IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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February 01, 2019

Illinois Corporation Svcs Co, Registered Agent
Lincolnshire Living & Rehab Center, LLC
801 Adlai Stevenson Drive
Springfield, Illinois 62703

RE: Complaint #: IL00107541
Survey Date: December 06, 2018
Docket Type: Level A
Docket #: 19-C0032

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Warren Barr Licolnshire.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Enclosure
cc: Administrator
File
Warren Barr Licolnshire/December 06, 2018//RegAgent/S.Geer

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant,	)	Docket No. NH 19-C0032
v.	)	
LINCOLNSHIRE LIVING & REHAB CENTER, LLC, D/B/A, WARREN BARR LICOLNSHIRE Respondent.	)	

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE; NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF CONDITIONAL LICENSE; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint IL00107541 Investigation conducted by the Department on December 06, 2018, at Warren Barr Licolnshire, 150 Jamestown Lane, Licolnshire, Illinois 60069. On January 31, 2019, the Department determined that such violations constitute one or more Type "A" violations of the Act and the Skilled and Intermediate Care Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in The Statement of Licensure Violations which is attached hereto and incorporated herein as Attachment A and made a part hereof.

Pursuant to Section 3-303 of the Act, the above-referenced facility is hereby ordered to abate and/or eliminate the above violation(s) immediately.

A Type "A" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF CONDITIONAL LICENSE

In accordance with Sections 3-305 and 3-311 of the Act, the Department hereby issues a Conditional License for the operation of the Facility. This license replaces the unrestricted license issued to Warren Barr Licolnshire, 150 Jamestown Lane, Licolnshire, Illinois 60069 on May 15, 2018. The Facility's current license number is 0053587. The term of the conditional license shall be from March 02, 2019 to September 01, 2019. THE CONDITIONAL LICENSE SHALL FOLLOW UNDER A SEPARATE COVER LETTER. THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON MARCH 02, 2019.

The Conditional License will be withdrawn and an unrestricted license will be issued to Respondent upon the expiration of the term of the Conditional License.

During the term of the Conditional License, Respondent will retain its status as a certified provider of Medicaid services so long as Respondent's facility complies with the applicable federal regulations.

If the Respondent timely requests a hearing to protest the basis for the issuance of the Conditional License, the terms of the Conditional License shall be stayed pending the issuance of the Final Order at the conclusion of the hearing and the facility may operate in the same manner as with an unrestricted license.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$25,000.00**, as follows:

Type A violation of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b), 300.1210d)2)6) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)6) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
525 West Jefferson, 5th Floor, Quality Assurance
Springfield, Illinois 62761

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department;

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license, the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation.

Plans of Correction, Hearing and Waiver Requests can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulation

Dated this 1st day of February, 2019.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. LINCOLNSHIRE LIVING & REHAB CENTER, LLC D/B/A, WARREN BARR LICOLNSHIRE Respondent.	)	Docket No. NH 19-C0032

PROOF OF SERVICE

The Conditional License will follow under a separate cover letter.

The undersigned certifies that a true and correct copy of the attached Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Illinois Corporation Svcs Co
Licensee Info:	Lincolnshire Living & Rehab Center, LLC
Address:	801 Adlai Stevenson Drive Springfield, Illinois 62703

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 1st day of February, 2019.

Sammye Geer
Administrative Assistant
Long Term Care- Quality Assurance
Office of Health Care Regulations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR LINCOLNSHIRE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(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) COMPLETE DATE
S 000	Initial Comments Complaint 1817645/IL#107541 Partial Extended Survey conducted.	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210d)2) 300.1210d)6) 300.3240a 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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.

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:

2) All treatments and procedures shall be administered as ordered by the physician.

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide Physician ordered one to one supervision for a resident with a known risk for elopement. R1 left the facility, unknown to staff, on November 22, 2018 and traveled over a mile from the facility. R1 was found wandering outside by the emergency medical services and taken to the hospital for

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S9999	Continued From page 2	S9999		

evaluation.

This applies to 1 of 3 residents (R1) reviewed for elopement in the sample of 4.

The findings include:

R1's Physician's Order sheet shows he was admitted to the facility on 10/26/18 with diagnoses including non-traumatic subdural hemorrhage with surgery to repair, seizures and alcohol abuse.

R1's 11/2/18 Minimum Data Set (MDS) assessment shows R1 had wandering behaviors and required supervision of staff for walking in his room or the corridor, dressing and personal hygiene.

R1's 11/1/18 Progress notes show "Resident continues to ask when he is going to be discharged." 11/8/18 Progress notes show "(R1) noted to be restless and agitated after his brother left the facility. He was observed walking around frequently and changing position almost every 10-15 minutes. Patient was seen sitting in the Palm Beach (name of the unit R1 was on) TV area, then walked back in his room, walked out of his room back to the TV room, sitting on the couch in between the nurse stations. Patient was asked if we could help him with anything or if there is anything that bothers him tonight. He just smiled and did not say a single word and then he walked back to his room again."

V14's (Licensed Clinical Psychologist) Neuro-psychological test report of 11/5/18 shows "(R1) is slowly recovering neurologically and may have experienced long-term damage of some of his short-term memory skills as well as his

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S9999	Continued From page 3	S9999		

hunger/saturation signals in his hypothalamus ...It may be beneficial that (R1) be monitored to that end." The report shows "His short-term memory was compromised as a result of his seizures and double craniotomy." The report also shows "He mentioned on several occasions he wanted to return to home, return to work, exercise and his routine. When this writer discussed changes in his lifestyle and the importance of his having supportive monitoring, assistance initially with medication management and a safe discharge from residential, R1 seemed to avoid or discount his need and was focused on returning home as primary."

The 11/14/2018 Social Services UDA (user defined assessment) shows R1 does not appear to be able to refrain from self-harmful and/or socially inappropriate behavior while in the community (including abstaining from alcohol and illicit drugs, avoiding persons who constitute a bad influence and is not able to practice "harm reduction" strategies). The assessment shows R1 does not appear to be capable of unsupervised outside pass privileges at the time of assessment and supervision is recommended while in the community for safety purposes. The assessment shows R1 has attempted an actual elopement in the last year, roams or wanders throughout the facility, does not respond favorably to staff redirection and has verbalized a strong desire to leave the facility and has the ability to do so. The assessment also shows R1 has made comments asking about the nearest streets. He is at risk for elopement at this time for safety precautions and staff is aware of the residents who are a wander/elopement risk.

On 11/15/2018 an order was written for 1:1 supervision. The 11/15/18 facility's Room

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S9999	Continued From page 4	S9999		

Transfer Notification 1.2 shows R1 was transferred to another room in the facility due to elopement precaution.

V3's (NP-C Nurse Practitioner) notes e-signed on 11/20/18 show "Per staff, patient had an elopement risk on 11/15/18 where he threw his red suit case over the fence. At that time the patient was unable to be redirected. However, he was not able to elope due to not feeling well and having intermittent headaches leading him to be sent out to the ED (emergency department). Upon readmission to (the facility), the patient was moved to the locked unit."

R1's 11/10/18 Progress notes show R1 was out of his room walking around. Agitated and not answering questions.

R1's 11/11/18 at 8:15 AM Progress notes show "Resident slow to respond. Agitated and not answering questions. Complained of pain to top of head 7 out of 10 on pain scale with nausea and blurred vision and photophobia. Blood pressure 178/98. At 11:10 AM Progress notes show a change in condition and documents R1 shows a decreased level of consciousness and increased confusion or disorientation. R1 keeping his eyes closed and refusing to answer questions. At 1:14 PM progress notes show R1 with "episodes of anger, acting out and being verbally abusive with staff. Resident is unable to be directed at this time." The facility staff called V13 (R1's Power of Attorney) to inform her that R1 had returned from the hospital, where he had been sent out for evaluation after a change of condition (head pain, nausea, elevated blood pressure, decreased level of consciousness and increased confusion or disorientation). While speaking with V13, she voiced concerns about R1 not sleeping at night

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S9999	Continued From page 5	S9999		

and calling/texting her at 4:00 AM.

R1's 11/15/18 at 7:30 AM Progress notes show "Resident awake and walking around. Periods of confusion. 11:40 AM notes show R1 was expressing that he is missing his red suit case. Resident stated that he did not leave the premises but threw his suitcase outside with an attempt to leave but he did not feel well. POA stated resident called her this morning about his suitcase but she thought it was just him being delusional given his cognition sometimes. The notes show "He will also have a room change to a more secure unit and have 1:1 for supervision at this time."

The 11/11/18 at 1:30 PM Progress notes show "Administration aware that this resident needs continual 1 on 1 care."

R1's 11/16/18 Progress notes show at 7:30 AM R1 needed redirecting and close monitoring and at 3:56 PM one on one CNA staff close supervision/safety ensured.

R1's 11/20/18 Progress notes show R1 was still on one on one supervision. The notes show "Noted resident ambulating from bed to toilet without clothes; resident reoriented to get dressed."

R1's 11/21/18 Daily Evaluation form shows R1 is on one on one supervision. The evaluation shows R1 displaying agitation/restlessness and a depressed affect.

V7's (Registered Nurse-RN) 11/22/18 ,8:53 AM Progress notes show that at 11:15 PM (on 11/21/18) V7 was informed that one on one supervision was arranged for R1. V7's 11/22/18

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S9999	Continued From page 6	S9999		

Progress notes show V7 spoke with CNA on duty specifically assigned to R1 for one on one at 1:00 AM, the CNA said R1 is asleep comfortably.

R1's 11/22/18 at 6:00 AM Progress notes show around 6:00 AM V8 (Licensed Practical Nurse-LPN) was alerted by V4 (Certified Nursing Assistant-CNA/Sitter) that R1 was not in his room during routine monitoring rounds. "Patient search conducted by staff immediately in unit and facility. V6(Registered Nurse- RN/Night Supervisor) was informed. Staff conducted further search in and around facility but unable to locate patient." The notes show the writer spoke with an RN at a local hospital and was informed R1 was being admitted due to mental status changes.

The facility's Incident Report form shows V8, LPN, was notified by V4 (CNA) around 6:00 AM that R1 was not in his room. Patient search conducted by staff immediately in unit and facility. V6 informed. Staff conducted further search in and around facility premises but unable to locate patient. V1 (Administrator) and V2 (Don) were notified immediately by V6. Further search conducted in R1's room noted broken window screen. 911 and local police department called for assistance. The incident report shows one of the police officers from the local police department informed staff that R1 was transferred to a local hospital for evaluation. Interviews done by facility management staff show V4 said she did not go into R1's room during her one on one supervision to check on R1 until 6:00 AM on 11/22/2018. From 11:00 PM, 11/21/2018, through 6:00 AM 11/22/2018, V4 did not go into R1's room to check on him. At that time, she noticed that R1 was not in his room and she notified V8 , LPN on duty.

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S9999	Continued From page 7	S9999		

The 11/22/18 Emergency Department Documentation shows R1 was alert to self, otherwise confused. The notes show "Patient is a 49 year old with a history of two craniotomies secondary to subdural hematomas brought in by EMS (emergency medical services) for altered mental status ...Patient had eloped from the facility sometime early this morning and was found by EMS wandering the streets. Upon EMS arrival, patient was alert and oriented times one (to person)."

The 11/22/18 notes from the local hospital show R1 presented to the hospital with a history of alcohol abuse and two prior subdural hemorrhages with craniotomies. The notes show R1 developed altered mental status and was found to have bilateral subdural hematomas which had worsened on the left side with some midline shift. R1 was taken to the operating room and bilateral craniotomies were performed.

The (City) Police report shows on 11/22/18 at 6:22 AM, V17 (Police Officer) was dispatched to the facility for a public complaint after the County Sheriff's office had responded to an earlier call around 5:39 AM regarding a subject standing outside with his pants down at a location 1.2 miles away from the facility. The County Sheriff's office had responded to that call and learned the subject was supposed to be in a secured wing of (the facility) and was supposed to be with staff at all times because he was a flight risk patient. The report shows when V17 arrived at the facility, he was notified by his department that the facility was calling to report one of their residents missing. The same report shows V17 was taken to R1's room and shown the window screen which was cut/slit around the edges. The report shows V17 walked outside to look at the window.

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S9999	Continued From page 8	S9999		

V17 observed the hedges were disturbed and obsderved a branch that appeared to be freshly broken. V17 observed shoeprints in the mud/mulch bed, facing west. V20 (Deputy Sheriff from the County Sheriff's office) arrived at the facility and informed V17 that R1 had been transported to the local hospital where he was currently being evaluated.

The AccuWeather forecast for local weather conditions the morning of 11/22/18 show the temperatures on that day were a low of 33 degrees and a high of 39 degrees.

On 11/28/18 at 11:43 AM, the screen on the right window in R1's room had a cut down both sides and at the bottom. The front door to the facility is visible from R1's window. At 11:45 AM the area from the facility to the location R1 was found was retraced by this surveyor. R1 would have had to cross 2 busy highways to get to that location. One highway is 4 lanes with a speed limit of 45 miles/hour. The other highway is a 2 lane highway with 2 turn lanes and a speed limit of 35 miles per hour. The speed limit at the location R1 was picked was 35 miles per hour. This was a 2 lane road with 1 turn lane.

On 11/28/18 at 11:10 AM, V21 (Social Services Director) said she is familiar with R1. V21 said when R1 first got to the facility he did not have any behaviors. V21 said R1 attempted to elope when he was in the hospital. V21 said over time, R1 wanted to go home. "He didn't understand his limitations." V21 said. R1's behaviors increased and he became agitated with staff. V21 said R1 wanted to go home independently, however, he could not do this due to his short term memory loss. V21 said R1 threw his suit case out of one of the doors. V21 said R1's head was hurting and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN BARR LINCOLNSHIRE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(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) COMPLETE DATE
S9999	Continued From page 9	S9999		

that is why he never left the building after putting his suitcase outside. V21 said R1 was placed on one on one after that. .

On 11/28/18 at 3:33 PM, V18 (Police Officer) said he was one of the officers that went to the nursing facility to see if the subject that was picked up was a resident of the facility. V18 said upon arriving at the facility, he received notification from dispatch that the facility had just called the police department and was in the process of reporting a missing resident. V18 staed he did not see R1, however he remembers being told by the County Sheriff that R1 did not have any pants on. V18 said the individual that was supposed to be doing the one on one supervision informed him that she did not check on R1 when she began her shift. V18 said he saw the cut screen, a bush that was disturbed and footprints in the dirt near the window. V18 said R1 had to cross two major intersections to get to the location he was found wandering.

On 11/28/18 at 5:45 AM, V2 (Director of Nursing-DON) said when a resident is on one on one supervision, staff are expected to have a visual of the resident they are watching. V2 said; "(R1) was a one on one supervision. He verbalized on and off that he wanted to go home. He supposedly was looking for belongings and threw them outside of our building so he could go home. It was the Thursday before Thanksgiving. He was put on 1:1 from that time on. Prior to that R1 was at risk for elopement when he was in Palm Beach because he would walk around a lot." V2 said she got a call at 6:30 AM on 11/22/2018, from V6 (RN, Night shift Supervisor), informing her that R1 was missing. V2 said around 6:00 AM V4 noticed R1 was missing. V2 stated, "Prior to that the last time he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING _____ B. WING _____	C 12/06/2018

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S9999	Continued From page 10	S9999		

observed was on the 3-11 PM shift." V2 said one of the CNAs saw R1 close to 11:00 PM before she left. V2 said V4 did not go in and "put eyes on R1 the whole time and that is why the facility had to let her go." At 10:31 AM, V2 said they are still trying to figure out how R1 got his suitcase out of the building. V2 said the neurosurgeon said R1 still needs to be supervised and he cannot function independently. V2 said R1 is impulsive . He is not able to make own meals or drive. R1 has short-term safety awareness. V2 said she was told that R1 was wearing shorts and a sweatshirt, and had socks and shoes on when he was last seen. V2 said R1's diagnosis at the hospital was altered mental status.

On 11/28/18 at 2:45 PM, V4 CNA said "I worked the 11 PM-7AM shift on 11/21/18. My job duties that night were to watch over (R1). He was a one on one. That meant keeping an eye out for him. Making sure he did not exit the unit or the facility. The door to (R1's) room was cracked open a little bit. I did not physically see him. I talked to the CNA that worked the 3-11 PM shift. I worked with R1 three times. All three times were for a one on one. The other times he would come out of his room at 4:30 or 5:30 AM and sit in the TV area on the couch. I was sitting on the couch in the TV area, staring at his door, the whole shift. I don't know why they (the facility) are so upset with me. The other two times I did one on one with him I did the same thing. I guess I was supposed to be in the room with him. If they wanted me in the room with him, they should have told me that." V4 said R1 had brain surgery so she z "guesses he (R1) had something wrong mentally." V4 said "(R1) did not come out to sit on the couch like he usually does, so around 6:00 AM, I went into his room to check on him . He was not in there. I told the Nurse that had come in early (V8). We

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	IL6014377	A. BUILDING _____ B. WING _____	C 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 11	S9999		

checked the bathroom and outside of the unit. " V4 said another CNA went into R1's room and saw the screen to the window in R1's room was cut open. V4 said they saw footprints going out towards the road.

On 11/28/18 at 5:10 AM, V5, CNA, said he worked the night shift on 11/21/18 the night R1 got out. V5 said he worked on the unit that R1's room was on, but he was not assigned to R1. V5 said V4 was assigned to R1. V5 said R1 was an elopement risk and V4 was assigned to do one on one supervision with R1. V5 said one on one means to focus on the resident assigned. Keep an eye on them and make sure they are alright. Sitting with them at all times. With R1, V4 should have been in the same room with him. V5 said he checked on R1 at the start of his shift between 11:00 and 11:15 PM and that was the only time he saw R1 during that shift. V5 said he was getting residents up in the morning and that is when V4 went in to check on R1 and realized he was not in there. I think it was about 5:30 AM. V5 stated, "For the most part I just saw (V4) sitting in the TV room. I did not see her go into (R1's) room."

On 11/28/18 at 7:50 AM, V7 (RN) said she was the Nurse working both the Melbourne (the unit R1 was located) and the Barcelona units on 11/21/18 into the morning of 11/22/18. V7 said she did not see R1 at all during the night. V7 said V4 was assigned to be a one on one with R1. V7 said at 1:00 AM, she asked V4 if she was checking on R1. V4 replied yes. V7 said V8, LPN, came in around 5:00 AM to help with the morning medication pass. V8 was passing medications on the unit R1's room was lcoated. V7 said one on one means direct supervision. Keeping the resident visible at all times. V7 said V4 was watching R1's door and did not have

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S9999	Continued From page 12 direct eye contact with R1. On 11/28/18 at 8:10 AM, V8 (LPN) said he went into work on 11/22/18 at 5:00 AM. V8 said he was passing medications on the wing that R1's room was located. V8 said during report from the night nurse, he was told that everything was good and that it had been a quiet night. V8 said V5 (CNA) told him that everything was good. V8 said V5 informed him that V4, CNA was doing one on one with R1. V8 said he did not talk to V4 until about 6:00 AM when V4 told him she could not find R1. V8 said the facility initiated the elopement protocol by searching the units and around the premises. V1 (Administrator) and V2 (DON) were notified. V8 said: "One of the CNAs went into R1's room and noticed the screen was cut. We went outside and saw the footprints and notified the police." V8 said the facility was told that R1 had already been located and was at a local hospital. V8 said he called V13 (R1's Power of Attorney-POA) to inform her. V13 said she was already aware of the situation. V8 said one on one supervision means specifically assigning a staff member to physically be with the resident and have visual contact at all times. If that staff member needs to go somewhere, they need to let another staff member know so they can watch the patient. V8 said R1 has tried to leave the facility before and that is why he was put one on one. On 11/28/18 at 7:38 AM, V6 (RN, Night shift Supervisor) said she was working Wednesday,11/21/18. V6 said R1 was supposed to be a one on one the night he (R1) got out of the building. V6 said one on one supervision means a staff member should have eyes on the resident at all times. V6 said staff discovered at 6:00 AM that R1 was not in his room. V6 said	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014377	A. BUILDING: _____ B. WING _____	C 12/06/2018

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WARREN BARR LINCOLNSHIRE	150 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

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S9999	Continued From page 13	S9999		

staff reported it to her and the staff did a search of the facility. V6 said a staff member drove around the building because one of the CNAs showed her that R1's window screen was cut at the bottom. V6 said she called V2 and V1. V6 said when staff were not able to locate R1, they called the police. V6 said she did not see R1 at all on 11/21/18-11/22/18.

On 11/29/18 at 10:10 AM, V2 (DON) said the investigation into R1's elopement is finished. "The screen was damaged that night, we were not able to figure out how he cut the screen, the only thing I can think of is a bread knife. We searched the room. I don't know how he cut it, a new screen was ordered. 1:1 it depends on resident assessment-if a resident ambulates quick they are placed on 1:1, 1:1 you have to visually watch that person, if you have to go to the bathroom they have to get someone else to cover, the resident has to be visually seen all the time. There is not a policy regarding 1:1 definition. V4 just watched the door, not the resident. We let her go because she did not follow his plan of care."

On 11/29/18 at 12:35 PM, V1 (Administrator) said one on one supervision means having an eye on the resident at all times. V1 said V4 was the staff member assigned to do the one on one supervision. V1 said R1 was last visualized at 11:00 PM on 11/21/18 and staff realized R1 was not in his room about 6:00 AM. V1 said V4 should have known what her task for one on one was, as far as visualizing the resident during the shift.

On 11/28/18 at 6:40 AM, V9 (LPN) said; "One on one means one person is responsible for just one resident. All of the time the staff member should be right by the resident with their eyes on the

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S9999	Continued From page 14	S9999		

resident . It is important to keep an eye on them so they can't get out. Outside they are not safe due to cold weather, and cars out there. They could get hurt. They could fall and break something."

R1's elopement care plan initiated on 10/29/18 shows R1 presents a potential elopement risk. He does not fully comprehend why he needs to be at the facility and he had attempted to leave the hospital twice before his admission. The care plan shows "Resident verbalized he wants to leave today, but has not verbalized any intent to do so without permission. He is not responding well to discussions about needing long-term care support. He believes he is more capable than he is." R1's cognition care plan initiated on 11/19/18 shows he displays impaired cognitive function/dementia or impaired thought processes related to or as evidenced by current medical condition. He displays short-term memory loss in relation to medical history as well as history of substance abuse. The care plan shows R1 needs supervision with decision making.

R1's Activities of Daily Living care plan initiated on 10/26/18 shows he has a self-care performance deficit and impaired mobility related to subdural hematoma. The care plan shows R1 requires supervision with transfers and supervision with toileting.

R1's Seizure disorder care plan initiated on 11/07/18 shows he has a seizure disorder related to a head injury.

R1's care plan titled Presence of Abuse and Neglect Factors initiated on 10/27/18 shows R1 presents with behavioral symptoms including recent physically inappropriate behavior while

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S9999	Continued From page 15	S9999		

hospitalized. When the resident was in the hospital, he knocked down two nurses in his attempt to elope from the hospital multiple times (during his hospital stay between 10/13/18 and 10/26/18 in which he had a craniotomy due to subdural hematoma).

The facility policy and procedure titled Elopement Policy with a revision date of 2/20/17 shows "It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible." The policy shows "Routine Procedure for Wandering Residents and Prevention of Missing Residents/Elopement: 3. All residents who are at risk for possible elopement/wandering shall be accompanied by staff or responsible party when leaving the residents unit and/or facility grounds."

On 11/29/ 18 at 6:50 AM, V20 (County Sheriff) said he was the officer that responded to the call regarding R1 on 11/22/2018. V20 said "(R1) was not dressed appropriately for the weather. I cannot remember exactly what he was wearing because I answer so many calls but I do remember that he was not dressed appropriately. He did not appear to me, to be able to make good decisions or care for himself. The paramedics were asking him questions and he was not responding to their questions." V20 said R1 should not have been outside. At 10:42 AM V20 said the local ambulance were the ones that transported R1 to the hospital. V20 said R1 could have frozen to death. It was cold.

On 12/3/18 at 3:10 PM, V22 (ER-Emergency Room Physician) said she saw R1 the morning of 11/22/18 in the ER. V22 said R1 was very confused, almost lethargic. V22 said in that state of mind R1 was in no conditions to make good

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S9999	Continued From page 16 decisions or care for himself. (A)	S9999		

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: WARREN BARR LINCOLNSHIRE COMPLAINT #: 0107541
LIC. ID #: 0053587
DATE COMPLAINT RECEIVED: 11/27/18 09:14:00

IDPH Code	Allegation Summary	Determination
104	NEGLECT	2
105	IMPROPER NURSING CARE	1

X The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.