Section C. Brief Interview for Mental Status (BIMS) score is a 5. R2 has severe cognitive impairment. Section GG. Self-Care: C. toileting hygiene is coded with a 4 which indicates supervision or touching assistance. (Helper provides verbal cues and/or touching/steadying and or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently). Mobility: I. Walk 10 feet is coded with a 4 which indicates supervision or touching assistance. Mobility devices: B. Walker."	S9999					

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S9999	Continued from page 2 R2's Physician Order Set (POS) active orders as of 3/13/26 documents, "May use bed and chair alarm." R2's (4/26/25) care plan documents, "(R2) at high risk for falls related to dementia, behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Cognitive deficit such as poor awareness, decrease comprehension impulsive memory deficit. Interventions: Remind me to ask for assistance. Reorientate me on how to use the call light if necessary. Please make sure that my call light is within my reach and encourage me to use it for assistance as needed. (4/26/25) R2 requires assistance with Activity of Daily Livings (bed mobility, transfers, dressing, walking, personal hygiene, eating, and toileting). (6/27/25) (R2) demonstrates movement behavior that may be interpreted as wandering, pacing, or roaming. Interventions: (R2) to be frequently monitored. (9/30/25) Focus: (R2) uses chair/bed alarm related to potential fall." R2's (11/29/25) hospital record documents, "Chief complaint syncope, Patient reports walked to bathroom used the bathroom, got up and walked a few steps and then only remembered waking up on floor. Laceration to forehead s/p (status/post) repair with sutures. Computerized Tomography (CT) of head shows small right superficial frontal scape hematoma." R2's (11/29/25) fall risk assessment documents, D. Cognition: 1. Does the resident display a memory problem, YES. F. Mobility: 2. The resident gait would be described as 1. UNSTEADY. G2. History: Did the resident just have a fall? YES. R2's fall risk score is 13 which indicates R2 is high risk for falls. R2's (12/1/25) fall risk evaluation documents, 1. Is this assessment an annual significant change in status and /or quarterly? NO. R2's score is 0, which indicates low risk for falls. R2's (1/5/26) fall risk evaluation documents in part, 1. Is this assessment an annual significant change in status and /or quarterly? NO. R2's score is 0, which indicates low risk for falls. R2's progress notes, dated 11/29/25 at 11:25 am, documents, "Writer (V11, License Practical Nurse/LPN) was notified by (R4) that (R2) was on the floor in the shared bathroom. Upon assessment, resident was observed laying on his back in the bathroom. When asked what happened, the resident stated, 'I don't recall, it all happened so fast.' An open area with blood and swelling was noted to the resident's forehead. Area was cleaned with normal saline and applied pressure until bleeding subsided. The resident is alert and verbally responsive. 911 was called, writer and Certified		S9999				

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S9999	Continued from page 3 Nursing Assistant (CNA) on duty remained with the resident until the arrival of the (city) Fire Dept paramedics." On 3/13/26 at 11:00 am, R2 was in R2's room lying in bed. R2 stated he did not recall falling in the facility. R2 sat up on the side of the bed and the bed alarm sounded. V4, License Practical Nurse (LPN), was already in the room. R2's call light was observed at the head of R2's bed on the floor. V4 stated the call light should not be on the floor and should be in R2's reach in case R2 needed something. On 3/13/26 at 11:50 am, V2, Director of Nursing (DON), stated, "We did have only one nurse with three CNAs on the second floor for 38 residents. I would consider that to be a staffing problem. One nurse cannot give quality care to that many residents and it can put the residents at risk." DON was asked is it safe to have one nurse taking care of 38 residents? V2 DON stated, "In my opinion, No". On 3/13/26 at 1:48 pm, V7, Nurse Practitioner, stated, "(R2) lived alone and kept falling at home, and that is why he was admitted to the facility. (R2) has a history of being impulsive and should have been on fall precautions. He was moved close to the nurse's station; his call light should be in reach whether he uses it or not. I am not sure if the bed alarm was in place at the time of (R2's) fall. If (R2) had assistance with toileting, it would have prevented him from falling. He does need supervision and constant safety reminders. Supervision should be in place to prevent falls." On 3/13/26 at 2:25 pm, V11, License Practical Nurse (LPN), stated, "(R2) was in the bathroom, and a resident was passing by and saw (R2) on the floor. I responded immediately and at that time (R2) was alert and responsive. (V12, Certified Nursing Assistant/CNA) came into the room and helped. We encourage him to use the call light, but he always gets up by himself. He does require frequent monitoring. He should have been supervised going to the bathroom or when ambulating. He is at high risk for falls because he does have a history of falls. He was on fall precautions at that time. He had a bed alarm, but I did not hear the bed alarms. I had the whole floor and was at the other end of the hallway. At that time, I was the only nurse working the entire floor. There were 3 CNAs also working on the floor. It could have been a safer environment if there was more than one nurse working on the floor." On 3/13/26 at 2:45 pm, V12, CNA, stated, "I was		S9999				

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S9999	Continued from page 4 assigned to (R2) the day of the fall. I heard one of the roommates say, 'That boy done fell' (sic). I went into the bathroom in the room and (R2) was laying on his back, there was blood coming out of the front of his head. I called the nurse to come into the room. He did not have his walker with him at that time. When he has the urge to go to the bathroom, he will just go. He did have the bed alarm at that time. The alarm was very faint like the battery needed to be changed. The alarm could not be heard in the hallway. If it had not been for the roommate, we would not have known he had fallen. I had already rounded that room I was a few rooms over. We make rounds every 2 hours. His call light should be in place if the residents need anything, they can get help instead of the other resident saying, "That boy needs help." On 3/13/26 at 3:00 pm, V2, Director of Nursing/DON stated only residents who are at high risk for falls have bed alarms. If a fall occurred, they should be considered as high risk for falls. Surveyor inquired about R2's December 2025 and January 2026 fall risk evaluation that R2 was categorized as low risk for falls with a score of 0. V2 stated, "That assessment is not accurate; he should be high risk for falls. Bed alarms batteries are changed by the restorative aides and CNAs. Call lights should always be in reach whether they are used or not. Staff should be rounding on residents every two hours and PRN (As Needed)." Facility's job description titled, "LPN Floor Nurse", dated 12/1/19, documents, "Summary/ Objective: In keeping with our organization's goal of improving the lives of the guest we serve, the LPN plays a critical role in providing superior customer service and nursing care to all guests. The LPN 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." Facility's job description titled "Certified Nursing Assistant", dated 5/20/22, documents, "Summary/ Objective: In keeping with our organization's goal of improving the lives of the guest we serve, the CNA plays a critical role in providing superior customer service and nursing care to all guests. The CNA safeguards the health, safety and welfare of all guests under their care by following applicable laws, regulations, and established nursing policies and procedures. Essential function: 11. Follow established safety precautions when performing tasks and using equipment and supplies. 13. Report all hazardous		S9999				

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S9999	Continued from page 5 conditions, damaged equipment, accidents/incidents and supply issues to the supervisor." Facility's policy titled, "Fall Occurrence", dated 6/30/25, documents, "Policy Statement: It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and interventions are reevaluated and revised as necessary. Procedure: 1. A fall risk assessment form will be completed by the nurse or the falls coordinator upon admission, readmission, quarterly, significant change, and annually. 2. Those identified as high risk for falls will be provided fall interventions... 3. If a resident had fallen the resident is automatically considered as high risk for falls... (B)		S9999				