STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000343	A. BUILDING: _____ B. WING _____	C 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALIYA OF OAK LAWN	6300 WEST 95TH STREET OAK LAWN, IL 60453

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S 000	Initial Comments Complaint Investigations: 2398646/IL165588 2398652/IL165605 2398377/IL165265	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 3: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)5) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999		

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S9999	Continued From page 2 seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Regulations are not met as evidenced by: A. Based on interviews and record reviews, the facility failed to monitor, re-evaluate the treatment plan for a resident's facility acquired wound, and revise treatment to reduce the risk of worsening or developing an infection. This affected one of three residents (R11) reviewed for wounds. This failure resulted in R11 developing a wound on top of right second toe on 9/11/23. On 9/22/23, R1 was admitted to the hospital with a wound infection with bone involvement requiring amputation of the toe. B. Based on interviews, and record reviews. The facility to follow their physician order policy and failed to document administered medication in the MAR (Medication Administration Record). Facility failed to enter order for glucagon intramuscular injection (medication used for hypoglycemia) in physician order sheet and failed to document glucagon administration in resident's MAR. This deficient practice affects one resident (R4) of three residents reviewed for physician order and medication administration documentation.	S9999		

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S9999	Continued From page 3 Findings include: a) On 10/26/23 at 8:45am, R11 who was assessed to be alert and oriented to person, place, and time, stated that he hit his right second toe on his bed frame, it was bleeding, and he informed the nurse. R11 stated that the nurse cleaned the toe and put a dressing on it and did not do anything else with his wound. R11 stated that he has decreased sensation to feet related to diabetes. R11 stated that he was not aware that his toe wound was worsening. R11 stated that he found out in the hospital his toe was infected to the bone and required amputation. On 10/26/23 at 11:15am, V22 (wound care nurse) stated that does not recall R11. V22 stated that wound care team (nurse and physician) sees all residents with pressure and non-pressure wounds. V22 stated that the wound care team would have continued to monitor and treat R11's right second toe wound once it was identified. V22 stated that if R11's initial treatment order was to apply betadine and leave open to air, R11 would have been seen 3 times a week by wound care nurse and once a week by the wound care physician. V22 stated that any wounds on the feet would require doppler study to rule out or in if wound was a pressure ulcer. On 10/26/23 at 12:40pm, V17 (nurse) stated that if the nurse identifies a new wound on a resident, the nurse is expected to report wound to the physician and the wound care nurse. V17 stated that the nurse is expected to obtain initial wound care treatment orders from the physician and provide wound care treatments until the resident is seen by the wound care team. V17 stated that she does not recall if the wound care team was providing wound treatments to R11's wound on	S9999		

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S9999	Continued From page 4	S9999		

top of right second toe. V17 stated that she performed some of the wound treatments and the wound did not look bad.

On 11/3/23 at 10:30am, V14 (wound care coordinator) acknowledged that the wound care team should have been monitoring R11's right second toe wound between 9/12 and 9/22.

On 11/3/23 at 12:40pm, V14 stated that she reviewed R11's chart and did not find any additional notes for R11, other than the ones on 9/11 and 9/12. V14 stated that she spoke with V17 (nurse) who performed some of the wound treatments, V17 does not recall the toe looking bad. V14 stated that she has no explanation for reason R11 went to the hospital with an infected right second toe wound to the bone, with purulent drainage, requiring surgical amputation. V14 stated that she was not working here at the time wound was identified and V31 (former wound care nurse) did not offer any further information.

On 9/11/23, V31 (former wound care nurse) noted V31 made aware of R11's new skin impairment. Skin assessment completed. R11 is noted with a wound to his right second toe. R11 stated "I keep bumping my foot on my bed's foot board and that is what caused my wound on my toe." Wound care provided and R11 tolerated well.

On 9/12/23, V32 (wound care physician) noted R11 with wound to right second toe partial thickness. Wound measured 1.1cm (centimeters) x 2cm with dried fibrinous scab. Treatment plan betadine apply three times per week.

There is no further documentation in R11's medical record noting R11's right second toe

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S9999	Continued From page 5 wound was monitored by the wound care team from 9/13/23 until hospitalization with right second toe infection on 9/22/23. R11's TAR (treatment administration record), dated September 2023, notes V17 provided wound care treatment to R11's right second toe wound on 9/13, 9/15, and 9/18. There is no documentation found noting R11 received any further wound treatments between 9/18 and 9/22. Review of R11's medical record notes diagnoses including, but not limited to, osteomyelitis right ankle and foot, diabetes, sepsis, difficulty walking, generalized muscle weakness, amputation of toes left foot and right great toe. R11's POS (physician order sheet), dated 9/11/23, notes orders for an x-ray of R11's right foot wound, right second toe; podiatry consult related to right second toe wound; and right second toe-cleanse with normal saline or wound cleanser, paint with betadine, and leave open to air every Monday, Wednesday, and Friday. On 9/22 there is an order to send R11 to the hospital to rule out sepsis. R11's progress notes, dated 9/11/23, V17 (nurse) noted R11 seen by nurse practitioner. Right second toe tip open. R11 states he hit toe on foot of bed. Wound care nurse made aware. New orders for antibiotic oral x/times 7 days. On 9/22/23, V17 (nurse) noted temperature 100, blood pressure 160/88, heart rate 110 beats/minute, oxygen saturation level 97% on room air, respirations 18/minute. Order received to send R11 to the local hospital. R11 admitted for gangrene second toe.	S9999		

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S9999	Continued From page 6 R11's hospital medical record, dated 9/22-9/28, R11 presented to the hospital with chief complaint of infection in right second toe, ulcer of right second toe, fever, and elevated heart rate. Podiatric surgery was consulted for evaluation of right digit with necrotic tissue and gangrenous changes. R11 noted with full thickness necrotic ulceration, right second digit at the distal tip extends plantarly to the IPJ (interphalangeal joint) with a necrotic base that measures approximately 2cm (centimeters) x 1cm. Surrounding skin with apparent sloughing of epidermal tissue. There is bogginess and crepitus noted upon palpation of the distal tip of the second digit. Mild purulence noted. Right second digit is also swollen and reddened. A sharp excisional wound debridement down to and including the level of the bone was performed on 9/22/23. Deep wound cultures were taken which noted proteus mirabilis, E. faecalis/VRE. R11 was very upset that R11 has to get the toe amputated due to infection in bone. Soft tissue necrotizing infection right second toe (x-ray of foot noted soft tissue emphysema to the distal tip of second digit). On 9/26/23, R11's right second toe was surgically amputated. b) During record review R4 had a hypoglycemic (low blood sugar) reaction on 10/11/23. Documented on 10/11/23 that R4 had a blood sugar reading of 37 mg/dl and R4 unresponsive. Glucagon IM (intramuscular) given. Blood sugar went up to 39 mg/dl. Nurse practitioner made aware. Glucagon IM given again. Blood sugar went up to 59 mg/dl. R4 unresponsive and 911 was called. On 10/26/23 at 10AM, V20 (Nurse Practitioner) interviewed stated that V20 received a call from V17 registered nurse (RN) around 7-730am,	S9999		

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S9999	Continued From page 7	S9999		

nurse reported that R4 has low blood sugar, and that glucagon shot was already given. V20 gave order to give another shot of glucagon. And said she will be coming in the facility to see the resident.

On 10/26/23 at 1:00PM, V17 (RN) confirmed that V17 gave 2 shots of glucagon taken from the east and northeast crash cart. V17 tried getting glucagon injection first from cubex (medication machine) but the computer was taking so long, so V17 grabbed the glucagon injections from the 2 crash carts.

On 10/27/23 at 12PM re-interviewed V20 (Nurse Practitioner) stated that V20 reviewed documentation for that day and V20 documented that R4 received 4 glucagon injections in the facility. V20 does not recall who reported this to V20, but V20 stated that's what was documented as what we did to R4 while in the facility. "If I documented 4 doses of glucagon was given, then R4 received 4 glucagon injections that day. What happened is what was documented in my notes".

On 11/3/23 at 1:30 PM, V3 (Previous DON/Infection Control Nurse) stated that the facility has 3 emergency carts, and each cart has glycogen IM injection. They have Cubex (Electronic Medication Machine) that has 2 glucagon IM injection in there. For emergency, nurse should attend to resident's emergency needs, then call the attending doctor, enter the order in electronic charting physician order, and sign the MAR. It is expected to enter orders and sign the MAR for it is a form of documentation that a medication is administered to a resident.

V20 documentation dated on 10/11/23, and uploaded in R4's chart on 10/27/23, reads in part:

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S9999	Continued From page 8 RN called this morning. R4 blood sugar is very low. Gave orders to give glucagon and recheck sugar. RN gave 4 shots of glucagon, APN in building R4 still not responding: RN at bedside. R4's blood sugar got as high as 59. R4 was still unresponsive. 911 called and R4 sent to ER (Emergency Room). Physician order sheet and Medication Administration for October 2023 provided by the facility reviewed and there is no order for glucagon IM injection and documentation in MAR that the glucagon IM injection was given on 10/11/23. Medication Administration policy dated 1/2023, reads in part: All medications are administered safely ad appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. An order is required for administration of all medication. Physician Orders policy dated 2/20/23, reads in part: Drugs will be administered only upon a clean, complete and signed order of a person lawfully authorized to prescribe. Verbal orders will be received only by licensed nurses or pharmacist and confirmed in writing by the physician. Electronic orders transmitted via NCPDP Script 10.6 will be accepted. Each medication order is documented in the resident's medication record with the date and signature of the person receiving the order. The order is recorded on the physician order sheet in PCC and the Medication Administration Record (MAR) or Treatment Administration Record (TAR). (A)	S9999		

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Statement of Licensure Violations 2 of 3:
300.610a)
300.1010h)
300.1210a)
300.1210b)
300.1210d)5)

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 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for

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S9999	Continued From page 10 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 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not	S9999		

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S9999	Continued From page 11 develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Regulations are not met as evidenced by: Based on interviews and record reviews, the facility failed to follow their skin care prevention policy. The facility failed to identify a skin alteration upon readmission in the facility and failed to have appropriate treatment for a pressure injury skin alteration. This affected one of three residents (R4) reviewed for pressure ulcer. This failure resulted in R4 being admitted to the facility with unassessed stage 2 pressure ulcer in the sacrum area on 8/25/23, R4 went without treatment and R4's stage 2 progressed into an unstageable by 9/5/23. Findings Include: R4 readmitted to the facility on 8/25/23. Reviewed Admission/Readmission Evaluation dated 8/25/23: there is no documentation for any skin alteration in sacral and/or coccyx area for R4. Hospital record dated 8/23/23, reads in part: Coccyx stage 2 pressure injuries measures 4.0cm x 3.0 cm x 0.1 cm. scant serosanguinous drainage. Peri-wound notes with blanching erythema On skin progress notes dated 8/26/23, reads in part: Redness and discoloration observed to R4's sacral area.	S9999		

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S9999	Continued From page 12 R4's Shower sheet reviewed from August 2023 to September 2023. On 8/27/23, sacral area was circled. Abnormal skin assessment was categorized in skin worksheet as: broken, bruised or reddened areas. On 8/27/23 to 9/23/23, the sacrum area was circled in the skin worksheet, indicating abnormal findings. New Skin Condition dated on 9/5/23, reads in part: Coccyx open area sacrum. Progress notes dated 9/5/23, reads in part: Nurse Practitioner and son made aware of new skin alteration and treatment in place. Facility wound doctor first documentation of sacral wounds was on 9/5/23, reads in part: Unstageable due to necrosis, wound size 3 x 2x 0.1 cm. Per-wound radius: surrounding DTI (deep tissue injury) (purple/maroon), maceration ecchymosis, Moderate serosanguinous. Physician Order Sheet reviewed, and Sacral wound has a treatment order on 9/5/23 to cleanse with Normal Saline Solution. Apply Thera honey, then cover with bordered gauze. Apply z-guard to peri-wound every Tuesday, Thursday, and Saturday, and as needed. R4's Braden Assessment dated 8/25/23 shows 13 (Moderate Risk) for pressure sore. On 10/24/23 at 10:00 AM, V14 (wound nurse) stated that R4's wound on 9/5/23 was documented that the wound on sacral has opened/unstageable. Acquired in the facility. Treatment: thera honey. Prior to this sacral to open was just redness. Verified by V14 that there is no other documentation prior to 9/5/23 about	S9999		

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S9999	Continued From page 13 the sacral wound, it was just redness. On 11/3/23 at 12:40pm V14 (wound nurse) stated that barrier cream is for redness only and not appropriate for any other skin alteration higher than stage 2. Expectation for the staff to do if there is a change in skin alteration is to notify MD and get appropriate treatment, informed the wound nurse, and do incident note. Upon admission our expectation is for the nurse to do a full body assessment and have treatment order for any skin issues. For unstageable necrotic pressure injury, it is not appropriate to have just barrier cream for treatment, most of the time the wound MD would place them in medihoney. If barrier cream is the treatment for an unstageable then it was not being treated appropriately. Skin Care Prevention policy dated 1/2023, reads in part: All resident will receive appropriate care to decrease the risk of skin breakdown. The nursing department will review all new admission/readmissions to put a plan in place for prevention based on the resident's activity level. Comorbidities, mental status, risk assessment and other pertinent information. All residents will be evaluated for changes in their skin condition. (B) Statement of Violations 3 of 3: 300.610a) 300.1210b) 300.1210d)3)6) 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	S9999		

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S9999	Continued From page 14 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 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	S9999		

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S9999	Continued From page 15 care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These Regulations are not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to adequately monitor a resident with advancing dementia and history of wandering, recent episodes of wanting to leave the facility unauthorized, and without facility staff knowledge. This affected one of three residents (R1) reviewed for supervision and monitoring. This failure resulted in R1 leaving the facility unauthorized, being found walking and falling on the sidewalk next to a busy street. A bystander notified EMS (emergency medical services) 911 for police assistance for R1. R1 was transported to the local hospital for further treatment. R1 sustained a laceration and nasal fracture. Findings include:	S9999		

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Upon entering this facility on 10/17/23, this surveyor observed the main doors unlocked and no staff present at the front desk in the main lobby. There were no staff observed in the four offices across from the main desk. There were three residents outside unsupervised. Five minutes lapsed before a staff member came to the main lobby to assist this surveyor.

On 10/17/23 at 12:00pm, V4 (director of rehabilitation) stated that R1 had cognitive issues. V4 stated that V4 saw R1 on 10/10/23 for physical therapy session. V4 stated that he tried to have R1 use a two wheeled walker, but R1 was noncompliant with its use. V4 stated that R1 walked without an assistive device; R1's balance was off, gait unsteady, and R1 was a fall risk. V4 stated that R1 would wander off the nursing unit, staff were able to re-direct R1. V4 stated that on 10/10/23, R1 exhibited elopement type behaviors. V4 stated that R1 has decreased safety awareness and needed line of sight monitoring for safety. V4 stated that he did communicate these cognitive and safety concerns with R1's nurse and social worker on 10/10/23.

R1's physical therapy note, dated 10/10/23, notes R1 is at high risk for falls secondary to decreased safety awareness and requires line of sight supervision secondary to elopement type behaviors. Communicated to nursing and social worker about this concern.

On 10/17/23 at 1:40pm, V5 CNA (certified nurse aide) stated that R1 was confused, ambulatory, balance off, and will hold on to walls at times. V5 stated that on 10/10/23, R1 was really confused, wandering on unit, re-directed to his room by staff several times. V5 stated that dinner is served

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between 6:30pm and 7:00pm. V5 stated that V5 last saw R1 before dinner. V5 denied seeing R1 leaving the facility. V5 stated that a police officer came in and spoke with R1's nurse, unsure of time.

On 10/17/23 at 1:47pm, V6 (nurse) stated that R1 was alert and oriented x 1. V6 stated that when R1's family present, R1 was oriented x 2. V6 stated that R1 was not aware of what was going on around him. V6 stated that R1 ambulated and was a little off balance sometimes. V6 stated that on 10/10, R1 came out to the nurses' station once, stood near water fountain, stated he wanted to cook, was attempting to remove plastic covering from water fountain. V6 stated that R1 was re-directed back to his room. V6 stated that she doesn't think therapy gave her an update on R1. V6 stated that the main door is open/unlocked from 8:00am-8:00pm, other doors are always locked. V6 stated that she worked day shift on 10/10/23 and did walking rounds with the oncoming nurse between 2:15pm and 2:30pm; R1 was in his room and appeared calm at that time.

On 10/18/23 at 12:20pm, V9 CNA stated that she worked the evening shift on 10/10/23. V9 stated that at the beginning of shift, V9 went into R1 and R4's room to obtain R4's vital signs and observed R1 sitting on his bed. V9 stated that she didn't think anything about it because she was only assigned to R4. V9 stated that a little before 7:00pm, she brought R1 his meal tray, R1 was not present in room. V9 stated that she didn't think anything about it because residents go out to smoke. V9 stated that the next thing she knew the police were at the nurses' station informing V7 (nurse) that R1 had fallen in the parking lot.

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S9999	Continued From page 18 On 10/18/23 at 1:00pm, V7 (nurse) stated that R1 was last seen by V7 between 6:15pm and 6:30pm when he passed medications to R1 and R4. V7 stated that R1 was laying in his bed at that time. V7 stated that he did not see R1 after that as he got a new admission at 6:30pm. V7 stated that he was in with new admit performing an assessment. V7 stated that when he came out, he went to the nurses' station and observed a police officer at the nurses' station. V7 stated that the officer asked him if he had a resident on this unit with that name and responded yes. V7 stated that the police officer informed him that he observed R1 in the parking lot and saw R1 fall sustaining a laceration to R1's head. Police officer called EMS (emergency medical services) 911 and R1 was transported to the local hospital. On 10/18/23 at 3:45pm, V3 (interim director of nursing) stated that if a resident is missing, all staff are expected to stop what they are doing, do head count of residents, and search facility for resident. V3 stated that residents exhibiting wandering/elopement type behaviors should be monitored more often by staff. V3 stated that the main doors are unlocked from 8:00am to 8:00pm and a receptionist is at the main desk during that time. V3 stated that during the day shift, the activity aide will monitor the front desk so receptionist can take a meal break. V3 stated that on the evening shift, the receptionist will call the nursing units to find a nurse or CNA that can cover the front desk. On 10/19/2023 at 2:00pm, V1 (interim administrator) presented a timeline of events involving R1 on 10/10/23. On 10/10/23 at lunchtime per staff interviews, R1 displayed confusion such as walking with his bags saying he was looking for his truck and staff were able to	S9999		

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reorient R1. V1 confirmed this was an accurate timeline of events.

On 10/18/23 at 4:05pm, V11 (receptionist) stated that she worked 4:00pm-8:00pm on 10/10/23. V11 stated that residents are supposed to sign in and out when they go outside to smoke, but usually they don't. V11 stated that she writes their names in the logbook as they go out and come back in. V11 stated that she did not see R1 exit the building that evening. V11 stated that she must call around to find staff that would be able to cover the main desk when she takes break. V11 stated that she does leave main desk unattended to use the bathroom as she is only gone a few minutes. V11 stated that sometimes it is difficult to distinguish residents from visitors by what they are wearing.

R1's medical record notes R1 was admitted to this facility on 10/4/2023 with diagnoses including, but not limited to, metabolic encephalopathy, dementia with behavioral disturbances, and cerebral amyloid angiopathy.

R1's BIMS (brief interview of mental status) score, dated 10/10/23, is 3 out of 15.

This facility's fast track assessment, dated 10/3/23, was completed while R1 was still in the hospital. Per R1's family, R1 has slowly been having some confusion at baseline. R1 has got very confused since R1's primary caregiver (family member) went to the hospital and R1 has not been caring for himself. Met with R1 at bedside. On one occasion, R1 did leave his house and could not find his way home.

R1's pre-admission hospital record, dated 9/29/23-10/4/23, notes R1 is confused. Speech

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intact. Progressively worsened dementia with intermittent confusion. R1 had sundowning and agitation in hospital. R1 is alert and oriented x 2, unable to provide much history. R1 was brought into the emergency room by a local police officer for wandering around the streets. R1 is acting more confused than normal, he typically knows his name, address, days of the week, and what is happening. Neurologist noted R1 was found wandering around the streets at the police department. MRI (magnetic resonance imaging) of brain compared with MRI of brain completed in April 2023 consistent with numerous chronic lobar micro-hemorrhages in the bilateral cerebral hemispheres which have increased. This is consistent with progression of cerebral amyloid angiopathy. R1's confusion is likely consistent with amyloid spell and worsening of his baseline dementia which could be vascular related.

R1's pre-admission hospital physical therapy (PT) documentation notes R1 is alert, confused, oriented to person. R1's overall functional communication is impaired. Attention span is impaired. R1 can follow one step commands. Organization, sequencing, and problem-solving functioning is impaired. Memory is impaired, decreased recall of recent events, decreased short term memory. Safety Awareness/Insight - decreased awareness of need for safety and decreased awareness of need for assistance. Awareness of Deficits - assistance required to compensate for deficits and decreased awareness of deficits. Impairments that require further therapy intervention: executive functioning, safety awareness, cognition, strength, activity tolerance and balance.

R1's EMS (emergency medical services) report, dated 10/10/23, notes dispatch was notified at

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7:20pm of resident injury. Ambulance crew arrived on scene at 7:25pm. In summary, crew called to the scene for wellbeing check for R1 due to multiple falls. Upon arrival crews located R1 seated in rear seat of police squad car. R1 found alert and oriented x 2 with no obvious distress. R1 presents with obvious injury to right eyebrow with controlled bleeding. R1 reports multiple falls while walking on sidewalk. Unknown if loss of consciousness occurred. Police on scene report locating R1 walking down 95th street confused. Police called to the scene by passerby who witnessed falls and not on scene. Police made contact with R1's family member who arrived on scene shortly after ambulance crew's arrival. R1's family informed crew that R1 is currently residing at this facility, and she was not contacted by facility to notify of R1 missing from facility. R1 reports pain and burning to abrasion on right side of face and bilateral knees. R1 and R1's family request transport for evaluation to hospital. R1 assisted to stretcher and care provided in route to hospital without complications. This facility notified of R1's locations and transport by police on scene.

R1's hospital medical record, dated 10/10/23, notes R1 presented to the emergency room at 7:55pm. R1's history obtained from EMS as R1 is confused. EMS states that bystander saw R1 fall multiple times, so they called EMS. Upon their arrival, police informed him that R1 was a resident at this facility. No missing person report had been filed. They noted bleeding from R1's forehead. Discharge summary from 10/4/23 was reviewed; R1 presented with altered mental status and confusion, which was thought to be due to worsening of R1's dementia. CT (computerized tomography) scan of R1's head noted nondisplaced fracture at the midline and

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S9999	Continued From page 22 right para midline nasal bone. (A)	S9999		