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	03/20/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50662 Based on interview and record review the facility failed to assure that one resident (R2) with intact skin, received the necessary treatment and services to prevent the development pressure wounds. This failure resulted in R2's development and worsening of two pressure ulcers, requiring hospitalization for wound infection and surgical intervention of wound. Findings include: R2's medical diagnoses include but are not limited to intraspinal abscess and granuloma, neuromuscular dysfunction of bladder, unsteadiness on feet, secondary malignant neoplasm of colon, neoplasm of unspecified behavior of endocrine glands and other parts of nervous system, essential hypertension. R2's Minimum Data Set (MDS) dated [DATE] has a Brief Interview for Mental Status (BIMS) score of 15, which indicates R2's cognition is intact. R2's Care plan dated 02/19/25 documents in part, R2 has an ADL (Activities of Daily Living) self-care performance deficit and Impaired mobility .R2 will be assisted with ADLs as needed .Toilet hygiene: I require total assistance to maintain perineal hygiene .Bed mobility: I require weight bearing assistance to move to and from a lying position, turn side to side, and position while in bed or alternate sleep furniture .Ambulation: I am non ambulatory. R2's care plan dated 02/20/25 documents in part, R2 has impaired ability in moving to and from a lying position, turning side to side, and positioning self in bed due to generalized weakness, decreased endurance, limited ROM (range of motion) and forgetfulness related to cognitive impairment .R2 will participate in turning and repositioning program to remain free of complications related to immobility, including contractures, thrombus formation skin-breakdown .Place pillows for positioning as needed. R2's care plan dated 02/20/25 documents in part, R2 was admitted with a scar on his upper back, R2 is at risk for impairment to skin integrity due to comorbidities and a Braden scale score of 14 .resident will continue to have skin intact .High risk - skin check every shift. Report abnormalities to the nurse. Keep skin clean and dry. LAL (low air loss) mattress .Turn and reposition at least every 2 hours and as needed. R2's progress note with date of service dated 02/20/25 documents in part, Skin: warm and dry, intact, no open wound. (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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R2 wound assessment dated [DATE] documents in part, Skin Alteration #1 .1. Is this a New skin alteration: Yes .Site: Right buttock, Type: Pressure, Length: 4 centimeters, Width: 5 centimeters, Depth: 0.1 centimeters, Stage: Unstageable .Skin Alteration #2 .1. Is this a New skin alteration? Yes .Site: Left heel, Type: Pressure, Length: 5 centimeters, Width 5 centimeters, Depth 0.1 centimeters, Stage 2. R2 wound assessment dated [DATE] documents in part, Skin Alteration #1 .1. Is this a New skin alteration: Yes .Site: Right buttock, Type: Pressure, Length: 10 centimeters, Width: 6 centimeters, Depth: 0.1 centimeters, Stage: Unstageable .Skin Alteration #2 .1. Is this a New skin alteration? Yes .Site: Left heel, Type: Pressure, Length: 5 centimeters, Width 5 centimeters, Depth 0.1 centimeters, Stage 2. On 03/17/25 at 12:55pm, R2 stated that he was admitted to the facility with no wounds and his skin was 100% intact. R2 stated that he has no control over his body and was unable to reposition himself in bed. R2 stated that he needed assistance from the nursing staff to be repositioned in bed. R2 stated that the facility's staff did not check on him regularly. R2 stated that after his wounds developed, staff still never checked on him and repositioned him regularly even when asked. R2 stated that he was admitted to the hospital with symptoms of fever and chills and was told he had a flesh-eating bacteria. R2 stated that he already had pain from the cancer that he has but has been experiencing more pain since the development of the wounds. R2 stated that he feels horrible and anxious because he is not able to continue treatment for his cancer until the wound heals. On 03/16/25 at 12:21pm V11 (Licensed Practical Nurse/LPN) stated that R2 never refused to be cleaned or repositioned. V11 stated that sometimes when she went to give R2 medications that he would ask to be repositioned. V11 stated that R2 was incontinent of bowel and bladder and would put on the call light when he needed to be cleaned. On 03/16/25 at 2:05pm V13 (Wound Care Director) stated that a bedbound resident should be repositioned every 2 hours. V13 stated that R2 was admitted to the facility on [DATE] with intact skin. V13 stated that she was informed on 02/26/25 that R2 had developed two new wounds. V13 stated that R2 had developed a wound to his right buttock and left heel. V13 stated that R2 never refused care. V13 stated that on 03/03/25, R2's wound had gotten worse, so an air mattress and heel protectors were ordered for R2. V13 stated that if an air mattress would have been ordered on the day that the R2's wound was first discovered, R2's wound may not have gotten worse. V13 stated that on 03/09/25, she was informed by another wound nurse that R2's wound didn't look good. V13 stated that at that point she went to assess R2's wound herself and noticed purulent drainage and a strong odor from the wound. On 03/17/25 at 11:22am V15 (Wound Care Nursed Practitioner) stated that she first assessed R'2 skin on 02/20/25 and R2's skin was intact. V15 stated that the wound care team was first notified of R2's new wound on 02/26/25. V15 stated that she first assessed R2's new wound on 03/03/25. V15 stated that R2 had limited bed mobility and was dependent on the staff to reposition him. V15 stated that based on her assessment, R2 developed a pressure ulcer due to not being repositioned, possibly not being cleaned, along with his comorbidities as a risk factor. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R2's physician progress note dated 02/20/25 documents in part, decreased sensation to both legs .patient has risk for developing contractures, pressure ulcers, poor healing or fall if not receiving adequate therapy and pain control. R2's Nurse Practitioner (NP) progress note dated 02/26/25 documents in part, On admission skin assessment, patient has no open wounds or skin issues .continue with turning and repositioning schedule per protocol for pressure prevention. R2's progress note dated 03/03/25 documents in part, Wound care team was notified of new wounds. Upon assessment, patient had an unstageable pressure injury on the right buttock and a stage 2 pressure injury on the left heel .The patient is at increased risk for developing skin breakdown and moisture associated skin damage due to fecal and urinary incontinence, inability to perform self-care. Patient is at moderate risk for pressure ulcer formation related to decreased mobility, comorbidities, incontinence of urine and stool. R2's physician hospital note dated 03/09/25 documents in part, Large paramedian right gluteal ulcer with scattered subcutaneous air tracking into the right gluteal subcutaneous soft tissue and gluteus maximum muscle. Findings can be seen in the early necrotizing fasciitis .purulent, malodorous right gluteal wound . Plan: General surgeon on consult status post I&D (incision and drainage) at bedside today, plan for OR (operating room) tomorrow for more extensive I&D. Facility's policy titled Wound Care Guidelines dated 01/23/25 documents in part, Overview of the Program . The goal of this care guidelines is to achieve compliance to regulatory requirements and provide evidence-based recommendations for the prevention and treatment of pressure injuries that can be used by the health professionals in the facility .1. Procedures: .C. Each risk factor and potential causes identified should be reviewed individually and addressed into the resident's care plan. D. Facility shall develop a plan of care and implement intervention according to the resident's Braden Scale and Clinical Evaluation or identified individual risk factors .3. Prevention of skin breakdown includes but not limited to: B. Daily regular skin hygiene. C. Inspection of the skin every shift with care for signs of breakdown. H. Administration of scheduled shower/bath and documentation of completion and findings in Task/POC .4. Activity, Mobility, and Positioning .B. Establish an individualized turning and repositioning schedule if the resident is immobile or with impaired physical functioning. C. While in bed, resident should be turned/repositioned at least every 2 hours or as indicated in the residents' plan of care. While resident sitting in wheelchair, resident should be turned/repositioned at least every hour or as indicated in resident's plan of care. D. While in a sitting position and/or if the head of bed is elevated greater than 30 degrees, resident should be repositioned at least every 2 hours or as indicated in the plan of care .J. Off load elbows and heels as needed. K. Elevate resident heels off the bed as indicated .5. Skin Protection .E. Assess and treat incontinence. As part of incontinent care, apply protective ointments, moisture barriers and other products to the skin to counteract effects of excessive moisture on the skin. 9. Documentation .C. The care plan shall be evaluated and revised based on resident's response to treatment, treatment goals and outcomes Facility's policy titled Skin Care Regimen and Treatment Formulary dated 01/24/25 documents in part, It is the policy of this facility to ensure prompt identification, documentation and to obtain appropriate treatment for residents with skin breakdown .Procedures .6. Residents who are not able to turn and reposition themselves will be turned and repositioned at least every 2 hours unless otherwise specified by the physician.