STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145661	A. Building B. Wing	02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ryze West	5130 West Jackson Boulevard Chicago, IL 60644

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on observation, interview and record review the facility failed to follow policy on self- administration of Medications by leaving inhalers and tablets / capsules form medications within access and administration residents without license nursing staff supervision or assistance. These failures are potential to affect 2 out of 3 residents (R1 and R9) on taking incorrect dose, not taking the medicine as scheduled and incorrect time when taking the medicine. Findings include: Facility policy under procedure reads: The interdisciplinary team evaluates resident to determine if criteria for participation in self-administration program are met. Resident criteria for participation includes: A) The resident must be able to state the name, dose, strength indications for use, directions for use and possible side effects of his/her medications. B) The resident must demonstrate how to correctly administer his/her medications. C) The resident must be able to state if his/her medication requires specific monitoring and if so, what the monitoring requirements are. D) The resident must be able to appropriately store his/her medication in a locked compartment or as deemed appropriate. E) The resident must be able to correctly document administration of his/her medications on the appropriate form. If interdisciplinary team determines that self-administration would be safe for particular resident and the resident wishes to do so, the attending physician initiates an order specifying permission for the resident to self-medicate. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/8/2022 at 11:28 AM. R1 was seen with R9 his roommate, R1 was alert and able to express his thoughts. R1 stated that he has concern with not receiving his medication as scheduled. R1 said, There are times that nurses did not come and give my medicine. On the table near the television, there were 2 inhalers colored red has a print that reads albuterol. R1 said, That is my inhalers for my breathing. I let R9 help me taking those inhalers every time I needed it. And Yes, I can take it as long as I needed it. R9 then said that R1 was blind and confirmed that he was helping R1 with his medication. On R9's bedside table there are 2 medication cups with medicine tablets. First cup has 6 different colors of 5 tablets and 1 capsule. The second cup has 1 white tablet. R9 said, That 1 white pill is for my diabetes and I take it around 11:30 AM. Those 5 pills include, medication for my allergies and the rest I do not know. The nurse gave me those medication earlier around 9 in the morning, but I take it when I can. Then R9 simultaneously took placed the 1 white tablet in his palm and took the medicine by mouth. And then in the same matter took those 5 medicines thereafter. On the same bedside table of R9, there are 2 inhalers, 1 color red that reads albuterol and the other color white with orange cap that reads budesonide formoterol. R9 said, Those are my inhalers and I use them because I have a breathing problem. I can use them when I needed them and as often as I can. V3 (Licensed Practical Nurse) at the Nurse's Station was informed. V3 said, Medications such as Inhalers and pills must be taken out of resident's room and placed inside medication cart. And nurses during medication administration should stay until resident's medication has been fully administered. Then V3 went to inside R1 and R9 room and opened the drawer at the bedside of R9. Inside the drawer are 2 more medication cups. First cup has 2 tablets and the second cup has 5 tablets. V3 then said, The room needs to be search, medication should not be left in this drawer. At 12:54 PM V2 (Assistant Director of Nursing / Infection Preventionist) stated that medication should not be left on the bedside. V2 said, Medications like pills and inhalers should not be left on the bedside. And resident that self-administered their own medications should be assessed, care plan and physician need to give order. Specific instructions and return demonstration from the resident should be given. R1 was [AGE] years old, with medical diagnosis of diabetes mellitus and chronic obstructive pulmonary disease (COPD), brief interview for mental status dated 10/14/2021, R1 has a score of 15 that means R1 cognitive status during the interview was intact. R1 health records including medication orders, assessments and care plan were reviewed. R9 was [AGE] years old, with medical diagnosis of respiratory failure with hypercapnia and diabetes mellitus, brief interview of mental status dated 1/2/2022, R9 has a score of 15 that means R9 cognitive status during the interview was intact. R9 health records including medication orders, assessments and care plan were reviewed. Both R1 and R9 Health Records does not include, interdisciplinary assessments, care planning and physician orders for self-administration of medication.

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. 45001 Based on interviews and record reviews, the facility failed to provide a resident and POA access to the resident's personal and medical records within 24 hours of request. This failure affects one resident(R3) of three residents reviewed for medical records request. Findings include: On 2/8/2022 at 1:36PM, V21(Health Information Management Director) stated that V21 talked with V22(family/POA of R3) personally to get the medical record request in order. V21 stated that V21 filled-out the form for the medical records and sent it to corporate. V22 sent the request to corporate on 12/6/2021. V21 stated that once V21 sends the request to corporate, V21's part in the process is complete, corporate takes over and contacts the POA. Records are sent from corporate not the facility. V21 stated that V21 started this position in November 2021. The release of information was signed prior to V21 starting the position. V21 stated that V21 received a copy of the release from V22 when V22 called V21 to check on the records because they had not been received. V21 stated that the requests go to corporate to avoid legal issues. On 2/8/2022 at 3:00PM, V1(Administrator) stated that V1 spoke to V22 on 12/6/2021 regarding the request for medical records. V1 filed a Concern form on behalf of V22 on 12/6/2021 and referred it to the medical records department. V1 stated that requests for entire records are sent to corporate because corporate attorneys will review it for legal reasons. On 2/9/2022 at 9:02AM, V22 stated the medical records still have not been received. On 2/9/2022 at 11:38AM, V21 stated that corporate outsources the requests to an outside company that cannot presently be reached. V21 stated that V21's consultant at corporate stated that the invoice may not have been paid by the resident/POA. Medical Records Request Form dated 10/11/2021 documents, R22 requests for R3's medical records. Release of Protected Health Information form dated 10/11/2021 shows V22 signed and submitted form along with medical requests form. Concern Form dated 12/6/2021 documents V22 made medical record request for R3.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44314 Based on interviews and record review, the facility failed to report resident drug overdose to the State Department of Public Health in a timely manner. This failure applies to one resident(R11) of three reviewed for illegal substances. This has the potential to affect 56 residents who are known drug users. Findings include: According to Face Sheet, R11 is a 58-year resident admitted to the facility on [DATE]. According to physician assistant note dated 09/25/2022, R11 has a history of drug and alcohol use. Nursing progress note dated 11/26/2021, documents R11's active use of drugs and drug overdose. Facility incident Report dated 02/07/2022 documented: Writer (V15/Licensed Practical Nurse /LPN) was informed by another resident that R11 was found lying on the floor in his room unresponsive and sweating. On 02/09/2022 at 12:30pm, reviewed facility's reportable incident binder and noted that the facility did not report R11's drug overdose that occurred on 02/07/2022. On 02/09/2022 at 12:32pm V1 (administrator) stated, I did not report R11's drug overdose to the state agency. I did not report it because I did not know that we had to. R11's care plan dated 02/08/2022 indicated R11 has a history of substance abuse and interventions for monitoring and supervision listed are for resident to provide urine sample, resident to address chemical dependency by actively participate in group treatment program. Nursing Progress Note dated 02/07/2022 authored by V15 documented: Writer was informed by another resident that R11 was found lying on the room floor unresponsive and sweating. Writer knows that the resident has a drug history and writer administered 4mg x4 Narcans in nostrils. Resident(R11) became responsive, and resident stated, what all the staff in here for. Reporting of unusual occurrences policy (dated 10/03/2021) states that if the incident report is serious, by which there is serious harm or injury, it will be reported initially to the State Department of Public Health within appropriate time frames and a final summary sent per states reporting guidelines.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44314 Based on observation, interviews and record review, the facility failed to have a system in place to alert staff when an illegal drug enters the facility, if a resident uses illegal drugs within the facility and discourage the possession of an illegal drug by a resident and failed to have a care plan and implement interventions to decrease a resident's repeated use of an illegal drug. This applies to one of three residents (R11) reviewed for illegal substances and has the potential to affect 56 residents who are known drug users. As a result, R11 with a known history of illegal drug use, had repeated overdose from illegal drugs while in the facility. This was identified as an immediate jeopardy situation which began on 02/07/2022, when R11 was found on the floor unresponsive. On 02/16/2022 the administrator was notified of the immediate jeopardy. The immediate jeopardy was removed on 02/18/2022. However, the deficiency remains at the second level of harm until the facility determine the effectiveness of the implementation of the removal plan. Findings include: 1. According to a face sheet, R11 is a 58-year resident admitted to the facility on [DATE]. According to physician assistant note dated 09/25/2022, R11 has a history of drug and alcohol use. Nursing progress note dated 11/26/2021, documents R11's active use of drugs and drug overdose. R11's Minimum Date Set assignment dated 01/06/2022 indicated R11 has a Brief Interview for Mental Status (BIMS) score of 15, which indicates resident has intact cognitive response. R11's care plan dated 02/08/2022 indicated resident has a history of substance abuse and interventions for monitoring and supervision listed are for resident to provide urine sample, resident to address chemical dependency by actively participate in group treatment program. A facility incident Report dated 02/07/2022 documented: Writer (V15 a licensed practical nurse / LPN) was informed by another resident that R11 was found lying on the floor in his room unresponsive and sweating. Nursing Progress Note dated 02/07/2022 authored by V15 documented: Writer was informed by another resident that R11 was found lying on the room floor unresponsive and sweating. Writer knows that the resident has a drug history and writer administered 4mg x4 Narcans in nostrils. Resident(R11) became responsive, and resident stated, what all the staff in here for. Writer contacted (NP/Nurse Practitioner) about resident overdosing and NP stated, resident is medically cleared to be discharged home and to revoke all passes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R11's progress note dated 11/26/2021 documented: On rounding, resident was noted to be slumped over on a corner, food tray and debris all over clothes. He was breathing very heavily, unable to respond by name or touch, even sternal rub. He was sweating profusely and drooling at the mouth. Writer recognized signs of overdose and administered a total of 4 narcans intranasally with full response after about 8 to 10 minutes. Writer attended to other roommate in same state, other staff members witnessed resident holding same yellow baggies found on roommate that contained the drugs. When resident got back to his feet and back to baseline, AOx4, he was able to hide drugs. Resident denied having them or turning them over even after staff witnessed him in possession of them. MD notified of overdose with new order to stop all passes, discontinue narcotic pain medications. Staff continuing to monitor resident closely. Will be referred to SSD/Social Services Director in AM. On 02/08/2022 at 12:32pm, V1 (administrator) stated, I am aware a resident, R11, overdosed inside the facility yesterday. I met with social services this morning to make sure things are put into place. I met with V7 (social worker) and V9 (social worker), our social services. The room search, behavioral contract and reassessment for community pass have not been done but we will do it. This resident is known to have problems with drug use. R11 has overdosed in the past, so we are aware that R11 has an issue with drug use. On 02/09/2022 at 10:54am V15 (LPN) stated, R11 has an order for Narcan because R11 has overdosed in the past. I was the nurse for R11 on the night that R11 overdosed. I was working during the 3-11 shift on 02/07/2022. R11 was out on pass on 02/07/2022 and returned about an hour before R11 was found unresponsive. I did my rounds at 4:10pm and R11 was not back yet because he was out on pass. I'm really not sure how long R11 was back for before R11 overdosed. I don't remember what time R11 returned, but it's possible that R11 returned between 5 and 6 pm. I was getting ready to start passing my 7pm medication and I found R11 lying flat, face down on the floor in his room. I found R11 lying face down on the floor, around 7:30pm. I assessed R11 and R11 was sweaty, and the other CNAs helped me turn the resident over and that's when I administered Narcan. I administered a total of 8 mg into each nostril. R11 received a total of 16mg of Narcan. After I administered the Narcan, a CNA and myself were giving R11 chest rubs and R11 came out of it and became responsive. I called 911. The ambulance came and the resident refused to go with them to the hospital. So R11 refused hospitalization . The supervisor on duty stated that R11 has the right to refused going to the hospital. This is not the first time that R11 overdosed, so R11 had the order for Narcan in place. R11 is not a resident that is safe to go out on pass because R11 has a drug use problem and R11 has overdosed in the past. On 02/09/2022 at 2:34pm, R11 stated, I was out on Monday, and I was drinking and then I passed out. I did use drugs on Monday, and I was drinking alcohol. I took cocaine. I used other drugs before, but I didn't like it. I used cocaine on Monday, and I passed out and they brought me back. I used to do a lot of drugs. I used cocaine couple times recently and I was drinking on Monday as well. They gave me a pass to go out and I was out on pass on Monday. I did overdose few months ago and they brought me back. On 02/09/2022 at 2:45pm, V14 (receptionist) stated, R11 left out of the facility at 10:30am on 02/07/2022. R11 signed R11 out at 10:30am but never signed back in so we don't know what time R11 actually returned. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/09/2022 at 3:35pm, V10 (social worker) stated, R11 overdosed on 02/07/2022 and they revoked his community pass privilege. R11 had his pass revoked in December 2021 because R11 overdosed on drugs. R11 had his pass reinstated after that just recently. The other social worker reinstated the community pass by the end of January. So R11 just had his pass reinstated. R11 did not have any behaviors recently, except drug use in November or December. We have to revoke resident's pass privilege for a specified amount of time. I did not reinstate R11's community pass privileges, that was the other social worker that used to work here. I know that R11 has a drug use problem, and I was not the one who reinstated R11's community pass. The nurse practitioner and the doctor also help to determine if the resident is safe to go out into the community. R11 has overdosed in the past and I was not the one who reinstated R11's community pass. I'm not sure why they allowed R11 to go back out into the community unsupervised. On 02/10/2022 at 11:11am, V25(NP) stated, I am the nurse practitioner for R11. R11 has a history of drug use, and R11 did overdose on 02/07/2022. R11 is usually a quiet resident and a stable resident. R11 did overdose. R11 does have a standing order for Narcan which was ordered on 12/15/2022. R11 was prescribed Narcan because it helps to bring the resident back when they overdose on drugs. Narcan is generally prescribed to counter the effect of the opioid, it is used to save someone's life when they overdose on drugs. On 11/26/2022 R11 overdosed also. That's why the Narcan was prescribed because this is not the first time that R11 overdosed. R11 is not safe to be out in the community not supervised. R11 will not be given permission to go out into the community unsupervised. R11 was not safe to be out in the community independently because R11 is a known drug used and R11 did overdose in the past, so R11 was not safe to be in the community. R11 was out on pass on 02/07/2022, but R11 was not supposed to be out on pass because of R11's drug and overdose history. I don't remember giving R11 a pass to go out into the community, because R11 is not safe to be out in the community unsupervised. I am not sure why R11 was out in the community, but I did not give R11 a pass because R11 is not safe given R11's drug history. If R11 was not on pass, this drug overdose which occurred on 02/07/2022 could have been avoided. On 02/18/2022 at 9:41am, V1 (administrator) stated, I don't know how R11 was able to get into the building, I have to check with the receptionist. When the resident is returning into the building, the receptionist must make sure that the resident is signing back in. R11 does not have a pass to go back out into the community. When the pass is reinstated for R11, R11 will be searched when returning into the facility, as well as room searches. We will be searching the residents who are returning into the facility from pass. The residents are aware now that when they go out on pass, they will be searched upon return to the facility. We will also monitor the visits in the facility, and we have to make sure that we report any suspicious activity. We will search the visitors if they are brining bags into the building to make sure that drugs are not being brought into the facility. Front Desk Sign Out Book documents that R11 went out on pass on 02/07/2022 at 10:30am. R11 signed self out. R11 failed to sign self-back in when returned to the facility on [DATE]. Social Service: Behavioral Contract signed by R11 on 1/29/2022. Behavior Contract explains the nature of resident's behavior that presents an infringement to the health, safety, welfare, and rights of other individuals. Social Service: Behavioral Contract signed by R11 on 02/08/2022. Behavior Contract explains the nature of resident's behavior that presents an infringement to the health, safety, welfare, and rights of other individuals. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. According to social service interview on 02/15/2022 at 1:47pm, V7 (social service director) stated that the facility has a total of 56 residents with a known history or current use of illegal drugs. On 02/08/2022, surveyor informed V1 (administrator) that R8 identified R10 as the resident who sells the illegal street drugs inside the facility. V1 informed surveyor that V1 will inform two social workers, V7 and V9, and a search will be conducted with the assistance of the police department. On 02/08/2022 at 1:05pm, surveyor observed V4 (staffing coordinator) warning and informing the resident, R10, that the police is on the way and that the resident will be searched for possession of drugs. This incident was corroborated by video surveillance which captured the visual and audio evidence of V4 impeding on the investigation by informing R10 of the upcoming search. Employee Report (dated 02/08/2022) documents: V4 (staffing coordinator) was suspended due to providing information to a resident of an investigation, therefore, impeding on the investigation. On 02/09/2022 at 11:10am and 2:30pm, contraband policy was requested. Facility failed to provide contraband policy. On 02/09/2022 at 2:45pm, surveyor requested resident admission packet which provides notification for non-use or possession of illegal drug within the facility. Facility failed to provide resident admission packet. When asked if the facility allow a resident to have possession of illegal drug, the administrator responded, The residents are not allowed to use or possess illegal drugs or alcohol in the facility. Residents are made aware of this strict non-tolerance policy on admission into the facility. The surveyor confirmed through observations, interviews, and record reviews that the facility took the following actions to remove the Immediate Jeopardy: 1. On 02/16/2022, V1 (administrator) has educated V7 (social service director) on the room search policy which indicates that in the event that a resident gives the facility just cause for suspicion, the resident's room may be searched for unauthorized medication, weapons or illegal substances. 2. On 02/18/2022 the facility has completed an investigation launched to identify staff members potentially involved in aiding resident's usage of drugs or possession. A confidential questionnaire has been distributed to staff members to report any concerns or suspicions they may have in the facility. They have been advised to hand form only to the Administrator to maintain confidentiality. 3. On 02/18/2022V26 (Director of Nursing) started providing an in-service to all staff on the need to immediately report to Director of Nursing and Social Service Director any suspicious or suspected drug activity. Staff members will be contacted by phone if not scheduled to work to provide verbal education. If staff member is unattainable, the staff member who has not been educated will not be allowed to work in facility until education is completed. 4. On 02/18/2022, V7 (social service director) created a monitor list to identify residents who need supervised visits when visitors enter the facility. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on observation, interview and record review the facility failed to follow policy Administration of Medications by leaving medication with the resident without remaining with the resident until medication was fully administered. These failures are potential to affect 2 residents (R1 and R9) out of 3 reviewed for taking incorrect dose, not taking the medicine as scheduled and incorrect time when taking the medicine. Findings include: Facility policy on Administration of Medication under Purpose: To provide guidelines for the administration of medication within the facility. Under Policy: The facility staff will provide safe and accurate medication administration to the residents. Under Procedure reads: The nurse or certified medication aide will remain in the presence of the resident while the resident takes the medication. On 2/8/2022 at 11:28 AM. R1 was seen with R9 his roommate, R1 was alert and able to express his thoughts. R1 stated that he has concern with not receiving his medication as scheduled. R1 said, There are times that nurses did not come and give my medicine. On the table near the television, there were 2 inhalers colored red has a print that reads albuterol. On 2/8/2022 at 11:28 AM, R1 said, That is my inhalers for my breathing. I let R9 help me taking those inhalers every time I needed it. And Yes, I can take it as long as I needed it. R9 then said that R1 was blind and confirmed that he was helping R1 with his medication. On R9's bedside table there are 2 medication cups with medicine tablets. First cup has 6 different colors of 5 tablets and 1 capsule. The second cup has 1 white tablet. R9 said, That 1 white pill is for my diabetes and I take it around 11:30 AM. Those 5 pills include, medication for my allergies and the rest I do not know. The nurse gave me those medication earlier around 9 in the morning, but I take it when I can. Then R9 simultaneously took placed the 1 white tablet in his palm and took the medicine by mouth. And then in the same matter took those 5 medicines thereafter. On the same bedside table of R9, there are 2 inhalers, 1 color red that reads albuterol and the other color white with orange cap that reads budesonide formoterol. R9 said, Those are my inhalers and I use them because I have a breathing problem. I can use them when I needed them and as often as I can. V3 (Licensed Practical Nurse) at the Nurse's Station was informed. V3 said, Medications such as Inhalers and pills must be taken out of resident's room and placed inside medication cart. And nurses during medication administration should stay until resident's medication has been fully administered. Then V3 went to inside R1 and R9 room and opened the drawer at the bedside of R9. Inside the drawer are 2 more medication cups. First cup has 2 tablets and the second cup has 5 tablets. V3 then said, The room needs to be search, medication should not be left in this drawer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145661	A. Building B. Wing	02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ryze West	5130 West Jackson Boulevard Chicago, IL 60644

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:54 PM V2 (Assistant Director of Nursing / Infection Preventionist) stated that medication should not be left on the bedside. V2 said, Medications like pills and inhalers should not be left on the bedside. And resident that self-administered their own medications should be assessed, care plan and physician need to give order. Specific instructions and return demonstration from the resident should be given. R1, [AGE] year old, with medical diagnosis of diabetes mellitus and chronic obstructive pulmonary disease (COPD), Brief Interview for Mental Status(BIMS) dated 10/14/2021 documents: R1 has a score of 15 that means R1 cognitive status during the interview was intact. R9, 64 y/o, with medical diagnosis of respiratory failure with hypercapnia and diabetes mellitus, BIMS dated 1/2/2022, R9 has a score of 15 that means R9 cognitive status during the interview was intact.