STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145632	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Barr South Loop	1725 South Wabash Chicago, IL 60616

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent loss or potential diversion of a controlled substance medication. This failure affects one (R3) resident out of three residents reviewed for medications.Findings include: On 06/16/2026 at 9:59AM, R3 states he goes to a counseling center every two weeks on Thursdays to receive Methadone medications. R3 states each time he goes to the counseling center, he receives 13 bottles of Methadone to bring back to the facility to store for him. R3 states the facility administers him 1 bottle of methadone every day in the mornings. R3 states when he was located on the third floor of the facility about 1.5 months ago, he experienced one of his methadone bottles going missing in the facility. R3 states he complained about it and V2 (Director of Nursing/DON) came to speak with him. R3 states V2 informed him that she would get to the bottom of things. R3 states he told V2 that someone in the facility was taking his Methadone medication. On 06/16/2026 at 2:18PM, V15 (R3's Family Member) states R3 reported to her that one of the nurses gave R3's Methadone medication to another resident at 9:00PM. V15 states R3 usually has 13 bottles of Methadone, but one Wednesday morning, he was missing a bottle and only had 12 bottles. V15 states she inquired to the facility about R3's medication and V15 observed that R3's medication logbook documented that a nurse with V20's (LPN) initials signed that R3's Methadone was given at night. V15 states R3 is not prescribed Methadone at nighttime. V15 states after this incident, R3 was moved to another floor of the facility. R3's facesheet documents that R3 was admitted to the facility on [DATE], with a diagnosis not limited to: opioid abuse, uncomplicated. R3's POS (Physician Order Statement) documents in part the following orders: On 4/30/2026, counseling center incorporated, patient going out to appointment at 10:00AM. The resident must be accompanied by assistant transport. This is a standing order for every other Thursday until discharge. Methadone HCL Intensol Oral Concentrate 10 MG/ML (Methadone hcl) *Controlled Drug* Give 70 mg by mouth one time a day. Do not open the bottle to self-administer!!! There must be supervised self-administration. Do not let the patient open the bottle to self-administer!!! Related to opioid abuse, uncomplicated. Review of R3's medication administration record/MAR dated 05/04/2026, documents that V20 (LPN) cared for R3 on 05/04/2026, during the night shift. R3's Controlled Drug Administration Record for 05/2026, was reviewed and documents that the facility received 13 bottles of Methadone for R3 on 04/30/2026 and R3's first administered dosage was on 05/01/2026. R3's Methadone drug supply was enough to last from 05/01/2026 to 05/13/2026 if administered per physician's orders. R3 was scheduled to go back to the counseling clinic on 05/14/2026 to receive a new 13-day supply of Methadone medication. R3's Controlled Drug Administration Record documents that on 05/04/2026, R3 was administered his Methadone medication at 9:00AM as scheduled, leaving a total of 9 bottles left. R3's drug sheet also documents that on 05/04/2026, V20 (LPN) signed that an unscheduled dose of Methadone was administered to R3 on 05/04/2026 at 9:00PM leaving a total of 8 bottles left. On 06/17/2026 at 11:42AM, V20 (Licensed Practical Nurse/LPN) states on 05/04/2026, she worked the 3:00PM-11:00PM shift and was assigned to care for R3. V20 states during her shift, she did not administer Methadone medication to R3. V20 states she only administered Methadone medication to (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	another resident who was scheduled the same medication that night. V20 states she is aware that she documented on R3's controlled drug administration record that she administered Methadone medication to R3. V20 states she must have been moving too fast and was overwhelmed when she mistakenly documented that she administered Methadone to R3. V20 states there is no possibility that she administered R3's Methadone medication to another resident. V20 states approximately 1-2 weeks after her shift on 05/04/2026, she was contacted by V2 (DON) and V2 asked V20 about why her name was documented on R3's drug sheet. V20 states at this time, V2 informed her that she would be suspended from the facility pending an investigation because R3's Methadone medication was missing. V20 states she also told V2 that she did not administer Methadone to R3 and is not sure why the medication is missing. V20 states she was suspended for two days and was able to return to work after that. On 06/17/2026 at 12:43PM, V2 (DON) states R3 went to his counseling clinic on 04/30/2026 and received thirteen bottles of Methadone and began taking the first bottle on 05/01/2026. V2 states R3 was supposed to have enough bottles of Methadone to last him until his next appointment on 05/14/2026. V2 states she was first made aware of allegations of R3's missing Methadone medication from another staff member. V2 states she also saw that there was a discrepancy on R3's drug administration sheet for Methadone. V2 states V15 (R3's family member) made allegations that the facility was doing something strange pertaining to R3's Methadone medication. V2 states she then started an investigation right away and performed a count of R3's Methadone medication and R3 was missing a bottle of Methadone for Wednesday 05/13/2026. V2 states R3's counseling clinic is closed on Wednesdays and R3 was not scheduled to receive more Methadone medications until Thursday 05/14/2026. V2 states due to this, the facility ordered a one-time dose of Methadone from the facility's pharmacy for R3 so he would not miss his dose of medication. V2 states during her investigation, V20 told V2 that she does not remember giving Methadone medication R3. V2 states she believes that V20 (LPN) was not being truthful when V20 stated she did not administer Methadone to R3 because V20's signature documents that she administered the medication and R3's Methadone medication bottle was missing. V2 states it's possible that R3 took the Methadone medication instead of telling V20 that his Methadone medication was not yet due for administration. V2 states it is the nurses' responsibility to follow the rights of medication to prevent medication errors. Facility document dated 05/13/2026 documents that the facility received Methadone 10mg/ml medication for a total of 7ml from the facility's pharmacy for R3. Review of R3's MAR documents a one-time order for Methadone medication dated 05/13/2026 was administered to R3. Facility policy dated 07/02/2025 titled, Medication Pass documents in part, It is the policy of the facility to adhere to all Federal and State regulations with medication pass procedures. Facility policy dated 08/2020, titled Controlled Substance Prescriptions documents in part, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances and medications classified as controlled substances by state law are subject to special ordering, receipt, and recordkeeping requirements in the facility, in accordance with federal and state laws and regulations. The Director of Nursing and the contracted consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications.