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	02/19/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete neurological monitoring following an alleged head injury. This failure affected one resident (R1) in the sample of five residents reviewed for accidents and incidents. Findings include: R1 has diagnosis which include but are not limited to: traumatic subarachnoid hemorrhage without loss of consciousness subsequent encounter, history of falling, syncope and collapse, unspecified asthma uncomplicated, hemiplegia hemiparesis following cerebral infarction affecting right dominant side, atherosclerotic heart disease of native without angina pectoris, type 2 diabetes mellitus without complications R1's Brief Interview for Mental Status (BIMS) dated 12/25/25 shows a score of 14 which indicates that R1 is cognitively intact. The facility's Initial Reportable Incidents dated 1/12/26 at 6:21 am, documents in part: On 1/12/26 at approximately 5:40 am, V7 (RN) nursing supervisor reported to V1 (Administrator) the resident R1 stated CNA hit her head while she was being changed. A head-to-toe assessment was initiated immediately with no redness bruising or injuries noted. CNA TV was suspended immediately pending investigation of this alleged incident physician and family were contacted regarding the alleged incident. The facility's Final Reportable Incidents dated 1/126/26 at 6:32 am documents in part: V1 interview V8. V8 stated that she would never intentionally harm a resident. V8 stated that she takes her job seriously, is becoming a nurse, and cares deeply for her residence . At this time, we were unable to substantiate the allegation of abuse. On 2/18/26 at 9:53 am, V8 (Certified Nursing Assistant, CNA) stated that she has worked at the facility for the past two years on the night shift. V8 stated that she recalls R1 at the facility and explained that R1 was alert, oriented, able to make needs known, incontinent of bowel and bladder, one person assist resident who was verbally combative at times during care. V8 then explained that she provided care for R1 multiple times at the facility prior to 1/12/26. V8 further explained that on 01/12/26 around 4:30 am, she was providing incontinence care to R1, she cleaned the front of R1's peri area and R1's right side of her buttocks area while R1 was laying on her right side. V8 continued to explain while she attempted to reposition R1onto her left side, she (R1) was holding onto the bedrail on her left side to assist V8 with repositioning R1 when R1 suddenly stated that she felt that V8 bumped her head on the headboard of R1's bed. V8 then stated that she immediately ceased care with R1 and reported R1's allegations to V15 (Registered Nurse, RN) and V7 (RN, Nursing Supervisor). V8 then explained that she informed V7 and V15 regarding R1's allegations of her (V8) bumping her head. V8 stated that after she reported the incident to V15, V15 completed R1's perineal care while V8 was at the nurses station. V8 also stated that R1 did not have a roommate during the time of this incident and then explained that V7 sent R1 home after informing V8 that there would be an investigation conducted. V8 then stated that V1 (Administrator) called her 30 minutes later asking V8 about R1's allegations. V8 finally explained that she was off work for about five days after R1's allegations of V8 bumping her head and that she no longer saw R1 from that day forward. On 2/18/26 at 10:49 (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	am, V15 (Registered Nurse, RN) stated that she has worked at the facility for about one year on the evening and night shift. V15 then stated that she recalls caring for R1 at the facility and explained that she came into R1's room on 1/12/26 around 4:00 - 5:00 am, after V8 (Certified Nursing Assistant, CNA) called her to R1's room. V8 further explained that V8 stated that R1 said she hit her. V15 then explained that she asked V8 what happen and V8 explained that she was just changing R1 and R1 said that V8 hit her head. V15 then explained that she then asked V8 if she hit R1's head and V8 stated, No. Not that I'm aware of. V15 further stated that she went into R1's room and asked R1 what happened and that R1 stated that V8 hit her head on the bed and on the right side of her face and that V8 also punched R1 in the face. V15 then explained that she assessed R1 head and did not find any bruising, swelling, bleeding or obvious injuries. V15 also explained that R1 did not complain of any pain to touch. V15 explain that she assessed R1 alone and that V7 (Registered Nurse, RN, Supervisor) was not present. V15 further explained that R1 explained that V8 was being rough while changing her (providing incontinence care) and then punched her (R1) in the face. V15 then stated that she informed R1 that she would report R1's allegations to V7 (RN, Nursing Supervisor). V15 explained that she then informed V7 of R1's allegations and instructed V8 to complete a report regarding R1's incident. V15 further explained that she completed a risk assessment reports, a physical injury incident report, and a pain assessment report. V15 was asked regarding R1's neurological assessment and monitoring and V15 stated that R1 did not lose consciousness and did not show any physical injury thus V15 did not complete a neurological assessment for R1. V15 then explained that neurological monitoring should be conducted anytime there is a report of a head injury or suspected head injury. V15 further explained that a neurological assessment is conducted for head injuries because there might be complications from a head injury and the resident may need to be sent to the hospital right away. V15 also explained that she informed R1's physician and the R1's family regarding R1's incident of alleged head injury and that she did not make a progress note regarding R1's incident with the details of the conversations because she was instructed by risk management at the facility not to complete a progress note and to only complete the risk assessment forms that V15 completed.On 2/18/26 at 11:41 am, V2 (Director of Nursing, DON) stated that R1 is alert, oriented times three with dysphagia and was at the facility recovering from sub arachnoid hemorrhage stroke with right side weakness. V2 then stated that R1 required one person assist for her Activities of Daily Living (ADL's). V2 explained that on 1/12/26, R1 alleged that her head was hit on her bed while V8 (CNA) was providing care. V2 explained that V15 (Registered Nurse, RN) , V7 (RN) both conducted a pain, skin assessment, incident report and a post altercation allege abuse follow up form for R1's incident. V2 stated that when she spoke with R1, it was the next day and R1 stated that during care her head was hit but she did not feel it was intentional. V2 stated that she asked R1 if she felt safe and R1 stated that she has received good care and felt safe at the facility. V2 further stated that she assessed R1's head and she did not see any bumps or discoloration, and she told R1 to let staff know right away if she does not feel safe. V2 then stated that R1 did not have any further concerns after R1's allegation of her head being hit. V2 explained that a risk management form was completed. V2 explained that for a suspected head injury, the facility should check orientation, cognition, the residents vital signs, and pain. When V2 was asked regarding R1's neurological assessment monitoring from R1's 1/12/26 reported head injury V2 stated that she did not complete one. V2 then explained that a witness or unwitnessed head injury requires the residents neurological status to be monitored with neurological checks for 72 hours for change of condition and should be treated appropriately. V2 also explained that unwitnessed head injury should be especially monitored for a change of condition. V2 also explained that (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	checking the residents vital signs is not the same as performing neurological checks. V2 stated that if a reported head injury does not receive neurological monitoring the resident could suffer complications and die.R1's Post Altercation/Alleged Abuse assessment dated [DATE] at 6:25 am, reviewed and shows assessment incomplete with no neurological checks conducted. R1's Accident/Incident Report dated 1/12/26 reviewed and shows no neurological checks conducted. R1's Risk Management dated 1/12/26 reviewed and shows no neurological checks conducted. R1's progress notes dated 01/12/26 through 1/15/26 with no documentation of neurological checks documented or performed. The facility's policy dated 07/2/25 and titled Neurocheck documents, in part: Procedures: The nurse will inform the physician of the incident and will follow physicians orders including a neurocheck on the resident.