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	03/21/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on interviews and record reviews, the facility failed to ensure individualized and appropriate fall interventions were identified and implemented to provide necessary supervision to prevent a resident from falling for 1 (R1) out of 4 residents reviewed for falls. Findings Include: R1's Fall note dated 2/28/25 at 9:00 PM documented by V4 (Licensed Practical Nurse) reads in part: Noted resident [R1] walking out of room with foley catheter in his hand. [R1] walked in front of the nursing station and fell and hit the back of his head. [R1] unable to give description. Full body assessment with no noted bruises or bumps. Emergency ambulance called and transferred R1 to the hospital. V4's (Licensed Practical Nurse/LPN) witness statement reads in part, Noted resident walking out of room and walk in front of nursing station and fall and hit his back of his head. V5's (LPN) witness statement reads in part, Resident noted walking by nursing station unassisted and lost his balance falling and hit his back and side of head. R1's clinical records show a re-admission to the facility on [DATE] with included diagnoses but not limited to chronic obstructive pulmonary disease, schizophrenia, dementia, and restlessness and agitation. R1 had a significant change of condition minimum data set assessment dated [DATE] that revealed R1's preferred language was Cantonese and needed an interpreter. R1 was still able to make his needs known, had moderate impairment with cognition, and required substantial maximal staff assistance for walking, transferring, and toileting. R1's Fall Risk assessment dated [DATE] shows R1 was high risk for falling, had history of falling and had impaired gait. R1's fall comprehensive care plan have the following fall interventions: anticipate and meet R1's needs (initiated 3/1/21), be sure R1's call light is within reach and encourage R1 to use it for assistance as needed, needs prompt response to all requests for assistance (initiated 3/1/21), educate R1/family/caregivers about safety reminders and what to do if a fall occurs (initiated 3/1/21), remind R1 to call for help before getting up and attempting to transfer or ambulate (initiated 3/3/25 post fall), and staff to monitor for behaviors of laying or throwing self on floor (initiated 12/3/24). R1's comprehensive fall care plan was not individualized and revised based on his significant change assessment on 2/26/25 to meet all his needs to prevent him from falling. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 12:17 PM, a phone interview was conducted with V4 (LPN) about R1's fall incident that happened on 2/28/25. V4 stated between 9:00 PM and 10:00 PM, V4 saw R1 walked out of his room and walked towards the nurses' station where he lost balance and fell . R1 hit the back of his head. V4 stated R1 used to walk by himself but was not supposed to anymore because R1 has been sick. R1 went to the hospital and came back weak. V4 stated R1 did not speak English, is confused, and bedridden. V4 stated he does not think R1 knew how to use the call light and the last time V4 saw R1 was 20 minutes before the fall when R1 was in bed awake. V4 stated R1 could not explain why he got up from bed. V4 stated, I was not told he [R1] was high risk for falling. I never witnessed him [R1] having any behaviors. When [R1] fell , he was barefoot. He was bedridden. They would not put socks or shoes on a resident who is bedridden. There were no fall interventions in place for him [R1] because he is not considered a fall risk. He [R1] was bedridden and would not be considered at risk for falling. On 3/18/25 at 12:35 PM, V2 (Director of Nursing/Interim Fall Coordinator) stated residents are identified for at risk for falling by checking their history, their gait, cognitive status, and medications that needs to be done on admission, re-admission, post fall, and needs to be re-evaluated quarterly, annually, and with significant change. V2 stated all residents in the facility are at risk for falling. V2 stated fall interventions are initially all standardized. If a resident does not fall, it will all be standard fall interventions. V2 stated R1's fall interventions prior to the 2/28/25 were standardized because R1 never had a fall before. On 3/18/25 at 2:00 PM, V32 (Restorative Director) stated the residents' care plans should be individualized based on the needs of the residents. V32 stated care planning is an interdisciplinary team approach and fall interventions should be based on the team's assessments and reviews. V32 stated fall interventions should address the resident's needs such as language barrier, vision problems, and gait problems. V32 stated it is important for staff to know and follow the resident's fall interventions to prevent resident from falling and prevent the risk of injury. V32 stated R1 was able to walk on his own before and he had been having slow decline. There are days R1 would get up and there are days he would stay in bed. R1 had the tendency to get up by himself because he used to walk on his own. R1 had confusion and had language barrier. V32 stated R1 gets agitated when nobody understands him. R1 knew how to use the call light. R1 forgets to use it at times. V32 stated R1 would need non-skid socks and staff needs to apply them when R1's is in bed in case he gets up without assistance, and it needs to be part of the fall intervention. V32 stated R1's significant change assessment was completed on 2/26/25 because R1 had overall functional decline. V32 stated the fall care plan should have been reviewed and revised after the significant change assessment to reflect his functional decline. V32 stated prior to the 2/28/25 fall, R1 required one staff substantial maximal assistance with transfer, bed mobility, and walking. That means one staff should be assisting R1 and holding him during these activities. The staff is doing more than 50% of the work for R1. V32 stated if staff saw R1 standing and walking by himself, they should right away attend to him and assist him with walking because R1 had unsteady gait and was high risk for falling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Falls and Fall Prevention policy dated 11/2024 documents in part: To ensure residents admitted are assessed for potential fall risk. To ensure a fall prevention program will include measures which will determine the individual need of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices as indicated based on assessment. Residents who are assessed as at risk for falls will have a care plan initiated to include approaches for the prevention of falls as they apply to the individual resident. The interdisciplinary team will include specific interventions such as but not limited to a recommendation for a low bed, footwear, lighting bed or chair alarm and changing resident's room. Nursing staff will be informed of residents who are at risk of falling. Resident fall risk interventions will be identified on the care plan. Resident care plan intervention will be updated as indicated.