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ARTIS SENIOR LIVING OF LAKEVIEW	3535 NORTH ASHLAND AVENUE CHICAGO, IL 60657

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A 000	Initial Comment Annual Licensure Survey Conducted.	A 000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 2 Violation Section 295.4060 Alzheimer's and Dementia Programs b) No person shall be admitted or retained in an assisted living or shared housing establishment if the establishment cannot provide or secure appropriate care, if the resident 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 150(b) of the Act) c) No persons shall be accepted for residency or remain in residence if the person's mental or physical condition has so deteriorated to render residency in such a program to be detrimental to the health, welfare or safety of the person or of other residents of the establishment. The assessment must be approved by the resident's physician and shall occur prior to acceptance for residency, annually, and at such time that a change in the resident's condition is identified by a family member, staff of the establishment, or the resident's physician. (Section 150(c) of the Act)	A4060		

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A4060	Continued From page 1 e) No person shall be accepted for residency or remain in residence if the person is dangerous to self or others and the establishment would be unable to eliminate the danger through the use of appropriate treatment modalities. (Section 150(d) of the Act) h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 5) Provide, in the service plan, appropriate cognitive stimulation and activities to maximize functioning, which include a structure and rhythm that are comfortable and predictable; offer an appropriate balance of rest and activity and private and social time; allow residents to express their accustomed social roles, whatever they may be; offer residents access to familiar activities that they enjoyed doing and that tap memories and retained abilities; and provide the flexibility to accommodate variations in the resident's mood, energy level, and inclination; These Requirements are not met as evidenced by: Based on interview and record review, facility failed: To manage 1 Dementia Resident (R2) out of 3 reviewed for physical aggression; Allowed continuing residency for one resident (R2) who requires total assistance with 2 or more activities of daily living out of 3 reviewed for residency requirements; and Organized unsafe activity for one resident(R3) with severe dementia out of 3 reviewed for activities.	A4060		

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These failures resulted in R2 hitting care partners on multiple occasions. R2's physical aggression is a danger to staff and other residents who live in the memory care unit close to R2. R2's aggressive behavior as well as total care requirements in 2 or more activities of daily living do not meet residency requirements.

R3 was allowed to play bingo and managed to put small ball like object from bingo game in his mouth. Bingo ball object poses a swallowing hazard for R3 who has severe dementia.

Findings include:

R2 was admitted to the memory care facility on 12/14/23 with diagnoses of Lewy Body Dementia with Behavior Disturbance. Health assessment of 7/9/24 describes R2 as having "anxiety, hallucinations, delusion." MMSE(mini mental state examination) of 12/7/23 has no score. R2 did not complete this cognition test. R2 is described as having severe Dementia per E2(Assistant Director of Nursing).

R2 resides in the 2nd floor memory care unit. Born on 7/1/1955, R2 is 69 years old. Medical evaluation with fax stamp of 12/8/23 and 12/14/23 documents R2 as having history of aggressive behavior. A number of notes describes R2's history of agitated behavior and need for psychiatric admission.

Limited notes are available from a Hospital Psychiatric admission of 2/5/24. MD describes R2 as having issues with agitation and documents R2 as having "2 recent admits at (hospital) for agitation." On page 10 the note documents "it was felt that part of his agitation

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was triggered by his left shoulder pain ..." The notes continue to reflect episodes of agitation and in A/P(Assessment/Plan) the physician writes, "LBW(lewy body dementia) with behavioral disturbance, possibly mixed with alz dementia with multi domain dementia. Left should rotator cuff tear ..." It is not clear from forwarded material whether the Left shoulder rotator cuff tear was surgically repaired. However, 3 months later R2 continues to have physically aggressive potentially serious injurious behaviors.

Review of facility nursing notes documents physically aggressive behavior by R2 against care partners many times including:

5/22/24 fighting care partner
6/22/24 combative with care partner
7/21/24 Bit care partner in upper arm
8/5/24 hit care partner in face. Grabbing, scratches and hitting.

On 8/16/24 E1(Executive Director) was advised of hitting of care partners on multiple occasions and responded, "(R2) too weak to hit." R2's episodes of aggression with description were reviewed with E1 including the 8/5/24 episode in which R2 hit the care partner in the face. E1 responded, "to be honest with you I didn't know about 8/5/24 hitting incident." On 8/20/24 E1 sends additional documentation and reporting she believes R2's aggressive behavior is due to pain.

On 8/16/24 at 2:28 pm E2(Assistant Director of Nursing) was informed of R2's hitting behavior and responded, "(R2) just grabs. (R2) doesn't hit." The descriptions of R2's aggressive behaviors do not match E2's explanation.

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A4060	Continued From page 4 On 8/16/24 at 11:44 am E3(Director of (facility) way and Manager of Memory Care) stated in part, "(R2) sees monsters. Thinks people monsters ..." In addition to aggressive behavior, R2's Assessment dated 7/9/24 documents R2 as needing "total assistance with showers," "dependent on staff" for grooming assistance and requiring "assist of 2 + staff for transfers. Due to R2's "severe confusion" the assessment states "requires constant redirection." Requested current service plan from E2(ADON). In response an assessment dated 7/9/24 and an assignment sheet with date printed of 12/26/23 was forwarded. E2 had explained both these documents serve as the service plan with the assignment sheet geared toward care partner responsibilities. The assignment sheet describes R2 as able to ambulate independently with a walker. There is no mention of behaviors and interventions related to physical aggression in the assignment sheet. The assessment on page one identifies use of a lidocaine patch for management of back and shoulder pain. In response to R2's resistive behavior the assessment/service plan states, "(R2) is resistive with care. (R2) can become aggressive and combative during the task. Staff goes to assist in pairs, and care partners are aware to be careful and cautious when providing care to (R2)." Facility documentation reflects R2 as a serious safety issue with an inadequate plan to ensure the safety of others. In addition, R2 is requiring physical assistance outside of the scope of facility license.	A4060		

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A4060	Continued From page 5 R3 resides on the 1st floor of the memory care unit and has diagnoses including severe Dementia with behavioral disturbance, and Delusional Schizophrenia. MMSE (mini mental) of 1/26/24 is scored as 0. Assessment of 1/26/24 documents under heading of "behavior and cognition," R3 as having "severe confusion requires constant redirection." Accident/incident report of 5/1/24 at 12:00 pm documents R3 as taken up to the 2nd floor for bingo activity. R3 placed on bingo ball in mouth. On 8/16/24 at 9:40 am E2(Assistant Director of Nursing) stated in part, "they were in bingo in life enrichment center. (R3) will put objects in mouth. Like Large. Don't leave anything laying around. Removed all little stuff ..."	A4060		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform	A6000		

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A6000	Continued From page 6 labor; These Requirements are not met as evidenced by: Based on interview and record review, the facility failed to provide adequate care, support and supervision for 1 resident(R1) out of three reviewed for falls with injury. This omission resulted in R1 sustaining brain bleed injury on 5/28/24 from a fall while in assisted living which resulted in an Intensive Care unit admission and on 8/1/24 bleeding from a cut on forehead of unknown cause requiring dissolvable sutures. Findings include: Facility is currently operating without a Director of Nursing. E3(Director of (Facility) Experience/Manager of Memory Care) is not a clinical manager. In absence of Director of Nursing, E2(Assistant Director of Nursing/Licensed Practical Nurse) who has not been in this role for long was the clinical contact for facility. R1 was initially admitted to the 5th floor of the Assisted Living section of the facility on 12/22/22, according to E1(Executive Director). Face sheet diagnoses are listed as "CHF(heart failure), Dementia, Rib fracture, Atrial fibrillation, falls and history of breast cancer." According to E1(Executive Director) R1 resided in Assisted Living(5th floor) until 7/3/24 when R1 was admitted to the memory care unit on the 3rd floor. There is conflicting information regarding R1's room on readmission on 7/3/24. On 7/6 and 7/7 there are notes placing R1 in room in Assisted living room 506. After this there is documentation placing R1 in memory care on the 3rd floor.	A6000		

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A6000	Continued From page 7 Health assessment of 2/10/24 which was forwarded by E2(Assistant Director of Nursing) as most up to date assessment and service plan, R1 is "high risk for falls" with history of falls, needs "reminders to use walker," "refuses medications at times," and has "moderate confusion/ requires some redirection/may have unpredictable behavior." Under "behavior and cognition" heading R1 is described as "can be agitated and will be verbally aggressive." The document is signed on 2/29/24 by E1(Executive Director) and on 4/11/24 by "signature of resident or responsible party." Included in this document are many handwritten entries for R1's falls located under Medical History, Health Monitoring and Pain management, fall risk, Dressing and Grooming, Mobility and Transferring Heading. There is an additional fall entry that is handwritten below the signature page. This is not a cohesive, organized approach to falls as fall interventions are listed under many different headings. There are also discrepancies between this service plan interventions and assignment sheet/care requirements used by care partners. After continued questions E2 presents an additional document as part of the service plan used by the care partners to assist with completion of tasks. This document presented later by E2 was titled, "Assignment Sheet" with a printout date of 7/15/24 which E2 reported was the information/service plan care partners are to follow. E2 was asked for the date this assignment sheet became effective and stated she couldn't tell. Both of these documents are located in a binder on the unit which the care partners have access to. No other documents	A6000		

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A6000	Continued From page 8 were designated as part of the service plan by E2. Based on the review of these documents as well as the nursing notes, R1 had falls on 12/22/23, 5/24/24, and on 5/28/24 at approximately 8:10 pm with resulting intensive care hospitalization for cerebral bleed. R1 was gone from the facility on 5/28/24 due to the cerebral bleed and returned to the facility on 7/3/24. R1 began to fall again on 7/12/24 at 12:30 pm, 7/18/24, 7/31/24 at 5:17 am, and on 8/1/24 at 8:15am with resulting laceration requiring sutures. 3 days after a fall with injury R1 continues falling on 8/4/24 at 4:15 am, 8/6/24 at 3:00 am, 8/8/24 (R1 is sent to the hospital and a urinary tract infection is diagnosed) and on 8/11/24 at 1:30 am. The service plan when compared to the care partner assignment sheet and the nursing notes does not include all the fall interventions documented by the facility. The fall management system is fragmented and different parts of the documentation are missing fall interventions. For example, the assignment sheet for the care partner identifies R1 as having unsteady gait/balance. One nursing note identifies the need for a gait belt on 7/31/24. The next day R1 falls and requires sutures to her forehead. There is no evidence a gait belt was being used or implemented as an intervention on her service plan/assignment sheet. There are also interventions to remind R1 to use her walker, however, based on the falls, R1 is not using her walker as needed and as per observations on 8/16/24 at 11:30 am, R1's walker was not in her room but outside the door of her	A6000		

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room. R1 was awake but confused on 8/16/24 at 11:30 am during interview.

According to nursing notes on 5/2/24, R1 starts to have "episode of epistaxis" with R1 educated that she "is on blood thinners and nose bleeds may take longer to stop." On 5/14/24 R1 again has a "bloody nose."

The next documented fall in the forwarded clinical notes is on 5/24/24 when R1 has a fall, which is documented in a midnight note by the nurse, in the bedroom with bleeding noted on the left side of the head. R1 is sent to the hospital and returns. There are no listed interventions for the fall on 5/24/24 and no explanation of the cause of the fall.

The 2/10/24 dated assessment has an entry documenting the fall in R1's room on 5/24/24 with no new orders/injuries or interventions in place for high fall risk. The service plan at this point does not address R1's fall risk despite a fall resulting in visible bleeding and being on blood thinners.

On 5/28/24 nursing writes at 12:00 am, "(R1) has a fall on 5/28/2 8:10 pm ...observed (R1) on the 5th floor hallway laying on the floor bleeding from the left side of the head ...EMT(Emergency Medical Technician) arrived at 8:25 pm (R1) was still alert and had two episodes of emesis ..."

A follow up 5/29/24 nursing note states in part, "(R1) admitted to ICU(intensive care unit) ...CT(Cerebral Tomography) scan shows bleeding in the brain appears to be confused ..." This note refers to a Director of Nursing who no longer works at the facility.

According to E1(Executive Director) and

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E2(Assistant Director of Nursing) it is the Director of Nursing who is responsible for updating of the service plan. E2(Assistant Director of Nursing) reported she and E1(Executive Director) were responsible for updating the service plan in DON's absence.

By 7/3/24 R1 returns to the facility and is readmitted to the 3rd floor memory care unit according to E1(Executive Director). On return to the facility R1 is noted to have "bruise under left eye and back of head," according to nursing note of 7/3/24 at 1:08 pm. The 7/3/24 note states R1 is able to ambulate with scooter but additional notes on 7/4/24 describe R1 as highly agitated, screaming at care partner and knocking at nursing station door and screaming at nurses with R1 refusing morning medications and on 7/5/24 refusing night medications.

Although E1 is stating R1 returned to the memory care unit which is located on 1st, 2nd and 3rd floor, nursing notes of 7/6/24 at 6:33 am and 7/7/24 at 6:47 am have R1 in room 506 which is an assisted living room.
On 7/6/24 at 6:33 am R1 is described as in room 506(AL) and "locking the door after every check." R1 is screaming at all the residents on 5 and has a copy of keys and card for elevator. On 7/7/24 R1 is "currently in room 506."
On 7/7/24 facility nurse calls R1's nurse practitioner but received no answer. 7/8/24 R1 continues "screaming all day long ..." with E1(Executive Director) informed. 7/9/24 a new order for Seroquel(antipsychotic) and an increase in sertraline (selective serotonin reuptake inhibitor) is ordered.

After the 5/28/24 fall the next fall for R1 is on 7/12/24 at 12:30 noon. The fall is witnessed. R1

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is described as "sitting in bed then stood up walk and witness (R1) loss balance, writer tried to catch but was late end up on the floor on her butt ..." No interventions are listed on the health assessment/service plan for this fall. The nursing note states the nurse practitioner has ordered the resident to be monitored.

On 7/14/24 R1 refuses medications at times and is "confused at times throughout conversation in the day as to what was going on in the community and where she might have to be."

On 7/18/24 nursing writes at 12:39 pm "(R1) was found on the floor with a pillow ...(R1) defecated on the floor around the room. The last time was check was at 6:00. Care partner on 1 shift found (R1) around 7:30(am) to 8:00 am ..." The resident is cleaned up and no injuries are documented in the note.

On 7/31/24 at 5:17 am nursing note documents another unwitnessed fall with R1 screaming and found "sitting in urine on the floor of the bedside." No injuries were identified. According to intervention in health assessment/service plan of 2/10/24 staff are to "toilet resident around 5 am and check for incontinence to prevent falls moving forward."

An additional nursing service plan of 7/31/24 at 3:30 pm describes R1 as "confused" with "gait belt present when ambulating and used ..." The use of a gait belt as an intervention is not present in the service plan. It is also not listed in the care partner Assignment sheet as an intervention under mobility. Care partner assignment under heading of mobility/transferring which was forwarded by E2(ADON) as service plan for R1 with a printout date of 7/15/24 describe R1 as

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"able ambulate and transfer independently, however, she does need reminders to use her walker as she will often start walking without it. Also her gait is unsteady/balance is unsteady."

By 8/1/24 nursing note of 1:15 pm documents "(R1) was confused during morning medication pass, (R1) was walking around without pants, (R1) was looking for grand kids, (R1) refused to use walker, after that writer was called to let me know that resident was on the floor bleeding (from) a cut on (R1) forehead. Send to hospital ..." By 8/2/24, R1 returns to the facility with "dissolvable sutures." Health assessment of 2/10/24 has handwritten note dated 8/1/24 that staff "will continue to redirect on usage of walker. Physical therapy ordered." Care partner assignment sheet under mobility/transfer with date of 8/2/24 has handwritten instruction to "please round every 30 minutes. Assist with toilet/walking. Always should have walker as of 8/2/24."
On 8/4/24, R1 is found on the floor "around 4:15 am." The floor is described as wet with urine. According to the note a toileting schedule of every 2 hours is implemented and staff are to report (R1) behavior if (R1) does not want help."
On 8/11/24 at 1:30 am, R1 is found sitting on the floor. R1 explains she was trying to go to the bathroom and lost her balance.
E1(Executive Director) reported R1 did receive physical therapy while at the facility. All physical therapy notes for R1 were requested from E1.

The P.T notes begin on 7/15/24 and end on 8/19/24. P.T(physical therapy) notes document in part:

8/19/24 R1 sit to stand with supervision and verbal cues for sequencing. Ambulated with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510512	A. BUILDING: _____ B. WING _____	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LIVING OF LAKEVIEW	3535 NORTH ASHLAND AVENUE CHICAGO, IL 60657

(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
A6000	Continued From page 13 rolling walker with supervision and cues. 8/14/24 R1 was seen in her room and was walking without her rollator and without pants on. R1 confused, assisted in toileting and CGA/SBA (contact guard assist/standby assist). Patient educated on importance of using rollator at all times during transfers and ambulation to decrease fall risk, inconsistent carry over and retention due to cognition. 8/7/24 Continued gait training in the apartment, hallway, on and off elevator x SBA(standby assist) to focus on upright posture, obstacle negotiation and use of rollator seat as needed. 8/4/24 R1 needed verbal and tactile cues for safety with use of rolling walker. R1 needed cues to enter elevator safely and to maneuver around other passengers. 7/28/24 R1 impulsive movements lead to poor safety awareness with gait and transfers. 7/21/24 R1 assisted with foot placement. Gait training hand holding with PT from dining room in her unit to 5th floor gym and return. Lateral walking along hand rail in unit. 7/15/24 Gait = SBA(standby assist) Based on physical therapy notes R1 needs either standby assist or contact guard assist and cueing for ambulation. The physical therapy recommendations are not included in R1's service plan. Physical therapy has also assessed R1 as having poor safety awareness with gait and transfers. Facility approaches for R1 are not addressing R1's supervision and care requirements related to ambulation.	A6000		

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A6000	Continued From page 14 Facility fall policy and procedure recognizes 3 main elements are needed in a fall program. This includes addressing a resident's risk factors, service plan and interventions that are risk specific and continuous review of effectiveness of the service plan and interventions. R1's fall interventions are insufficient to mitigate the risk of injury and do not address her impulsive behavior leading to poor safety awareness or her supervisory needs. E1(Executive Director) was advised R1's walker was outside her door. E1 explained that the walker was being left outside the door because R1 would not walk without the walker. This explanation is not consistent with physical therapy observation of R1 being found on 8/14/24 ambulating in her room without the walker.	A6000		