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S 000	Initial Comments Complaint Investigation 2489184/IL180676 - 300.686 a)8)11) g) h) Facility Incident Report of 10/12/24 (IL181167) - 300.690 c)	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 3): 300.610a) 300.1210b) 300.1210c) 300.3240a) Section 300.610 Resident Care Policies a) 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 b) 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 each resident's comprehensive resident care	S9999		

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plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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 interview and record review the facility failed to ensure one resident (R4) was free from staff to resident physical abuse. This failure affected one resident (R4) in a total sample size of three residents (R1, R2 and R4) reviewed for abuse. This deficient practice resulted in harm for one resident (R4) experiencing physical pain and bruising.

Findings include:

R4's medical diagnoses include but not limited hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, convulsions, chronic obstructive pulmonary disease, essential hypertension, contracture right elbow, major depressive disorder, anxiety disorder.

R4's Minimum Data Set (MDS) dated 10/23/24 has a Brief Interview for Mental Status (BIMS) score of 3, which indicates R4's cognition is

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severely impaired.

R4's physician order dated 11/07/24 documents in part, "Behavior: Monitor for itching, picking at skin, restlessness, agitation, hitting, kicking, spitting, cursing, elopement, stealing, delusions, hallucinations, refusing care, anxiety, insomnia, depression ...Interventions: A. Redirection/Refocus B. Comfort objects ...D Remove from situation ...F. Offer choices."

R4's care plan documents in part, "Assessment reveals factors may increase his/her susceptibility to abuse/neglect ...R4 will be treated with respect, dignity and reside in the facility free of mistreatment (abuse/neglect) ...Assure R4 she is in a safe and secure environment ...Provide all interaction and care to R4 with respect, dignity and free of mistreatment."

On 11/18/24 at 1:07pm, V29 (R4 family member) stated she was informed by the facility her mom had a bruise on her leg. V29 stated R4 had a purple knot on her right thigh. V29 stated she feels someone from the facility beat her mom's leg. V29 stated she sent R4 back to the hospital two days later because R4 was still complaining of pain to her right leg.

R4's hospital report dated 11/10/24 documents in part, "Daughter reports the patient is occasionally aggressive and is concerned the nursing staff are hitting R4. R4 has a large bruise on her right thigh ...patient with history as stated above presenting to the emergency department for right thigh hematoma and concerns for elder abuse ...Diagnoses (Active) Elder abuse, hematoma."

On 11/18/24 at 12:34pm, V28 (Certified Nursing Assistant/CNA) stated R4 was very combative

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when being cleaned and sometimes it took two staff members to clean her. V28 stated one staff member would hold R4 down to prevent R4 from kicking and scratching while the other staff member would clean R4. V28 stated while cleaning and holding R4 down, R4 would tell the staff they are going to jail.

On 11/19/24 at 11:55am, V31 (CNA) stated he noticed a tennis size ball size raised purple area on R4's right thigh. V31 stated he had taken care of R4 the day before and the area on R4's right thigh was not there before.

On 11/19/24 at 12:15pm V32 (Licensed Practical Nurse/LPN) stated she was informed by V31 of a bruise to R4's thigh. V32 stated she looked at the area and noticed a raised purple area to R4's right thigh.

On 11/19/24 at 1:55pm V35 (LPN) stated he examined R4's right thigh and the area was purple and circular with some swelling. V35 stated he can't diagnose but the area reminds him of a hematoma. V35 stated R4 sometimes screams "no, no, no" when the staff area cleaning her. V35 stated most confused residents say no at the beginning when staff first start cleaning them, but they eventually stop saying no and just allow staff to clean them.

On 11/19/24 at 10:55am V4 (Wound Care Coordinator/Nurse Manager) stated, "We kind of have to brace her legs down to prevent her (R4) from kicking when we take care of her".

On 11/20/24 at 11:50am V2 (Director of Nursing/DON) stated it would be considered abuse if a staff member held a resident down. V2 stated if a resident is saying no to care, then staff

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should stop caring for the resident and document refusal.

Facility's policy dated 10/24/2022 titled, "Abuse Prevention Policy" documents in part, "This facility, Uptown Care and Rehabilitation, 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 ...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 ...assuring physical restraints are used sparingly and properly ...Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident ...The term "willful" in the definition of "abuse" means the individual must have acted deliberately, not the individual must have intended to inflict injury or harm."
Facility's undated job description titled "Certified Nursing Assistant" documents in part, "Summary: The Certified Nursing Assistant (CNA) is responsible for providing resident care and support in all activities of daily living and ensures the health, welfare and safety of all residents ...Adhere to professional standards, company

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policies and procedures, and all federal, state, and local requirements, including JCAHO standards, when applicable.
Facility's undated policy titled "Statement of Resident's Rights" documents in part, "Each resident shall have the right to be free from verbal, sexual, mental, or physical abuse: free from corporal punishment and involuntary seclusion: and free from chemical and physical restraints, except those restraints authorized in accordance with applicable federal and state laws and regulations."
(B)

Statement of Licensure Violations (2 of 3):

300.610a)
300.690c)
300.1210b)
300.1210c)
300.1210d)6)
300.1220b)3)

Section 300.610 Resident Care Policies

a) 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.

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Section 300.690 Incidents and Accidents

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

Section 300.1210 General Requirements for Nursing and Personal Care

b) 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 each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the

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following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to follow the Care Plan and failed to provide adequate supervision to one resident (R1) who was assessed as a high fall risk which resulted in multiple falls for one resident (R1) reviewed for resident injury, demonstrating inadequate care; the facility failed to notify the Regional Office of the Final investigation within 5 days after a serious injury for one (R1) resident reviewed for

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resident injury.

This failure resulted in R1 falling on 10/12/2024 and sustaining a head injury which required R1 to be sent to the hospital where R1 received 3 staples to close the laceration to R1's head and again falling on 11/05/2024 which required R1 to be sent to the hospital for evaluation and testing.

Findings include:

R1's hospital records, dated 10/12/2024, documents, in part, " ... 67-year-old male ... brought in by EMS (Emergency Medical Services) for unwitnessed fall at the facility ... The wound was irrigated copiously with normal saline or sterile water ... Staples were placed using a surgical stapler with approximation of the wound edges."

R1's hospital records, dated 11/05/2024, documents, in part, " ... 67-year-old male ... brought in by EMS (Emergency Medical Services) for unwitnessed fall at the facility."

Facility presented document listing R1's falls for the past year showing that R1 has had 6 falls within the past year. R1 had falls on 4/15/24 at 5:04AM, 6/5/24 at 12:30AM, 10/2/24 at 7:45AM, 10/8/24 at 2:00AM, 10/12/24 at 10:15AM and 11/5/24 at 7:32PM.

On 11/18/24 at 1:35pm, with V8 (Activity Aide) interpreting for R1 due to R1's primary language being Spanish, R1 stated, "I (R1) fell the day I was sent to the hospital (10/12/24) because I (R1) was trying to get up from the bed. Yes, the call light was by me. I (R1) don't need the call light. I (R1) can do for myself. I'm (R1) fine. They (staff) just need to let me be."

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R1's Face Sheet, documents, in part, that R1's diagnoses include unspecified lack of coordination; unsteadiness on feet; chronic obstructive pulmonary disease, unspecified; type 2 diabetes mellitus without complications; schizoaffective disorder, bipolar type; anxiety disorder, unspecified; bipolar disorder, unspecified; laceration without foreign body of scalp, subsequent encounter.

R1's Minimum Data Set (MDS), dated 10/16/24, documents, in part, R1's Brief Interview for Mental Status (BIMS) score is 03 which indicates R1's cognition is severely impaired. R1's Functional Status, shows R1 requires "Substantial/Maximal Assistance for Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. R1 requires Substantial/Maximal Assistance to walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space."

R1's Fall Risk Assessment, dated 10/11/24, documents, in part, a score of "55" which is the category of "High Risk for Falling" with a history of previous falls.

R1's Care Plan, date Initiated: 08/23/2019; revision on: 10/26/2024, documents, in part, "FALLS: (R1) is at risk for falls r/t (related to) weakness ... Resident is an extensive assistance of one staff member for transfer, bed mobility and toileting. Resident is supervision with set up for meals. Resident has functional incontinence of bowel and bladder. Resident ambulates with walker with slow and somewhat steady gait with staff for a short distance. Resident requires rest periods to complete task. Resident utilizes

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wheelchair as primary mode of transportation. Resident requires cueing for all tasks. Poor safety awareness present. Impulsive behavior presents with unknown cause. close monitoring needed." Care Plan interventions, documents, in part, "Move closer to nurse's station. One on One monitoring d/t impulse poor safety awareness behavior."

On 11/19/24 at 11:06am, V9 (Restorative Nurse/License Practical Nurse/LPN) said, "I (V9) am the fall nurse ... pretty much. Yes, I'm familiar with (R1). (R1) has been here for a while. First (R1) came and walked by himself (without assistance). Then he had to use a walker. Then he had to use the wheelchair. So, we're (staff) trying to get him (R1) walking using the walker and then without any assistive device. R1 is on monitoring, close monitoring, monitoring when engaging in activities. Everything is in his (R1) Care Plan. (R1's) bed is by the nurse's station for close monitoring too. (R1) mental status varies. He (R1) knows where he's at. He (R1) always knows when its Sunday and mealtime. Sometimes he knows where he's (R1) at. He (R1) knows familiar faces. That's pretty much how he's (R1) been since he's been here."

On 11/19/24 at 12:02pm, "V7 (License Practical Nurse/LPN) said, "I (V7) had (R1) a few times. I (V7) on October 12th. After passing meds, we (staff) heard a sound from (R1's) room. We ran to the room and seen (R1) on floor on right side. Noticed skin alteration on head ... R1 is a pretty confused man. We asked him, but sometimes he's hard to understand". On 11/19/24 at 2:28pm, V7 said, "One on one monitoring is when we have a CNA (certified nursing assistant) scheduled for a patient that is fully observed and attends to

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every needs of a resident ... The one on one observed is with the resident at all times ... On October 12th, (R1's) room was close to nurse's station ... I (V7) would say no, he (R1) was not receiving one on one monitoring."

On 11/19/24 at 1:04pm, V16 (License Practical Nurse/LPN) said, "He (R1) was my resident for a while. I (V16) worked October 12th when (R1) fell. I (V16) did work but I (V16) was not assigned to him (R1). I (V16) was at the nurse's station, heard a sound close to (R1's) room, ran to room, and seen (R1) on floor with bleeding from his head. We (staff) called an ambulance and sent him (R1) to the hospital. People are prone to fall. He's (R1) forgettable sometimes and forgets to pull call light."

On 1/19/24 at 2:15pm, V34 (Nurse Practitioner) said, "I'm pretty familiar with him (R1). Been taking care of him for the past 2 years. What I (V34) see in a lot of patients is steady decline. They (patients) don't understand that they're (patients) declining. During that transitional phase, they (patients) either forget or are noncompliant. I (V34) believe that (R1) is going through that right now. We (staff) have to do constant reminders and remind him (R1) to let him (R1) know that he (R1) needs assistance. He's (R1) one person assist. I (V34) wouldn't go for letting him (R1) walk by himself even with a walker. I (V34) do consider sutures serious and harmful to someone especially to the head. Falls can cause brain bleeding. Take it seriously. Any falls could cause fractures. We never know, that's why we take falls very seriously."

On 11/19/24 at 2:52pm, V6 (Registered Nurse/RN) said, "On November 6th, I (V6) was informed by CNA (certified nursing assistant) that

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he (R1) was found on floor. He's (R1) a fall risk. Sent him (R1) out to hospital. He (R1) was supposed to have a sitter, but the sitter left before the other sitter came. It (the fall) was not witnessed. One on one monitoring is when someone has to be with them to attend to their needs to maintain safety for the patient to prevent, for instance, issues like the one that transpired. I (V6) was not aware that he (R1) was not receiving his (R1) one on one monitoring. I (V6) did not know the CNA left. I (V6) knew that he (R1) had one on one. Sitter was not present."

On 11/20/24 at 11:47am, V2 (Director of Nursing/DON) said, "A resident who requires sutures is a serious injury. A resident who requires staples is a serious injury. Both should be reported to Public Health. One on one monitoring would be one person assigned to monitor that one person the whole shift. The person should be with resident at all times. There is no separate paperwork for one on one monitoring. I (V2) will have to find out if there is a policy on one on one monitoring. (R1's) did not have one on one monitoring on October 12th and November 5th due to staffing issues. We didn't have the staff for it. I (V2) believe he needs the one on one monitoring." On 11/20/24 at 12:32 pm, V2 said, "I (V2) cannot technically say that (R1's) falls would have not happened if he (R1) had a one on one. He (R1) does get out of bed without asking for help. If they (staff) were doing a one on one I (V2) don't know if they (staff) would be able to catch him. I (V2) just don't know."

On 11/20/24 at 12:17pm, V1 (Administrator) said, "One on one monitoring is generally exactly that. A staff member that is focused on that one resident. Sometimes can be a group a room and several residents." When asked about the one on

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	IL6006134	A. BUILDING: _____ B. WING _____	C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UPTOWN CARE AND REHABILITATION	4920 NORTH KENMORE CHICAGO, IL 60640

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one monitoring in R1's Care Plan, V1 replied, "So I (V1) was told. The Care Plan was not updated."

R1's progress note by V36 (Licensed Practical Nurse/LPN), dated 10/02/24 at 2:17pm, documents, in part, " Resident is back from (Hospital) after evaluation from a fall incident ... The laceration to the left with stitches; order to remove sutures in 7 days. wound nurse notified of the removal of sutures in 7 days."

R1's October 2, 2024, FRI (Facility Reported Incident) Final confirmation to the Illinois Department of Public Health, documents, in part, "Sent: Sunday, October 13, 2024 5:23 PM." This is 11 days after the serious injury incident occurred.

Facility policy titled, "Accident / Incident Reporting," revised July 1, 2024, documents, in part, "Definitions: 1. An accident or incident is an unexpected, unintended event that caused a resident bodily injury. This may include but is not limited to falls, bruises, skin tears, fractures and all situations requiring the emergency services of a physician, hospital, police or fire department, coroner, or other service providers on an emergency basis. 6. All serious incidents and incidents requiring the intervention of the police or fire department, or hospital emergency room intervention must be reported to the Illinois Department of Health within 24 hours of the incident and five day follow-up report."

Facility policy titled, "Falls and Fall Prevention," date revised November 2024, documents, in part, "1. To ensure residents admitted are assessed for potential fall risk. 2. To ensure a fall prevention program will include measures which will determine the individual need of each resident by

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assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices as indicated based on assessment. 4. 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. 13. The frequency of safety monitoring will be determined by the resident's risk factors and care plan."

Facility policy titled, "Comprehensive Resident Care Plans," revised August 2024, documents, in part, " ... Each care plan shall include measurable objectives and time tables to meet all resident needs identified in the comprehensive assessment."

Facility presented pamphlet titled, "Residents' Rights for People in Long-Term Care," revision date 11/18, documents, in part, " ... Your facility ... must care for you in a manner that promotes your quality of life ... Your facility must provide equal access to quality care regardless of diagnosis, condition, or payment source ... Your facility must provide services to keep your physical and mental health, at their highest practical levels ..."

Facility job description titled, "Director of Nursing," undated, documents, in part, " ... The primary purpose of the Director of Nursing position ... to ensure that the highest degree of quality care is maintained at all times ..."

Facility job description titled, "Registered Nurse (RN)," undated, "The RN is responsible for providing direct nursing care to the residents, ... to ensure that the highest degree of quality care is maintained at all times ..."

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S9999	Continued From page 15 Facility job description titled, "Licensed Practical Nurse (LPN)," undated, "The LPN is responsible for providing direct nursing care to the residents, ... to ensure that the highest degree of quality care is maintained at all times ..." (B) Statement of Licensure Violations (3 of 3): 300.686g) Section 300.686g) Unnecessary, Psychotropic, and Antipsychotic Medications g) Except in the case of an emergency, psychotropic medication shall not be administered without the informed consent of the resident or the resident's surrogate decision maker. (Section 2-106.1(b-3) of the Act) Additional informed consent is not required for changes in the prescription so long as those changes are described in the original written informed consent form, as required by subsection (h)(12)(A). The informed consent may provide for a medication administration program of sequentially increased doses or a combination of medications to establish the lowest effective dose that will achieve the desired therapeutic outcome, pursuant to subsection (h)(12)(A). This requirement is NOT MET as evidenced by: Based on interview and record review, the facility failed to obtain informed consent for psychotropic medication prior to administering the medication. This failure affects 1 resident (R2) in a sample of 3 residents (R2, R3, R5) reviewed for psychotropic medications.	S9999		

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Findings include:

R2's diagnoses include schizoaffective disorder bipolar, violent behavior, generalized anxiety disorder, paranoid schizophrenia.

R2's Minimum Data Set (dated 10/9/2024) documents in part a brief interview of mental status summary score of 9, indicating that R2's cognition is moderately impaired.

R2's physician order's documents in part an active order for Fluphenazine decanoate (antipsychotic medication) "inject 50 mg intramuscularly one time a day every 4 weeks on Thu (Thursday) related to SCHIZOPHRENIA ..." with a start date of 7/26/2024.

R2's medication administration records indicate that R2 received Fluphenazine Decanoate intramuscular injection on 10/24/24, 09/25/24, 08/29/24, 07/04/24, 07/8/24.

R2's psychotropic consent dated 11/30/23 indicate R2's refusal of psychotropic medication. R2 had no other consent to indicate R2 consented to psychotropic medication.

On 11/18/24 at 11:55am R2 stated that R2 refused to sign the psychotropic consent because R2 did not want to take the psychotropic medication.

On 11/18/24 at 2:23pm, V3 (Assistant Director of Nursing/ADON) stated R2 gave V3 verbal consent for the psychotropic medications but was unable to provide proof because V3 did not document the verbal consent.

On 11/20/24 at 11:50am V2 (Director of

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S9999	Continued From page 17 Nursing/DON) stated that a consent for psychotropic medication should be obtained before administration of a psychotropic medication is given. V2 stated that residents have the right to refuse medication. Facility's undated policy titled "Psychotropic Medication Consent Policy" documents in part, "Policy: 1. To ensure residents with physician orders for psychotropic medication administration have signed or given verbal consent for administration of medication ...Procedure: 1. Residents newly admitted on psychotropic medication, consent to administer will be obtained from resident and/or legal guardian. 2. Verbal consent will be acceptable with 2 witness staff. 3. Residents with medication change and/or dose change will require a new consent signed. 4. Resident signing with "X" will be acceptable if witnessed by staff." (C)	S9999		