

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 12/29/2025
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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</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 - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to protect one resident (R1) from physical and emotional abuse from V8 (Licensed Practical Nurse-LPN). This failure affected one resident (R1) of 3 reviewed for abuse. This failure resulted in R1 reporting she was hurt in her arms and neck. X-Ray of right and left elbows, forearm, wrist, and hand reveals mild soft tissue swelling. Findings include: R1 has a diagnosis of but not limited to Epilepsy, Cerebral Infarction, Vascular Dementia, Type 2 Diabetes Mellitus with Diabetic Nephropathy, Essential (Primary) Hypertension, Allergic Rhinitis, and Hyperlipidemia. R1 has a Brief Interview of Mental Status score of 14. R2 has a Brief Interview of Mental Status score of 15. R3 has a Brief Interview of Mental Status score of 15. On 12/27/2025 at 10:29am R1 stated the lady (V8) pushed me around and grabbed my throat. R1 stated she doesn't recall whether she (V8) had given her medicine or not. R1 stated she doesn't recall what she (R1) was doing before the incident happened but said, Yes, she (V8) hurt my neck and both my arms. Stated that she does feel safe in the building now because she has not seen that lady (V8 Licensed Practical Nurse-LPN). On 12/27/2025 at 11:22am surveyor watched video footage from 12/25/2025 before, during and after the time of abuse allegation. Video footage with a time stamp of 9:40am displays V8 (Licensed Practical Nurse-LPN) talking to R1 outside of room [ROOM NUMBER] and pushing R1's left hand away. At 9:41am video footage show V8 use her foot to put R1's legs onto the footrest and V8 use her hands to push and hold R1's hands down to her sides. At 9:42am video footage shows V8 pointing her finger in R1's face, pushing R1 back into the Geri chair (type of wheelchair) and holding R1's right hand and it appears V8 is squeezing R1's hand while talking to R1. Footage also shows V8 walking behind R1's Geri chair, grabbing the back of R1's shirt and yanking R1 back, with force, to get R1 to sit back in the chair. At 9:43am it shows V8 holding R1's hands down by her side, talking in her face as she continued to hold R1's hands and arms down to her side. On 12/27/2025 between 12:25pm and 12:52pm R2 and R3 stated they heard the nurse cursing, loudly yelling and talking on her cell phone. R2 stated she heard R1, who a little lady, say, You are hurting me, you're pushing and pinching me. R2 also said you can hear R1 telling the nurse to leave her alone. R3 stated you can hear R1 saying, Would you stop pushing me and heard her (R1) yelling. Police Report dated 12/25/2025 documents, in part, Other Offenses-Abuse at Care Facility. R1 care plan focus for abuse with a problem start date documents, in part, short term goal: resident will be free of abuse/neglect daily. R1's progress note dated 12/25/2025 at 12:08pm by V12 (Licensed Practical Nurse) documents, in part, it was alleged that assigned nurse (V8) was being rude and aggressive with R1. Assigned nurse (V8) was removed immediately and redness noted to arm bilaterally. R1's progress note dated 12/25/2025 at 12:14pm by V6 (Registered Nurse) documents, in part, R1 noted with discoloration to bilateral arms and complained of mild pain to both arms. NP (Nurse Practitioner) notified; new orders received for Tylenol 500mg, two tablets PO (by mouth) every 4 hours as needed for pain; and x-ray of bilateral arms. On 12/27/2025 at about 12:30pm surveyor reviewed V8 employee file that documents, in part, that V8 completed the review of Abuse and Neglect policy on 12/18/2025. On 12/27/2025 at about 12:35pm surveyor completed Healthcare Background Check for V8 and found V8's license had been suspended for a short time due to unpaid State taxes not being paid. No other disciplines noted. R1's progress note dated 12/26/2025 at 01:31pm by V6 X-ray tech from medical diagnostics here, STAT (Immediately) x-ray done. R1's x-ray results dated 12/27/2025 documents, in part, right and left elbow, forearm, wrist, and hand examination reveals mild soft tissue swelling. R2's Witness Statement dated 12/26/2025 documents, in part, R2 stated the nurse was seen and heard loudly talking on the phone. R2 stated she heard another resident say, You're pushing me and You're hurting me. Witness statement dated 12/25/2025 documents, in part, I (V12-LPN) observed nurse in hallway restraining R1 with physical touch being aggressive. V8 (LPN) was also seen putting her hand on the R1's face. V8 then rolled R1 down the hall by chair then grabbed R1 by the collar of her shirt. On 12/27/2025 at 3:16pm by V9 (LPN) Stated R1 was brought upstairs right before lunch at about 10:30am. V9 stated I could see that R1 was a little upset by her facial expression, but she never told me what happened or how she felt about the situation. On 12/27/2025 at 4:57pm V11 (Receptionist) stated he was able to see a bit from his office, but he heard commotion (loud yelling) in the hallway from V8. V11 stated he saw V8 putting her finger in R1's face and V8 was saying to R1 to stop. When I came out of the office V8 was taking R1 to the other end of the hallway. V11 stated he called the administrator, who is the abuse coordinator, to report the verbal abuse. V11 stated V10 (Certified Nursing</p>		