Illinois Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 11/19/2023 B. WING IL6006134 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4920 NORTH KENMORE** UPTOWN CARE AND REHABILITATION CHICAGO, IL 60640 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 S 000 Initial Comments Complaint Investigations: 2389366/IL166516 2389384/IL166552 S9999 S9999 Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with Attachment A each resident's comprehensive resident care Statement of Licensure Violations plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 12/20/2023 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C IL6006134 B. WING 11/19/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4920 NORTH KENMORE UPTOWN CARE AND REHABILITATION** CHICAGO, IL 60640 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 1 S9999 care needs of the resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide timely care to three of five residents (R2, R3, R4). Two of these residents (R3, R4) had to hold their feces and/or urine for multiple hours before they were able to relieve themselves or receive care. This put residents at risk for harm due to holding their feces and/or urine. R3 had a swollen, distended stomach due to holding his feces, causing him severe pain. The failure affects three (R2, R3, R4) of five residents reviewed for neglect. Findings include: According to current POS (Physician Order Sheet), R2 is a 63-year-old female. R2's diagnoses are but not limited to quadriplegia, lung disorders, asthma, pressure ulcer of sacral region, lung clots, diabetes, high blood pressure, and high cholesterol. MDS (Minimum Data Set) dated 10/06/2023, notes R2 is alert and needs extensive assistance.

disease, heart failure, kidney disease, pressure

According to current POS (Physician Order Sheet), R3 is a 61-year-old male. R3's diagnoses are but not limited to respiratory failure, lung

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6006134 11/19/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4920 NORTH KENMORE** UPTOWN CARE AND REHABILITATION CHICAGO, IL 60640 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 S9999 Continued From page 2 ulcer of the right heel, diabetes, heart disease, obesity, high cholesterol, depression, anxiety disorder, and constipation. MDS dated 08/25/2023, notes R3 is alert and requires two-person total assistance. According to current POS (Physician Order Sheet), R4 is a 74-year-old male. R4's diagnoses are but not limited to cellulitis, clot in the right leg, lung disorder, heart failure, chronic lung clots, diabetes, major depressive disorder, kidney disease, fluid overload, and anxiety disorder. MDS dated 08/31/2023, notes R4 is alert and requires total two-person assistance. On 11/18/2023, at 12:50 PM, R2 stated, "The CNA (Certified Nursing Assistant) has not come to change me yet. " On 11/18/2023, at 1:02 PM, V5 (Certified Nursing Assistant) stated, "I came to check on R2 at 7:00 AM. R2 was sleeping. " On 11/18/2023, at 1:10 PM, V5 came to change R2. No previous attempts to change R2 were made by V5 before 1:10 PM. On 11/18/2023, at 1:31 PM, R3 stated, "I have been holding my urine and feces since this morning. No one wants to do their job. I hold my urine and feces all the time. My stomach is very swollen and it hurts. I would rate it a six out of ten. This has happened on many occasions. If one of the staff needs to go to the bathroom they can. I must wait for them. V5 had an attitude so I told her to get out. " During this interview, R3's stomach was very swollen and full of flatus (gas). R3 rated R3's pain level high due to the gas.

Illinois Department of Public Health

SRT211

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: IL6006134 B. WING 11/19/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4920 NORTH KENMORE** UPTOWN CARE AND REHABILITATION CHICAGO, IL 60640 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) S9999 Continued From page 3 S9999 On 11/18/2023, at 1:45 PM, surveyor overheard V5 tell V6 (Registered Nurse) that V5 had not changed R4 yet. On 11/18/2023, at 1:51 PM, R4 stated, "I have not been changed today. I have been asking to be changed for hours. Other days I always call the supervisors. The staff argues in front of my door. The staff that know what to do, they move them. If a person needed help, they would be dead. The other day they forgot to give me an aide. I was holding it. I need my bandage changed. I need someone to help me because I cannot walk. They need more than two people on this floor. There is a couple of times they have left me in my feces because they go home. This happens all night. The third shift sleeps. I have not seen my aide all day. They came in with an attitude this morning. I have not seen anyone, and I have not washed up. This happens frequently. I am just tired of it. I deal with this all the time. I just hold it because I just do not want to lay in my stuff. They take all my money, and I cannot get anyone in here to wipe my butt? My stomach hurts and I am just tired of all of this." On 11/18/2023, at 2:30 PM, surveyor asked V6 about care for the residents. V6 replied, "Everyone is upset. What can I do?" On 11/18/2023, at 3:04 PM, V7 (Lead CNA) stated, "I expect staff to change the residents every two hours. " On 11/18/2023, at 4:05 PM, V9 (Certified Nursing Assistant) stated, "There are some residents that urinate frequently. We need to keep changing them. When I work on the second floor, I have eight residents that are total care. The facility is

Illinois Department of Public Health

STATE FORM

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: B. WING 11/19/2023 IL6006134 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **4920 NORTH KENMORE UPTOWN CARE AND REHABILITATION** CHICAGO, IL 60640 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX in (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 Continued From page 4 S9999 short staffed. " On 11/19/2023, at 5:05 PM, V10 (Director of Nursing) stated, "I expect the staff to round every two hours on the residents. They are also supposed to answer the call lights to see what is going on". Facility policy titled Abuse Policy, dated 1/23, notes each resident has the right to be free from abuse. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. (A)