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CARRINGTON AT LINCOLNWOOD	3501 NORTHEAST PARKWAY LINCOLNWOOD, IL 60712

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A 000	Initial Comment Facility Reported Incident Investigations #IL195983 - 295.2000, 295.4010 #IL194749 - 295.4010	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: Type 2 Violation Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act) d) A resident with a condition listed in subsection (c) shall have their residency terminated in accordance with Section 295.2010. (Section 75(d) of the Act) e) Residency shall be terminated in accordance with Section 295.2010 when services available to the resident in the establishment are no longer adequate to meet the needs of the resident. This provision shall not be interpreted as limiting the authority of the Department to require the residency termination of individuals. (Section 75(e) of the Act)	A2000		

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A2000	Continued From page 1 This requirement is NOT MET as evidenced by: Based on observation, interview, and record review, the establishment failed to ensure that a resident remained appropriate for placement in the assisted living unit after a significant change in condition that has led to a decline in cognition and behaviors; the resident is no longer safe on an assisted living unit. This failure applied to one (R1) of three residents reviewed for residency requirements and has the potential to cause substantial harm to the resident. Findings include: R1 is a 74-year-old female currently residing in the establishment on the 4th floor Assisted Living Unit. R1 has medical diagnoses that include: Dementia, major depressive disorder, and conductive hearing loss. Establishment submitted incident report documenting that on 07/01/25, R1 eloped from the facility and was returned to the facility by the local police who found the resident at a nearby fitness center with her dog. 7/1/25 13:40 Incident Note reads: Note Text: Around 12:58PM, writer got a call from CNA supervisor that resident was brought back to facility by the police. Per concierge, police found resident carrying her dog walking by Planet Fitness and escorted resident back to the facility. Writer re-directed resident back to her apartment. V/S taken BP:127/76, P:70, SPO2:97%RA, T:97.8. Resident is alert and in stable condition. Writer called POA (power of attorney) and suggested the use of elopement bracelet/wander guard, POA gave verbal consent for the use of elopement bracelet to be worn by resident. Hourly	A2000		

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checks and 72hrs incident reporting initiated. DON, NP made aware. Monitoring and endorsing to oncoming shift and in 24hr report.

R1 Service Plan includes the following listed under Special Instructions: EASILY AGITATED*****CONSENTED TO NOT HAVE THE DEADBOLT LOCK ON APARTMENT DOOR*FEMALE CNA/CC TO PROVIDE SHOWER ON SCHEDULED DAYS: TUESDAYS AND SATURDAYS IN THE MORNING*IF RESIDENT IS NOWHERE TO BE FOUND IN THE COMMUNITY, PLEASE CALL THE DAUGHTER BECAUSE SHE HAS AIRTAG ON (R1) **SHE'S UNDER THE CARE OF ***, PSYCHE NP. WANDERGUARD CONSENTED 7/1/2025

Establishment provided Elopement policy dated 11-12-24 that documents that if the resident's physician deems the resident can remain in the community, the resident ' s service plan will be adjusted, and all changes immediately implemented to prevent further elopements.

R1 elopement risk screening tool dated 8/28/24 documents that R1 is at risk for elopement.

Elopement risk focus was added to service plan (date initiated: 7/01/25) with interventions to add monitoring device bracelet and to hourly wellness checks to be documented hourly with confirmation by nursing.

R1 Service Plan with focus of safety (date initiated: 9/12/24) includes intervention(s): safety check every hour as needed (date initiated: 5/4/24); safety check every hour as needed, CNA/CC assigned must check R1's whereabouts and inform the nurse on duty (date initiated:

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9/12/24); POA/daughter has air tag on R1, nursing staff to call daughter if she ' s nowhere to be found in the community (date initiated: 9/12/24); NOD to offer Wander guard and to be consented by POA/daughter or son for R1 (date initiated: 9/12/24).

Establishment provided email communication from E4 (Physician) to R1's POA (power of attorney) notifying the POA that the recommendation is for R1 to transition into a memory care unit for her safety, as a result of a decline in her cognition and behavior. This communication is dated 7/2/25 at 7:30PM.

Physician progress note reads: Visited on: 2025 Jul 02 11:00
CC (chief complaint): elopement; cognition decline
Subjective: 74-year-old female with underlying cognitive deficits/dementia not fully characterized as Alzheimer's vs Vascular vs. other psychiatric condition; She has been on psychotropics without ill effects; Recently, she has been noted to have cognitively declined, has eloped from the building, and is not properly caring for her dog from caregiver accounts. She left the building during a hot weather day to Planet Fitness with her dog; She seems aware of her elopement and issues with her dog but cannot clearly communicate rationale. She partially blames the dog for some care issues. Nursing is requesting she be transferred to memory care ASAP.

Psychological symptom due to dementia: progressive decline in cognition likely due to underlying dementia process; hasn't been characterized as Alzh vs Vascular vs other; High risk as she has already eloped and has episodes of agitation; No acute process is appreciated; will

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update lab to be thorough; Ordered transfer to memory care when able; Message sent to POAH; Modify Seroquel to 25 BID and daily PRN; may need to further titrate.

Establishment provided documentation indicating R1 ' s escalating exit seeking behaviors as evidenced by the following documentation:

- Effective Date: 06/24/2025 03:12 Type: Behavior Note, Note Text : Resident noted with behavior during this shift. Woke up around 2:30AM and insisted on taking her dog out for a walk outside the building. several attempt to redirect her back to her apartment prove abortive. Staff had to follow her to the ground floor to prevent her from leaving the building before she decided to go back to her appointment [sic].

- On July 1, 2025, at approximately 12:51 PM, the writer received a call from the Independent Living Concierge reporting that the resident, 74 yrs old female with diagnoses of Dementia, Depression, and Conductive Hearing Loss from 4th Floor Assisted Living had been returned to the community by the Lincolnwood Police Department. The writer notified the CNA Supervisor and requested a written statement from the CNA assigned to the resident, regarding the time of the most recent wellness check. The Nurse on Duty (NOD) was informed by the CNA Supervisor at approximately 12:58 PM, and according to the nursing report, the police found the resident walking by Planet Fitness while carrying her dog and subsequently the police escorted her back to the community.

- On July 1, 2025, at approximately 5:00 PM, the resident was observed outside with her dog, accompanied by two CNAs. Given the earlier

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elopement incident, the Dementia Director and Director of Health & Wellness assisted in redirecting the resident to the dining room on the 1st floor of the Assisted Living unit. The resident was supervised during her meal. The Director of Nursing (DON) contacted the POA/daughter to inform her that the resident had verbalized a desire to " go home. " Both directors reassured the resident that her home is her apartment on the 4th floor. The POA/daughter stated she intended to come to the facility but was delayed due to traffic in the downtown area. After finishing her meal, the Dementia Director accompanied the resident back to her apartment and remained with her while awaiting the POA/daughter ' s arrival. Daughter was documented to have arrived at 6:10 PM.

- Effective Date: 07/01/2025 21:31 Type: Incident Note, Note Text : Around 3:10pm, writer received resident with her dog in the elevator and aggressive towards staff. Writer was able to calm resident down and took her to her room. PRN given with no effective result. Later resident went outside the building. Resident was hard to redirect. Writer notified resident's daughter. Daughter came and went out with resident for a while. Resident in her room, calm at this time.

- Effective Date: 07/06/2025 12:54 Type: Incident Note, Note Text : At around 0730 am staff noted resident was seeking exit with her belongings. Staff able to redirect resident back to her room. Seroquel PO given as ordered and tolerated well. Resident came out again after couple minutes and used the fire exit stairs. Wander guard was on however fire door exit opens after an alarm for emergency purposes. Staff followed resident outside facility. Resident verbalized "leave me alone I need to go" Staff redirected resident and

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A2000	Continued From page 6 education provided however resident is non-compliant, agitated, and combative towards staff. POA and Son was called 6 times with no answer. Staff able to bring back facility on a stable condition after 3 staff assist ... - Effective Date: 07/06/2025 18:34 Type: Incident Note, Note Text : Around 8:00 AM I received a call from the CNA on duty reporting that the resident had attempted to leave the facility using the exit door and had taken some personal belongings with her. Staff responded immediately, located her outside the building, and returned her to facility. Later the nurse on duty informed me that the resident was no longer in her room. Staff conducted through check and discovered that the resident was with the dog walker, who had taken her out without notifying facility staff. - Effective Date: 07/11/2025 08:55 Type: Behavior Note, Note Text : At around 04:30 am staff noted resident was exit seeking through the elevator with her Dog, insisting on going for a walk, NOD was able to redirect resident back to her room, wander guard present, Resident continues to try leaving the floor using the three elevators on the floor staff continues to redirect resident and walk her back to her room, resident was compliaint, offered water, taken and tolerated well, at 6:35am NOD was notified by the CNA that resident was not in her room during her rounds. Room check was done, floor check was done, front desk was informed, no elevator alarms going off, Resident used the fire exit stairs in the back. Wander guard was on however fire door exit opens after an alarm for emergency purposes, Resident was seen by the maintenance Staff by the door leading to the parking lot, Resident was stopped and redirected education provided, resident is	A2000		

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compliant, Staff able to bring back resident to facility on a stable condition DON updated, voice message left for POA, MD notified. wellness check done after, incoming NOD updated.

- Effective Date: 07/11/2025 11:39 Type: Behavior Note, Note Text: On July 11, 2025, at approximately 8:00 AM, the writer interviewed the NOC, NOD regarding the resident ' s whereabouts earlier that morning. During a 9:00 AM meeting, the writer found out that the resident had been observed outside with her dog. The Plant Operations Director confirmed that he and his staff had seen the resident in the back parking lot with her dog. He stated that the resident did not go far, as nursing staff promptly intervened and redirected her back inside the community. The writer appreciated the timely and relevant information provided by the Plant Operations Director.

- Effective Date: 07/11/2025 22:46 Type: Behavior Note, Note Text : Around 1:22pm the POA notified NOD that the caregiver called her and told her that he took the resident out for a walk and then the resident ran to planet fitness, he attempted to bring the resident back to the community but he couldn't, the POA stated she had to come to planet fitness and both of them were chasing her down, eventually they were able to bring the resident back to the community after almost 2 hours. The POA stated that the resident did not fall or got injured. POA stated will try to hire a caregiver, but it will be on Sunday. POA requested to be called in case the resident is anxious and attempting to elope, she stated would come to the community if necessary. Resident has been closely monitored this shift. Will update NOD.

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A2000	Continued From page 8 When asked about the plan of care and interventions regarding elopement for R1 on 7/11/25 at 10:45AM, E2 (Health & Wellness Director) said that R1 has not eloped since the 7/1/25 incident but this morning she did make it downstairs. Since the monitoring bracelet alerted the staff, they starting looking for R1 immediately and found her downstairs. After the 7/1 incident, we talked to the doctor and family and advised them that R1 is no longer safe in assisted living; she needs to be in a memory care unit now. The family is currently trying to find placement ...the family is trying their best as are we. 7/12/25 at 10:52AM surveyor observed staff sitting in a large chair that was blocking the emergency exit doorway across from R1 ' s room on the fourth floor of the establishment. Surveyor approached staff and asked why she was sitting in the chair by the emergency exit doorway and staff, (E10/CNA) responded that she was sitting there to monitor the hall and in particular R1 ' s room since she been trying to leave. E10 confirmed that only the first floor of the establishment is memory care and that the residents on the other floors (2, 3, and 4) are able to come and go as they please; 3rd floor has some restricted residents but that ' s why on the third floor there is always a staff monitoring the front elevators. E10 confirmed that there are other residents she is assigned to care for and cannot sit in the hall to continuously monitor R1 but that she put the chair in front of the doorway so that if R1 sees the chair blocking the door she will not try to go out of that door. When asked if R1 can go out independently, E10 said, no because she can get confused and go off in the wrong direction; she needs a caregiver with her. 7/12/25 at 11:07AM E5 (LPN) confirmed that R1	A2000		

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will try to go out the back door (emergency exit door across from her room) and the alarm will sound since it is an emergency door but that the door will open. Staff will hear the alarm and respond. E5 explained that R1 has a monitoring bracelet that will not allow her to get off the floor via the elevators but that she can still get out through the emergency exit doors although the alarm will go off; E5 affirmed that R1 does not have any physical impairments that would impede her from being able to open the doors. When asked if R1 is appropriate to be in the room she is currently residing in on the fourth floor, E5 responded that it is up to management, but she believes it is time for R1 to transition to memory care.

7/12/25 at 11:19AM E11 (CNA) said that she is familiar with R1 and that she was helping look for her when staff were notified that she was missing some time last week, but the police ended up bringing R1 back to the building. E11 said that they have to monitor R1 constantly and that this floor (fourth floor) is not appropriate for R1 because she can get out and can be combative and hard to redirect. E11 affirmed that to her knowledge, R1 is the only resident on the fourth floor with these behaviors.

7/12/25 at 11:27AM E12 (Concierge) said that there is an elopement binder kept at the front concierge desk so that staff know which residents should not be going out independently, they must be signed out with a caregiver. E12 also said that there is someone at the front desk from 9am-5pm daily on the assisted living side of the facility but that the residents have access to open and close the doors 24 hours a day by using their key fob.

7/12/25 at 12:13PM E1 (Executive Director) was

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A2000	Continued From page 10 asked when is negotiated risk form provided for residents and E1 said it is only issued if there is a concern. Asked at what point is R1 not going to be appropriate to be in assisted living on the 4th floor, being that she keeps trying to leave and that it recently took the caregiver almost two hours to get R1 back in the building after going out; E1 responded now, since he was not aware of information provided by surveyor but that he will look into it and based on this information he affirmed that R1 needs to be in a memory care unit. E1 added that E2 is already working with the family to transition R1 to a new placement so they are just waiting on them for a decision.	A2000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: General Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) The service plan shall be developed by: 1) The resident, resident's representative or any individual requested by the resident;	A4010		

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A4010	Continued From page 11 2) The manager or manager's designee; and 3) A registered nurse, if the resident is receiving nursing services or medication administration or is unable to direct self-care. c) The service plan shall be signed and dated by all individuals involved in its development. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised, if necessary, immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). f) Based on the physician's assessment, the service plan may provide for the disconnection or removal of any kitchen appliance. (Section 15 of the Act) g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; B) dietary needs, if the establishment provides therapeutic diets; and C) special accommodations for the resident;	A4010		

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A4010	Continued From page 12 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; 4) Any risk being negotiated; and 5) Whether the resident requires medication reminders, supervision of self-administered medication, or medication administration. h) The service plan shall include all support services provided or arranged for by the establishment. i) Nothing in this Part limits a resident's ability to direct his or her own care and negotiate the terms of his or her own care. Residents have the right to refuse certain services or approaches that would otherwise be recommended based on the physician's assessment if the resident has received clear information regarding the risks and benefits of such a choice and the choice does not put other residents or staff at risk. Disclosure of the risks of refusing services or approaches must be documented in the service plan. This requirement is NOT MET as evidenced by: Based on observation, interview, and record review, the establishment failed to have effective interventions in place to ensure that a resident (R1) did not leave the establishment unsupervised for a resident assessed to require supervision when leaving the building; the facility also failed to provide service and care in accordance with a resident's (R2) service plan. These failures applied to two (R1, R2) of three residents reviewed for service plans and resulted	A4010		

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A4010	Continued From page 13 in R1 eloping from the facility and being found and brought back to the building by local police and in R2 not being assisted to bed at night per R2's service plan and preference. Findings include: R1 is a 74-year-old female currently residing in the establishment on the 4th floor Assisted Living Unit. R1 has medical diagnoses that include: Dementia, major depressive disorder, and conductive hearing loss. Establishment submitted incident report documenting that on 07/01/25, R1 eloped from the facility and was returned to the facility by the local police who found the resident at a nearby fitness center with her dog. 7/1/25 13:40 Incident Note reads: Note Text: Around 12:58PM, writer got a call from CNA supervisor that resident was brought back to facility by the police. Per concierge, police found resident carrying her dog walking by Planet Fitness and escorted resident back to the facility. Writer re-directed resident back to her apartment. V/S taken BP:127/76, P:70, SPO2:97%RA, T:97.8. Resident is alert and in stable condition. Writer called POA (power of attorney) and suggested the use of elopement bracelet/wander guard, POA gave verbal consent for the use of elopement bracelet to be worn by resident. Hourly checks and 72hrs incident reporting initiated. DON, NP made aware. Monitoring and endorsing to oncoming shift and in 24hr report. R1 Service Plan includes the following listed under Special Instructions: EASILY AGITATED*****CONSENTED TO NOT HAVE THE DEADBOLT LOCK ON APARTMENT	A4010		

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A4010	Continued From page 14 DOOR*FEMALE CNA/CC TO PROVIDE SHOWER ON SCHEDULED DAYS: TUESDAYS AND SATURDAYS IN THE MORNING*IF RESIDENT IS NOWHERE TO BE FOUND IN THE COMMUNITY, PLEASE CALL THE DAUGHTER BECAUSE SHE HAS AIRTAG ON (R1) **SHE'S UNDER THE CARE OF ***, PSYCHE NP. WANDERGUARD CONSENTED 7/1/2025 Establishment provided Elopement policy dated 11-12-24 that documents that if the resident's physician deems the resident can remain in the community, the resident's service plan will be adjusted, and all changes immediately implemented to prevent further elopements. R1 elopement risk screening tool dated 8/28/24 documents that R1 is at risk for elopement. Elopement risk focus was added to service plan adter elopement (date initiated: 7/01/25) with interventions to add monitoring device bracelet and to hourly wellness checks to be documented hourly with confirmation by nursing. R1 Service Plan with focus of safety (date initiated: 9/12/24) includes intervention(s): safety check every hour as needed (date initiated: 5/4/24); safety check every hour as needed, CNA/CC assigned must check R1's whereabouts and inform the nurse on duty (date initiated: 9/12/24); POA/daughter has air tag on R1, nursing staff to call daughter if she ' s nowhere to be found in the community (date initiated: 9/12/24); NOD to offer Wander guard and to be consented by POA/daughter or son for R1 (date initiated: 9/12/24). Establishment provided email communication	A4010		

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A4010	Continued From page 15 from E4 (Physician) to R1's POA (power of attorney) notifying the POA that the recommendation is for R1 to transition into a memory care unit for her safety, as a result of a decline in her cognition and behavior. This communication is dated 7/2/25 at 7:30PM. Physician progress note reads: Visited on: 2025 Jul 02 11:00 CC (chief complaint): elopement; cognition decline Subjective: 74-year-old female with underlying cognitive deficits/dementia not fully characterized as Alzheimer's vs Vascular vs. other psychiatric condition; She has been on psychotropics without ill effects; Recently, she has been noted to have cognitively declined, has eloped from the building, and is not properly caring for her dog from caregiver accounts. She left the building during a hot weather day to Planet Fitness with her dog; She seems aware of her elopement and issues with her dog but cannot clearly communicate rationale. She partially blames the dog for some care issues. Nursing is requesting she be transferred to memory care ASAP. Psychological symptom due to dementia: progressive decline in cognition likely due to underlying dementia process; hasn't been characterized as Alzh vs Vascular vs other; High risk as she has already eloped and has episodes of agitation; No acute process is appreciated; will update lab to be thorough; Ordered transfer to memory care when able; Message sent to POAH; Modify Seroquel to 25 BID and daily PRN; may need to further titrate. Establishment provided documentation indicating R1's escalating exit seeking behaviors as evidenced by the following documentation:	A4010		

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A4010	Continued From page 16 - Effective Date: 06/24/2025 03:12 Type: Behavior Note, Note Text : Resident noted with behavior during this shift. Woke up around 2:30AM and insisted on taking her dog out for a walk outside the building. several attempt to redirect her back to her apartment prove abortive. Staff had to follow her to the ground floor to prevent her from leaving the building before she decided to go back to her appointment [sic]. - On July 1, 2025, at approximately 12:51 PM, the writer received a call from the Independent Living Concierge reporting that the resident, 74 yrs old female with diagnoses of Dementia, Depression, and Conductive Hearing Loss from 4th Floor Assisted Living had been returned to the community by the Lincolnwood Police Department. The writer notified the CNA Supervisor and requested a written statement from the CNA assigned to the resident, regarding the time of the most recent wellness check. The Nurse on Duty (NOD) was informed by the CNA Supervisor at approximately 12:58 PM, and according to the nursing report, the police found the resident walking by Planet Fitness while carrying her dog and subsequently the police escorted her back to the community. - Effective Date: 07/01/2025 21:31 Type: Incident Note, Note Text : Around 3:10pm, writer received resident with her dog in the elevator and aggressive towards staff. Writer was able to calm resident down and took her to her room. PRN given with no effective result. Later resident went outside the building. Resident was hard to redirect. Writer notified resident's daughter. Daughter came and went out with resident for a while. Resident in her room, calm at this time.	A4010		

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A4010	Continued From page 17 - Effective Date: 07/06/2025 12:54 Type: Incident Note, Note Text : At around 0730 am staff noted resident was seeking exit with her belongings. Staff able to redirect resident back to her room. Seroquel PO given as ordered and tolerated well. Resident came out again after couple minutes and used the fire exit stairs. Wander guard was on however fire door exit opens after an alarm for emergency purposes. Staff followed resident outside facility. Resident verbalized "leave me alone I need to go" Staff redirected resident and education provided however resident is non-compliant, agitated, and combative towards staff. POA and Son was called 6 times with no answer. Staff able to bring back facility on a stable condition after 3 staff assist ... - Effective Date: 07/06/2025 18:34 Type: Incident Note, Note Text : Around 8:00 AM I received a call from the CNA on duty reporting that the resident had attempted to leave the facility using the exit door and had taken some personal belongings with her. Staff responded immediately, located her outside the building, and returned her to facility. Later the nurse on duty informed me that the resident was no longer in her room. Staff conducted through check and discovered that the resident was with the dog walker, who had taken her out without notifying facility staff. - Effective Date: 07/11/2025 08:55 Type: Behavior Note, Note Text : At around 04:30 am staff noted resident was exit seeking through the elevator with her Dog, insisting on going for a walk, NOD was able to redirect resident back to her room, wander guard present, Resident continues to try leaving the floor using the three elevators on the floor staff continues to redirect resident and walk her back to her room, resident was complaint,	A4010		

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A4010	Continued From page 18 offered water, taken and tolerated well, at 6:35am NOD was notified by the CNA that resident was not in her room during her rounds. Room check was done, floor check was done, front desk was informed, no elevator alarms going off, Resident used the fire exit stairs in the back. Wander guard was on however fire door exit opens after an alarm for emergency purposes, Resident was seen by the maintenance Staff by the door leading to the parking lot, Resident was stopped and redirected education provided, resident is compliant, Staff able to bring back resident to facility on a stable condition DON updated, voice message left for POA, MD notified. wellness check done after, incoming NOD updated. - Effective Date: 07/11/2025 11:39 Type: Behavior Note, Note Text: On July 11, 2025, at approximately 8:00 AM, the writer interviewed the NOC, NOD regarding the resident ' s whereabouts earlier that morning. During a 9:00 AM meeting, the writer found out that the resident had been observed outside with her dog. The Plant Operations Director confirmed that he and his staff had seen the resident in the back parking lot with her dog. He stated that the resident did not go far, as nursing staff promptly intervened and redirected her back inside the community. The writer appreciated the timely and relevant information provided by the Plant Operations Director. When asked about the plan of care and interventions regarding elopement for R1 on 7/11/25 at 10:45AM, E2 (Health & Wellness Director) said that R1 has not eloped since the 7/1/25 incident but this morning she did make it downstairs. Since the monitoring bracelet alerted the staff, they starting looking for R1 immediately and found her downstairs. After the 7/1 incident,	A4010		

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we talked to the doctor and family and advised them that R1 is no longer safe in assisted living; she needs to be in a memory care unit now. The family is currently trying to find placement ...the family is trying their best as are we.

7/12/25 at 10:52AM surveyor observed staff sitting in a large chair that was blocking the emergency exit doorway across from R1 ' s room on the fourth floor of the establishment. Surveyor approached staff and asked why she was sitting in the chair by the emergency exit doorway and staff, (E10/CNA) responded that she was sitting there to monitor the hall and in particular R1 ' s room since she been trying to leave. E10 confirmed that only the first floor of the establishment is memory care and that the residents on the other floors (2, 3, and 4) are able to come and go as they please; 3rd floor has some restricted residents but that's why on the third floor there is always a staff monitoring the front elevators. E10 confirmed that there are other residents she is assigned to care for and cannot sit in the hall to continuously monitor R1 but that she put the chair in front of the doorway so that if R1 sees the chair blocking the door she will not try to go out of that door. When asked if R1 can go out independently, E10 said, no because she can get confused and go off in the wrong direction; she needs a caregiver with her.

7/12/25 at 11:07AM E5 (LPN) confirmed that R1 will try to go out the back door (emergency exit door across from her room) and the alarm will sound since it is an emergency door but that the door will open. Staff will hear the alarm and respond. E5 explained that R1 has a monitoring bracelet that will not allow her to get off the floor via the elevators but that she can still get out through the emergency exit doors although the

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alarm will go off; E5 affirmed that R1 does not have any physical impairments that would impede her from being able to open the doors. When asked if R1 is appropriate to be in the room she is currently residing in on the fourth floor, E5 responded that it is up to management, but she believes it is time for R1 to transition to memory care.

7/12/25 at 11:19AM E11 (CNA) said that she is familiar with R1 and that she was helping look for her when staff were notified that she was missing some time last week, but the police ended up bringing R1 back to the building. E11 said that they have to monitor R1 constantly and that this floor (fourth floor) is not appropriate for R1 because she can get out and can be combative and hard to redirect. E11 affirmed that to her knowledge, R1 is the only resident on the fourth floor with these behaviors.

7/12/25 at 11:27AM E12 (Concierge) said that there is an elopement binder kept at the front concierge desk so that staff know which residents should not be going out independently, they must be signed out with a caregiver. E12 also said that there is someone at the front desk from 9am-5pm daily on the assisted living side of the facility but that the residents have access to open and close the doors 24 hours a day by using their key fob.

7/12/25 at 12:13PM E1 (Executive Director) was asked when is negotiated risk form provided for residents and E1 said it is only issued if there is a concern. Asked at what point is R1 not going to be appropriate to be in assisted living on the 4th floor, being that she keeps trying to leave and that it recently took the caregiver almost two hours to get R1 back in the building after going out; E1 responded now, since he was not aware of

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information provided by surveyor but that he will look into it and based on this information he affirmed that R1 needs to be in a memory care unit. E1 added that E2 is already working with the family to transition R1 to a new placement so they are just waiting on them for a decision.

R2 is a 92-year-old female currently residing in the establishment on the 3rd floor Assisted Living Unit that is considered a "bridge to memory care" per interview with E2 (Health & Wellness Director). R2 has medical diagnoses that include: Dementia, age-related osteoporosis w/out current pathological fracture, urge incontinence, and Alzheimer's Disease.

Establishment submitted incident report documenting:

On 6/8/2025, it was reported by the nurse on duty that the, C.N.A. did not care for a resident assigned to her. This resident and 2 other residents were added to her assignment due to a call-in from another C.N.A.

During the investigation it was found that the C.N.A did not get the resident ready for bed; put the resident to bed, and when asked by nurse on duty to do the above-mentioned before leaving, the C.N.A did not complete the task.

During an interview with the HR Director the C.N.A acknowledged that she did not provide care for R2, who was added to her assignment.

During the course of this investigation, surveyor determined that E13 (CNA) and E14 (LPN) were the staff on duty assigned to care for R2 on the evening of the incident on 6/8/25.

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A4010	Continued From page 22 Morse Fall Scale dated 10/17/23 documents that resident has a score of 80 and is considered high risk for falling; contributing factors include: a history of falling, use of crutches, cane or walker, weak gait, and mental status = overestimates or forgets limits. For reference, score greater than 45 is considered high risk. R2's physician certification dated 2/4/25 documents that R2 warrants (not limited to) hands on assistance with dressing and transferring. R2's service plan with focus dressing/undressing (revised: 2/8/22) includes goal, "will be dressed appropriately with assistance via 1 CNA assist" (initiated: 8/9/23, revised: 6/3/25); goal "staff to remind/assist resident to get ready for bed at 8PM FEMALE ONLY" (initiated: 8/9/23, revised: 6/3/25); focus "FALLS balance issues" (initiated: 2/7/22, revised: 2/8/22) with goal "will remain free of injury" (initiated: 2/7/22, revision: 6/3/25), interventions include: "is at risk for falls due to balance issues" (initiated: 2/7/22), "staff to perform bed check for resident around 10:00pm to make sure the resident has not fallen asleep in the chair and can ambulate to bed safely after night meds" (initiated: 5/4/23, revised: 4/18/24). Surveyor observed posted nighttime routine for R2 per instructions from POA at nursing station during the course of this survey and in resident chart. 7/11/25 at 2:45PM, E6 (CNA) said that R2 needs help to the bathroom and that before bed staff are to help her get changed and get her ready for bed. 7/11/25 at 2:50PM E7 (LPN) said that staff are to	A4010		

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follow R2's routine (and pointed to posted routine on the wall) and stated, the daughter calls me right away if she has any issues. E7 added that staff are all good about following the resident's service plan but that she did have to remind E13 (CNA) a few times about her assigned tasks.

7/11/25 at 3:56PM E15 (CNA Supervisor/Scheduler) said that for the incident with R2 on 6/8/25, E14 (LPN) notified her that E13 (CNA) was upset that there were only two CNAs on the floor and that E13 said that she did not know that R2 had been assigned to her. I think there was one incident before with E13 and R2, where E13 was the assigned CNA and the oncoming overnight CNA called me to tell me that she found R2 in bed but without PJ's, she was still wearing her daytime clothes. At that time, I coached E13, and I asked her what happened, and she said that she was with another resident, and she forgot to go back and change R2's clothes. But since this new incident on 6/8/25 was the second time this happened with her, the nurse manager handled it. I think the nurse E14 had already told me that another family also complained about E13 that the way she expressed herself was strong. It just wasn't their preference. E15 added that there really aren't staffing issues since she is the scheduler and makes sure that they are staffed appropriately but, on this day, she made a mistake and accidently did not schedule three CNAs.

7/11/25 at 3:30PM E3 (Nurse Manager) said, it was reported to me from E14 (LPN) that when she walked past R2's room at about 11pm, R2 was still on the couch in her room and that E13 had not put her to bed yet. I don't remember all the details exactly but it's all in my report statement ...It is in R2's care plan per her

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A4010	Continued From page 24 families' request that she be put to bed between 8 - 8:30pm. E3 affirmed that in her interview with E13 (CNA), E13 did admit that she didn't do anything for the additional residents assigned (including R2). E3 affirmed that both E13 (CNA) and E14 (LPN) were terminated mostly related to an altercation that they had amongst each other about R2 not being put to bed ... no residents were involved directly in this incident and since this took place at the back elevator, I don't believe that any residents had their sleep disturbed. E14 (LPN) was terminated for the staff-to-staff interaction ...E13 (CNA) was terminated for neglect because she didn't follow the care plan for R2 and put her to bed between 8/8:30pm ...Her disciplinary action form has the actual part of our handbook that she violated for the neglect. Resident rights per establishment contract includes: Exhibit D Resident Rights ...5. The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; 6. The right to direct his or her own care and negotiate the terms of his or her own care ...8. The right to exercise free choice in selected activities, schedules, and daily routine ...	A4010		