STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145336	A. Building B. Wing	09/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Barr Gold Coast	66 West Oak Street Chicago, IL 60610

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 0689 Level of Harm - Minimal harm or potential for 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** 45000 Based on observation, interview and record review, the facility failed to implement fall precaution interventions for two (R2, R4) residents identified as a fall risk out of three residents reviewed for fall precautions. Findings include: 1. On 08/31/2024 at 11:54AM, surveyor observes R2 lying in R2's bed resting inside of R2's room in a supine position with head of bed elevated at 45 degrees. Surveyor observes R2's bed alarm pad hanging on the rails at the top/head of R2's bed. R2 is verbal and noted with confusion. On 08/31/2024 at 12:00PM, V5 (Registered Nurse/RN) now located inside of R2's room and observes R2's bed alarm pad. V5 states R2's bed alarm pad should not be there and V5 is not sure why R2's bed alarm pad is hanging over the top/head of R2's bed. V5 states R2's bed alarm pad should be placed underneath R2's body while R2 is in bed. V5 states if R2's bed alarm pad is not in place then R2 could move while in bed and fall. V5 states R2 could potentially injure herself or fracture a bone if R2 sustained a fall in the facility. V5 states R2 is assigned to have a CNA inside of R2's room monitoring R2 and providing 1:1 care for R2. V5 states with 1:1 care, a CNA should be inside of R2's room at all times monitoring R2. On 08/31/2024 at 12:04PM, V6 (Certified Nursing Assistant/CNA) enters R2's room and states she is the CNA assigned to R2's room to provide 1:1 care for R2. V6 states she just returned from her 30-minute break and informed another CNA staff member to monitor R2 during V6's break. Surveyor inquires to V6 about R2's bed alarm pad and its placement prior to V6 entering R2's room. V6 states she is not sure how R2's bed alarm pad was placed hanging on the rails at the top/head of the bed. R2's comprehensive care plan dated 08/15/2024 documents that R2 is care planned for risk for falls with interventions that include: Mobility alarm provided. R2's Nursing progress note dated 08/26/2024 at 2:05PM, documents in part, Situation: 1. The change in condition, symptoms, or signs observed and evaluated is/are: Pain in left thigh with no relief, 2. This started on: 08/26/2024, 2a. Since this started, it has gotten: Stayed the same, 5. This condition, symptom, or sign has occurred before? No, 6. Is the change in condition related to an incident (fall, skin alteration or injury of unknown origin)? Yes, 7. Other relevant information: R2 was stuck in between bed and side rail. A0x1 confused at baseline. (continued on next page)

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 08/31/2024 at 1:14PM, R4 located inside of her room lying in bed. R4 is verbal and noted with confusion and is a poor historian. On 08/31/2024 at 1:29PM, V7 (CNA) located inside of R4's room and observes that R4's bed alarm pad is in place underneath R4's body but R4's bed alarm pad is not plugged in. V7 takes the gray phone cord plug off the floor and places it into the bed alarm and surveyor hears an audible alarm once R4's bed alarm is plugged in. R4's bed alarm is labeled as follows: Deluxe Pad Alert, Do Not Disconnect. V7 states she was scheduled to start her shift at 6AM today but started her shift around 8AM and was not aware that R4 had a bed alarm. V7 states since R4's bed alarm was not plugged in, R4 could have fallen and the facility would not have known that R4 fell because the alarm was not plugged in. V7 states there is potential for R4 to hurt herself during a fall at the facility. On 08/31/2024 at 1:36PM, V8 (Licensed Practical Nurse/LPN) states, R4's fall precaution interventions include R4's bed being in the lowest position, floor mats in place, and R4 having a bed alarm in place. V8 states if a resident's bed alarm is not plugged in, then the staff would not be able to hear the resident's alarm if the resident falls. V8 states a resident could possibly injure themselves if they fall in the facility. V8 states R4 has a history of falls in the facility. R4's comprehensive care plan dated 07/17/2024 documents that R4 is care planned for risk for falls with interventions that include: Bed alarm provided upon admission. R4's fall risk assessment dated [DATE] documents R4 has a fall risk score of 13, indicating R4 is at high risk for falls. Facility policy dated 07/26/2024 titled Fall Occurrence documents in part, 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- 2. Those identified as high risk for falls will be provided fall interventions. 8. The Falls Coordinator will add the intervention in the resident's care plan.