STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006134	A. BUILDING: _____ B. WING _____	C 09/15/2023

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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S 000	Initial Comments Complaint Investigation: 2387290/IL163915	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2)6) 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 plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 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. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure resident safety by allowing a resident (R1) out on a community pass unsupervised. This failure resulted in staff not following the proper protocol procedures for residents with community pass privileges, which allowed R1, who can only go out on community pass supervised, to sign out on community pass on 8/31/23 unsupervised. R1 has not returned to the facility. Findings Include: R1's physician order sheet dated 5/2/23 denotes R1 may go out on pass supervised. On 8/31/23 R1 was allowed to sign out on community pass unsupervised but R1 is on	S9999		

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S9999	Continued From page 2 supervised community pass privileges only. On 8/31/23 staff (V5) did not check R1's community pass privileges before allowing R1 to sign out and leave the facility. R1 has a diagnosis that includes bipolar disorder and paranoid schizophrenia and has not returned to the facility. R1 was also receiving treatment for a wound to R1's left foot and did not finish her wound care and antibiotic therapy. R1's was reported missing to the police department on 8/31/23. R1's whereabouts are unknown at this time. Facility incident report, dated 8/31/23, denotes staff member (V5) was covering the front desk for the regular receptionist when receptionist went on lunch. Staff member let R1 out of the facility. R1 did not have unsupervised pass privileges. Facility immediately took discipline action against employee. Police were called. R1's daughter was notified as well. R1's 8/31/2023 19:15 Nurses Note Text states: Staff reported seeing resident (R1) walking down the street on when she (staff) was out to lunch at approximately 1:20 pm. R1 remains out at this time. DON (Director of Nursing) aware. R1's 8/22/2023 10:13 Psychiatry Progress Note states: MENTAL STATUS EXAMINATION - Appearance/Behaviors: Consistent with stated age. Chief Complaint: Review psychosis symptoms response to a current psychopharmacology. History of Present Illness: (R1) has a psychiatric history of schizoaffective-bipolar type and nicotine dependence. Declares mood is OK. Denies changes in eating or sleeping patterns. The	S9999		

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S9999	Continued From page 3 patient does not verbalize or exhibit any depression or anxious symptoms. There were no reports of psychotic or manic symptoms during this visit. Denies auditory or visual hallucination. Suicidal and homicidal ideation are both negative. Denies any paranoid thoughts. There are no reports of obsessive, intrusive, and persistent thoughts, or compulsive, ritualistic activities. Medication was well tolerated, with no reported side effects. R1's 8/24/2023 18:33 Health Status Note Text states: HISTORY OF PRESENT ILLNESS: (R1) was seen and examined today 8/24/2023 to follow up on wound culture results. Due to patient reporting toe pain and noncompliance to medication at times. To follow up on chronic medical condition management. Patient is observed to be walking around the hallway. Patient is calm and cooperative but withdrawn and not willing to engage in conversations. Calm Speech: Clear, normal volume, rate, and tone. Motor: no psychomotor agitation, no psychomotor retardation, no tics Thought Process: Linear Associations: Fair Thought Content: Denies SI, HI, AVH, no paranoid content elicited Mood: OK Attention: Fair Insight: Fair Judgment: Fair Sensorium: Alert Orientation: Self, place, time R1's 8/27/2023 15:46 Nurses Note Text reads: ... continues ABT Cipro 750mg Q 12 hours till 09/21/23 for wound to left foot. No noted distress. Resident denies any pain @ this time. T=97.6 During interview on 9/6/23 at 9:25 am V12 (Wound Doctor) R1's wound on her left foot did not look infected and was at a week away from healing. V12 stated there is a chance it could close on his own or chance that it could	S9999		

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deteriorate. V12 stated it all depends on how R1 takes care of herself.

During interview on 9/6/23 at 9:45 am V8 (Nurse Practitioner) stated R1 had a wound culture that showed a bacterium which mean she had an infection or colonization of bacteria. V8 stated V8 wanted the antibiotics to be given to R1 four weeks prophylactically preventative. V8 stated the antibiotics were prescribed to help the wound heal. V8 stated she ordered the antibiotics to be given as prescribed for four weeks which were to be started on 8/24/23.

During interview on 9/6/23 at 10:05 am V5 (Central Supply Director) stated he has been working at the facility for almost 15 years. V5 stated the last couple of years, when the main receptionist (V4) goes on break he covers the front desk. V5 stated when a resident wants to go out into the community on pass by themselves, V5 checks their pass card which is orange and has their picture on it. V5 stated when R1 came down to go out into the community R1 resembled another resident, that regularly goes out every day and V5 had R1 sign out. V5 stated while sitting at the front desk a few minutes later, another staff member (V9) reported they saw R1 outside the building. V5 stated he told V9 that it was not R1 but thought it was another resident that looked like R1. V5 stated immediately after speaking with V9, V5 was contacted by social services and the administrator. V5 stated he was told by management that V5 made a mistake letting R1 sign herself out. V5 stated the managers went outside and drove around to look for R1. V5 stated he knew he should for check for the community pass before letting a resident sign out but didn't and now has been not allowed to work at the facility. V5 stated he feels horrible and

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S9999	Continued From page 5 will be looking for employment elsewhere. State surveyor observed video on 9/7/23 at 12:15 pm in V2's office, showing R1 walk to front lobby at 1:08 pm on 8/31/23. V5 was observed sitting at front desk. R1 was seen to sign out, then leave the facility unaccompanied. During interview on 9/6/23 at 10:35 am V9 (Certified Nurse Aide) stated V9 was on lunch break driving and saw someone that looked like R1 walking down the street. V9 stated when she returned to the facility about 10 minutes later, V5 was sitting at the front desk. V9 stated V9 told V5 she might have saw someone that looked like R1 walking down the street. V9 stated the managers were informed, and they went outside looking for R1. V9 stated as of today (9/6/23) R1 has not returned to the facility. During interview on 9/6/23 at 10:55 am V10 (Social Worker) stated R1 has been in her caseload for a few months. V10 stated R1 can be lucid when having conversations. V10 stated R1 has delusions that R1 thinks R1 is a doctor or a lawyer. V10 stated R1 goes from being lucid to having delusions. V10 stated she assessed R1 for community access privilege and determined that she required supervision if she went on pass into community. V10 stated residents that require supervision into the community can go out with a staff or family member. V10 stated after residents are assessed to be able to go into the community with or without supervision, the nurses obtain a physician's order and put the order in the residents' electronic chart. V10 stated residents that can go out on pass unsupervised receive an orange card with their picture on it. V10 stated the card is supposed to be presented to the front desk staff so they know who can go out	S9999		

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unsupervised. V10 stated on the day that R1 left, the aide (V9) told them she saw R1 walking down the street. V10 stated she approached V5 and asked him what happen and V5 told V10 that V5 thought R1 was another resident that normally goes out on pass every day. V10 stated the managers immediately went outside looking for R1 in different cars. V10 stated R1 never told V10 she wanted to leave or that R1 did not want to stay in the facility. V10 stated R1 had never tried eloping or leaving before without permission.

During interview on 9/6/23 at 12:25 am V3 (Social Service Director) stated V3 has been working at the facility five months. V3 stated all residents with passes into the community are on a list that is given to the front desk. V3 stated the list includes residents with supervision and no supervision. V3 stated she updates the list every week and puts it at the front desk. V3 stated R1 has been in the facility for a few months. V3 stated R1 has some mental health diagnosis such as Schizophrenia and Bi-polar. V3 stated R1 was assessed to have a community pass with supervision only. V3 stated pass with supervision means that person is only allowed to go into the community with a family or staff. V3 stated residents that have unsupervised pass privileges are given an orange card that has their name and picture on it to show at the front desk when they want to go out into the community. V3 stated not too long after R1 left the facility a staff member witnessed R1 outside. V3 stated they then drove around the neighborhood for hours trying to locate R1. V3 stated they have a system in place that works but human error by V5 allowed R1 to elope.

During interview on 9/6/23 at 1:15 pm V14 (License Practical Nurse) stated V14 has worked

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at the facility for 17 years. V14 stated R1 was pleasant, withdrawn to herself and liked to smoke. V14 stated R1 would at times get delusional but most of the time she made sense when she talked. V14 stated the day R1 left it was lunchtime and she asked for an Ensure (supplement drink) then went downstairs. V14 stated after lunch V9 reported to her and social service that R1 was seen outside. V14 stated they started looking inside and outside for R1 but could not locate R1. V14 stated from what she remembered R1 had an order in her chart for outside pass with supervision. V14 stated if an order is in the chart or medical records, they are to follow it. V14 stated social service made the determination that R1 needed supervision if she went out on pass.

During interview on 9/6/23 at 1:35 pm V2 (Administrator) stated all the doors have alarms including the front door. V2 stated the only way out the front door is to be buzzed out or let out by the receptionist. V2 stated the only residents that go out the front door are residents with pass privileges. V2 stated the main receptionist (V4) was on break and another staff member, who is central supply (V5) normally covers for V4 when V4 goes on break. V2 stated V4 has been working at the facility over ten years and when V4 goes on lunch V5 covers the front desk which he has been doing for years. V2 stated V5 stated V5 knows to look for the orange card before a resident is allowed out of the facility. V2 stated he reviewed the building camera and it seemed that V5 did not check to see if R1 had an orange pass card. V5 allowed R1 to sign out of the facility. V2 stated they had to discipline V5 and V5 is no longer working at the facility because he did not follow the facility rules. V2 stated as soon as they realized R1 had left, staff went driving around

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looking for R1. V2 stated all pertinent people were notified including the police. V2 stated they have system in place that works and as long as staff follow the rules there are no issues. V2 stated they are replacing V5 and going to hire full time security guard that will check the residents in/out of the facility instead on receptionist.

During interview on 9/6/23 at 1:45 pm V4 (Receptionist) stated he has worked at the facility for 27 years. V4 stated they had instituted the orange pass card system several years ago. V4 stated social service has been strict to make sure staff follows the rule of residents showing their orange card before they can go outside alone. V4 stated he has been taking his lunch break for years at the same time 1-2pm. V4 stated for the last five years, V5 would cover the front desk when V4 goes to lunch. V4 stated on 8/31/23 he went to lunch at 1:00pm and returned at 2 pm. V4 stated he was told R1 left the facility. V4 said he saw a lot of staff driving and walking around looking for R1. V4 stated he got off work at 3:00pm and still saw some of the staff driving around looking for R1.

During interview on 9/6/23 at 2:10 pm V7 (Doctor) stated the staff felt from their assessment, that R1 needed supervision to go out on pass. V7 stated staff put the order in R1's electronic record. V7 stated typically if there is an order in a resident record the expectation is for staff to follow what the order says. V7 stated in the case with R1, R1 signed out on her own cognizant at the front desk and did not return. V7 stated in the medical community that it is called leaving AMA (against medical advice). V7 stated having a psyche diagnosis does not mean you cannot function. V7 stated R1 has Schizophrenia but was alert and oriented enough to still make her own

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S9999	Continued From page 9 medical decisions. During interview on 9/6/23 at 2:45 pm V11 (Psychiatrist) stated if a person is not cognitively impaired or does not have a guardian, he or she is able to make medical decisions. V11 stated residents with schizophrenia have good days and bad. V11 stated when he assessed R1, R1 was alert and oriented times three. V11 stated even though R1 had some psychiatric diagnosis, R1 was her own decision-maker from V11's perspective. V11 stated there was no justification in his mind, that R1 should have been in a locked unit in the facility or locked into the facility. V11 stated if R1 was demented or had dementia it would been a very serious thing that the facility allowed her to leave. V11 stated residents with Dementia must be, sometimes, in a secure or locked unit. V11 stated if the facility fails to keep a demented resident from leaving the facility it shows they failed to keep that resident safe. V11 stated if R1 wanted to leave AMA V11 would have to let her, and staff should have told V1 if they knew. Facility physician order policy denotes proper channels of communication are used to ensure accurate delivery of medications and treatments to all residents. Orders must be checked for completion including indication for use, or telephone order. Medication dosage, route of administration, number of days or doses, indication for use of PRN medication, date, and physician signature, time of day to be given, and any special instructions. Facility out on pass policy denotes physician order must be obtained indicating "Pass Privileges". (A)	S9999		

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