STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001465	A. BUILDING: _____ B. WING _____	C 10/04/2023

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S 000	Initial Comments COMPLAINT INVESTIGATION 2385673/IL161850 2386236/IL162537	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1210a) 300.1210b) 300.3240c) 300.3240e) 300.3240g) 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	S9999	**Attachment A** Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 1 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. Section 300.3240 Abuse and Neglect c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of	S9999		

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S9999	Continued From page 2 the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident was free from Sexual Abuse for 1 (R2) of 4 residents reviewed for abuse. This failure resulted in R2 who is cognitively impaired being found in R11's room naked from the waist down, requiring hospital evaluation and R2's laboratory result from the hospital affirming male DNA (Deoxyribonucleic Acid) was found in the vaginal specimen. Findings include: R2 Abuse assessment prior to 11/19/22 is inaccurate, R2 was scored as low due to numerous questions being answered wrong. The Facility does not have an effective Abuse Policy and V1 (Administrator) failed to identify the allegation as abuse. R11 was admitted to the facility on 05/28/21 with diagnosis not limited to Essential (Primary)	S9999		

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S9999	Continued From page 3 Hypertension, Anemia, Presence of Right Artificial Shoulder Joint, Localized Edema, Chronic Postprocedural Pain, Major Depressive Disorder and Cardiomyopathy. R11 MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating cognitively intact. R2 was admitted to the facility on 10/21/20 with diagnosis not limited to Essential (Primary) Hypertension, Hyperlipidemia, Dysphagia Following Cerebral Infarction, Gastrostomy Status, Anemia, Aphasia, Pseudobulbar Affect, Presence of Aortocoronary Bypass Graft, Major Depressive Disorder, Dermatitis, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side and Cough. R2 MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 00 indicating the resident was unable to complete the interview. [R2's diagnosis of Pseudobulbar Affect is defined as: pathological laughter and crying. Inappropriate laughing and crying due to a nervous system disorder. This condition is characterized by an involuntary and uncontrollable reaction of laughter or crying that's disproportionate to an event.] Reportable dated 11/19/22 and 11/23/22 was presented to the surveyor on 09/12/23. Facility's Final Reportable to the state agency regarding R2 and R11 dated 11/23/22 documents in part: On 11/19/22 at 04:45 PM V4 (Licensed Practical Nurse) went to R11's room when V24 (Agency Certified Nurse Assistant) asked the nurse to validate occupants in the room during the dinner tray service. When V4 opened the door, she noted R2 standing in R11's room by the door with no garments on her (R2) lower half, R11 was fully clothed. The two residents were immediately	S9999		

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CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

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S9999	Continued From page 4	S9999		

separated. R2 was unable to express what happened. R11 stated "Nothing happened." R11 was moved to the 5th floor and placed on 1:1 supervision. R2 was placed on 1:1 supervision as well. Nursing assessments done for both residents with no evidence of injury noted. The physicians for both residents were called, and orders obtained to send R2 to the ED (Emergency Department) for a forensic exam and R11 to be sent out for a psych evaluation. Since no bed was available in the psych unit, R11 was sent to the ED. The police were called, came to the building and made a report. Interview with R11 which stated that he (R11) was in his room and R2 came to his (R11) room by herself. R11 stated that "R2 gestured to me (R11) that she (R2) wanted to do something, and R2 seemed like she (R2) liked me. I took off R2 pants, but I thought better of it and stopped before anything happened." Interview with R2 was done by V15 (Social Worker). R2 was unable to state what happened and was smiling and laughing as is R2 usual demeanor. No evidence of physical injury noted during nursing evaluation or in hospital emergency department notes. R2's behavior remains at baseline, R2 presents as cheerful, interactive, relaxed and is wheeling her (R2) wheelchair around the unit as is R2's usual activity. R11 no longer resides in the facility. (Facility's reportable does not specify abuse was substantiated, even after R11 admitted he took R2's pants off)

R2's Physician order dated 11/19/22 document in part: Send the patient to Hospital for forensic examination due to potential sexually abuse. R2's Physician orders document in part: Doxycycline Monohydrate Oral Capsule 100 MG (Milligrams) Give 100 mg by mouth two times a day for prophylaxis for 7 Days -Start Date- 11/21/22

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CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

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S9999	Continued From page 5 2100. Flagyl Oral Tablet 500 MG (Metronidazole) Give 500 mg by mouth two times a day for prophylaxis for 7 Days -Start Date- 11/22/22. R2's Hospital Record dated 11/19/22 documents in part: Chief Complaint: R2 was seen in another patient's room with the diaper and underwear down to the floor. History of Present Illness: R2 presenting with possible sexual assault. Unknown exactly what happened but R2 was found in another patient's room with her diaper and underwear on the floor and the other resident in a state of undress. Medical Decision Making: R2 with possible sexual assault. Prophylactic azithromycin, ceftriaxone given. Will continue with 10-day doxycycline. Will give hormonal post prophylaxis for pregnancy. Assessment/Plan: Sexual Assault of adult. R2's Care Plan document in part: Need for Guardianship or Surrogate Decision Making: R2 demonstrate cognitive impairment, have a diagnosis of mental illness, impaired, compromised decision making, inability to understand course of treatment, compliance with care and prognosis/likely outcome. R2 is in need for V6 (R2 Family Member) to make health care and/or financial decisions or my (R2) behalf. V6 (R2 Family Member) is my Surrogate Decision maker per MD (Medical Doctor). Date Initiated: 11/02/21. R2 will acknowledge and respect that decisions made on my behalf reflect my best interest (to the best of their ability) and accept on-going communication between decision maker and facility staff, through next review Date Initiated: 11/02/21. Staff will contact the guardian/decision maker for appropriate treatment consent/authorization Date Initiated: 11/02/21. Communication Impairment: R2 presents with an alteration in ability to	S9999		

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	IL6001465	A. BUILDING _____ B. WING _____	C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

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S9999	Continued From page 6	S9999		

communicate related to or as evidenced by: Impaired speech (nonverbal). Date Initiated: 10/25/20. R2 has an ADL (Activities of Daily Living) Self Care Performance Deficit related to limited ability with Dressing and Grooming such as: Put on or take off clothing, Unable to obtain or replace article of clothing, Unable to fasten clothing. R2 is at risk for pressure injury development and other skin breakdown due to factors that include but is not limited to incontinence of bowel and bladder. History of suspected abuse: R2 comprehensive assessment reveals a history of suspected abuse and/or neglect or factors that may increase my susceptibility to abuse/neglect. Date Initiated: 11/23/22. Wandering: I demonstrate movement behavior that may be interpreted as Wandering, Pacing or Roaming. I become agitated when redirected. I Demonstrate signs and symptoms of mood distress, i.e., continued wandering. Date Initiated: 11/23/22. I am to be frequently monitored. Substance Abuse/Chemical Dependency: R2 has a history of substance abuse/chemical dependency to include alcohol, marijuana, and tobacco. Date Initiated: 10/25/20.

R2's Quarterly: Section VI. Abuse, Neglect, Exploitation & Trauma dated 08/25/22 document in part: I. Abuse, Neglect, Exploitation and Trauma 4. Does the resident have a history of substance abuse/chemical dependency. (no): Care plan documents R2 has a history of substance abuse. 5. Does the resident have a psychiatric history and/or mental health diagnosis (no). 7. Does the resident have a diagnosis of depression and/or history of depressive illness and/or present signs/symptoms of depression/mood distress, (no). Neglect/Abuse [R2 has a diagnosis of Major Depressive Disorder.] 10. 0-1 Low Risk. (R2 was scored as

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S9999	Continued From page 7 low due to numerous questions being answered wrong) R2's Progress Note dated 11/19/22 19:47 (7:47 PM) document in part: Health Status Note Text: Between 17:00 (5:00 PM) and 17:15 (5:15 PM) CNA (Certified Nurse Assistant) rushed to the assigned nurse to inform that she (CNA) saw a female patient in a male resident's room. The staff immediately went to room and observed both patients standing. The supervisor was notified immediately, and both were separated. Body assessment done on the (R2) female patient, and no evidence of injury noted. R2's Progress Note dated 11/19/22 20:01 (8:01 PM) documents in part: Health Status Note Text: Between 1700 and 1715 this patient (R2) was noted in a male patient's room. She (R2) unable to express what happened to her due to her (R2) medical condition - aphasia following cerebral infarction. She (R2) was immediately removed from the male patient's room and taken to her room and placed on one-to-one supervision. Nursing assessment done; no evidence of injury noted at 17:20. At 17:58, the patient's (R2) primary physician was notified, and he ordered the patient to be sent to the Hospital for evaluation. The assigned nurse called the Police to make a report and they arrived at the facility around 18:16. R2's Progress Note dated 11/22/22 10:24 document in part: Physician Progress Note Text: Patient (R2) Seen and examined. Patient (R2) was sent to Hospital ER (Emergency Room) on 19 November for alleged sexual assault. Rape kit was performed at Hospital ER and patient (R2) was given 5 mg of Rocephin, 1000 mg of azithromycin and a prescription for doxycycline	S9999		

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CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

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S9999	Continued From page 8	S9999		

100 mg twice a day for 10 days. Patient (R2) was also given 2 tablets of low overall, and she (R2) was also given 2 tablets to take with her (R2) to the nursing home to be given in 12 hours. Patient (R2) was also given a supply of doxycycline 100 mg twice a day to complete the course for 10 days. However, patient (R2) was not given metronidazole for trichomonas. I did prescribe metronidazole on 22 November when I saw her (R2) at the nursing home, and this was conveyed to the nurse practitioner question and to director of nursing. Examination reveals persistent left-sided hemiplegia.

R2's Progress note dated 11/22/22 13:35, document in part; Discussed with doctor. Will add Flagyl 500mg (Milligram) bid (Twice a day) x 7 days to cover prophylaxis for trichomoniasis.

R2's Progress note dated 12/30/22 09:55 document in part: Social Service Note Text: Quarterly Note: R2's mother, is R2 surrogate decision maker. Staff BIMS assessment indicates severe cognitive impairment.

R2's Laboratory Report DNA-Outsourcing Report dated 04/20/23 document in part: Description: Sexual assault evidence collection kit from R2. List of evidence received on 01/06/23 for possible DNA analysis: 1B Vaginal Swab(s): Male DNA Screening Conclusion: The evidence was screened to identify samples containing sufficient male DNA expected to produce data suitable for comparison. STR (Short Tandem Repeat Analysis) Processing, Results and Conclusions: 3. The partial DNA profile obtained from the epithelial fraction of 1B Vaginal Swab(s): sample is consistent with a mixture of two individuals including R2 and one male contributor. R2 is expected to be present in the mixture obtained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001465	A. BUILDING: _____ B. WING _____	C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

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S9999	Continued From page 9	S9999		

from the epithelial fraction of sample and was subtracted from the mixture for interpretation purposes.

On 09/12/23 at 10:47 AM, V6 (R2 Family Member) stated "the Rape incident happened on 11/19/22. It took a while for the DNA (Deoxyribonucleic Acid) test to come back, and I was waiting for the results. V31 (Detective) called and told me that there were five rape kit swabs done at the hospital. V31 said she did not know about the additional swabs that were taken and one of the swabs came back containing male DNA. I was told by the facility that R2 was found in a male room, nude from the waist down and they are sending R2 to the hospital. I did not receive any additional information."

On 09/12/23 at 02:35 PM, V4 (Licensed Practical Nurse) stated "I think that day after med pass at 3 something R2 was in the wheelchair. During dinner time the Agency Certified Nurse Assistant was passing trays and notified me that there is one tray for that room, and she saw 2 people in the room. When the agency CNA (Certified Nurse Assistant) reported to me, I went to the room, and I saw R2 standing half naked. We saw both of them standing. The other resident was fully dressed. We separated the residents, notified the physician, then got an order to send R2 to the hospital for evaluation. R2 just smiles but is nonverbal."

On 09/13/23 at 09:48 AM, R2 was observed in the second-floor lounge room in a wheelchair unsupervised. R2 is nonverbal and smiles when spoken to.

On 09/13/23 09:57 AM, V16 (Certified Nurse Assistant) stated "R2 is an extensive care,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 10	S9999		

nonverbal and not able to undress herself."

On 09/13/23 at 10:25 AM, V10 (Certified Nurse Assistant Supervisor) stated "R2 is a wanderer and goes from room to room. R2 is friendly and boy crazy, if there is any man speaking, R2 smiles. R2 is in a wheelchair and propels herself with her legs."

On 09/13/23 at 10:40 AM, V15 (Social Worker) stated "On 11/19/22 I was the manager and staff reported R2 was in the room with R11. R2 was immediately separated. We attempted to interview R2. R11 said nothing happen, R2 was just visiting. R2 was sent out for an exam and R11 was sent out for a psych evaluation."

On 09/13/23 at 12:19 PM, V19 (Nurse Practitioner) stated "I recall the allegation of R2's sexual abuse. R2 went to the hospital. I talked to V23 (Medical Doctor) and added the Flagyl to cover for trichomonas in case there was any sexual abuse that occurred to cover that for prophylaxis."

On 09/13/23 03:32 PM, V32 (Licensed Practical Nurse) stated "R2 wonders in other residents' rooms and is not able to take off her clothes by herself. The Certified Nurse Assistant was trying to go in R11's room and noticed the lady (R2) was in the room according to the CNA. We separated R2 and R11. R2 was sent to the hospital for evaluation."

On 09/14/23 at 09:20 AM, Per telephone interview V24 (Agency Certified Nurse Assistant) stated "I was passing trays and I saw 2 residents in a room. R2 was using a wheelchair and they were behind the curtain, but I never saw R2 and R11 getting sexual."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 11	S9999		

On 09/14/23 at 09:53 AM, Per telephone interview V22 (Registered Nurse) stated R2 was in R11's room. R2 was immediately removed from R11's room and placed on 1:1 supervision. The doctor was called and ordered to send R2 out for an evaluation."

On 09/14/23 at 10:17 AM, V3 (Director of Nursing) stated "I got the call that day R2 wandered into R11's room. They were immediately separated and R2 was sent out to the hospital to be evaluated because they found R2 in the room with the male (R11) and we believed something sexual. R2 was behind the door and the guy (R11) was standing in front of her (R2). The rape kit test takes a long time to be processed. We did not follow-up to check if the rape kit test was negative or positive."

On 09/14/23 at 10:59 AM, V1 (Administrator) stated "the rape test is sealed in the Emergency Room."

On 09/14/23 at 11:02 AM, Per telephone interview V23 (Medical Doctor) stated "R2 was given the antibiotics in the hospital. The medication that R2 received was the standard of care in any alleged sexual abuse. The medications are given for chlamydia, gonorrhea, trichomonas and recommended 2 tablets for birth control. If the rape kit came back positive, it would be the police department to follow up."

On 09/14/23 at 11:32 AM, V1 (Administrator) stated "I was called at home to inform me that R2 was found in R11's room. R2 had her undergarments down and R11 was fully dressed. R2 and R11 were separated and R2 was sent to the hospital for evaluation. We were not able to

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 12	S9999		

determine what happened. R11 claimed adamantly that nothing happened. The detective closed the case and said that it was unfounded about 2 - 3 months later."

On 09/15/23 at 09:37 AM, per telephone interview V31 (Detective) stated, R2's lab result did show male DNA. The swabs were taken at the hospital for criminal sexual assault. A complete kit was done. The lab report shows the vaginal swab that they took showed male DNA."
While looking at the actual report V31 (Detective) read the results to the surveyor. R2 was treated at the hospital however V31 (Detective) stated that "she cannot release the actual test report to the state agency however R2's results documents male DNA."

On 9/22/23 at 1:49 pm, V31 (Police Detective) said, the rape kit collected from R2's vaginal canal came back with male DNA. V31 said, the male DNA could be from semen or fingers, however it is enough to compare the DNA to the male offender. V31 said, the DNA will be compared to R11's DNA. V31 said, the facility provided a video footage outside of R11's room. V31 said, on 11/19/22 at 3:17 pm, R2 wheeled herself to R11's room, the door was open. V31 said, after R2 entered the room, someone closed the door, unsure who (either R2 or R11) as the footage did not show who closed the door after R2 entered the room. V31 said, at 4:40 pm, a staff member during meal pass entered the room and discovered R2 also present in R11's room, and that staff member left and got help and numerous staff started to enter R11's room. V31 said, R2 was in R11's room for 1 hour and 23 minutes.

On 09/26/23 at 09:36 AM, per telephone interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001465	A. BUILDING _____ B. WING _____	C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

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S9999	Continued From page 13	S9999		

V24 (Agency Certified Nurse Assistant) stated "we were working, and it was 2-3 CNAs (Certified Nurse Assistant). One of the CNA's, I don't know her name because I was agency, asked me to pass trays. She asked me how many trays I was passing in R11 room. I saw 2 people and she said there is only one resident in that room. I saw a female and a male in the room. The other CNA went to the nurse to tell them that there were two residents in the room and that they should come see. There is a privacy curtain, and the two residents were behind the curtain beside the wall."

On 09/26/23 at 09:58 AM, V39 (Social Worker) stated "R2 is alert and oriented to self and place. The residents have choices, and they can make their own choice. I could not say if R2 and R11 were in a relationship with one another. R2 had never been in R11's room and R11 had never been in R2's room prior to this. I just came in on Monday and they told me R2 was in R11's room. R2 and R11 were alone in the room and the door was closed. R2 rolls around in the wheelchair and goes to the dayroom. R2 will go in a resident room if she (R2) is welcomed in or knows that she (R2) can go in. R2 can stand with assistance. and is staff assessment; meaning R2 remembers people, staff, her room and faces. I believe R2 would laugh, and I believe R2 would consent to sex. R2's mother is R2's surrogate decision maker. I go off resident rights, if R2 can somehow make decisions. Once R11 came back from the hospital R11 really wanted to leave and said he (R11) did not want to be here anymore. When R11 returned from the hospital R11 was on 1:1 supervision for I think it was a couple of days. We were told by the administrator just in case anything else were to happen. Precautions."

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S9999	Continued From page 14 On 09/26/23 at 11:57 AM, V4 (Licensed Practical Nurse) stated "When sitting in the wheelchair R2 wheels herself around the unit. I was sitting at the nurse station and about thirty minutes earlier R2 rolled past in her (R2) wheelchair. The assigned V24 (Agency Certified Nurse Assistant) was the one that told me there were 2 people in R11's room but there was one food tray for the room. Right away I went to R11's room because as a nurse V24 told me 2 people were in the room. When I entered the room that was only assigned to one male resident there were 2 residents in R11's room. I entered R11's room by myself then I called the supervisor. When I entered the room, I saw a male (R11) and a female (R2) resident in R11 room, and we had to take action. When the door was opened to the right R11 was standing behind the door to the rear edge of the door with the wheelchair closer to him (R11) and R2 was standing to the left of the wheelchair. The wheelchair was behind both of them, but I did not check the direction of the wheelchair. R2 and R11 were both standing facing the entrance. R2 can walk with assistance but that was the first time that I saw R2 standing. The door was closed but just open with a little crack. R11 was just standing there doing nothing when I opened the door, I could immediately see R2. R11 was fully dressed and R2's shirt covered the front and back so I could not see R2's private area. The leggings that R2 was wearing were around R2's calf area and I pulled R2 pants up. I am not sure if R2 had on a pull up or diaper, but I know for sure I pulled R2's pants up. I went and paged the supervisor, and the CNA took R2 to R2's room. Some staff, the supervisor and the social worker came to R11's room. The CNA may have seen R2's pants down. I asked R11 what was going on and R11 said "nothing." I asked R2 also and R2 was just smiling. I have never seen R2 in R11's room	S9999		

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	IL6001465	A. BUILDING: _____ B. WING _____	C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

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S9999	Continued From page 15	S9999		

before and I have never seen R2 and R11 interact with each other. To my knowledge R2 has never had any physical interactions with any other residents. R2 was put to bed fully dressed and I did R2's assessment with V22 (Registered Nurse) in the room. I removed R2's top, but I did not remove a diaper because R2 did not have a diaper on. R11 was in a 2-bed bedroom, the curtain for the second bed was closed where I could not see the second bed by the window. I can't say if it was abuse because we have to do an investigation before we can say that it is abuse. R2 is nonverbal. R2's facial expressions will let you know if R2 is not feeling well. I am not sure if R2 is cognitively impaired because I don't read all the care plans and I don't work on just one floor. I am not sure if R2 was care planned for wandering." The surveyor showed V4 (Licensed Practical Nurse) R2's care plan on the computer. V4 responded "The care plan that I am now reading documents that R2 is cognitively impaired and R2 does not make her own decisions."

On 09/26/23 at 12:46 PM, V1 (Administrator) Reviewed the reportable and stated "based on my (V1) findings there was no evidence of physical injury noted during the nursing evaluation, emergency department notes, R2's behavior remain at baseline, R2 presents as cheerful, interactive and is wheeling her (R2) wheelchair around the unit as R2 usual activity. I did not put a statement of judgement (result of abuse investigation) in the reportable because it was hard for me to put a judgement statement. I could only put objective documentation of what was observed and told to me during the interviews. V24 (Agency Certified Nurse Assistant) was delivering lunch trays, saw two residents in the room and only had one tray. That

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CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

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S9999	Continued From page 16	S9999		

is why V24 came out to get the nurse. That is what V24 told me, she (V24) only saw the legs and wandered why she only had one tray for the room. I did see the video footage and saw V24 go in R11's room then go to the food cart looking for the tray. V24 got V4 (Licensed Practical Nurse) and V4 went to R11's room. R2 was taken out of R11's room in the wheelchair. V15 (Social Worker) was called and lots of staff were milling around the area. The police were called, came in and extracted the video on their own. I don't know how long R2 was in R11's room. V31 (Detective) called me after V31 talked to you (Surveyor) and told me R2 was in R11's room for over an hour. I talked to V31 about 2 months after the incident and was told that they were closing the case. R11 said that he (R11) took R2 pants off. The nurse told me that R2 was found in R11's room with her (R2) pants down. I could not substantiate or unsubstantiate the abuse. I have never written a reportable like this before. This is the first time that I have done a reportable without making a call in the end. There was no evidence of injury, we watched R2's behaviors, they remained at R2's baseline and that implies that R2 did not experience trauma. That is a great question as to why I did not unsubstantiate the abuse. It was a poor decision on how I worded it. I should have sent in an addendum after the detective closed the case. After the detective closed the case about 2 months later, I would have unsubstantiated the abuse. There was no evidence of injury, R11 denied that he had done anything to R2, the emergency room nurse on duty said there was no evidence so all those point to unsubstantiating the abuse. The reportable written the way I did; I would have definitely made an addendum to unsubstantiate the sexual abuse. I am unsubstantiating sexual abuse. I don't know how to answer the question if R11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001465	A. BUILDING: _____ B. WING _____	C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

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S9999	Continued From page 17	S9999		

pulled R2's pants down does he (R11) have the right to pull R2 pants down, absolutely not. The detective said the rape kit came back with male DNA to the outside of the vaginal area. The only way they can know if it was R11 DNA is if they get an oral swab from R11 and the results can take 9 months to a year. We don't have enough information because we have to wait for R11 buccal swab to come back. We are not sure if R2 was an active participant. Statements based on what I know is if R2 does not like anything R2 will cry and scream. R2 was not in R11's room screaming and I think that is important to note and consider. I think R2 BIMS cannot be assessed because of R2's aphasia. R2's care plan document R2 is cognitively impaired and cannot answer the BIMS questions. It is hard for me to make a statement about that. R2 has her mother as her surrogate decision maker. I think it is appropriate that R2 has a surrogate decision maker because R2 cannot verbally communicate to us. Seeing that R2 is cognitively impaired and cannot communicate verbally, how R2 can give consent to any sexual activity. I can't and don't know how to answer that question. R2 travels around the unit and decides where she is going. Closing statement, this is one of the most difficult as an administrator, hardest and most difficult situation going through the steps of the suspicion of abuse. There is so much gray and seeing that R2 cannot articulate words. I feel the facility did what they were supposed to do. We put R11 on 1:1 and may have been overcompensating. R11 was placed on 1:1 because I felt there would be a survey on this and to make sure I was doing everything that I possibly could. If R11 would have stayed here I would have continued the 1:1 supervision and decreased, it if R11 showed it was no longer warranted. If there is an allegation of sexual abuse, I would follow the abuse policy."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001465	A. BUILDING: _____ B. WING _____	C 10/04/2023

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CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

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S9999	Continued From page 18 On 09/26/23 at 01:38 PM, V15 (Social Worker) stated "I was working as manager that weekend day. They called the nurse to inform her that they found R2 in R11's room with her (R2) pants down and they did not know what happened. V4 (Licensed Practical Nurse) told me when they finally got R11's door open, they saw R2 with her pants down. R2 is nonverbal, makes vocal sounds and R2 is pretty alert. R2 gets around with her wheelchair, is never really sitting still, if R2 gets bored in one spot R2 goes to the next spot. I am not sure if she (R2) is able to consent to any sexual activity." On 09/26/23 at 02:45 PM, per telephone interview R11 stated "I was at the facility, but I never touched anyone inappropriately. I did not pull down R2 pants. I went to the hospital because I was having trouble with my back and the hospital transferred me to another facility. Am I in trouble?" On 09/27/23 at 11:32 AM, per telephone interview V31 (Detective) stated "my investigation is still ongoing. I watched the body camera of the investigators that were there at the facility and R11 first said R2 wanted me (R11) to do something then R11 said he did not do anything. R11 was changing his story back then. I never called V1 (Administrator) to tell her (V1) that the case was closed. We suspend them but never closed the case until it is investigated to the fullest extent. Suspended means that nothing is active until evidence start coming in. It would be confusing to a lay person. I would not have told V1 that the case was closed, how V1 interpreted it, V1 could have misunderstood me." On 09/27/23 at 01:09 PM, per telephone interview	S9999		

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	IL6001465	A. BUILDING: _____ B. WING _____	C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

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S9999	Continued From page 19 V40 (Forensic Scientist) stated "The partial DNA profile obtained from the epithelial fraction of 1B Vaginal Swab(s): is consistent with a mixture of two individuals including R2 and one male contributor. R2 sample was outsourced. R2 was subtracted for epithelial purposes, and they would have done a differential. R2 would be taken out and see what is left over. There has to be a Y peak to say that there is one male contributor." On 09/27/23 at 02.18 PM, per telephone interview V23 (Medical Doctor) was asked by the surveyor if there was male DNA found in the vaginal sample of R2 what your interpretation is. V23 stated "I'm not the expert but common sense, if there was male DNA in the sample there was sexual contact. As a physician if a sample was taken at the hospital and if there is DNA of a male there was sexual contact with a male." On 09/27/23 at 02:23 PM, per telephone interview V23 (Medical Doctor) stated "the facility said that the sample was from the vaginal or pubic area. That could have come from anyone providing R2 care and changes the scenario. If the DNA is from the vaginal or pubic area it could have come from someone providing R2 care." V23 was asked as a Nurse the nurses and CNA's wear glove when providing care and if that is the case should another person DNA be found in the vaginal sample. V23 responded "it should not happen from wearing gloves." V23 was asked by the surveyor if there were only female staff providing R2 care should male DNA be present. V23 responded "If only females were providing care for R2 there should not be any male DNA present." On 09/28/23 at 12:28 PM, V3 (Director of Nursing) was asked by the surveyor the staff	S9999		

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	IL6001465	A. BUILDING: _____ B. WING _____	C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

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S9999	Continued From page 20	S9999		

procedure when providing incontinent care to the residents. V3 responded "they will do hand hygiene, gather supplies, go in the room, and start providing care. They are supposed to wear gloves and if something can cause a splash, they should wear a gown depending on the situation. They should at least always wear gloves for infection control, standard precautions." V3 was asked by the surveyor does the staff provide incontinent care without wearing gloves and V3 responded "they are not supposed to touch the resident private parts, we use towels and put on gloves."

Policy:
Titled "Abuse and Neglect" reviewed 07/14/23 document in part: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. Types of abuse and examples: 5. Sexual abuse is defined as non-consensual sexual contact of any type with a resident. Sexual activity or fondling where one of the resident's capacity to consent is unknown. Instances where the alleged victim is transferred to a hospital for examination and or treatment of injuries resulting from a possible sexual abuse. Sexual abuse also includes non-consensual sexual relationship between residents or a consensual relationship involving residents who want the sexual relationship but has no cognitive ability to make consent. If abuse is suspected the facility will: 3 Conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses. Seven steps in Abuse

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	IL6001465	A. BUILDING: _____ B. WING _____	C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

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S9999	Continued From page 21 Prevention: Screening, Training, Prevention, Identification, Investigation, Protection and Reporting/response. Titled "Incontinent and Perineal Care" revised 07/28/23 document in part: It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition. Procedures. 4. Perform hand hygiene before the procedure. Put on gloves and appropriate personal protective equipment if indicated. 8. Remove gloves and dispose to designated containers/plastic bag. 9. Put on new set of clean gloves to put on clean brief/incontinent pads. Titled "Infection Prevention and Control" Revised 06/01/23 document in part: The facility has established a policy to prevent infections in the facility. Precautions to prevent transmission of infectious agents and transmission-based precautions. 1. Standard Precautions - based on the principle that all blood, body fluids, secretions, excretions, non-intact skin, and mucous membrane may contain transmissible infectious agents. Infection prevention practices include hand hygiene, use of gloves, gown, or mask. (A) Statement of Licensure Violations (2 of 2) 300.610a) 300.1210a) 300.1210b) 300.1610a)1)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001465	A. BUILDING _____ B. WING _____	C 10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

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S9999	Continued From page 22	S9999		

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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary

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CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

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S9999	Continued From page 23 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. Section 300.1610 Medication Policies and Procedures a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. These Requirements were not met as evidenced by: Based on interview and record review the facility failed to provide one of four residents [R1] with prescribed medications. This failure resulted in [R1] being hospitalized for shortness of breath, low oxygen levels, and left lobe pneumonia. Findings include: R1's clinical review documents in part; R1 is a 62-year-old admitted on 6/13/23, with medical	S9999		

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S9999	Continued From page 24	S9999		

diagnosis of pulmonary fibrosis, asthma, latent tuberculosis, and essential hypertension. R1's minimum data set [MDS] brief interview mental status score dated 6/20/23=15 indicates R1 is cognitively intact.

R1's June 2023 EMAR [Electronic Medication Administration Record] noted Physician Order dated 6/13/23- Nintedanib Esylate 150 mg, give every 12-hours for pulmonary fibrosis was not administered from 6/13/23 thru 6/30/23. R1's July 2023 EMAR noted - Nintedanib Esylate 150 mg was not administered from 7/1/23 thru 7/6/23. [From R1's admission (6/13/23) to hospitalization (7/6/23) R1 did not receive any doses of Nintedanib Esylate].

R1's Physician Order dated 6/13/23-Rifapentine 150 mg (antibiotic), give 4 tablets one time a day every seven days (Wednesday) for latent tuberculosis, was not administered on 6/14/23, 6/21/23, or 6/28/23, [missing three weeks in total of the antibiotic Rifapentine].

R1's emergency room entrance form dated 7/6/23 indicates but not limited to; Nursing home staff reported sudden shortness of breath, increase in heart rate, and low oxygen levels. R1 presented to the emergency department with shortness of breath, hypoxic (low oxygen levels) with oxygen levels in the 80's, and respiratory rate of 35. R1's chest x-ray showed acute on chronic changes, pulmonary fibrosis, left lower lobe pneumonia, and elevated white blood count. Intravenous antibiotic started, and R1 admitted to the hospital.

On 9/13/23 at 3:04 PM, V3 [Director of Nursing] stated, "R1 was admitted to the facility on 6/13/23. R1 was sent to the hospital on 7/6/23,

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	IL6001465	A. BUILDING _____ B. WING _____	C 10/04/2023

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CARLTON AT THE LAKE, THE	725 WEST MONTROSE AVENUE CHICAGO, IL 60613

(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) COMPLETE DATE
S9999	Continued From page 25 due to increase in chest congestion and increase in heart rate of 113 beats per minute. R1 returned to the facility the next day on 7/7/23. On 7/8/23, R1 was noted with a high heart rate and low oxygen level and sent to the emergency department. On 7/8/23 was admitted with pulmonary fibrosis and has not returned back to this facility. I was made aware that R1's pulmonary fibrosis medication [Nintedanib Esylate 150 mg orally every 12 hours] was not available. R1 was admitted with that order from V21 [Pulmonologist]. I was made aware via email by our facility's pharmacy that the medication [Nintedanib Esylate] was not available and the medication required special procedure for dispensing. The facility's pharmacy could not obtain this medication [Nintedanib Esylate]. I called the specialized pharmacy all day on 6/15/23, no answer and no return call back, I did not document the phone calls made. I notified V19 [Facility Nurse Practitioner] and she told me to call R1's pulmonologist about the medication. On 6/16/23, I noted the number for V21 [R1's Pulmonologist] I called the office. I spoke with V21's nurse and asked for a temporary supply of R1's medication [Nintedanib Esylate], the nurse explained the office did not have any available sample medications, and I did not document the phone call to the V21's office. Then I went to R1 and asked if he had a supply of the medication at home, R1 said the medication Nintedanib Esylate was given to him during his hospital stay prior to coming to this facility. R1 also said that his lawyer is trying to have R1's previous employer pay for the medication. R1 is suing his previous employer, I did not document R1 and my conversation. On 6/17/23, I asked R1 for the status of the medication, R1 said that the former employer is responsible to pay and provide the medication and he [R1] would let me know what	S9999		

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S9999	Continued From page 26	S9999		

his [R1] lawyer says, I did not document R1 and my conversation, I did not call R1's lawyer. On 6/20/23, I sent an email to my corporate pharmacy office to let them know all my effort. That same day I received a response of a list of pharmacies that can supply the medication. That day I called all the pharmacies. All the pharmacies said they do not have R1's insurance information. One of the pharmacies said R1 should have been registered by the prescriber, or R1 can register himself. The pharmacist said she needs to talk to the prescriber or resident himself. I took the number and the name of the pharmacist to R1. I stood there and helped R1 get registered with the pharmacy. On 6/21/23, the pharmacy said R1's insurance did not cover the medication. I went to R1 and told the resident the medication was not covered under his insurance, and R1 said his lawyer will make the previous employer pay. I only called the pulmonologist office one time to see if the physician had any free samples of the medication. I did not request to speak with V21. R1 missed 23 days of Nintedanib Esylate to treat pulmonary fibrosis and three weeks of Rifapentine weekly dose of antibiotic to keep the level of bacteria down to prevent lung infection, which could potentially make R1's lung symptoms worse."

On 9/13/23 at 12:25 PM, V19 [Nurse Practitioner] stated, "I have been working here for seven years. I work with all the physicians here at the facility. I am familiar with R1. He [R1] is alert and oriented x 3. Some medical diagnoses are pulmonary fibrosis, asthma, latent hypertension, hyperlipidemia, and hypertension. R1 was ordered Nintedanib Esylate oral capsule 150 mg by mouth every 12-hours dated 6/13/2023, by V21 [R1's Pulmonologist]. I'm not sure when I

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S9999	Continued From page 27	S9999		

was made aware R4's medication was not available. V3 [Director of Nursing] called the hospital to get the medication and was told the medication comes from a specialty pharmacy. I assisted with completing a prior authorization for Nintedanib, and it was denied, then I completed another authorization for the insurance company and the second time the authorization was approved. The specialty pharmacy was going to send R4's Nintedanib, but R4 went to the hospital. R4 went to the hospital around 7/6/23 due to heart palpitations, chest congestion and shortness of breath. R1 returned to the facility on 7/7/23. On 7/8/23, R1 went back to the hospital due to fast heart rate and low oxygen level. The heart rate and low oxygen level was not documented. I do not know R1's admitting diagnosis. The medication Nintedanib Esylate helps slow the progression of the lung fibrosis. Overtime the scarring of the lungs will progress then eventually will become terminal. If a resident with the diagnosis of pulmonary fibrosis does not receive Nintedanib that was prescribed, it could potentially worsen the resident's health condition of their lungs. R1 was ordered (6/13/23)-Rifapentine oral tablet 150 mg, give 4 tablets by mouth one time per week for tuberculosis treatment. Rifapentine is an antibiotic. If a resident does not receive a prescribed antibiotic, it can potentially make their respiratory condition worsen."

On 9/14/23 at 10:12 AM, V30 [R1's Former Facility Physician] stated, "I was made aware of R1's pulmonary fibrosis medication [Nintedanib Esylate] was not available. I assisted with filling out the authorization forms with the insurance company and pharmacy. I did not instruct the facility director of nursing or nursing staff to notify V21, that R1 was not receiving the prescribed

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S9999	Continued From page 28	S9999		

medication [Nintedanib Esylate], is for the treatment of pulmonary fibrosis. I was not made aware of R1 not receiving Rifapentine 150 mg tablet to give 4 tables by mouth once a week, is for the treatment of tuberculosis. R1 was sent to the hospital in July for increase in heart rate, and low oxygen saturation level. However, in my professional opinion, R1 being sent to the hospital for shortness of breath, was not related to him [R1] not receiving Nintedanib Esylate, or Rifapentine. R1 not receiving the lung medication or antibiotic did not make R1's lung condition worse, because R1 already has end stage pulmonary fibrosis."

On 9/14/23 at 11:40 AM, V21 [R1's Pulmonologist] stated, "I received a message that someone from R1's facility inquired about samples of Nintedanib Esylate. I forward another prescription to the specialty pharmacy, and R1 was made aware. When my nurse followed up with the pharmacy, the medication was filled. I was not made aware that R1 was not receiving his Nintedanib Esylate. No one from the facility phoned my office for a different medication or treatment plan. The medication Nintedanib Esylate is designed to slow down the pulmonary fibrosis disease process. Rifapentine is an antibiotic to help decrease bacteria in the lungs to prevent lung infections. I have not looked over R1's hospital medical chart, so I cannot say certainly that R1 was hospitalized because he did not receive his medications of Nintedanib Esylate and Rifapentine. I will say, due to R1 not consistently receiving all his prescribe medications it could potentially cause the pulmonary fibrosis to continually progress or worsen."

[The facility did not call R1's V21 [Pulmonologist],

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S9999	Continued From page 29 to notify the medication [Nintedanib Esylate] was not being administered. The facility did not call V21 to request a different medication or a different treatment plan]. Policy-Documents in part: Physician Orders dated [7/28/23] -The facility shall ensure to follow physician orders as it is written in the physician order sheets [POS] -Upon admission and readmission, the facility will verify transfer orders from the hospital with the resident's attending physician (A)	S9999		