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	07/05/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50057 Based on observation, interview and record review, facility failed to follow professional standards of practice and facility policy in documenting post-surgical wound assessment in two residents (R2, R5) out of 15 residents. Findings: On [DATE] at 12:45 PM R5 was interviewed and stated, I saw Dr. V39 (Spine Surgeon) last week. He took out the stitches. No one has looked at my back since then. V39 was upset that no one was looking at the wound after surgery. They (the nursing staff) did not look at the wound but once when I first got here. On [DATE] At 12:45 PM, R5's wound was observed to be well-approximated and healed with no redness, swelling or drainage. On [DATE] at 12:58 PM V22 (LPN) was interviewed and stated that upon a new resident's admission, nursing staff does a full body, head-to-toe skin assessment. V22 stated, We look at the surgical incision or surgical wound at the time of admission and then the wound care team looks at it for assessment and treatment. Wound team will look at the surgical incision one to three times a week. We don't mess around with wounds once wound care is involved. We don't look at resident's incisions or wounds because wound nurses follow them. On [DATE] at 1:15 PM V23 (Wound Director) was interviewed and stated, Every new admission is seen by a wound nurse. If the resident has a wound, the orders come from the doctor. I'm very strict. Once wound nurses are involved, the floor nurse does not manage the wound unless it is a surgical wound or surgical incision. If it is a surgical wound, the floor nurse will monitor the wound and let the wound nurse know if they have any concerns. The wound nurse will enter a 'monitor wound order' for surgical incisions so that the floor nurses assess and document the assessment of the surgical incision. V23 looked at the documentation for R5 in the electronic health record. V23 stated the wound nurse did an assessment on [DATE]. V23 stated, I don't' see a monitor order. We got orders that after the negative pressure wound therapy system died , we were done. The negative pressure wound therapy system was removed on [DATE]. The nurses need to monitor the surgical incision and let me, or the outside physician know if there is a concern. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:20 PM V2 (Director of Nursing) was interviewed and stated For surgical wounds, if there are instructions, we follow them. V23's team does not touch surgical wounds unless there are specific instructions or if there are clinical concerns. Nurses on the floor should be monitoring for any issues with the wound. If they can't see the wound because of a dressing or they have instructions not to touch the dressing, the nurses should be documenting on the skin assessment any complaints or pain and assessment of the wound or assessment around the dressing. The nurses should be documenting that assessment in the nurses' notes. On [DATE] at 12:15 PM V2 (Director of Nursing) provided a single nurses note dated [DATE] which stated R5 also complained of itching at her wound site (back). V37 (Physician) was informed with new orders being carried out. V2 stated that the [DATE] note and the [DATE] notes were the only notes that V2 could find in R5's electronic health record relative to R5's surgical incision. V2 stated, The [DATE] note does not state that the wound was assessed, only that the resident complained of itching and that the doctor was called. Policy titled Wound Management Policy was not dated and stated in part: Purpose: To provide guidelines for the assessment, treatment, and management of wounds in residents, ensuring compliance with federal, state and local regulations and promoting the highest quality of care. 4. Infection Control, bullet one: Signs of wound infection will be monitored, including redness, edema, pain, increased exudate and peri wound surface warmth. 5. Documentation and Compliance, bullet one: All wound care activities will be documented in the resident's medical record, including assessments, care plans, interventions and progress noted. Bullet two: Documentation will comply with CMS regulations and professional standards of practice. 5. Staff Qualifications and Training. Bullet one: Wound care will be provided by trained and competent staff, including licensed nurses and wound care specialists.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50057 Based on observation, interview and record review, the facility failed to provide therapy services in a timely manner and failed to follow facility policy for two residents (R1, R5) out 15 residents in the sample. Findings 1. On 7/2/2024 at 10 AM the electronic health record of R1 was reviewed. R1 was admitted to the facility on [DATE]. An order for Physical Therapy to evaluate and treat was entered on 5/7/2024. An order for Speech Therapy to evaluate and treat was entered on 5/7/2024. An order for Occupational Therapy to evaluate and treat was entered on 5/7/2024. An order for Occupational Therapy evaluates and treat related to right hand limited range of motion was entered 5/31/2024. An Occupational Therapy clarification order was entered on 6/17/2024 for Occupational Therapy to evaluate and treat for 2-4 times/week for 41 days to address activities of daily living training, therapeutic exercise, therapeutic activities Neuromuscular Rehabilitation (NMR) and patient education was ordered on 6/17/2024. On 7/2/2024 at 10:30 AM V21 (Director of Rehabilitation Services) was interviewed and stated rehabilitation services are provided depending on the resident's insurance payor. If a resident has Medicare Part A, the resident automatically gets put into the system for Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy. Rehabilitation Services completes a screening of residents with Medicare Part A. Following the screening, Rehabilitation Services determines if the resident needs skills rehabilitation services. For residents who have Medicare Part B, referrals to Rehabilitation Services comes from nursing staff or Restorative Care. If a resident has Medicaid benefits, the facility administrator signs off on any Medicaid referral and the corporate Chief Executive Officer (CEO) also signs off before Rehabilitation Services can complete an assessment of the resident or begin rehabilitation services begin. V21 stated, V1 (Administrator) signs off and then V28 (Corporate CEO) signs off and then we can evaluate the resident. V1 stated if a doctor or nurse practitioner or physician assistant writes an order for therapy, they need to inform Rehabilitation Services they are writing the order. There is no notification in the electronic medical record. V21 stated, We don't get notified of the order unless they tell us they are writing the order. R1's documentation was reviewed by V21. V21 stated R1 was admitted to the facility on [DATE]. V21 stated when R1 was admitted , an initial evaluation for physical therapy and occupational therapy was completed. V21 stated, They did the screening, and it was determined PT and OT were not warranted. V21 went to a white binder and stated she could not find any documentation of the PT or OT screening evaluation. V21 stated the ordering provider would have been notified PT was not warranted. V21 stated she could not produce documentation of provider notification because it would be documented on the screening evaluation documentation. V21 stated, I can't find the documentation. V21 stated Restorative Care recommended OT so OT was started on 6/17/2024. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/2024 at 11:36 AM V12 (Director of Restorative Nursing) was interviewed and stated V21's department works with Rehabilitation Services. V12 stated, We work to maintain or improve residents' functioning. is our goal. V12 stated if a resident says they want to exercise, they come to Restorative Care and the resident creates attainable goals. V12 stated if V12 believes the resident can benefit from therapy, V12 tells V21. V12 stated R1 came to V12 and said she could not rotate her hand and it was weak. V12 stated R1 wanted therapy. V12 stated, I saw it myself. (R1) had weakness and no grip. V12 went to V21 and V21 started R1 in OT. V12 stated, We are ordering her a hand brace for R1 to see if helps. On 7/2/2024 at 11:52 AM, R1 was interviewed. R1 stated therapy services is now working with her. R1 stated, My son-in-law helped me by reminding me to lift and get my strength back. They (facility) had nothing to do with it. I was here for a month before they would evaluate me. I could have been going through an outside facility's physical therapy program, but they would not tell me anything here. On 7/2/2024 at 1:25 PM V1 (Administrator) stated if a resident has an order for PT, OT or speech therapy, the resident should be assessed by PT, OT and/or Speech Therapy, whatever the order says within 24 hours of the order being placed. V1 stated, The insurance does not make any difference. Whatever is ordered, they get. When V1 was asked if there could be a one to two week delay for Rehabilitation Services to be initiated if the resident has Medicaid, V1 stated, That is not supposed to happen. There should be no delay. V1 stated, R1 was a hiccup in the process. There should not have been a delay. There was an issue, we met, and we tweaked the process. On 7/3/2024 at 11:50 AM V21 (Director of Rehabilitation Services) stated if a resident is Medicare Part A or Part B, the resident is screened upon admission by Rehabilitation Services. If the resident has Medicaid, the resident is screened by Restorative Care and Restorative Care determines if the resident would benefit from Rehabilitation Services. V21 stated, for residents with Medicare A and Medicare B insurance, Most times, the resident is evaluated by PT and OT. They only get a speech therapy evaluation if they have cognitive deficits which is defined as a BIMS of twelve or less or if the resident has dysphagia. V21 stated, R1 did not have a speech evaluation upon admission or since R1 has been at the facility. On 7/3/2024 at 12:05 PM V12 (Director of Restorative Care) presented a list of the Restorative Care staff and their credentials. V12's department is comprised of V12 who an LPN and 6 Certified Nurse's Aides is. V12 stated Rehabilitation Services sees residents upon admission if they have Medicare Part A or Part B. V12 stated Restorative Care sees all residents upon admission regardless of their insurance. V12 stated, If a resident has Medicaid, I send V21 the referral. V12 stated, Rehab does not do evaluations upon admission on any residents with Medicaid. V12 stated, Before V21 started, Rehab services saw everyone, and we worked collaboratively without any problems. Since V21 started, I have to make the referral if a resident has Medicaid. There is no guarantee Rehab will see the resident if they have Medicare either. I have to put in the referral. V12 stated V1 and V2 are aware and trying to find a solution. 2. On 7/2/2204 at 10 AM, the electronic health record of R5 was reviewed. R5 was admitted to the facility on [DATE]. On 6/6/2024, orders were entered for Physical Therapy (PT) to evaluate and treat, Occupational therapy (OT) to evaluate and treat. Speech Therapy to evaluate and treat. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/2024 at 11 AM V21 (Director of Rehabilitation Services) was interviewed and stated R5 was admitted on [DATE]. R5 had PT, Speech Therapy and OT ordered on 6/6/2024. R5 had an OT evaluation was 6/7/2024. R5's PT evaluation was completed on 6/19/2024. V21 stated R5's PT was not started until 6/19/2024, because we were waiting approval from administration because she is a Medicaid patient. V21 stated, R5 was evaluated by OT, but then the rules at the facility changed and PT needed to get authorization from V1 and V28 before we could do the PT evaluation. Change went into effect on 6/7/2024. The reason the PT evaluation was not done until 6/19/2024 was because we were waiting authorization from the facility. V21 stated, There have been delays. V1, V21 and V28 are talking about how we create a more cohesive process. We are still working through it. Restorative and Rehabilitation Services may try to do more screenings together and we are also trying to get authorization more quickly. On 7/2/2024 at 11:36 AM V12 (Director of Restorative Nursing) was interviewed and stated V12 evaluated R5 on 6/6/2024. V12 stated her recommendations at time was PT and OT. V12 stated R5 needed help with dressing and walking and had potential to go back into the community. R5 was in a wheelchair when she first arrived. R5's goal was to walk and leave the facility. On 7/2/2024 at 12:45 R5 was interviewed and stated, When I first came, the staff introduced themselves, but then nothing was done for a week. I just sat here for a week or so. I talked to a friend who said they would talk to someone. Eventually they (the facility) started working with me. I was in a wheelchair. It is very good now. I have PT twice a week. I'm getting stronger. I walk with a walker. I can go to activities. I just felt like the first week I was just here nothing was getting done. Now it is better. On 7/3/2024 at 11:50 AM V21 (Director of Rehabilitation Services) stated, R5 did not have a speech evaluation upon admission or since R5 has been at the facility. A memo dated 6/1/2024 to all department heads from V28 (Corporate CEO) stated, All therapy requests need to be signed off by admin on the payor verification form. If the payor is Medicaid, the therapy company will reach out to V28 to confirm the approval. Policy titled Physicians Orders Policy dated 1/2018 stated in part: Proper channels of communication are used to ensure accurate delivery of medication and treatments of all residents. This is achieved by using telephone order sheets, physician order sheets, medication administration records, treatment administration records and transfer sheets. Policy titled Therapy Policy with no date stated in part: Purpose: To provide guidelines for the delivery of therapy services, including physical, occupational and speech/language therapy, to residents. This policy ensures compliance with federal, state and local regulations and promotes the highest quality of care. 1. Assessment: Residents will be assessed by licensed therapists (physical, occupational, speech/language) upon admission, quarterly, and as needed based on changes in condition. Assessment includes a comprehensive evaluation of the resident's functional abilities, including mobility, activities of daily living (ADLs), communication and cognitive function. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Documentation and Compliance: All therapy services will be documented in the resident's medical record, including assessments, care plans, interventions and progress notes. Documentation will comply with CMS regulations and professional standards of practice. The facility will conduct regular audits to ensure compliance with documentation and care standards. Procedure Referral and Initial Assessment: Upon referral, the appropriate therapist will conduct an initial assessment within 48 hours.