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	02/26/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486 Based on observation, interview, and record review, the facility failed to ensure resident medication was administered as ordered by the physician. This failure affects 1 (R1) out of 3 residents reviewed for medication administration. Findings Include: R1's Electronic Medical Record (EMR) revealed R1 was admitted to the facility on [DATE] and is [AGE] years of age with diagnoses that included but were not limited to: Hemiplegia and Hemiparesis following cerebral infarction affecting left non-dominant side, Aphasia following cerebral infarction, Dysphagia following cerebral infarction, Essential Primary Hypertension, and Hyperlipidemia. On 2/25/25 at 11:05 AM, R1 is non-verbal and R1 uses a tablet (iPad) voice machine to communicate. R1 stated that he was ignored and was not provided morning medications including R1's blood pressure medication on 2/16/25 and today 2/25/25. R1 stated that most nurses give his medication whole, but V6 (Licensed Practical Nurse/LPN) working today decided to crush R1's medication, and he refused to take the medication. R1 stated that on 2/16/25, he requested for his blood pressure medication (Lisinopril 10 mg, 1 tablet daily at 9am) around 11:30AM, and that V6 stated the medication time had passed. R1 stated V6 did not check his blood pressure which is always high. R1 stated R1 has no problem swallowing whole medications, and that the nurses are lying about R1 having problem to swallow whole medication. R1 stated that on 2/17/25 or 2/19/25 R1's blood pressure medication was skipped, and the nurse did not even come to ask R1. R1 stated the nurse lied about him not wanting to be bothered. R1 stated that he never said that he does not want to be bothered to anyone. R1 does not believe the facility did not have R1's medication and has no issues with other shifts just this morning shift, when he needs his blood pressure medication. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 12:22 PM, V6 (LPN) stated if a resident refused medication, she would educate, notify the physician regarding the reason for the refusal, and follow up with the physician's order. V6 stated she did not check R1's blood pressure and did not administer blood pressure medication to R1 this morning because R1 gave V6 the middle finger when V6 told R1 that the medication will be crushed. V6 stated she did not notify the physician, but V6 should have notified the physician for a possible new order to change into a liquid form. V6 stated she did not give R1 blood pressure medication on 2/16/25 because R1 asked for the 9 am medication at 11:30 AM. V6 stated since R1 is scheduled to take the blood pressure medication daily at 9am, V6 should have called the physician to change the timing. V6 stated that failure to administer blood pressure medication to R1 has the potential to increase R1's blood pressure and may cause R1 to have another stroke. At 12:40 pm, V6 was ask if V6 attempted again to take R1's blood pressure this morning, V6 stated no, but she will try now. V6 went into R1's room to take R1's blood pressure with a reading of 154/110. V6 stated that she is calling the physician now and will follow up with the surveyor. At 12:52 PM, V6 stated the physician stated V6 should call the pharmacy to convert the blood pressure to liquid or syrup if possible. At 1:40 PM, V6 stated the pharmacy stated the blood pressure medication (Lisinopril 10mg) could not be converted to a liquid form. V6 stated that V6 will notify the physician. At 2:39 PM, V6 stated that the physician gave order to administer R1's medication whole in apple sauce and monitor. At 2:46 pm, V6 stated that V6 administered the blood pressure medication whole in apple sauce to R1 without any difficulty. On 2/25/25 at 3:49 PM, V5 (Assistant Director of Nursing/ADON) stated that nurses should be calling the physician when a resident refuses medication. V5 stated that failure to administer blood pressure medication as ordered by physician could potentially result into high blood pressure that can lead to a medical emergency. On 2/25/25 at 4:18 PM, V10 (LPN) stated that V10 has been working in the facility for over one year, 7AM-3PM shift. V10 stated that V10 worked with R1 on 2/19/24 and V10 gave R1's medications whole without any complaint. V10 stated that V10 did not ignore R1, V10 gave R1 blood pressure medication as scheduled because R1's blood pressure is always high, and R1 did not tell V10 that R1 does not want to be bothered whenever. On 2/25/25 at 4:30 PM, V2 (Director of Nursing/DON) stated that it is V2's expectation nurses would document medication refusal with the reason and notify the physician immediately. V2 stated R1 has been refusing R1's blood pressure medication because R1 does not want R1 medication crushed. V2 stated there was no specific physician order or recommendation from the speech therapist that R1's medication should be crushed. V2 stated constant refusal of the blood pressure medication by R1 could lead to R1 having another stroke. V2 stated the nurse should have notified the physician with the reason for the refusal to prevent another stroke and medical emergency. V2 stated V2 will provide in-service on notifying the physician for any medication refusal and proper communication between the therapist and the nursing staff. Documents Reviewed: R1's Minimum Data Set, dated dated dated [DATE] shows R1 is cognitively intact. R1's Physician Order Sheet (POS) shows active order of Lisinopril oral tablet 10mg, give 1 tablet by mouth one time a day for hypertension. R1's Electronic Medical Record (EMR) shows R1 did not receive Lisinopril 10 mg on 2/16/25, 2/17/25, and 2/25/25. There were no documentations that the physician was notified with a reason for the refusal found in R1's EMR. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan dated 2/20/25 documents in part: R1 has diagnosis of hypertension, goal-R1 will remain free of complications related to hypertension. Intervention: Give anti-hypertensive medications as ordered. Policy on Medication Administration and Storage Policy dated 07/02/18 documents in part: If the resident has refused a medication. State reasons for the refusal. Physician must be notified when medications are not administered as per physician orders.