

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  01/15/2025
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>44103</p> <p>Based on interview and record review, the facility failed to follow their Fall Prevention Program policy and procedure to ensure residents fall care plan interventions were revised after each fall for 2 (R1, R2) out 3 residents reviewed for fall incidents.</p> <p>Findings Include:</p> <p>R1's clinical records revealed R1 had fall incidents on 12/15/24, 12/18/24, and 1/8/25. R1's progress notes dated 12/15/24 at 3:20 PM documents R1 fell going to the bathroom. R1's progress notes dated 12/18/24 at 3:20 AM documents R1 lost balance and fell trying to pick up [R1's] phone on the floor. R1's progress notes dated 1/8/25 documents R1 fell on [R1's] knees trying to go to the bathroom. R1's fall care plan date initiated on 4/10/24 do not show interventions were revised after R1's fall incidents on 12/15/24, 12/18/24, and 1/8/25. R1's care plan history printed on 1/14/25 at 3:28 PM shows V3 (Restorative Director) just created a fall intervention on 1/14/25 that reads, Continue to monitor for behavior of falling.</p> <p>R2's clinical records revealed R2 had a fall incident on 1/4/25. R2's progress notes dated 1/4/25 at 1:57 PM documents R2 was found on the bathroom floor in a sitting position. R2's fall care plan date initiated on 12/26/24 do not show interventions were revised after R2's fall incident on 1/4/25. R2's care plan history printed on 1/14/25 at 3:26 PM shows V3 just created a fall intervention on 1/14/25 that reads, pt/ot [physical therapy/occupational therapy] raised toilet seat.</p> <p>On 1/14/2025 at 10:55 AM, interviewed V3 (Restorative Director) and stated that fall care plan is initiated on admission, updates with any changes, annually, quarterly, significant change, and re-admission. V3 stated that the fall care plan needs to be updated after each fall and interventions are based on the root cause analysis of the fall.</p> <p>On 1/14/25 at 2:23 PM, interviewed V2 (Director of Nursing) and stated that after a fall, the fall care plan interventions should be updated. V2 stated, What we do after a resident's fall is we would have a discussion about it and what intervention should we include in the care plan and then [V3] adds the intervention in the system. That should be done each fall incident. V2 stated that the purpose of the fall interventions is to prevent and reduce risk of falls, and if it's not updated, then staff won't know the fall interventions and residents would be at more risk for falling.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Fall Prevention Program policy dated 11/15/23 documents in part: The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. The fall prevention program includes the following components: Immediate change in interventions that were successful. Care plan incorporates interventions are changed with each fall, as appropriate.</p> <p>The facility's Comprehensive Resident Care Plans policy dated 8/2024 documents in part: Resident's plan of care is reviewed quarterly and as necessary to address the current needs of each resident.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103</b></p> <p>Based on interview and record review, the facility failed to follow their Fall Prevention Program and a resident's comprehensive care plan by not providing appropriate staff assistance to the washroom to prevent a resident from falling for 1 (R2) of 3 residents reviewed for fall incidents. This failure resulted in R2's having a fall incident while using the washroom unassisted and was found on the washroom floor.</p> <p>Findings Include:</p> <p>On 1/14/25 at 1:08 PM, interviewed R2 regarding the fall that happened on 1/04/25. R2 was noted to be alert and oriented to person, place, time, and date. R2 stated that after lunch, [R2] was lying in bed. R2 stated that [R2] pressed the call light to ask for help to go to the washroom to brush [R2's] teeth. R2 stated that [R2] was waiting more than 15 minutes for a staff to come, but no one came, so [R2] decided to transfer himself on the wheelchair and wheel himself to the washroom. R2 stated while in the washroom, R2 stood up from the wheelchair, lost balance, fell backwards and sat on the floor. R2 stated [R2] did not feel any pain and did not injure himself. R2 stated [R2] did not hit [R2's] head. R2 stated [R2] pulled the washroom call light, and the nurse came and found [R2] on the floor.</p> <p>On 1/14/2025 at 10:55, interviewed V3 (Restorative Director) and stated that R2 fell on [DATE]. R2 was observed on the bathroom floor in a sitting position. V3 stated R2's fall risk assessment dated [DATE] indicates R2 is moderate risk for falling. V3 stated R2 requires partial to moderate assist with bed mobility, transfer, toileting, personal hygiene, and walking, which means the staff is physical touching and assisting R2 with activities of daily living (ADL).</p> <p>On 1/14/25 at 11:44 AM, interviewed V4 (Licensed Practical Nurse/LPN) and stated V4 was the nurse in charge when R2 fell on [DATE]. V4 stated around 2:00 PM after lunch, [V4] heard R2's bathroom call light went off and answered it right away. V4 stated [V4] saw R2 on the bathroom floor. V4 asked R2 what happened and R2 answered that [R2] fell on [R2's] buttocks. V4 stated R2 was not hurt, vital signs were stable, and R2 was transferred back to bed via mechanical lift transfer. V4 stated the last time [V4] saw R2 was around 30 minutes before the incident and R2 was lying in bed.</p> <p>On 1/14/25 at 12:55 PM, interviewed V5 (Certified Nursing Assistant/CNA) and stated V5 was the CNA in charge of R2 the day R2 fell but did not witness the fall because V5 was busy with another resident at that time. V5 stated V4 (LPN) found R2 on the bathroom floor in R2's room. V5 stated 20 minutes before R2 fell, V5 checked on R2 and R2 was in bed resting. V5 stated R2 likes to do everything by himself. V5 stated R2 goes to the toilet by himself and does not need staff assistance. V5 stated R2 does not call for help when [R2] needs to go to the toilet because R2 is independent.</p> <p>On 1/14/25 at 2:23 PM, interviewed V2 (Director of Nursing) and stated all residents in the facility are at risk for falling and their call lights should be within reach. V2 stated staff should be answering call lights within minutes no more than 15 minutes. V2 stated the staff are supposed to be assisting resident to the bathroom if they are at risk for falls. V2 stated if the resident calls for help staff should attend to their needs.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's face sheet shows an admitted [DATE] with included diagnoses but not limited to End Stage Renal Disease and Primary Osteoarthritis. R2's Minimum Data Set, dated dated [DATE] shows R2 is cognitively intact with BIMS (Brief Interview for Mental Status) of 15. It also shows that R2 requires partial/moderate assistance with toileting, personal hygiene, and toilet transfer. R2's Fall Risk assessment dated [DATE] shows R2 is moderately at risk for falling, has weak gait and knows own limits. R2's fall care plan date initiated on 12/26/24 indicates that R2 is at risk for falls related to weakness. Interventions include: Anticipate and meet [R2's] needs and Be sure [R2's] call light is within reach and encourage [R2] to use it for assistance as needed. [R2] needs prompt response to all requests for assistance. R2's ADL care plan date initiated on 12/26/24 indicates that R2 has an ADL self-care performance deficit related to weakness due to ESRD with hemodialysis and Left Hemiplegia. R2 is a limited assistance of one staff member for transfers, bed mobility and toileting.</p> <p>R2's progress notes dated 1/04/25 at 1:57 PM documented by V4 reads in part: Call Light came on from [R2's] room. [V4] walk into Resident room to ask what [R2] want. [V4] observed [R2] in the bathroom floor in a sitting position. [R2] verbalized in quote (I was trying to use the bathroom and I fell on my b**t. I am fine. I am not in any pain). Head to Toe assessment was conducted. No injury or skin alterations noted. Vitals taken and are as follows. B/P [blood pressure]- 132/70. P [pulse]-80. RR [respiratory rate]-18. O2SAT [oxygen saturation]-100. TEMP [temperature]-97.6. BS [blood sugar]- 121. [R2] denies any pain at this time.</p> <p>The facility's Fall Prevention Program policy dated 11/15/23 documents in part: The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Fall/safety interventions may include but are not limited to: Call lights are answered promptly. Residents who require staff assistance will not be left alone after being assisted to bathe, shower, or toilet. Residents at risk for falling will be assisted with toileting needs as identified during the assessment process and as addressed on the plan of care.</p>