

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  10/10/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47303</b></p> <p>Based on interviews and record review, the facility failed to properly document one resident's (R9) personal belongings upon admission. This failure has resulted in R9 missing clothes.</p> <p>Findings include:</p> <p>R9 is [AGE] year old with diagnosis including but not limited to: Morbid obesity, cerebral palsy, primary osteoarthritis, other reduced mobility and other specified disorder of bone density and structure.</p> <p>During investigation on 10/02/2024 at 11:36 AM, R9 said, I am missing a lot of my clothes and I have seen a few residents wearing my clothes. In the resident council meetings, I have complained about my missing clothes, and nothing has been done so far. At that time, R9 proceeded to show Surveyor photos on his phone of residents wearing his clothes.</p> <p>On 10/08/2024 at 2:35 PM, V26 (Laundry Attendant) said, I don't have any clothes at this time for R9. The only time that clothes become misplaced is when they are sent down to the laundry room with no name labeled on it. Clothes that are not labeled are kept so that residents can come to the laundry room to claim any missing items. The laundry department is not responsible for keeping inventory of resident's personal items.</p> <p>On 10/09/2024 at 3:05 PM, V2/DON (Director of Nursing) stated the facility does not have an initial inventory list on file for R9 and that the 06/05/24 inventory list for R9 was his only belongings list.</p> <p>On 10/09/2024 at 3:05 PM, V2/DON said, It is important to take inventory of resident's personal belonging to ensure that all personal items are accounted for. The CNAs are to take inventory of all resident's clothes upon admission and label their belongings with their name. If no inventory list is on file, the facility will not be responsible for missing items.</p> <p>Resident Council meeting minutes dated September 17, 2024 documents complaints from residents regarding missing clothes.</p> <p>R9's Admission Record documents an admitted [DATE].</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R9's Inventory list was dated 06/05/2024.</p> <p>Facility policy titled Policy for Clothing and Personal Items documents, upon admission the CNAs (Certified Nurse Assistants) must take inventory and record each and every article that the resident brings in.; the nurse on duty should supervise this process and one the list is completed it is to be put into the system and uploaded to the resident's medical chart.</p> <p>Facility policy titled Resident's Rights documents, facility must try to keep resident's property from being lost or stolen.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47303</b></p> <p>Based on interviews and record review, the facility failed to ensure a cataract surgery was scheduled for one resident (R13) as ordered resulting in R13 experiencing continued visual difficulties and failed to ensure two residents (R2 and R11) attended Doctor's appointment as scheduled.</p> <p>Findings include:</p> <p>R13 is [AGE] year old with diagnosis including but not limited to: Dry eye syndrome of unspecified lacrimal gland, other visual disturbances, prediabetes, major depressive disorder and anxiety.</p> <p>R13's BIMS (Brief Interview of Mental Status) score is 15, which indicated cognitively intact.</p> <p>R11 is 67 old with diagnosis including but not limited to: Contracture of left hand, unspecified lump in breast, unspecified asthma, hypertensive heart and chronic kidney disease with heart failure.</p> <p>R11's BIMS (Brief Interview of Mental Status) score is 15, which indicated cognitively intact.</p> <p>During investigation on 10/01/2024 at 1:33 PM, R13 said she (R13) was still waiting on her eye appointment for cataract surgery and had been experiencing visual problems.</p> <p>On 10/10/2024 at 11:15 AM, DON (Director of Nursing) said, R13 went to the eye Doctor on 08/14/1014 and we (facility) were supposed to receive a call about R13's eye surgery but I don't know what happened with that. I can say that we dropped the ball. We (facility) should have called and followed up with her appointment.</p> <p>On 10/09/2024 at 2:35 PM, R13 stated it had been almost six months that she (R13) had been inquiring about her cataract surgery and that she has difficulty reading and watching television because of her cataracts.</p> <p>At that time, R13 said, When I read, the letters all look zigzag. Also, when I watch television, the picture looks zigzag.</p> <p>On 10/01/2024 at 1:15 PM, R11 stated that he had missed a few doctor's appointments.</p> <p>On 10/07/24 at 10:18 am, V22 (Medical Scheduler and Transportation) stated R11's 09/11/2024 orthopedic follow-up appointment was canceled because R11 did not have an escort.</p> <p>On 10/07/24 at 10:18 am, V22 stated the facility is responsible for providing an escort for medical appointments and that she (V22) schedules escorts for the residents.</p> <p>On 10/07/24 at 11:44am, V22 stated R2 missed several consultation appointments during R2's stay at the facility. V22 presented R2's appointment transportation log that showed on 1/16/24, 1/19/24, 2/09/24, and 5/10/24, R2 missed consultation appointments due to transportation being late.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On at 10/09/24 at 4:15pm V2 (DON) stated the facility is going to work with V22 on getting the information to the nurse to have the physician notified and on scheduling alternative transportation because it can be said that the resident did not get necessary care.</p> <p>R11's nursing progress note documents an appointment for hand surgery on 07/11/2024.</p> <p>R11's nursing progress note documents, R11 is back in the facility from surgery to his left hand.</p> <p>R11's Order Summary Report documents the following order entered no 08/21/2024: Follow-up with orthopedic Doctor on 09/11/2024.</p> <p>Facility appointment/transportation schedule documents an appointment for R11 on 09/11/2024.</p> <p>R11's MDS (Minimal Data Set) - Functional Abilities section dated 08/08/2024 documents the following: R11 uses a wheelchair; R11 requires supervision with locomotion via wheelchair; R11 requires maximal assistance with wheelchair transfers.</p> <p>R13's Order Summary report documents an order entered on 7/12/2024 as follows: Ophthalmology Consult due to Cataracts.</p> <p>R13's eye appointment form dated 08/14/2024 documents findings of cataracts.</p> <p>R13's Nursing progress note dated 08/14/2024 documents R13's cataract surgery will be scheduled with a call to indicate and confirm date per ophthalmology office.</p> <p>R13's Care Plan dated 06/10/2021 documents, R13 has potential for impaired vision related to diagnosis of blurred vision and dry eye; Interventions include arranging consultation with eye care practitioner as required.</p> <p>R13's Care Plan dated 08/29/2023 documents, R13 has been determined by comprehensive assessment to have care needs that require supportive services provided by facility; R13 will be provided care to enable her (R13) to function at her highest most practical level.</p> <p>Facility policy titled Resident's Appointment documents, to ensure residents are scheduled for medical appointments as per physician orders; charge nurses will follow-up with resident's physician, as indicated.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47303</p> <p>Based on interviews and record review, the facility failed to ensure that one resident's (R1) psychotropic medication/ controlled substance was properly documented after administration. This failure has the potential to affect all residents who are currently prescribed controlled substances.</p> <p>Findings include:</p> <p>R1 is [AGE] year old with diagnosis including but not limited to: Generalized anxiety disorder, post-traumatic stress disorder, primary insomnia, unspecified asthma, personal history of other mental and behavioral disorders.</p> <p>R1's BIMS (Brief Interview of Mental Status) score is 15, which indicated cognitively intact.</p> <p>During investigation on 10/01/2024 at 2:14 PM, R1 stated that she was administered Lorazepam on three occasions without requesting it and that she was never given Lorazepam at 1:00 am on 08/26/2024 (as indicated by controlled substance accountability record). R1 said, I sleep throughout the night, so I don't know why it is documented that I received it Lorazepam on 08/26/2024 at 1:00 AM. I usually receive all of my medications at the same time right before bed.</p> <p>On 10/07/2024 at 9:45 AM V2 (DON/ Director of Nursing) stated that the MAR was a part of the EHR.</p> <p>On 10/07/2024 at 9:45 AM V2 (DON) said, It is expected that each and every medication is signed off on the MAR to prevent medication error and to account for controlled substances.</p> <p>Surveyor inquired about the signatures for 08/23/24, 08/24/24 and 08/26/24 on the controlled drug accountability record. V2 (DON) stated that the signatures on the controlled drug record were V12 (LPN/ Licensed Practical Nurse) and V13 (LPN).</p> <p>On 10/10/2024 at 2:05 PM, V12 (LPN) stated she administered R1 a 0.5 Lorazepam mg (milligram) tablet on 08/24/2024 at 4:00 PM but forgot to document it in the MAR/EHR (Medication Administration Record/ Electronic Health Record).</p> <p>On 10/10/2024 at 2:09 PM, V13 (LPN) stated she does not recall administering R1 a 0.5 mg tablet of Lorazepam on 08/26/2024 at 1:00 AM. V13 stated she recalls administering R1 a 0.5 Lorazepam mg (milligram) tablet on 08/23/2024 at 9:35 AM but forgot to document it in the MAR/EHR (Medication Administration Record/ Electronic Health Record).</p> <p>On 10/10/2024 at 3:38 PM, V2 (DON) stated she did not have a list of residents talking controlled substances.</p> <p>R1's Order Summary Report dated 10/03/2024 documents the following order active between the dates of 08/19/2024 through 09/02/2024: Lorazepam oral tablet 0.5 MG, give 1 tablet by mouth every 12 hours as needed for anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Controlled Drug Record documents a 0.5 Mg Lorazepam tablet administered to R1 on the following dates: 08/23/2024, 08/24/2024 and 08/26/2024.</p> <p>R1's Medication Administration Record for the period of 08/01/2024 through 08/31/2024 documents no administration of Lorazepam on the following dates: 08/23/2024, 08/24/2024 and 08/26/2024.</p> <p>Facility Nursing Schedule documents the following: V13 assigned to R1's unit on 08/23/2024; V12 assigned to R1's unit on 08/24/2024; and V13 assigned to R1's unit on 08/26/2024.</p> <p>Medication Administration and Storage policy documents, to ensure medications are administered and stored in accordance with Standard of Practice; Narcotics must be signed out in the EHR (electronic health record) and the Narcotic sheet.</p> <p>Oral Medication Administration Policy documents, Chart medication on Medication Administration Record Immediately following each resident's medication administration.</p>