

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145881	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER Uptown Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356</p> <p>Based on interviews and record review the facility failed to give proper notice requirements per their policy to a resident was involuntarily transferred to the hospital for 1 (R1) out of 3 residents reviewed for admissions, transfers, and discharges. These failures affected 1 resident's (R1) right to be informed or notified of the reason for their transfer or discharge.</p> <p>Findings include:</p> <p>R1 is [AGE] years old, initially admitted on [DATE]. R1's initial medical diagnosis opioid dependence and mental and behavioral disorder. Per progress notes, R1 was sent to the hospital through involuntary discharge on 6/3/2024. V6 (Licensed Practical Nurse) and V5 (Social Worker) noted R1 became upset because his community pass was revoked. As a result, aggressive behavior was directed by R1 to V4 (Social Service Director).</p> <p>R1 referral dated 10/22/2023 prior to initial admission in the facility dated 10/27/2023 documents R1 was medically diagnosed with opioid use disorder and substance abuse.</p> <p>On 6/20/2024 at 10:01 AM, V5 (Social Worker) stated R1 is a chronic substance abuser. R1 was involuntarily discharged because R1 threatened and was verbally aggressive to V4 (Social Service Director) on 6/3/2024. V5 stated R1 had a previous involuntary discharge in April this year. R1's aggression started when R1 was informed his out on pass, or community pass was revoked due to not following facility's policy on substance abuse.</p> <p>On 6/20/2024 at 10:33 AM, V4 (Social Service Director) stated in the morning of 6/3/2024, after R1 was informed his community pass was not reinstated, R1 became verbally aggressive with her (V4) calling her vulgar names and screaming and threatening her (V4). V4 stated because of R1 being aggressive, R1 was transferred to the hospital through involuntary discharge. It was not a new involuntary discharge because there was a previous involuntary discharge. At 11:54 AM, V4 during review of facility policy on Involuntary Discharge, V4 said, We did not document notice was given to R1, or the reason notice was given, that part we missed. V4 stated the involuntary petition dated 4/9/2024 was due to R1's welfare unable to be met. The facility could not provide R1's needs related to his continued substance abuse.</p> <p>(continued on next page)</p>

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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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/20/2024 at 1:29 PM, V3 (Admission Director) stated the hospital called informing her (R1) was coming back to the facility. V2 (Director of Nursing) and V4 (Social Service Director) told her (V3) R1 was not supposed to come back because R1 was sent to the hospital via IVD (Involuntary Discharge).</p> <p>R1's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents dated 4/9/2024 shows, Federal Proceeding. Indicated reason: Your welfare and needs cannot be met in the facility, as documented in your clinical record by your physician. Document was signed by V5 (Social Worker).</p> <p>Petition for Involuntary/Judicial admitted d 6/3/2024 for R1 documents the following:</p> <ul style="list-style-type: none"> - R1 a person with mental illness who; because of his illness is reasonably expected, unless treated on an inpatient basis to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed. - That R1 a person with mental illness who; because of his illness is unable to provide his basic physical needs so as to guard himself from serious harm without the assistance of family or others, unless treated on an inpatient basis. - That R1 a person with mental illness who refuses treatment or is not adhering adequately to prescribed treatment; because of the nature of his illness is unable to understand his needs for treatment; and if not treated on an inpatient basis is expected; after such deterioration. R1 needs immediate hospitalization for the prevention of such harm. <p>Notes: Staff reports R1 was a danger to others. R1 followed V4 around the facility. R1 was verbally aggressive and threatening V4 because V4 removed community access due to non-compliant of substance abuse policy. Document was signed by V5 (Social Worker) witnessed by V4 (Social Service Director) and V6 (Licensed Practical Nurse).</p> <p>Page 5 of the document needs certification R1 was provided a copy of the petition or form paged 1-5 was left blank.</p> <p>R1's progress notes for the months of April, May and June 2024 were presented and there was no documentation R1 was notified for both 4/9/2024 Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents and 6/3/2024 Petition for Involuntary/Judicial Admission.</p> <p>Involuntary Discharge Policy dated 1/16, reads:</p> <p>To ensure compliance with State and Federal regulations and guidelines for involuntary discharge / transfer. Under documentation, Social Services will document in the resident medical record the following:</p> <ul style="list-style-type: none"> - A 30-day notice has been given to the resident. - The reason for the 30-day notice being issued. - Public health was informed via certified mail. <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356</p> <p>Based on interviews and review of records the facility failed to provide a copy of Bed Reserve Notification as per policy during involuntary transfer of 1 (R1) out of 3 residents reviewed for admissions, transfers, and discharges. This failure affected 1 resident (R1) on knowing the rights afforded to residents during transfers.</p> <p>Findings include:</p> <p>R1 is [AGE] years old, initially admitted on [DATE]. R1's initial medical diagnosis opioid dependence and mental and behavioral disorder. Per progress notes, R1 was sent to the hospital through involuntary discharge on 6/3/2024. V6 (Licensed Practical Nurse) and V5 (Social Worker) noted R1 became upset because his community pass was revoked. As a result, aggressive behavior was directed by R1 to V4 (Social Service Director).</p> <p>On 6/20/2024 at 10:01 AM, V5 (Social Worker) stated R1 is a chronic substance abuser. R1 was involuntarily discharged because R1 threatened and was verbally aggressive to V4 (Social Service Director) on 6/3/2024. V5 stated R1 had a previous involuntary discharge in April this year. R1's aggression started when R1 was informed his out on pass or community pass was revoked due to not following facility's policy on substance abuse.</p> <p>On 6/20/2024 at 10:33 AM, V4 (Social Service Director) stated in the morning of 6/3/2024, after R1 was informed his community pass was not reinstated. R1 became verbally aggressive with her (V4) calling her vulgar names and screaming and threatening her (V4). V4 stated because of R1 being aggressive, R1 was transferred to the hospital through involuntary discharge. It was not a new involuntary discharge because there was a previous involuntary discharge. At 11:54 AM, V4 during review of facility policy on Involuntary Discharge. V4 said, We did not document notice was given to R1, or the reason notice was given. part we missed. V4 stated the involuntary petition dated 4/9/2024 was due to R1's welfare cannot be met, and needs cannot be met. And the facility cannot provide R1's needs related to his continued substance abuse. At 12:06 PM, V4 was asked if R1 was given a bed hold notice? V4 stated What bed hold notice?! As far as I know there was no notice to R1 about any bed hold.</p> <p>On 6/20/2024 at 1:29 PM, V3 (Admission Director) stated the hospital called informing her (R1) was coming back to the facility. V2 (Director of Nursing) and V4 (Social Service Director) told her (V3) R1 was not supposed to come back because R1 was sent to the hospital via IVD (Involuntary Discharge).</p> <p>R1's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents dated 4/9/2024 shows, Federal Proceeding. Indicated reason: Your welfare and needs cannot be met in the facility, as documented in your clinical record by your physician. Document was signed by V5 (Social Worker).</p> <p>Petition for Involuntary/Judicial admitted d 6/3/2024 for R1 documents the following:</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- R1 a person with mental illness who; because of his illness is reasonably expected, unless treated on an inpatient basis to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed.</p> <p>- That R1 a person with mental illness who; because of his illness is unable to provide his basic physical needs so as to guard himself from serious harm without the assistance of family or others, unless treated on an inpatient basis.</p> <p>- That R1 a person with mental illness who refuses treatment or is not adhering adequately to prescribed treatment; because of the nature of his illness is unable to understand his needs for treatment; and if not treated on an inpatient basis is expected; after such deterioration. R1 needs immediate hospitalization for the prevention of such harm.</p> <p>Notes: Staff reports R1 was a danger to others. R1 followed V4 around the facility. R1 was verbally aggressive and threatening V4 because V4 removed community access due to non-compliant of substance abuse policy. Document was signed by V5 (Social Worker) witnessed by V4 (Social Service Director) and V6 (Licensed Practical Nurse).</p> <p>Page 5 of the document needs certification R1 was provided a copy of the petition or form paged 1-5 was left blank.</p> <p>R1's progress notes for the months of April, May and June 2024 were presented and there was no documentation bed hold notice was given to R1.</p> <p>Policy on Bed Reserve dated 2008, reads: This Bed Reserve Policy will be given to you at the time of admission and a copy will be given to you each time you are transferred from the facility.</p> <p>Facility policy on Notice of Bed Hold and Return dated 11/20/2017, reads:</p> <p>Before the nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the facility will provide written information to the resident or resident representative specifies the duration of the state bed-hold policy of 10 days during which the resident is permitted to return and resume residence in the nursing facility.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, the nursing facility will provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy of 10 days. The nursing facility's bed-hold policies apply to all residents. The first notice of bed-hold policies will be given well in advance of any transfer during the admission process. A second notice of the facilities bed hold policy is issued to the resident at the time of transfer and includes the resident's bed will be held for 10 days.</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356</p> <p>Based on interviews and review of records the facility failed to permit 1 (R1) out of 3 residents from returning back to the facility after hospitalization in accordance with their policy. This failure affected 1 resident (R1) to their right to return to the facility they considered as home.</p> <p>Findings include:</p> <p>R1 is [AGE] years old, initially admitted on [DATE]. R1's initial medical diagnosis opioid dependence and mental and behavioral disorder. Per progress notes, R1 was sent to the hospital through involuntary discharge on 6/3/2024. V6 (Licensed Practical Nurse) and V5 (Social Worker) noted R1 became upset because his community pass was revoked. As a result, aggressive behavior was directed by R1 to V4 (Social Service Director).</p> <p>On 6/20/2024 at 10:01 AM, V5 (Social Worker) stated R1 is a chronic substance abuser. R1 was involuntarily discharged because R1 threatened and was verbally aggressive to V4 (Social Service Director) on 6/3/2024. V5 stated R1 had a previous involuntary discharge in April this year. R1's aggression started when R1 was informed his out on pass, or community pass was revoked due to not following facility's policy on substance abuse.</p> <p>On 6/20/2024 at 10:33 AM, V4 (Social Service Director) stated in the morning of 6/3/2024, after R1 was informed his community pass was not reinstated, R1 became verbally aggressive with her (V4) calling her vulgar names and screaming and threatening her (V4). V4 stated because of R1 being aggressive, R1 was transferred to the hospital through involuntary discharge. It was not a new involuntary discharge because there was a previous involuntary discharge. At 11:54 AM, V4 during review of facility policy on Involuntary Discharge, V4 said, We did not document notice was given to R1, or the reason notice was given, that part we missed. V4 stated the involuntary petition dated 4/9/2024 was due to R1's welfare unable to be met. The facility could not provide R1's needs related to his continued substance abuse.</p> <p>R1 referral dated 10/22/2023 prior to initial admission in the facility dated 10/27/2023 documents R1 was medically diagnosed with opioid use disorder and substance abuse.</p> <p>On 6/20/2024 at 1:29 PM, V3 (Admission Director) stated the hospital called informing her (R1) was coming back to the facility. V2 (Director of Nursing) and V4 (Social Service Director) told her (V3) R1 was not supposed to come back because R1 was sent to the hospital via IVD (Involuntary Discharge).</p> <p>R1's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents dated 4/9/2024 shows, Federal Proceeding. Indicated reason: Your welfare and needs cannot be met in the facility, as documented in your clinical record by your physician. Document was signed by V5 (Social Worker).</p> <p>Petition for Involuntary/Judicial admitted d 6/3/2024 for R1 documents the following:</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- R1 a person with mental illness who; because of his illness is reasonably expected, unless treated on an inpatient basis to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed.</p> <p>- That R1 a person with mental illness who; because of his illness is unable to provide his basic physical needs so as to guard himself from serious harm without the assistance of family or others, unless treated on an inpatient basis.</p> <p>- That R1 a person with mental illness who refuses treatment or is not adhering adequately to prescribed treatment; because of the nature of his illness is unable to understand his needs for treatment; and if not treated on an inpatient basis is expected; after such deterioration. R1 needs immediate hospitalization for the prevention of such harm.</p> <p>Notes: Staff reports R1 was a danger to others. R1 followed V4 around the facility. R1 was verbally aggressive and threatening V4 because V4 removed community access due to non-compliant of substance abuse policy. Document was signed by V5 (Social Worker) witnessed by V4 (Social Service Director) and V6 (Licensed Practical Nurse).</p> <p>Page 5 of the document needs certification R1 was provided a copy of the petition or form paged 1-5 was left blank.</p> <p>V4 (Social Service Director) provided email correspondence between her (V4) and V11 (Attorney of Facility) dated 6/5/2024 reads as follows: V4 informed V11 that R1 was petitioned out to the hospital due to threats against her (V4). V11 responded amendment / change was made to Notice to discharge due to safety reasons. The facility will not take R1 back.</p> <p>On 6/21/2024 at 11:21 AM, V1 (Administrator) stated the original petition was the facility cannot meet R1's needs. According to V1, the original petition was appealed by R1. V1 stated after the incident on 6/3/2024 when R1 was threatening to V4 (Social Service Director), the facility change the petition R1 based on the incident happened on 6/3/2024. V1 said, The reason why facility did not accept R1 back was because R1 was threatening V4. V1 was asked if there was an effort by the facility or coordination with the hospital to determine R1's status after R1 was hospitalized. V1 responded, To be honest with you, it was because of the advise of our attorney (V11) not to accept R1. V1 said he will reach out to V11 to let V11 speak to writer. At 1:46 PM, V1 stated V11 is on vacation. V1 restated the reason why R1 was not accepted to return to the facility was due to advised from their attorney (V11).</p> <p>Facility policy on Notice of Bed Hold and Return dated 11/20/2017, reads:</p> <p>Before the nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the facility will provide written information to the resident or resident representative specifies the duration of the state bed-hold policy of 10 days during which the resident is permitted to return and resume residence in the nursing facility.</p> <p>(continued on next page)</p>

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>If a resident, whose hospitalization , or therapeutic leave exceeds the bed-hold period, the resident is allowed to return to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility; and is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356</p> <p>Based on observation, review of records, and interviews the facility failed to document physician coordination of medications not received by resident per medication administration policy. Facility also failed to administer insulin as ordered by physician for 1 (R2) out of 3 residents reviewed for facility pharmaceutical services. These failures have the potential to affect 1 resident (R2) has history of stroke/cerebral infarction and diabetes mellitus in maintaining stable health condition.</p> <p>Findings include:</p> <p>R2 is [AGE] years old, initially admitted on [DATE] with medical diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and diabetes mellitus.</p> <p>On 6/18/2024 at 12:03 PM, R2 was seen on the hallway near the nurse's station sitting on his wheelchair. R2 was alert and verbally able to express his thoughts and agreed to talk to his room. R2 stated his concern was his medication not given because he has swelling on his left lower leg. R2 took his left shoe off and swelling was observed on the left foot.</p> <p>Review of R2 MAR (medication administration records) for the month April, May and June 2024 documents multiple medication for diabetes and hypertension was coded as not given due to multiple reasons including drug refused, hold of medication, other reason, or no documentation.</p> <p>Per the same MAR (medication administration record), R2 blood pressure results and blood sugar results were not controlled. R2's systolic blood pressure went as high as 200. Diastolic blood pressure went as high as 110. R2's blood sugar results went as high as 268.</p> <p>Per MAR (medication administration records) and progress notes of R2, on May 23, 2024, Humalog was held by the nurse because blood sugar result was 145. Per physician order hold if blood sugar is less than 100.</p> <p>Per MAR (medication administration records) June 2024 documents for Humalog insulin majority of days of the month R2 did not receive the insulin. Per physician's order instructions, R2 needs to take 13 units four (4) times a day.</p> <p>On 6/18/2024 at 2:46 PM, V2 (Director of Nursing) was informed multiple medications of R2 including insulin and blood pressure medications are documented on the MAR as not given. V2 stated when medication is refused, nurses need to notify the physician. V2 was also informed R2's blood pressure and blood sugar were not controlled. Per MAR, R2's systolic blood pressure elevated to 180 or more, and R2 was not receiving blood pressure medications and insulins on multiple days. V2 stated, Really? I will check R2's MAR and check if the nurses informed the doctor.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/20/2024 at 12:06 PM, with V2 (Director of Nursing) and V9 (Assistant Director of Nursing). V2 stated in cases of residents refusing medication, there needs to be education. MD (medical doctor) needs to be notified. V2 was asked if R2's doctor was notified when R2 refused medication. V2 stated she needs to review documentation of R2 to see if nursing staff notified the doctor. V2 stated R2 had a history of a stroke. R2 high blood pressure may put him at risk of recurrent stroke.</p> <p>Medication Administration Record (MAR) policy not dated, reads:</p> <p>Under procedure, if a resident refuses medication initial the box and circle your initial; if the resident continues to refuse medication, the physician should be notified and have the medication discontinued, change, or give other orders. It is up to the discretion of the physician to discontinue the medication. Documentation of medication refusal is also to be done in the Nurse's Notes.</p>