

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 07/25/2025
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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to follow their policy and procedure to develop a baseline care plan that included individualized information to ensure that the resident's immediate care needs are met and maintained for 1 (R1) out of 4 residents reviewed for baseline care plans. Findings Include: R1's clinical records revealed R1 was admitted in the facility on 6/23/25 and was discharged home on 7/9/25. R1's listed diagnoses include but not limited to cerebral infarction, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, unspecified severe protein-calorie malnutrition, dysphagia pharyngoesophageal phase, and major depressive disorder. R1's Minimum Data Set, dated [DATE] shows a BIMS (Brief Interview for Mental Status) score of 14, which indicates R1 was cognitively intact, and was total dependent on staff's assistance for her activities of daily living. R1's care plan does not address at risk for skin breakdown. On 7/24/25 at 10:01 AM, V2 (Director of Nursing) stated that skin preventative measure should be individualized, and it should be part of the resident's care plan. V2 stated that it's important to address at risk for skin breakdown with interventions in the care plan to prevent skin breakdown or if they have wounds to prevent it from worsening. V2 stated that the purpose of the care plan is to guide the staff on how to take care of the resident. V2 stated the care plan should address any current problems and needs of the residents and should be completed 21 days from admission. V2 stated baseline care plan should be completed within 48 hours from admission and it's in the electronic chart of the resident. Surveyor and V2 reviewed R1's electronic chart and V2 confirmed that R1's baseline care plan was not completed. V2 stated that the baseline care plan should address if the resident is at risk for skin breakdown. V2 stated that according to R1's assessment dated [DATE], R1 was at mild risk in developing skin breakdown due to immobility. The facility's Care Plans - Preliminary dated Augusts 2006 documents in part: A preliminary plan of care to meet the resident's immediate needs shall be developed for each resident within twenty-four (24) hours if admission.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to evaluate and address a resident's continued poor appetite for adequate nutrition and hydration, failed to follow the dietary's recommendation, and failed to consistently implement interventions, monitor the effectiveness of interventions and revising them as necessary for one (R1) out of four residents reviewed for nutritional services. These failures resulted in R1 being hospitalized due to hypovolemic shock, malnutrition, and dehydration. Findings Include: R1's clinical records revealed R1 was admitted in the facility on 6/23/25 and was discharged home on 7/9/25. R1's listed diagnoses include but not limited to cerebral infarction, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, unspecified severe protein-calorie malnutrition, dysphagia pharyngoesophageal phase, and major depressive disorder. R1's Minimum Data Set, dated [DATE] shows a BIMS (Brief Interview for Mental Status) score of 14, which indicates R1 was cognitively intact, and was total dependent on staff's assistance for her activities of daily living (including eating). R1's weight record shows 88.3 pounds on 6/23/25. No other weights recorded for the entire stay of R1 in the facility. R1's physician orders reads in part: General diet (ordered on 6/24/25) and House Supplement 1 carton three times a day (ordered on 6/25/25). R1's progress notes dated 6/26/25 to 7/9/25 revealed no documentation of any follow-up notification to V20 (R1's Physician) or V10 (Registered Dietitian/RD) about R1's consuming 25% or less of her meals. R1's vitals report revealed R1's amount eaten for breakfast, lunch, and dinner (25% or less): 6/24/25: 1-25% for dinner 6/26/25: 1-25% for dinner 6/29/25: 1-25% for dinner 7/2/25: None eaten for breakfast 7/3/25: 1-25% for breakfast and lunch 7/5/25: 1-25% for breakfast and lunch 7/6/25: 1-25% for breakfast and lunch 7/7/25: 1-25% for breakfast and lunch 7/8/25: 1-25% for breakfast and lunch R1's progress notes dated 6/25/25 at 11:41 AM documented by V10 reads in part: RD new admission referral for this 78 y/o female. admitted [DATE]. DX/PMH [Diagnoses/Primary Medical History] including but not limited to cerebral infarction, COPD, T2DM, chronic respiratory failure with hypoxia, severe protein-calorie malnutrition, MDD, dysphagia, glaucoma, anxiety DO, bilateral primary osteoarthritis of knee, hypertensive heart disease without HF, rheumatoid arthritis, spinal stenosis, radiculopathy, retention of urine, GERD, pain in left hip, central retinal vein occlusion, brachial plexus DO, Vitamin D deficiency. Reviewed orders. NKA per EMR. Diet: general. Per progress notes, no teeth observed, no dentures, noted decreased vision in both eyes. Per EMR, PO intake 6/23-6/25 was variable 26-100% of meals, with 1 meal 1-25%. Weight on 6/23 was 88.3 [pounds], Ht: 64 (per hospital records), BMI 15.2-underweight. Wt [Weight] stability/gain beneficial d/t [due to] underweight status. Skin intact per wound report. Per progress notes, two healed/closed pressures ulcers on the left and right ankle. No edema noted. No GI problems. No recent labs. Estimated needs using IBW (55kg): 1650-1925kcal/day (30-35kcal/kg), 55g protein/day (1.0g protein/kg), 1650-1925mL/day (1ml/kcal). Recommend SLP [Speech Language Pathologist] referral for appropriate diet consistency d/t no teeth and house supplement/med pass 1 carton TID [three times a day] to promote wt stability/gain, Refer to RD as needed. R1's progress notes dated 7/4/25 at 5:32 PM documented by V34 (Licensed Practical Nurse) reads in part: R1 had inadequate meal intake and consumed 750cc fluids. Total assist with ADL's provided by staff and all care provided in resident room. R1's hospital records (7/11/25 to 7/14/25) documented in part: [R1] recently completed 2 week stay at [Nursing Home Facility Name] for respite care, [V33 (R1's Daughter)] is primary caregiver. On return home patient [R1] was noted by daughter [V33] to be altered with slurred speech. admitted with AMS [Altered Mental Status], hypotension and elevated lactic acid thought initially to be due to urosepsis however urine culture grew mixed flora. Therefore, shock due entirely to hypovolemia. Stroke workup negative for acute stroke. [R1] (90 pounds) received 7L [liters] of IV [Intravenous] fluids for resuscitation guided by lactic acid levels and bedside IVC ultrasound without signs of volume overload. Hypovolemic shock is determined to be from lack of PO [by mouth] intake of food and water during stay at nursing home for respite care. [R1] report she did not receive food or water during her time at nursing home. On 7/23/25 at 10:56 AM, V11 (Licensed Practical Nurse) stated she was one of the regular nurses who took care of R1 in the facility. V11 stated R1 barely talked, total dependent, and was on general diet changed to mechanical soft because R1 was pocketing her food. V11 stated R1 ate at least 50% of her meals but there were days R1 ate less. V11 stated she did not inform V20 (R1's Physician) because R1 had poor appetite since the first day R1 was admitted in the facility. V11 stated that R1 was not on calorie count, R1 was on one-on-one feeding and not on any supplements. V11 stated she provides the residents water during</p>		