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	04/17/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067 Based on interview and record review, the facility failed to ensure residents remain free from physical abuse and verbal abuse. These failures affected R1 who was physically hit by R2 in the arm and R3 who was verbally abused with derogatory words from a staff member in the sample of 7 residents reviewed for abuse. Findings include: 1) On 4/14/25 at 2:13 pm, R1 stated that on 3/26/25 at around 7:00 pm, R1 was wheeling R1's self into the elevator to go downstairs to smoke. R1 said when R1 was wheeling into the elevator, R2 was inside the elevator in R2's wheelchair, and R7 was standing in the elevator. R1 asked R2 to move back for more space, and R2 said no. R1 stated R1 wheeled in on the side of R2 in R2's wheelchair, and R2 grabbed my arm and swung at me. R1 said R2 hit R1's arm. R1 said, (R2) attacked me. On 4/15/25 at 9:50 am, R2 stated on 3/26/25, R2 was already in the elevator going down to smoke break, and R1 wheeled in the elevator next to R2's wheelchair. When asked if R2 hit R1 in the elevator on 3/26/25, R2 stated, Yes, yes. I hit (R1). R2 said, (R1) bumped my wheelchair. R1's Admission Record documents, in part, diagnoses of chronic obstructive pulmonary disease, acquired absence of right leg above knee, hereditary and idiopathic neuropathy, hyperlipidemia, anemia, chondrocostal junction syndrome, chronic pain syndrome, acute embolism and thrombosis of deep vein of lower extremity (bilateral), disorder of adrenal gland, restless leg syndrome, phantom limb syndrome with pain, and diverticulosis of large intestine. R1's Minimum Data Set (MDS) dated [DATE] documents, in part, a Brief Interview for Mental Status (BIMS) score of 15 which indicates R1 is cognitively intact. R1's Functional Abilities for Mobility Devices is a manual wheelchair. R2's Admission Record documents, in part, diagnoses of schizoaffective disorder bipolar type, schizophrenia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, hypertensive chronic kidney disease stage 4, hyperlipidemia, bipolar disorder, dysarthria and anarthria, major depressive disorder, generalized anxiety disorder, mood (affective) disorder, insomnia, constipation, hypokalemia, syphilis, violent behavior, patient's noncompliance for medication regimen and medical treatment, and anemia. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's MDS dated [DATE] documents, in part, a Staff Assessment for Mental Status for Cognitive Skills for Daily Decision Making as moderately impaired. R2's Functional Abilities for Mobility Devices is a manual wheelchair. On 4/15/25 at 9:40 am, when asked if R7 witnessed an incident occurred between R1 and R2 on 3/26/25, R7 said, Yes, I (R7) did. R7 stated it was evening time, and it happened on the elevator. R7 stated, (R2) grabbed (R1's) arm and pushed (R1). When asked for details, R7 stated R2 and R7 were in the elevator already, and R1 wheeled into the elevator. R7 stated R1 asked R2 to move over a little to allow more room for R1's wheelchair, and R2 said, No. R7 said R1 was able to wheel into the elevator next to R2, and R2 hit (R1's) arm. R7 stated R2 used a closed fist to strike R1's arm. R7 stated R7 told R2 to stop from hitting R1, and R2 stopped. R7 stated R1 did not hit R2 back. When asked was there anything proceeded R2 hitting R1, like bumping wheelchairs, R7 stated no. R7's Admission Record documents, in part, diagnoses of chronic obstructive pulmonary disease, asthma, tachycardia, hyperlipidemia, dependence on renal dialysis, end stage renal disease, type 2 diabetes mellitus, abdominal pain, chronic systolic (congestive) heart failure, and chronic embolism and thrombosis of other specified veins. R7's MDS dated [DATE] documents, in part, a BIMS score of 15 which indicates R7 is cognitively intact. On 4/15/25 at 2:09 pm, V10 (Psychiatric Rehabilitation Service Coordinator, PRSC) stated V10 responded on 3/26/25 around 7:00 pm to the nurse's station after R1 and R2's incident occurred in the elevator. V10 stated R1, R2 and R7 were present, and V10 stated R2 said R2 grabbed and hit R1 in the elevator. On 4/15/25 at 2:48 pm, V12 (Licensed Practical Nurse, LPN) stated after R1 and R2's incident on 3/26/25, V12 assessed R2 per protocol. V12 stated R2 admitted to V12 saying R2 punched R1. Facility document titled Preliminary 24-hour Incident Investigation Report dated 3/26/25 documents, in part, on 3/26/25 at approximately 7:00 pm, R2 was allegedly noted striking R1 with the incident occurring in the elevator. Facility document titled Final Incident Investigation Report dated 4/1/25 documents, in part, Based on the known facts from medical record review and interviews, the following conclusions have been determined about the allegation: (X) Abuse . is (X) Founded. 2) On 4/14/25 at 2:06 pm, R3 stated on 3/22/25 after midnight, R3 went downstairs to the first-floor lobby via R3's manual wheelchair to get something. When asked if R3 knew V5 (Former Receptionist) prior to this incident, R3 stated R3 knew (V5), and they were friends. When asked what happened on 3/22/25 at 1:45 am when R3 saw V5 at reception desk, R3 stated, I (R3) was talking to my friend (V5) and we had a disagreement. I was about ready to leave. When asked what the disagreement was about, R3 stated, (V5) was saying something, talking about me. When asked what V5 specifically said, R3 stated, That's a personal matter. When asked if V5 said curse words towards R3 during their disagreement, R3 stated, Yeah, (V5) did. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Admission Record documents, in part, diagnoses of paraplegia, chronic osteomyelitis, pressure ulcer of right buttock stage 4, pressure ulcer of left buttock stage 4, pressure ulcer of right hip stage 4, neuromuscular dysfunction of bladder, encounter for attention to ileostomy, depression, cramp and tension, constipation, visual disturbance, sepsis, low back pain, urinary tract infection, primary generalized osteoarthritis, insomnia, dorsalgia, myositis, adult failure to thrive, peripheral vascular disease, and resistance to multiple antibiotics. R3's MDS, dated [DATE], documents, in part, a BIMS score of 15 which indicates R3 is cognitively intact. R3's Functional Abilities for Mobility Devices is a manual wheelchair. During this investigation, this surveyor attempted to contact V5 (Former Receptionist) for interview, but V5 was not reachable via phone. On 4/16/25 at 9:36 am, V18 (Nursing Supervisor 2, LPN) was the night nursing supervisor on the 3/21/25 to 3/22/25 night shift in the facility. V18 stated, I (V18) was made aware when the night receptionist (V5) over head paged me. I called (V5) back. I was on another floor. V18 stated V5 said R3 wouldn't leave the reception area despite V5 asking R3 to leave. V18 stated V18 went downstairs to the receptionist area (near lobby) and V5 said R3 had been trying to record V5 on R3's phone. V18 stated this behavior was not common from R3, so V18 used V5's receptionist phone to call down V17 for assistance with the situation. V18 stated V17 arrived, along with V11 (Registered Nurse, RN) and V16 (Certified Nursing Assistant, CNA), and R3 and V5 were both talking over each other with their accounts of what was happening. V18 stated V5 told R3 to shut up, and V18 told V5 to not say anything further. When asked if V5 called R3 any derogatory curse names, V18 stated, Yes, I am pretty sure (V5) said something back. This surveyor read to V18 her authored Witness Statement (dated 3/22/25). When asked is V18's statement accurate as the truth, V18 stated, Yes. Facility document titled Witness Statement, V18 (Nursing Supervisor 2, LPN) documents, in part, for R3's incident on 3/22/25 at the front desk/lobby area, V18 was called down to this receptionist area in the front lobby by V5 (Former Receptionist) at approximately 1:45 am. When V18 responded to the receptionist area to address the interaction between V5 and R3, V18 documents, Employee (V5) told resident (R3) 'Shut up b****.' On 4/15/25 at 4:03 pm, V17 (Nursing Supervisor 1, LPN) stated V17 normally works as the nursing supervisor but was working as a staff nurse on one of the resident floors for the night shift of 3/21/25 to 3/22/25. V17 stated on 3/22/25 at 1:50 am, V17 received a call from V18 (Nursing Supervisor 2, LPN) to come down to the 1st floor lobby for assistance. V17 stated V17 went downstairs with V11 (RN) to the lobby and observed R3 in R3's wheelchair with V17, V16 (CNA) and V5 present. V17 stated V17 assisted with separating V5 by staying with V5 as V5 was punching out to leave the facility. V17 stated V5 and R3 were calling each other curse words like b*** and h**, and V17 told V5 to stop talking to R3. This surveyor read V17's authored Witness Statement (3/22/25), and V17 stated, Yes, is my accurate statement. Facility document titled Witness Statement, V17 (Nursing Supervisor 1, LPN) documents, in part, for R3's incident on 3/22/25 at the front desk/lobby area, V17 was called down to this receptionist area in the front lobby by V18 at approximately 1:50 am. When V17 was in the receptionist area watching V5 punching out to leave the facility, V17 documents, The employee (V5) then turned and yelled 'Shut up b****.' (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility document titled Preliminary 24-hour Incident Investigation Report dated 3/22/25 documents, in part, V2 (DON) completed this form for R3 allegedly abused by V5. V2 documents, in part, On 3/22/25 at 1:45 am, in the reception area, resident, (R3), was in (R3's) wheelchair in the lobby area and had verbal argument with staff member, (V5), and this was witnessed by two staff members. Facility document tilted Final Incident Investigation Report dated 3/27/25 documents, in part, Based on the known facts from medical record review and interviews, the following conclusions have been determined about the allegation: (X) Abuse . is (X) Founded . As follows: Following a thorough investigation an allegation of verbal abuse is founded. On 4/16/25 at 11:27 am, V1 (Administrator) stated V1 is the abuse coordinator for the facility. V1 stated, Abuse is reported to me. V1 stated on 3/26/25 after V1 had left the facility, V1 received a phone call from V10 (PRSC) reporting of alleged abuse from R2 towards R1, and the residents had been separated. V1 stated R2 admitted to hitting R1, and this was corroborated by an eyewitness, R7. V1 stated V1 concluded physical abuse occurred towards R1 from R2. V1 stated for the incident occurred between R3 and V5, V1 conducted the abuse investigation. V1 stated V1 utilized the witness statements from V17 and V18; interview with R3; and a text exchange with V5 (Former Employee) who said they (R3 and V5) exchanged words with each other. V1 stated V1 concluded verbal abuse occurred towards R3 from V5. V1 stated V5 was terminated from employment in the facility due to verbal abuse towards a resident. Facility policy dated October 24, 2024 and titled Illinois - Abuse Prevention Policy documents, in part, . affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure the facility is doing all is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: . orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse neglect, exploitation, and misappropriation of property; establishing an environment promotes resident sensitivity, resident security and prevention of mistreatment . This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. Definitions. The following definitions are based on federal and state laws, regulations and interpretive guidelines . Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment (42 CFR 483.12 Interpretive Guidelines) . Verbal Abuse is the use of oral, written, or gestured language willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individuals' age, ability to comprehend, or disability. Facility policy dated November 2018 and titled Residents' Rights for People in Long-Term Care Facilities documented, in part, Your rights to dignity and respect: . Your facility must treat you with dignity and respect and must care for you in a manner promotes your quality of life . Your rights to safety: You must not be abused, neglected, or exploited by anyone - . physically, verbally.

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Uptown Care and Rehabilitation	4920 North Kenmore Chicago, IL 60640

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067 Based on interview and record review, the facility failed to timely submit an initial abuse report to the state agency within 2 hours which affected one resident (R3) in the sample of 7 residents reviewed for abuse. Findings include: On 4/14/25 at 2:06 pm, R3 stated that on 3/22/25 after midnight, R3 went downstairs to the first-floor lobby via R3's manual wheelchair to get something. When asked did R3 know V5 (Former Receptionist) prior to this incident, R3 stated that R3 knew (V5), and they were friends. When asked what happened on 3/22/25 at 1:45 am when R3 saw V5 at reception desk, R3 stated, I (R3) was talking to my friend (V5). And we had a disagreement. I was about ready to leave. When asked what the disagreement was about, R3 stated, (V5) was saying something, talking about me. When asked what V5 specifically said, R3 stated, That's a personal matter. When asked did V5 say curse words towards R3 during their disagreement, R3 stated, Yeah, (V5) did. R3's Admission Record documents, in part, diagnoses of paraplegia, chronic osteomyelitis, pressure ulcer of right buttock stage 4, pressure ulcer of left buttock stage 4, pressure ulcer of right hip stage 4, neuromuscular dysfunction of bladder, encounter for attention to ileostomy, depression, cramp and tension, constipation, visual disturbance, sepsis, low back pain, urinary tract infection, primary generalized osteoarthritis, insomnia, dorsalgia, myositis, adult failure to thrive, peripheral vascular disease, and resistance to multiple antibiotics. R3's MDS, dated [DATE], documents, in part, a BIMS score of 15 which indicates that R3 is cognitively intact. R3's Functional Abilities for Mobility Devices is a manual wheelchair. On 4/16/25 at 9:36 am, V18 (Nursing Supervisor 2, LPN) was the night nursing supervisor on the 3/21/25 to 3/22/25 night shift in the facility. V18 stated, I (V18) was made aware when the night receptionist (V5) over head paged me. I called (V5) back. I was on another floor. V18 stated that V5 said that R3 wouldn't leave the reception area despite V5 asking R3 to leave. V18 stated that V18 went downstairs to the receptionist area (near lobby) and that V5 said that R3 had been trying to record V5 on R3's phone. V18 stated that this behavior was not common from R3, so V18 used V5's receptionist phone to call down V17 for assistance with the situation. V18 stated that V17 arrived, along with V11 (LPN) and V16 (CNA), and R3 and V5 were both talking over each other with their accounts of what was happening. V18 stated that V5 told R3 to shut up, and V18 told V5 to not say anything further. When asked did V5 call R3 any derogatory curse names, V18 stated, Yes, I am pretty sure (V5) said something back. This surveyor read to V18 her authored Witness Statement (dated 3/22/25). When asked is V18's statement accurate as the truth, V18 stated, Yes. When asked did V18 notify V1 (Administrator) about the abuse allegation from V5 towards R3, V18 stated that V17 called V1, and V1 did not answer V1's phone. When was this call made by V18, V17 stated, Literally 3-5 minutes afterwards of R3/V5's incident occurring. V18 stated that V18 had left V18's cellular phone upstairs, so for privacy, V17 stepped into V2's office on the first floor to call to report the alleged abuse, while V18 stayed with V5. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility document titled Witness Statement, V18 (Nursing Supervisor 2, LPN) documents, in part, for R3's incident on 3/22/25 at the front desk/lobby area, that V18 was called down to this receptionist area in the front lobby by V5 (Former Receptionist) at approximately 1:45 am. When V18 responded to the receptionist area to address the interaction between V5 and R3, V18 documents, Employee (V5) told resident (R3) 'Shut up b****.' On 4/15/25 at 4:03 pm, V17 (Nursing Supervisor 1, LPN) stated that V17 normally works as the nursing supervisor but was working as a staff nurse on one of the resident floors for the night shift of 3/21/25 to 3/22/25. V17 stated that on 3/22/25 at 1:50 am, V17 received a call from V18 (Nursing Supervisor 2, LPN) to come down to the 1st floor lobby for assistance. V17 stated that V17 went downstairs with V11 (LPN) to the lobby and observed R3 in R3's wheelchair with V17, V16 (Certified Nursing Assistant, CNA) and V5 present. V17 stated that V17 assisted with separating V5 by staying with V5 as V5 was punching out to leave the facility. V17 stated that V5 and R3 were calling each other curse words like b*** and h**, and V17 told V5 to stop talking to R3. This surveyor read V17's authored Witness Statement (3/22/25), and V17 stated, Yes, that is my accurate statement. When asked about reporting this abuse allegation towards R3 from V5, V17 stated, I (V17) made the direct phone call. I first called (V1). Then send (V1) a text message. Then, I called (V2) since I was not able to get in touch (V1). V17 stated that V17 called and spoke with V2 about the abuse incident, when V2 said that V5 is to be sent home which V5 had already punched out. Facility document titled Witness Statement, V17 (Nursing Supervisor 1, LPN) documents, in part, for R3's incident on 3/22/25 at the front desk/lobby area, that V17 was called down to this receptionist area in the front lobby by V18 at approximately 1:50 am. When V17 was in the receptionist area watching V5 punching out to leave the facility, V17 documents, The employee (V5) then turned and yelled 'Shut up b****.' Facility document, dated 3/22/25 at 8:33 am, indicates that V2 (DON) submit the preliminary abuse report for R3 to the state agency via email. Facility document titled Preliminary 24-hour Incident Investigation Report dated 3/22/25 documents, in part, that V2 (DON) completed this form for R3 allegedly abused by V5. V2 documents, in part, On 3/22/25 at 1:45 am, in the reception area, resident, (R3), was in (R3's) wheelchair in the lobby area and had verbal argument with staff member, (V5), and this was witnessed by two staff members. On 4/16/25 at 10:36 am, V2 (DON) stated that V1 is the abuse coordinator for the facility. V2 stated that on 3/22/25 close to 7:00 am, V2 spoke to V17 (Nursing Supervisor 1, LPN) on the phone who was reporting the abuse allegation towards R3 from V5. V2 stated that V17 reported that V17 had tried to call V1 who was not available, and they (staff) tried to call me, but I miss it (the call). V2 confirmed that V1 was not reachable by phone due to religious holiday on 3/22/25 after the incident occurred in the facility. When asked if V1 is not available, who is the next person that staff should call to report an abuse allegation, V2 stated, Me next. When asked if V2 can't be reached, who are staff to call, and V2 stated, Call (V3, Assistant Administrator). This surveyor showed V2 the preliminary abuse report submission report (emailed confirmation) to the state agency sent on 3/22/25 at 8:33 am. When asked the process of notifying the state agency of an initial abuse allegation, V2 stated that it is to be reported to (state agency) in 2 hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/25 at 11:11 am, when asked about incident between R3 and employee in reception area on 3/22/25, was V3 (Assistant Administrator) notified by staff about this abuse allegation, and V3 stated, No. No. That's (V1). On 4/16/25 at 11:27 am, V1 (Administrator) stated that V1 is the abuse coordinator for the facility. V1 stated, Abuse is reported to me. V1 stated that for the incident that occurred between R3 and V5, V1 was not available via phone due to religious holiday on 3/22/25 at approximately 2:00 am. V1 stated that in V1's absence as the abuse coordinator (V1 is not available via phone), the staff must next report abuse to V2 (DON). When asked if V2 is not reachable, like if V2 misses the staff's phone call during middle of the night, who would the staff contact next to report alleged abuse, and V1 stated that it would be V21 (Chief Operating Officer). When asked the process of reporting of alleged abuse to the state agency, V1 stated, I follow the policy and regulations with allegation of abuse. There's a process for reporting timelines. When asked about these timelines regarding when is V1 to report an abuse allegation to the state agency, V1 stated, Usually 2 hours. Immediately. When are staff to have reported this incident to you (occurring at 1:45-1:50 am), V1 stated, Immediately. This surveyor showed R3's preliminary abuse report submitted to the state agency at 8:33 am on 3/22/25. When asking is this time frame greater than 2 hours, V1 stated, Yes. Facility policy dated October 2024 and titled Illinois - Abuse Prevention Policy documents, in part, . affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. This will be done by: . filing accurate and timely investigative reports . Procedures: . V. Internal Reporting Requirements and Identification of Allegations. Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance hotline or compliance officer. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence . Reports will be documented, and a record kept of the documentation. Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property. Upon learning of the report, the administrator or a designee shall initiate an incident investigation. Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but not more than two hours of the allegation of abuse.