| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145336 | A. Building<br>B. Wing | 07/09/2025 |

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

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| F 0573<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Let each resident or the resident's legal representative access or purchase copies of all the resident's records.<br><br>Based on interviews and records review, the facility failed to provide one (R4) resident of three reviewed with access to medical records in a total sample of six.<br><br>Findings include:<br><br>R4's current face sheet documents R4's medical conditions to include but not limited to: cerebral infarction due to embolism of right middle cerebral artery, chronic combined systolic (congestive) and diastolic (congestive) heart failure, type 2 diabetes mellitus without complications, atherosclerotic heart disease of native coronary artery without angina pectoris.<br><br>R4 is a closed record and was not residing in the facility during this investigation survey.<br><br>On 07/08/2025, at 10:36 AM, V4 (R4's daughter) via phone stated she did not have POA (Power of attorney) paperwork but had surrogate for health paperwork which she had been able to use at other facilities without any issues. V4 stated V3 (Medical Records) told her without the POA paperwork on file at the facility, he was not able to give her any information regarding R4. V4 stated to date, she has not received R4's medical records from the facility.<br><br>On 07/08/2025, at 1:44 PM, V3 (Medical Records Director) stated V4 requested for R4's medical records via email to V3 on 03/25/2025, which was after R4 had been discharged from the facility on 3/11/2025. V3 stated when he received R4's medical records request form, the POA (Power of Attorney) paperwork was missing. V3 stated he replied to V4 on the same day requesting V4 to send the POA paperwork. V4 responded she would work on that and on 4/28/2025, V4 sent V3 a document-Surrogate Decision (SD) form that stated V4 was R4's surrogate decision maker. V3 stated he sent R4's surrogate decision form to the corporate office on 5/12/2025 for them to review and tell V3 what to do. V3 stated on May 15th, 2025, corporate responded via mail and said she could not find the POA paperwork or the equivalent surrogate decision form. V3 stated he had attached the surrogate form on the email. V3 stated the facility accepts surrogate decision form for a person to be a resident's decision maker/POA.<br><br>V3 stated he assumed the corporate office saw the surrogate decision form he attached to the email, but he thinks corporate only looked at the first page and did not open the other attachments. The surrogate decision form is accepted by the facility to release a resident's medical records to the person listed as a surrogate on the form. V4 stated he did not follow up with the corporate office to see why the document was not deemed legit. V4 stated someone in facility corporate office dropped the ball.<br><br>(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 0573<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | V3 stated he reached out to V4 on 5/19/2025. V4 told her the surrogate document was not varied as a power of attorney document/surrogate form. V4 stated she had sent a surrogate decision form to V3 that was already completed to facilitate her (V4) in receiving R4's medical records from the facility.<br><br>After V3 completed the interview with surveyor and surveyor reviewed R4's documents, V3 came back after approximately an hour and gave the surveyor a concern form dated 07/08/2025. The form stated V3 reviewed the surrogate decision maker form and received approval to release medical records to V4. V3 stated there were not new documents added by V4 and the documents reviewed were the same ones V3 had sent to corporate on 5/15/2025 for approval. V3 stated the documents were approved today and V3 has sent to V4 R4's medical records. V3 stated R4's medical records should have been sent to V4 in May when V4 requested because V4 had sent the legal documents the facility accepts to release a resident's medical records to a surrogate.<br><br>Surveyor reviewed an email sent to the corporate office on 3/25/2025, with attachments of Health Care Surrogate Act Physician Documentation and Certification.<br><br>Reviewed Health Care Surrogate Act Physician Documentation and Certification signed by V4 on 3/15/2025 and the physician on 4/22/2025. It was given to V3 who sent it to the facility corporate office via email on 3/25/2025.<br><br>Policy titled Medical Records Request and access dated 8/16/24, documents:<br><br>-The resident or regal representative of the resident will be allowed access to inspect resident's medical records within 24 hours of a valid or oral or written request to the Administrator excluding weekends or holidays. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>Based on observations, interviews, and records review, the facility failed to provide sufficient nursing staff (Registered Nurses/Licensed Practical Nurses) to the third and fourth floors. This failure has the potential to affect 71 residents residing on these floors.<br><br>Findings include:<br><br>On 07/08/2025, at 12:45 PM, V12 (Licensed Practical Nurse-LPN) stated she is the only nurse on the third floor, and she was feeling overwhelmed. Medications were passed late this morning. She is not able to give the residents the attention and care they deserve because she is the only nurse taking care of 35 residents. V12 stated she started working full time at the facility in January and this change of having one nurse on the third floor was recently implemented but it is not working.<br><br>V12 stated she has informed V2 (Director of Nursing) and her supervisor that she is overwhelmed and was told the supervisors would help. V12 stated she was not able to attend to of all her resident needs this morning. The morning medications were late for some residents. V12 stated she has enough Certified Nursing Assistants (CNAs) but they cannot perform nursing duties and are also asking her questions when residents need help that the CNAs cannot assist with. V12 stated even though this unit is a long-term unit, the residents have needs and a lot of medications to be administered. One nurse is not enough to do all the work and take care of residents' needs.<br><br>On 07/08/2025, at 12:56 AM, V17 (Licensed Practical Nurse-LPN) stated she is the only nurse on the fourth floor. She is not able to provide and administer the residents morning medications on time or take care of the residents' needs at the same time. V17 stated she has 36 residents today and she was feeling overwhelmed. V17 stated she found out she would be working alone today when she came to work. V17 stated she was told the supervisors would help, but the supervisors are not always available to assist on the units.<br><br>V17 stated she cannot provide quality care to the residents when she is alone and does not think one nurse is enough to work on the fourth floor with 36 residents. V17 stated she has three CNAs working on the fourth floor. That is enough CNAs but they cannot do nursing work therefore they cannot help V17 with her work.<br><br>On 07/08/2025, at 3:00 PM, V22 (Staffing Coordinator) stated the facility staffs each floor with a different number of nursing staff. V22 stated each floor has three Certified Nursing Assistants (CNAs) in the morning, three on the evening shift and two for overnight. V22 stated on the third and fourth floors the nurses do 12-hour shifts. These two units are staffed with one nurse per floor. V22 stated on July 1st, 2025, there were 36 residents on 3rd floor, on 7/2/2025, 7/3/2025, 7/4/2025, 7/7/2025, 7/8/2025, there were 35 residents. On 7/5/2025 and 7/6/2025, there were 36 residents on the unit. V22 stated the third-floor houses long term residents therefore she was instructed by V2 (DON) to start staffing the units with only one nurse.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | V22 stated the fourth floor also houses long term residents. On 7/1/2025, 07/02/2025, 07/03/2025, 07/04/2025, there were 37 residents on the floor and on 7/05/2025, 07/06/2025, 07/07/2025, 07/08/2025, there were 38 residents. V22 stated she gets the directions on how to staff nurses from V2 (Director of Nursing). For the CNAs V22 does the math by dividing the three CNAs scheduled by the number of residents on the floor. V22 stated the nurses on the 3rd and 4th floor have complained to her that the 3rd and 4th floors are heavy for one nurse. V22 reported to V2 because she cannot make any decisions to add nurses because she is not a nurse herself. V22 stated there are supervisors to assist the agency nurses on the floors.<br><br>On 07/08/2025, at 4:00 PM, V2 (Director of Nursing-DON) stated the 3rd and 4th floors have always had one nurse because these floors hold long term residents. V3 stated the nurses on these floors work twelve hour shifts from 7:00 AM to 7:00 PM. V2 stated before, the third and fourth floors each had a nurse working 8:00 AM to 5:00 PM to assist the nurses on these floors. V2 stated the 3rd and 4th floors were transitioned last week from having a helping nurse to having only one nurse on the unit working twelve hours. V2 stated this one nurse assignment on the 3rd and 4th floors started on Sunday, 7/6/2025.<br><br>V2 stated even before this change was implemented, the nurses were already complaining that one nurse for the third and fourth was not enough because the workload was too much during the morning shift, which has the heaviest medication pass. V2 stated she told the nurses working on the 3rd and 4th floors to give it a try because the 7:00 AM medications and the 9:00 PM medications are almost similar. V2 stated the morning shift is busy because there are a lot of resident activities such as appointments, facility doctors rounding on residents, giving orders, phone calls from doctors to nurses, families calling the nurses, as well as CNAs asking nurses to assist with residents' needs that the CNAs cannot take care of.<br><br>V2 stated today the nurses on third and fourth floor notified her (V2) that they were overwhelmed with the loads of the medications to pass and other work assignments. V2 stated she told the CNAs if they needed anything not to bother the nurses but go to her for assistance. V2 stated she knows the assignments are overwhelming on the third and fourth floors but there is support from the nursing management team. V2 stated if the nurses on third and fourth floors are complaining they are overwhelmed, the residents are not getting the proper care they deserve. V2 stated she will evaluate the situation because she wants the residents to get quality care.<br><br>V2 stated she is the one who implemented the one nurse schedule for the third and fourth floors because she tried it herself and she was able to complete her work as a floor nurse on these units. V2 stated it was her fault that she implemented this schedule and reduced the nurses working on these two floors to one nurse per floor.<br><br>Reviewed nurse staffing schedules from 07/01/2025 that document one nurse each for the third and fourth floors.<br><br>Reviewed staffing policy dated 8/19/24 that documents:<br><br>-It is the facility's policy to provide adequate staff to meet the needs of the residents which is the requirement under the federal regulations. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observation, interview, and record review, the facility failed to administer resident's prescribed medications in a timely manner according to the physician orders. This failure affects 29 (R5, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, and R35) residents in a total sample of 35 residents.<br><br>Findings include:<br><br>On 07/08/2025, at 11:42 AM, surveyor located on the fourth floor of the facility with V17 (Licensed Practical Nurse/LPN). V17 states to surveyor that she started her scheduled shift at the facility at 7:00 AM. V17 states she began administering medications to residents at approximately 8:00 AM. V17 states she is the only nurse assigned to work on the fourth floor of the facility today. V17 states she was informed by V2 (Director of Nursing/DON) sometime last week that the staffing on the fourth floor would change from two nurses to one nurse. V17 states she was not aware of when the change would take effect. V17 states she has been off work for the past 5 days. When she returned to work today, she was the only nurse assigned to work on the fourth floor. V17 states she is still in the process of administering morning medications to residents. V17 states some of the resident's medications are late and have turned red in color on the eMAR/electronic medication record.<br><br>On 07/08/2025, at 11:45 AM, surveyor observes the eMAR that is deployed on the laptop computer attached to V17's medication cart. Surveyor observes the following resident's eMARs are red in color: R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21.<br><br>On 07/08/2025, at 12:07 PM, V10 (Registered Nurse/RN) arrived on the fourth floor and states she is assigned to help assist V17 (LPN) with the medication administration pass on the fourth floor. V10 states she will now continue administering medications for the residents who have not received their morning medications. V10 states she recently clocked in and was called by V2 (DON) to come to assist in the facility.<br><br>On 07/08/2025, at 12:20 PM, surveyor located on the third floor of the facility with V12 (Licensed Practical Nurse/LPN). V12 states she is the only nurse assigned to work on the third floor of the facility today. V12 states she was informed that this was a new nursing schedule that was being implemented. V12 states as of last week, there were 2 nurses assigned to work on the third floor of the facility. V12 states it now takes her longer to complete the morning medications pass due to only one nurse being scheduled to work on the third floor. V12 states some of the resident's medications are considered late and have turned red in color on the eMAR. V12 states she has not administered all scheduled medications to the resident's residing on the third floor of the facility. V12 states the time frame to administer resident's medication is one hour before the scheduled time and one hour after the scheduled time. V12 states if medication is administered an hour after it is scheduled, then it is considered late.<br><br>On 07/08/2025, at 12:23 PM, surveyor observes the eMAR that is deployed on the laptop computer attached to V12's medication cart. Surveyor observes the following resident's eMAR is red in color: R5, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Medication Audit Report dated 07/08/2025, documents that R5, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, and R35's scheduled medications were administered late.<br><br>Facility policy undated titled Medication Administration: General Guidelines documents in part, FIVE RIGHTS- Right resident, right drug, right dose, right route and route time, are applied for each medication being administered. A triple check of these 5 rights is recommended at three steps in the process of preparation of a medication for administration. Administration 2. Medications are administered in accordance with written orders of the prescriber. 10. Medications are administered within 1 hour before or after scheduled time. Unless otherwise specified by the prescriber.<br><br>Facility policy dated 04/12/2024 titled, Patient-Centered Medication Pass Clinical Guidelines documents in part, 4. Nurses will administer and document the resident medications based on the established medication administration window. |