STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145881	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Uptown Care and Rehabilitation	4920 North Kenmore Chicago, IL 60640

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15301 Based on interview and record review, the facility failed to develop and implement a policy to address strip/body searches of residents. This failure has the potential to affect two of three residents (R13, R4) reviewed for strip searches. This failure resulted in R13 feeling humiliated and ashamed; R4 feeling violated. Findings include: 1. R13's Face Sheet documents R13 is a [AGE] year-old admitted to the facility on 3.14.2024 with diagnoses including: Pain in Left Shoulder, Low Back Pain, Acquired Absence of Other Right Toe(s), and Acquired Absence of Other Left Toe(s). R13's MDS-Minimum Data Set of 6.12.2024 documents a BIMS (Brief Interview for Mental Status) score of 15 denoting resident is cognitively intact. On 8.20.2024 at 12:24 PM, R13 said approximately 1 1/2 months ago, he was subjected to a strip search because his former roommates credit card was missing. R13 said he was told by V25 (PRSC-Psychiatric Rehabilitation Services Coordinator) if he did not comply with the search, R13's parole officer would be contacted to obtain an order to return R13 to prison as R13 was on parole at that time. R13 said the search occurred in V25's office; V24 (Restorative Director) was also present. R13 said he took off his shirt, dropped his pants, underpants and bent over and coughed as instructed. R13 said V21 (Former Housekeeping/Laundry Supervisor) briefly stuck his head inside V25's office. R13 said the strip search made him feel humiliated and ashamed. 2. R4's Face Sheet documents R4 is a [AGE] year-old admitted to the facility on 2.8.2024 with diagnoses including but not limited to: Type 2 Diabetes Mellitus, Alcohol-Induced Chronic Pancreatitis, and Iron Deficiency Anemia. R4's MDS-Minimum Data Set of 6.4.2024 documents a BIMS (Brief Interview for Mental Status) score of 15 denoting resident is cognitively intact. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 8.21.2024 3:00 PM, R4 said when she returned to the facility on 6.12.2024, staff at the front desk stopped her to search her purse, R4 refused. R4 said, later V4 (Social Service Director) and V24 (Restorative Nurse) conducted a strip search in V4's office. R4 said, I was told to lift up my shirt, to lift up my bra, they could see my ti**es. R4 said they had me unzip my pants. I felt violated, like she (V4) had all the power. On 8.15.2024 at 4:20 PM V4 (Social Service Director) said she is not aware of any strip searches of any residents. On 8.21.2024 at 11:47 AM V24 (Restorative Director) said, If I'm asked to by Social Service, I do assist to conduct strip searches. I assisted with strip searches of R4 and R13. V4 (Social Service Director) needed me to assist with search of R4's room and to be a witness to R4's strip search. We had R4 pull her shirt and bra away from her body and shake them. R4 was wearing skintight leggings; when she took down her leggings, she had no panties on. I assisted V25 (PRSC-Psychiatric Rehabilitation Services Coordinator) with R13's strip search. R13's former roommate accused R13 of taking his credit or debit card. R13 took off shirt, shook it and placed it on V25's desk; he wasn't wearing an undershirt. R13 took off his shoes/socks off, then took off his pants and boxers down to his knees, then she had resident cough. No contraband was found during the strip searches of R13 and R4. On 8.21.2024 at 12:04 PM V25 (PRSC 6th Floor) said, I do not conduct searches (strip) of resident's bodies; usually nursing does that. I did not complete a search of R13, a nurse (V24) did that when his former roommate said credit or debit card was missing. The search took place in my office because the room is pretty big. Neither V24 nor myself actually touched him. He removed his own clothing. I can't remember if he took his shirt off, I know he lifted it. He did pull his pants down, he had underwear on, he did not take his underwear down or off. If any instructions were given it would have been V24 said, I don't recall V24 telling him bend over and cough. Facility's Routine Resident Checks and Safety Room Checks policy (Reviewed 7/24) documents: 4. To provide safety to all residents, Resident Room checks for unsafe items (contraband such as Alcohol, Medications, drug paraphernalia, and/or items that may be used by resident or others to cause harm). Resident upon entering the facility from independent pass, the facility reserves the right to check bags or resident coat/jacket and pockets. If resident is observed with unapproved items, appears to be under the influence, and/or has a history of safety concerns such as alcohol, illegal substances, etc., the facility will conduct search, with resident present to ensure the resident and other residents in the facility are safe and free from harm. The policy does not address strip search of residents.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45111 Based on interviews and records review, the facility failed to conduct interviews as appropriate to the allegations of abuse for one (R1) of four residents reviewed. Findings include: R1's current face sheet documents R1 is a [AGE] year-old individual whose medical diagnosis includes but not limited to acquired absence of right leg above knee, chronic kidney disease, stage 4 (severe), generalized anxiety disorder, nicotine dependence, cigarettes, uncomplicated. R1 left ama (against medical advice) 08/01/2024. R1's Brief Interview for Mental Status (BIMS) dated July 22, 2024, documents R1 has a BIMS score of 15/15, indicating R1 has an intact cognition. On 08/16/2024 at 9:44 am, V5 (Dietary Aide) accompanied V6 (Activity Aide) to interpret for V5 who speaks Spanish. V5 stated he takes breakfast upstairs to the units for residents who leave the facility early in the morning to go to dialysis. V5 takes the food cart upstairs from the first floor where the kitchen is located about 6:10am to 6:15am using the fleet elevators located at the back wall on the Northside of the facility. V5 stated residents can also use these elevators. V5 stated on 08/07/2024, V5 was inside the fleet elevator with one food cart holding eight trays of breakfast and V5 was taking the breakfast to residents who were leaving for dialysis morning. V5 stated as he was positioning the food cart properly into the service elevator. R1 was behind him walking fast to get into the elevator. V5 stated as V5 was getting himself and the food cart into the elevator, R1 was behind V5 and R1 got into the elevator too. It was just V5 and R1 in the elevator, and R1 was looking behind him and outside the elevator as if he was looking for someone else to get into the elevator. V5 stated R1 paused the elevator. V5 stated he thought R1 was looking/waiting for someone to come get into the elevator. V5 stated he (V5) told R1 he had to close the elevator doors and take breakfast food cart to the residents who were leaving for dialysis. V5 stated he was communicating to R1 in the little English V5 can speak. V5 stated R1 told V5, I don't care and R1 got behind V5. R1 pushed the cart out of the elevator, therefore V5 got out of the elevator and R1 closed elevator doors and the elevator went up to the units. V5 waited for the next elevator. V5 stated R1 closed elevator doors and the elevator went up to the units. V5 stated he did not push R1, but R1 is the one who pushed V5. V5 stated no one has come to interview V5 or asked V5 what happened on day (08/07/2024) between R1 and V5, and V5 never discussed it with anyone after the incident happened. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/16/2024 at 11:46am, V3 (Patient Escort) stated she remembers an incident involving R1 and was present the day of the incident on 08/07/2024. V3 stated they (R3 and V3) with R1 holding the elevator, were approaching the elevator when V3 saw V5 (Dietary Aide) get onto the elevator with R1. V3 stated V5 was upset R1 was holding the elevator for R3 and V3. V5 got impatient and when R3 and V3 got to the door of the elevator, V5 pushed R3's wheelchair to get it all the way into the elevator. R3's wheelchair hit R1 on R1's prosthetic leg which almost made R1 fall. V3 stated she did not know if V5 pushed the wheelchair roughly to hit R1 or if it was an accident the wheelchair hit R1. V3 stated V5 also pushed the meal cart onto the elevator and at this point, R1 pushed the meal cart back off the elevator. V5 got off the elevator with the meal cart. V3 stated she is not sure if V5's actions were intentional because V5 was trying to make room for the food cart in the elevator when V5 pushed R3's wheelchair hitting R1 on the leg. V3 stated R1 did not suffer any injuries. V3 stated after getting back from the methadone clinic, V3 went to V2's (Director of Nursing-DON) office to report what happened involving R1, R3, and V5. V3 stated V2 and V11 (Overnight supervisor/licensed Practical Nurse-LPN) were in V2's office. V3 stated V2 was on the phone and held up her hand gesturing for V3 to wait until V2 got off the phone. V3 stated V3 left V2's office and went outside. V11 came outside V2's office and asked V3 what happened. V3 stated she reported everything occurred on the elevator involving R1, R3, and V5 to V11. V3 stated she was never officially interviewed and there was no investigation done pertaining to the incident. The facility did not speak to R3 about what occurred either. V3 stated just before speaking with surveyors today, V1(Administrator) pulled V3 into his (V1) office told she (V3) would get into trouble for not reporting the incident involving R1, R3 and V5. V3 stated she had tried to speak to V2 and V1 regarding the situation several times but none of them would speak to her. On 08/16/2024 at 4:24 pm, V4 (Social Services Director) said she was not at the facility during the incident when R1 was on the elevator with R3, V3 and V5. V4 said V2 told V4, V11 told V2 she (V11) was at the back by the fleet elevator, when she (V11) heard the commotion and saw R1 going towards the elevator. V11 was not sure if R1 got into the elevator or not. V4 stated R1, R3 and V3 were on the elevator when V5 came towards the fleet elevator on the first floor and V5 was trying to push the breakfast cart on the elevator. V4 stated she heard R1 pushed the cart off the elevator and in effect pushing V5 off the elevator with the food cart. V4 stated all this was hearsay from V2. V4 stated V11 might have talked to V3 about this incident. V4 said V11 is the one who interviewed R1 because V4 thought words were being said between R1 and V5. V4 stated, I don't know what happened and I did not speak/interview the parties involved. V4 stated she heard after the incident, R1 rode the elevator upstairs. V4 stated she did not try to talk to V3 or V5. V4 stated she was in the building that day, but she (V4) did not talk to V3 stating she (V4) went with what V2 told her. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/20/2024 at 1:56pm, V11 (Overnight Supervisor/LPN) was reached via phone and said she was working on 8/7/2024 night shift and started her shift on 8/06/2024 at 7pm and got off 8/7/2024 at about 8-8:30am. V11 stated she was on the elevator with R1 coming from upstairs (5th floor) down to the first level. V11 stated she was going downstairs from the 5th floor and found R1 in the elevator also going downstairs. V11 stated she joined R1 in the elevator. V11 stated R1 was pacing in the elevator, eye rolling, and smirking his lips and R1 stated he was agitated because his orange community pass was restricted. V11 stated R1 was not aggressive towards V11 as they rode the elevator. V11 stated R1 never got out of the elevator once R1 and V11 got to the first floor. V5 was standing right outside the elevator waiting to get into the elevator with a food cart to go upstairs. V11 stated V11 got off the elevator and walked around the corner heading towards V2's office. V11 stated before she could make it to V2's office, V11 heard commotion near the elevator so V11 went back around the corner towards the elevator and at time the elevator doors were closing. V5 was standing outside the elevator with the food cart. V11 stated one of the workers form the kitchen translated to V11 what V5 was saying in Spanish. V11 stated V5 told her R1 pushed V5 out of the elevator with the food cart. V11 then called V2 to inform V2 R1 had just pushed V5 out of the elevator. V11 stated she then left and went home because V2 told V9 V2 did not need V11 to stay. V11 stated she was never interviewed again regarding the incidence between R1 and V5. On 08/20/2024 at 3:22pm V2 (Director of Nursing-DON) stated on 8/7/2024 V2 came into work in the morning about 7:10am. V11 came into to V2's office to give end of/change of shift report. V2 stated V11 told V2 about the incident in the elevator stating R1 pushed V5 out of the elevator. V2 stated V11 told V2 V11 was walking towards V2's office to give V2 a change of shift report, and as V11 was coming around the corner, V11 heard a commotion happening by the back elevator. V2 stated V11 run back towards the elevator and when V11 got back by the elevator, the elevator doors were closing and V11 could see R1 inside the elevator. V11 told V2 she (V11) saw V5 standing right outside of the elevator with the food cart and V5 looked a little frazzled. V11 stated per interpreter, V5 stated he was trying to get on the elevator with the food cart to take the food upstairs and R1 was in the elevator, and R1 pushed the food cart and V5 off the elevator. V2 stated she asked R1 what happened but did not document it. V2 stated while she was coming to the facility morning about 7:10am, she saw R1 and V3 getting into transportation to take R1 to the methadone clinic, and R1 did not look agitated or violent. V2, stated she did not investigate what happened, but she called the psychiatrist and got orders to send R1 out to the hospital based on what V11 told V2. V2 stated, I know the story was funky and I didn't chart when I (V2) spoke to R1, and if it's not documented it's not done. V2 stated she tried to speak with V3 regarding this incident but V3 would not come to V2's office, and V3 was avoiding V2, and to date, V2 has not spoken to V3 about the incident. V2 stated she charted R1's behavior based on what V11 told her. V2 stated she was supposed to investigate allegations, but if the allegations are resident to staff, then facility does not have to report to IDPH. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/2024 at 10:52am, V2 stated she was in the office with V11 talking about the incident when V3 came to the office after taking R1 to the methadone clinic. V2 stated V3 told V2 V3 wanted to speak with V2 about the incident. V2 stated she told V3, yes we need to talk. V3 walked away because V2 was in the middle of a conversation with V11. V2 stated V11 left V2's office after their meeting and V2 stated V3 never came back to speak to V2. V2 stated she looked for V3 but could not find V3. V2 stated she passed V3 several times in the hallways in the facility but V3 would not talk or look at V2. V2 stated the incidence between R1 and V5 could technically be abuse and should have been investigated by V2 or by V1 to make sure V2 and V1 knew the truth of what happened. V2 stated the importance of investigations is to get all sides of the story so the facility can put the information together, it paints a picture of the true story. V2 stated without an investigation, V2 did not get the whole story and she does not know completely what happened. V2 stated V3 was in the elevator and was a witness and should have been interviewed. V2 stated she did not start an investigation after surveyor informed V2 on 08/20/2024 at 3:30pm because after completing speaking with surveyor, V2 went to another meeting with another surveyor and by the time she was done speaking with the other surveyor, it was 5:30pm and she had to go home. V2 stated she did not investigate the allegation because it was hearsay. On 08/21/2024 at 12:05pm, V15 (Transportation coordinator/Escort) stated on 08/08/2024 at around 12:30pm, she did not know if V3 refused to talk to V2 because V2 did not say V2 tried to talk to V3. On 08/21/2024 at 12:22pm, V1 (Administrator) stated there was no camera footage of the elevator incident between R1 and V5 on 8/7/2024. V1 stated he started working at the facility on July 8th, 2024, as the administer. V1 stated the morning of the incident between R1 and V5 on 8/7/2024, someone (does not remember who) brought it to his attention R1 had shoved the food cart into the V5, but V1 stated he was not given the name of the staff member/dietary aide. V1 stated at time, the situation was being taken care of either nursing or social services. V1 did not investigate because everything he (V1) was told was subjective based on hearsay. V1 stated he was not handling the investigation and nursing, or social services were looking into the matter. V1 stated social services and nursing dealt with the situation and did the investigations and by the time V1 got to the facility the doctor had been contacted and orders given to send R1 to the hospital. V1 stated to date, he has not investigated the allegation. V1 stated he is the abuse coordinator. Facility policy titled Illinois-Abuse Prevention Policy, dated October 24, 2022, documents: -Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations of suspicion of potential abuse, neglect, exploitation, mistreatment, or misappropriation of resident property. Upon learning of the report, the administrator or a designee shall initiate an incident investigation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15301 Based on interview and record review, the facility failed to develop and implement a care plan to address a resident, with history of opioid dependence, for one of three residents (R1) reviewed for illegal drug use. Findings include: R1's Face Sheet documents R1 is a [AGE] year-old admitted to the facility on 2.10.2022 with diagnoses including but not limited to: Resistance to Multiple Antibiotics, Chronic Kidney Disease, Stage 4; Acquired Absence of Right Leg, and Opioid Dependence. R1's MDS-Minimum Data Set of 7.2.2024 documents a BIMS (Brief Interview for Mental Status) score of 15 denoting resident is cognitively intact. 8.21.2024 12:28 PM V8 (5th Floor PRSC) said V8 had to take R1's card (orange pass card) away for two weeks due to cocaine and marijuana found in drop (urine drug test). There should be an addiction care plan, I don't remember doing one. He should have had one because he came from 6th floor to 5th floor. I did not update his care plan. 8/1/2024 12:08 Psychosocial Note: Resident placed on restriction after testing positive for Cocaine, Marijuana, and Methadone. This is against the facility policy on substance abuse. Resident was explained to again what the rules are and informed of his 2 weeks restriction and it was suggest again that he attend the facility substance abuse program. Resident denies using and wanted to sign out AMA however after encouragement he retracted the statement. August 15th, 2024, he will be off restriction pending any other issues with the resident. 8/1/2024 00:58 Nurses Note Supervisor Note (in part): Resident agreed to take a drug test. Resident tested positive for cocaine, Marijuana, and Methadone. Resident became upset about the results of the drug test. Resident started yelling and requesting to go AMA. Review of R1's care plans did not document a care plan to address R1's illegal drug use. Facility's Comprehensive Resident Care Plans policy (revised August 2024) documents: Policy: Comprehensive resident care plans will be developed for each resident using the results of the comprehensive assessment. Each care plan shall include measurable objectives and timetables to meet all resident needs identified in the comprehensive assessment. Procedure: 1. Resident's plan of care shall be done within seven days after completion of the comprehensive assessment. 2. Comprehensive care plans must be prepared by the interdisciplinary team. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The resident and resident's family or the resident's legal representative to the extent practical. 4. Resident's plan of care shall be reviewed by the interdisciplinary team after each MDS assessment is conducted and revised as necessary to reflect the resident's current care needs. 5. Resident's plan of care are reviewed quarterly and as necessary to address the current needs of each resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 45001 Based on interview and record review the facility failed to provide quality care to one resident (R5) of three residents reviewed by not scheduling a biopsy in a timely manner. Findings include: On 8/16/24 at 12:12 PM, V3 (Patient Escort) stated, I'm with R5 a lot. R5 is having trouble with the tongue biopsy. The ENT (Ear Nose Throat) doctor from the hospital requested a tongue biopsy on April 15. A nurse from the hospital said she has sent paperwork to get the biopsy done. Many times, at least three to four times, I have brought the paperwork from the hospital saying that R5 needs a tongue biopsy. We (R5 and I) have gone to the hospital for follow-ups for the tongue biopsy, but nothing has been done because R5 has not gotten the tongue biopsy. Every time we go for an appointment, they send the same paperwork requesting a tongue biopsy. The Oncology doctor also wanted to see the results of the tongue biopsy. I was in the exam room with R5, and the Oncology doctor was looking for the results in R5's chart. The ENT doctor said my boss (V15) is supposed to make the appointment. Sometimes my boss or nurses on the floor make the appointments. I give the paperwork to R5's shift nurse at the time. On 8/16/24 at 3:20 PM, V15 (Transportation Scheduler Medical Appointments) stated, I schedule medical appointments and set up transportation to appointments and provide escorts to the appointments. In April, a tongue biopsy was ordered by the ENT doctor for R5. I tried to schedule R5 at the hospital. I have a couple of patients, not only R5. I don't schedule the lab work. The nurse schedules the lab work/pre-op preparations. The ENT doctor schedules the biopsy after the lab work and medical clearance is done. The medical clearance comes from the primary physician here at the facility. I have a binder of appointments/transportation request forms that nurses fill out of appointments I need to make. When I make the appointment, I put it in the calendar at the nursing station on each floor. The doctors will tell the nurse of an appointment. I tell my escorts to look at the discharge paperwork to tell me of any follow up appointments that I need to schedule. The escort also gives the paperwork to the nurse and the nurse is supposed to put it in the calendar. R5 has not had the biopsy. The ENT doctor said the biopsy appointment has not been made. I tried to make the appointment for the biopsy in April or May. The hospital was transferring me to different departments. The surgery department told me I don't schedule the biopsy it has to be the doctor who ordered it. I relayed the message to a nurse on the fourth floor. I told the nurse that she has to get the prescription for the biopsy from the ENT doctor. I forgot to follow up. No one followed up. I didn't follow up with the ENT doctor because that should have been the nursing department. On July 10, 2024 V2 (Director of Nursing) asked me what was going on with R5's appointments. I made an appointment for R5 to go back to the ENT doctor twice, 8/12 and 7/24, so R5 could find out about the biopsy, why it was not scheduled yet. R5 needed the biopsy for diagnosis of lesions of oral mucosa, to find out if cancer. R5 has a tongue mass. The mass on the tongue was found during a dental appointment. The dentist said R5 needs to see a surgeon. I made an appointment for the surgeon, 3/22. The Surgeon referred R5 to the ENT. First ENT appointment was 4/15/24. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 4:28 PM, V2 (Director of Nursing) stated, From what I understand the appointment for the tongue biopsy has been made for R5, on 8/12/24 there was an appointment that R5 went to with the ENT doctor and came back with orders for blood work for consultation of the tongue mass. The lab results came back 8/14. They were relayed to the NP (Nurse Practitioner) with an order to fax everything to the ENT doctor's office. 8/16 as per NP, either the NP or the primary at the facility will write H&P (Health and Physical) for pre-op clearance. The H&P should be faxed to the ENT doctor's office. We need to do a follow up with the ENT doctor. I need to follow up with the NP or the facility primary to see if the H&P was completed or to write it. Nursing has followed thru with blood work orders and relaying info to the NP. The tongue biopsy has not been done. We are working towards it. The original order for the tongue biopsy was ordered by the ENT on 4/15/24. The Nurse manager said every time they went to schedule the biopsy there was something else going on with R5 that required attention. Both the scheduler and nursing can schedule the biopsy. The biopsy appointment has taken a long time. Biopsy appointments don't generally take this long. On 6/18 I messaged V15 about the biopsy. 7/5 I followed up with V15 again who said the appointment was not made yet, V15 needed a physical prescription from the doctor that ordered the biopsy. I messaged V15 again on 7/10. 7/11 V15 responded the ENT was supposed to do the biopsy on 7/24. V15 said R5 did not miss any appointments. R5 had an appointment on 8/16 with ENT. A nursing note dated 8/16 states on 8/15 tracheal chondroma/benign tumor of the trachea was removed. I'm not sure why it took so long to get the biopsy. The mass could have been cancerous. The purpose of the biopsy is because they wanted to check for cancer of the tracheal mass that R5 has. Plan of Treatment from hospital discharge paperwork, 4/15/24, reads in part: I am strongly recommending a biopsy the patient dorsal tongue to help determine the pathology furthermore recommending a biopsy of the left posterior pillar of the tonsil region for possible squamous cell carcinoma. In addition, I would recommend that the patient be referred immediately to a pulmonologist for bronchoscopy and biopsy of the mass noted in the distal trachea. A copy of this note is being provided to the patient and staff to take back to the nursing home. Plan of Treatment from hospital discharge paperwork, 8/12/24, reads in part: I am strongly recommending a biopsy the patient dorsal tongue to help determine the pathology furthermore recommending a biopsy of the left posterior pillar of the tonsil region for possible squamous cell carcinoma. In addition, I would recommend that the patient be referred immediately to a pulmonologist for bronchoscopy and biopsy of the mass noted in the distal trachea. A copy of this note is being provided to the patient and staff to take back to the nursing home. Facility policy Residents Appointment, August 2024, reads in part: Charge nurse and/or designee will schedule resident's appointments and follow-up appointments, as indicated.