

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145828	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kenwood Vlge Nrsg and Rhb Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 4505 South Drexel Chicago, IL 60653	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>30279</p> <p>Based on interview, and record review the facility failed to ensure that one resident (R2) was free of abuse (theft). This failure affected R2 whose money and debit card were stolen with activities of withdrawal from their funds and has the potential to affect all the 100-resident residing at the facility.</p> <p>Findings include:</p> <p>On 09/10/24 at 10:46am, R2 stated that I (R2) kept my money and my card in my pillow, I (R2) count it now and then to make sure it's there. And then it was gone, I (R2) told the person in social services (referring to V13 PRSD Psychiatrist Rehabilitation Service Director) just to find out that my card was used. They (referring to the facility) gave me back my money and they called the police but I still want to know who stole my money so I (R2) can knock them out. The police did not tell me yet who did. When asked how it makes R2 feel. R2 stated awful sad and leery, It's just sad. R2 did not know who or how the money and the debit card got stolen.</p> <p>R2's medical record showed that R2's current admission was 02/05/2024 and latest admission was on 08/28/24. R2's diagnosis list includes but not limited to Myasthenia gravis without exacerbation, Type 2 diabetes mellitus without complications, Essential (primary) hypertension, restless leg syndrome and pain right foot.</p> <p>R2's MDS (Minimum Data Set) assessment tool used in assessing facility resident scored R2 BIMS as 15 indicating that R2 is not cognitively impaired.</p> <p>R3 stated that that about 3 months ago (R3)'s money was stolen. R3 stated the regular facility staff don't steal, it happened whenever they have agency staff especially on the night shift. R3 stated that I have been living here (facility) for eleven years and my money has not been stolen. They (facility) reimburse me, but I don't think it is fear, we are all sick in here and for someone with able body to come and steal from us is bad. When asked about how this occurrence makes R3 feel. R3 stated sad and not good.</p> <p>On 09/11/24, review of facility grievance/complaint form dated 08/07/24 showed documentation that on 07/21/24 R2 complained of \$100.00 missing with ATM card, and facility reimbursed R2 for it after searching and it was not found.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the same review of facility grievance/complaint form dated 08/07/24 showed documentation that on 08/04/24 R3 complained of \$40.00 missing, and facility reimbursed R3 for it after searching and it was not found.</p> <p>On 09/11/24 at 3:58pm, V1 (Administrator) stated that R3 did not say the money was stolen, it was misplaced and that is why I did not make any report to IDPH (Illinois Department of Public Health). The resident drawer at the bedside was provided with locks and residents educated on locking their money or have the facility keep their valuables.</p> <p>The facility policy titled Abuse Preventive Policy documented that this facility affirms the right of our residents to be free from abuse, that includes but not limited to misappropriation of property. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse that includes but not limited to misappropriation of funds. The facility is committed to protecting our (facility) residents from abuse that includes but not limited to misappropriation of property and mistreatment by anyone including but not limited to facility staff, other resident and staff from agencies providing services.</p> <p>The policy defines Misappropriation of resident property as the deliberate misplacement, exploitation or wrongful, or permanent use of a resident's belongings or money without the resident's consent.</p> <p>Under internal investigation documentation indicated that any incident or allegation of abuse that includes misappropriation of resident property will result in an investigation.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>30279</p> <p>Based on observation, interview, and record review the facility failed to ensure that the resident environment remain free of accident hazard and failed to ensure that treatment cart was locked when not in visual proximity of the nurse and not in use to prevent tampering and accidental hazard for one resident (R7) in the sample and the. This failure has a potential to affect R7 whose oxygen tank was stored on the bare floor in the room and inhaler was left on the bedside table visible to hallway. This as the potential to affect all the residents on the 1st and 3rd floor of the facility.</p> <p>Findings include:</p> <p>On 09/10/24 at 10:28am, on the 1st floor a treatment cart left in the hallway across from the elevator was observed unlocked and not in visual vicinity of the nurse.</p> <p>At 10:30am, this was shown to V3 ADON (Assistant Director of Nurse's) and was asked about the facility policy and protocol on medication cart/ treatment cart regarding being locked. V3 stated it should be locked when not in use and not within nurse's view.</p> <p>At 11:05am, on the 3rd floor noted from the hallway on R7's over the bed table an inhaler. R7 stated that is my inhaler. R7 stated I used that for my breathing.</p> <p>At 11:06am V9 RN (Registered Nurse) assigned to R7's medication was shown the medication. V9 and the surveyor noted the inhaler medication to be Symbicort Budesonide 160/4.5 inhaler aerosol. With no name, not in manufacturer's package, and no pharmacy label. V9 stated that there is an order for R7 to keep it at the bedside. Also noted by R7's bedside is a green oxygen tank stored on bare floor with no oxygen tank holder. V9 stated the oxygen is for R7 but it should not be stored in the room it should be taken down to the oxygen room. V9 stated they (referring to oxygen tanks) are stored in a tank holder for safety. Fire hazard.</p> <p>At 11:12am, both the surveyor and V9 checked R7's medical record medication orders and R7 did not have any order for Symbicort inhaler. V9 then stated it must be that R7 brought it from home. The surveyor asked V9 about the facility protocol/policy on resident bringing medication from home. V9 stated that any medication the resident has should be ordered by the facility physician and with an order to keep it at bed side. V9 stated rounds are made every two hours and this includes making sure the medications are not kept at bedside. V9 stated that medication ordered to be kept with the resident should be placed in their drawer.</p> <p>At 11:42am, V11 RN (Registered Nurse) assigned to the 1st floor when asked about the facility policy on medication /treatment cart. V11 stated that medication/treatment cart should be locked when not in use and within view because one can get distracted, and somebody (resident/visitor/ family) could get in the cart and take medications without the nurse knowing this.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 11:53am, V2 DON (Director of Nurse's) when the surveyor asked V2 about the facility protocol and policy on medication cart/treatment cart being left unlocked and not in nurse visual vicinity. V2 stated if they (carts) are not within the nurse eyesight they should be locked. V2 stated regarding medication being left at bedside an order is needed to keep medication at the bed side, however they brought it to my attention (referring to R3 medication being left at bedside). V2 stated that the inhaler is not from the facility. When asked how often you expect your staff to make Rounds. V2 stated that every staff should be making rounds every two hours. And when asked who is responsible for making sure medication are not left at the bedside in view of another resident/visitor. V2 stated everyone (all staff).</p> <p>On 09/16/24 at 11:20am, V2 stated that oxygen tank if not in use should be taken to the basement where the oxygen is usually stored, and the oxygen tank should be in oxygen holder. The nurse should not store oxygen tank in residents' room for safety issues.</p> <p>The facility Storage of Medication policy dated 10/25/2014 presented documented in part that medications and biologicals are stored safely, and properly. The medication supply is accessible only by licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. All medications dispensed by the pharmacy are stored in the container with pharmacy label. The nurse will check the expiration date of each medication before administering.</p> <p>Facility Medication Administration policy presented listed policy specifications that includes but not limited to drugs will be administered in accordance with orders of licensed medical practitioners of the state in which the facility operates, the cart will be locked when direct visual access is not possible, and residents will be allowed to self-administer medications only when the attending physician has written as order, and self-administered medications use and response will be monitored by licenses nurse.</p> <p>Facility Oxygen Fire Safety Precautions presented with effective date February 2014 documented in part that the policy is to assure that all personnel are aware of fire safety regulations for storage. Listed policy specifications includes but not limited to all cylinders must be stored in racks with chains, sturdy portable carts, or approved stands and never left free-standing or in any resident room or living area. All oxygen cylinders must be tagged or properly labeled to indicate the contents on the cylinders (i.e. full, half full, empty, etc.). This guideline was not followed.</p>		