

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0052415		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/30/2026	
NAME OF PROVIDER OR SUPPLIER WARREN BARR GOLD COAST				STREET ADDRESS, CITY, STATE, ZIP CODE 66 WEST OAK STREET , CHICAGO, Illinois, 60610			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000				
	Annual certification						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)						
	300.1210c)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. These Requirements were not met evidenced by: Based on interviews and record reviews, the facility failed to follow their policy and resident's care plans by not monitoring critical vital signs or notifying the attending physician of an emergent change in condition for one (R212) out of three residents reviewed for closed record, in a total sample of 35 residents. The failures resulted in R212 to be found unresponsive by a staff member three hours after receiving the last critical vital sign and eventually was pronounced dead by the paramedics on the scene. The facility also failed to follow residents' care plans, physician order sheets, and change-in-condition policy by not obtaining ordered weights for two (R172, R133) out of three residents reviewed for quality of care in a total sample of 35 residents. Findings include: R212's face sheet documents that R212 has diagnosis not limited to Dysphagia, Seizures, Malignant Neoplasm, Encephalomyelitis, Anemia, Pulmonary Embolism. R212's MDS (minimum data set) dated October 13,2025, documents that R212 BIMS (brief interview for mental status) has a score of 12 indicating that R212 has moderate cognitive impairment. On 01/08/2026 at 12:13 PM, V31 (Registered Nurse/ RN) stated she was the second shift nurse taking care of R212. V31 stated she had been taking care of R212 for two days. V31 stated on the first day that she cared for R212, he was complaint with his medication, alert and oriented. V31 stated on the second day of caring for R212, she noticed R212 was lethargic, refusing medications, and was not following commands. V31 stated he remained lethargic throughout the shift, so she assessed R212 vital signs. V31 stated after taking the vital signs, she noticed the blood pressure was low, notified the provider and the supervisor. V31 stated she endorsed the change of condition to the 3rd shift nurse. Surveyor reviewed R212 electronic medical records (EMR), there were no new physician orders entered in the EMR. On 01/20/2026 at 11:45 AM, V31 (Registered Nurse)		S9999				

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S9999	Continued from page 2 stated that it was more towards the end of the shift where she noticed a change in R212. V31 stated that she sent a message through R212's electronic medical record and paged the on-call doctor regarding R212's condition. V31 stated that she doesn't remember if she notified the next nurse on shift about R212's vitals. V31 stated that on her shift the CNA took the vitals and did not retake them after. V31 stated that she doesn't remember who took the vitals. On 1/8/2026 at 1:15 PM, V36 (Registered Nurse/ RN) stated at the start of the third shift she rounded on all her residents. V36 states that the second shift nurse endorsed to her that R212 was sleeping. V36 stated R212 was sleeping comfortably and was not in distress during her rounds. V36 stated she typically uses a flashlight to make sure her resident's chest is rising and falling, and there were no signs of distress with R212. Surveyor asked V36 if she had taken R212 vital signs upon the beginning of her shift. V36 stated she did not take R212 vital signs, but instead the certified nursing assistant (CNA) did take R212's vital signs. V36 stated during rounding the aide called her and notified her of a change of condition from R212. V36 stated the aid could not describe what was wrong with R212. V36 stated she ran to the room and found R212 unresponsive. V36 stated she touched the R212 and felt warm, and she then checked the EMR and confirmed R212 was a full code. V36 stated that when she did not feel a pulse, she began to cardiopulmonary resuscitation (CPR) on R212 and called 911. V36 stated the paramedics arrived around 2:35 AM, and they took over the resuscitation. V26 stated that shortly after starting CPR, the paramedics pronounced R212 dead. Surveyor reviewed the medical records and there is no documentation of R212's vital signs at any time of the third shift. On 01/20/2026 at 12:03 PM, V36 (Registered Nurse) stated that she worked from 11:00 PM to 7:00 AM on 10/31/2026. V36 stated that she was not notified of any change in condition in R212 by V31. V36 stated that she did not review R212's chart until 1:30 AM. V36 stated that she did not take R212's vitals upon starting her shift. V36 stated that the vitals should have been documented by the CNA. V31 stated that she does not know what it means when a task is not documented. On 01/08/2026 at 2:28 PM, V37 (Certified Nurse's Aide) stated she took vital signs for R212 at the start of the third shift. V37 stated she noticed the blood pressure was low and notified the nurse about it as soon as possible. V37 stated she is only allowed to take the vital signs but cannot record it on the EMR.		S9999				

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S9999	Continued from page 3 V37 stated she handed over the vital signs to V36. V37 stated she did not take any more vital signs for R212. V37 stated she typically does her rounding on her residents every 2 hours. V37 stated that during one of her rounds she found R212 unconscious. V37 stated she called V36 to come assess the R212. V37 stated all she can remember at the time is a code blue being announced. On 01/20/2026 at 12:58 PM, V47 (Registered Nurse) stated that she worked with V31 on 10/31/2025 from 3:00 PM to 11:00 PM. V47 stated that if there is a change in condition with any resident, they are expected to notify the supervisor on duty and then call the doctor. V47 stated that we do not notify the doctor by sending a message through the resident's health record but call them. V47 stated that some doctors respond quickly, and some take a while. If it is after hours, it would go to an answering machine where someone on call would respond to our call. V47 stated that she did not notify any doctor or provider of R212's change in condition. On 01/20/2026 at 2:26 PM, V45 (Registered Nurse) stated that she is the night supervisor from 11:00 PM to 7:00 PM. V45 stated that on 10/31/2025 around 3:00 AM, V36 paged for code blue. V45 stated that she went and assessed R212. V45 stated R212 was not breathing. V45 stated that she received hand off from the previous supervisor V45 stated that she was not notified of any change of condition from the previous supervisor. V45 stated she did not notify any doctor or provider of any change of condition for R212. On 01/20/2026 at 12:25 PM, V2 (Director of Nursing) stated that V36 should have assessed R212's vitals herself upon start of her shift and documented it. V2 stated that if no vitals or assessments are documented, then it is not done. V2 stated that V36 is the only nurse working the floor during her shift. V2 stated that upon any endorsing of any critical vital signs, nurses are expected to take the vitals themselves and do a change of condition assessment. V2 stated no follow-up vital signs by any nurse, and no assessments were completed because it was not documented. On 01/20/2026 at 12:41 PM, V2 (Director of Nursing) stated that there was no change in condition for R212 during the day. V2 stated that the earliest that V31 became aware of R212's change of condition around 11:00 PM. V2 stated that CPR was started on R212 after 2:00 AM on 11/01/2025. There was about 3-hour gap in between the first time the change of condition was identified till R212 was found unresponsive. V2 stated that V31 should have called V41, V11 or V39 getting in touch		S9999				

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S9999	Continued from page 4 with a physician immediately and she should have documented it. V2 stated that the correct system for notifying the provider would be to call them. V2 stated that the attending physicians' number is on the resident's Facesheet. They sometimes answer. If not, the call will go to an answering service where someone on-call will respond with new orders. 01/08/2026 at 3:20 PM, V41 (Attending Physician) stated R212 had a history of pulmonary embolism and might have suffered from it at the time of his death. Surveyor asked V41 when the last time was, she had assessed R212. V41 stated she had last assessed R212 two days prior to the incident. Surveyor asked V41 if a blood pressure of 87/41 is considered critical. V41 stated that blood pressure is critical for R212, and it was not usual for him to be that low. V41 stated she became aware of R212 change of condition on the following day, 11/1/2025. V41 stated the nurse paged her through the messaging application during afterhours on 10/31/2025. Therefore, she received the message on the following day on 11/1/2025. V41 stated the nurse should have called the answering service, it would have notified her through a page. V41 stated she never spoke to a nurse but did speak to the director of nursing on the following day (11/1/2025) regarding R212 change of condition, and his passing. V41 stated that if the nurse had called the answering service instead of using the messaging application regarding R212's blood pressure being critically low, she would have immediately started some labs, ordered some fluids or sent R212 back to the hospital. V41 stated in a situation where blood pressure is critically low and there are no provider orders, the nurse should have called 911 immediately. During record review surveyor noted nurses on the second and third shift failed to monitor R212's vital signs after a change of condition was assessed by V31. On 10/31/2025, V31 documented R212's vital signs as the following: Blood Pressure: 87/41, Heart rate: 118, Temperature: 98.2 degrees Fahrenheit, Oxygen saturation: 94%. Surveyor reviewed R212 EMR and noted there were no other vital signs documented throughout the second and third shift. V31 and V37 did not use the appropriate means of communication to contact the attending physician to provide proper care for R212. R212 coded during the third shift and eventually passed away. R212's care plan documents in part: R212 has a pacemaker related to dysrhythmias. Interventions are; monitor vital signs as ordered/per facility protocol and record. Notify MD of significant abnormalities.		S9999				

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S9999	Continued from page 5 Monitor, document, and report to medical doctor (MD) as needed any signs and symptoms of altered cardiac output or pacemaker malfunction: dizziness, syncope, difficulty breathing (Dyspnea), pulse rate lower than programmed rate, lower than baseline blood pressure. R212's progress note by V31 on 10/31/2025 at 10:59 PM documents in part: After caring for R212 for 2nd shift today and yesterday, a change in condition has been noted. R212 was observed to be disheveled, with broken English and diminished speech from his baseline as of today. R212 was noted to be lethargic with reduced energy. V41 rounded earlier today, however she was still notified of this change of condition for R212. R212 was unable to take his evening meds as he did not have the physical energy to take them. Supervisor and Dr are both aware of change and we are awaiting next orders. Vitals are as follows T 98.2 P 118 BP 87/41 O2 94. Policy titled Notification for Change of Condition with review date of 07/02/2025 documents in part, "The facility will provide care to residents and provide notification of resident change in status." "The facility must immediately inform the resident; consult with the resident's physician; and if known, notify the legal representative or an interested family member when there is: b. A significant change in resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications)." 2. R172's Face sheet documents in part: R172 has a diagnosis of transient cerebral ischemic attack, cerebral infarction, acute embolism and thrombosis of unspecified deep veins, open wound of right breast, malignant neoplasm of unspecified site of right female breast. R172's minimum data sheet (MDS) section C (10/24/2025) documents in part: R172 has a Brief Interview of Mental Status (BIMS) score of 4. R4 is severely cognitively impaired. R172's physician order sheet documents in part: Weight upon Admission/Readmission. Weekly x4, then monthly every evening shift for 1 Day AND every day shift every 7 day(s) for 28 Days. Weekly x4 and every day shift starting on the 21st and ending on the 21st of every month monthly.		S9999				

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S9999	Continued from page 6 On 01/06/2025 at 12:00 PM, surveyor observed Certified Nursing Assistant (CNA) on 7th floor bring R172's lunch tray to R172 in her room and then leave the room. Surveyor walks into R172's room and sees R172 not able to feed herself. R172 stated that she needs help feeding. Surveyor observed R172's meal tag which documents in part: 1:1 feed. There were no staff members in R172's room monitoring or feeding R172. On 01/06/2026 at 12:40 PM, surveyor observed R172 in her room still have not been fed. R172 stated she help her feed. R172's lunch was untouched. There were still no staff members in R172's room monitoring or feeding R172. On 01/06/2026 at 1:00 PM, surveyors observed V28 (Certified Nursing Assistant) walk into R172's room and take R172's lunch tray. V28 stated that R172 ate 20% of her meal. Surveyor asked to see R172's lunch tray. R172's lunch was untouched. V28 stated R172's lunch try was untouched and thought R172 had been eaten. V28 stated that she didn't feed R172. V28 stated that she is not R172's CNA. On 01/07/2025 at 10:00 AM, surveyor asked V5 and V7 (7th Floor Nurse Supervisor) to weigh R172. V5 and V7 lifted R172 with a hooyer lift with a capability of calculating weight. R172's weight came out 93.2 lbs. On 01/07/2026 at 11:10 AM, V4 (Dietician) stated that she is familiar with resident R172. V4 stated that residents are confused. V4 stated that her expectation is that if a resident's meal card says one-to-one feed, that resident should be fed. V4 stated that she was notified today of R172's significant weight loss. V4 stated that anytime there is a significant weight loss it should be carefully planned with appropriate interventions. V4 stated that she was not notified earlier of any weight loss because R172 kept refusing to get her weight. Surveyor showed a progress note by wound care identifying R172's weight loss on 10/29/2025. V4 stated she is not sure why no one notified her of R172's weight loss. V4 stated that someone should have notified her of R172's weight loss and she would address it immediately. 01/07/2026 at 12:48 PM, V12 (Minimum Data Sheet (MDS) Coordinator) stated that they divide responsibilities with social workers to assess a residents' functional and psychosocial status. V12 stated that the care plan is for standardized care guidance for staff on the floor so we can provide uniform care for patients. V12 stated that the interdisciplinary team decides how to care for the residents. Each department does their own		S9999				

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S9999	Continued from page 7 assessments and updates the care plan on their own. V12 stated that she is familiar with R172. V12 stated that if there is any continual refusal on any treatment, it should be carefully planned. This should be care planned so that the staff is aware of the behavior, so that we can have interventions in place to mitigate the behavior and find out the cause for that behavior. V12 stated that for R172's refusal of weighing her, they would have added encouragement, meet with the resident, and have family help motivate her. They usually are more cooperative with family around. V12 stated that R172 has a BIMS score of 4. V12 stated that a BIMS score of 4 means severely impaired cognition. V12 stated that according to this assessment, R172 cannot make decisions for herself and appropriate interventions in the care plan need to be in place. On 01/08/2026 at 12:26 PM, V32 (Social Services Director) stated the social worker does the cognition Brief Interview of Mental Status assessment for residents. A BIMS of 4 is severely cognitively impaired. Someone who has a BIMS of 4 cannot make appropriate decisions for themselves. A resident with a BIMS of 4 cannot cognitively and appropriately refuse treatment. On 01/08/2026 at 10:11 AM, V2 (Director of Nursing) stated nurses are expected to carry out all doctor's orders including medication and treatment administration. Any refusal of treatment should be documented in the medication administration record, treatment administration record or progress notes. V2 stated that if they continue to refuse then there should be an appropriate care plan which is specific to the problem with interventions in place. V2 stated the care plan is important because it is an individualized patient care treatment plan. The care plan must be followed because it is specific to a patient. We put interventions in the care plan to mitigate any refusal of treatment or any physician orders. Reviewed R172's Monthly Weight Report. R172 only has two weights taken prior to 1/7/2025. Upon admission on 10/21/2025, R172 had a weight of 144 lbs. On 12/9/2025, R172 had a weight of 142.3 lbs. On 01/07/2026 R172 had a weight of 93.2 lbs. This equals 34.5% weight loss in one month. Reviewed R172's full progress notes from 10/21/2025 to 01/07/2025. No documentation in progress notes regarding resident's refusal to gain weight. No documentation notifying physicians or dieticians of resident's refusal of taking weights. Also, there is no documentation to R172 or R172's family about the	S9999					

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S9999	Continued from page 8 importance of taking R172's weight. Reviewed R172's full care plan. No documentation of refusal of weights with appropriate interventions. R172's care plan documents in part: R172 is resistive to care. She has shown to refuse medications, refuse care from Certified Nursing Assistants (CNA), and refuse to participate in therapy. Intervention: Allow R172 to make decisions about treatment regimen, to provide sense of control. Educate R172 and family of the possible outcomes of not complying with treatment or care. 3. R133's Face Sheet shows diagnoses of moderate protein-calorie malnutrition, gastrostomy status, and essential hypertension. R133's Physician's Orders Sheet shows an order for daily weights (using same scale)- record weight and scale. If weight difference is 2 pounds or more from prior day, re-weigh and document everyday shift (ordered 12/29/25). R133's comprehensive care plan documents in part: [R133] is underweight and malnourished (Date Initiated: 12/6/24) with one intervention that reads: "Monitor weight in accordance with policy and plan of care" (Date Initiated: 12/6/24). R133's Weight Summary shows that he had weights done on 1/6/26 and 12/30/25. No weights were recorded from 12/31/25 to 1/5/26. Review of R133's comprehensive care plan and progress notes (12/31/25-1/5/26) do not show any documentation of refusals to be weighed. On 1/6/26 at 1:02 PM, R133 was eating in his room. On Regular diet, Puree texture, thin liquids consistency. On 1/7/26 at 12:56 PM, V21 (Registered Nurse Supervisor) said that weights should be done as ordered by the physician. V21 said that they are recorded in the electronic health records of the residents and are documented by the nurse the same day that weights are taken by the CNA (Certified Nursing Assistant). V21 said R133 has daily weights ordered and I'm not sure why weights from 12/31/25 to 1/5/26 were not recorded. Facility's Weights policy (7/3/2025) documents in part: It is the facility's policy to obtain resident's monthly weight unless otherwise ordered differently by the physician. During the 1st week of the month, the restorative staff or designer will weigh each resident to fulfill the monthly weight requirement. The significant weight changes (monthly (5%), quarterly (7.5%), and every 6 months (10%) will be assessed and		S9999				

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S9999	Continued from page 9 addressed by the interdisciplinary team which includes but is not limited to the dietician, physician, medical specialist, speech therapist, nutritionist, and nurses. A		S9999				