STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145828	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kenwood Vlge Nrsg and Rhb Ctr	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that four residents (R4, R6, R8 and R10) were free from abuse. This failure has affected four of seven residents reviewed for abuse.Findings include:R4 is a [AGE] year-old with diagnosis including but not limited to: Major depressive disorder, bipolar disorder, essential hypertension and hyperlipidemia.R6 is a [AGE] year-old with diagnosis including but not limited to: Unspecified dementia, repeated falls, unspecified asthma and chronic obstructive pulmonary disease.R8 is a [AGE] year-old with diagnosis including but not limited to: cognitive communication deficit, unspecified dementia, essential hypertension, muscle wasting and atrophy.R10 is an [AGE] year-old with diagnosis including but not limited to: Unspecified dementia, unspecified facture of right ilium, adult failure to thrive, unspecified atrial fibrillation and hypertensive heart disease with heart failure.Facility Incident Report form dated 11/05/25 documents the following: R4 reported to staff, R3 pushed him.R4's Care Plan documents, R4 is at risk for abuse due to psych diagnosis and verbal aggression.Facility Incident Report form dated 11/20/25 documents the following: there was an alleged altercation between R6 and R5. R5 apparently invaded R6 personal space which allegedly turned aggressive in an alleged physical altercation.R6's Care Plan documents, R6 is at risk for health, safety, and behavioral concerns. On 1/15/26 at 3:50 pm, R6 was observed in his bedroom and R6 stated that he was hit by another resident before they began to fight. Facility Incident Report form dated 1/12/26 documents, R7 showed aggression towards R8, and the alleged altercation was witnessed.Witness Statement dated 1/12/26 and written by V19 (Therapist) documents, roommate (R7) entered room, said hello then instantly punched R8.Facility Incident Report form dated 1/12/26 documents, R9 allegedly became agitated with R10 and allegedly hit R10.R10's Care Plan documents the following: R10 is at risk for abuse due to poor cognition related to diagnosis of dementia, severe with mood disturbance.On 1/20/26 at 2:20 pm, V17 (LPN/ Licensed Practical Nurse) stated the following, R9 was sent out to the hospital for hitting R10.During Interview on 1/15/26 at 10:45 am, V1 (Administrator) stated the following, No resident here deserves to be hit. We do the best we can to recognize the signs of aggression and intervene as quickly as possible to eliminate physical contact or harm, but yes there has been some physical altercations between residents here recently.Facility policy titled Resident Rights documents the following: Residents have the right to be free from verbal, sexual, physical, and mental abuse, involuntary seclusion, exploitation, and misappropriation of property by anyone.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that one non-ambulatory resident (R1) with dementia was sent to the hospital and evaluated after being found on the floor. This failure resulted in R1 being diagnosed with a clavicle fracture one day after an unwitnessed fall. Findings include:R1 is a [AGE] year-old with diagnosis including but not limited to: Unspecified dementia, history of falling, essential hypertension, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side.R1 has a BIMS (Brief Interview of Mental Status) score of 8, which indicates moderate cognitive impairment.On 1/15/26 at 3:36 pm, V2 (DON/ Director of Nursing) stated the following, R1 was discharged from the facility on 10/19/25 after complaining of pain. She (R1) was said to have a clavicle fracture that was noted at the hospital. Apparently, she (R1) had a fall the day prior (10/18/25), but the agency nurse (V4) had not reported the fall. I would expect for V4 to do an incident report after finding R1 on the floor. We take falls here seriously and it should have been investigated right then and there. I told V4 that any change of plane is considered a fall and R1 should have been properly evaluated.On 1/20/26 at 1:51 pm, V3 (Restorative Director) stated the following, If there is an unwitnessed fall, we do neurological checks and the patient is placed on post fall charting for the next 72 hours. The post fall charting will prompt the nurse to check for pain and to monitor for any complications of the fall. The CNA's (Certified Nurse Assistants) check every two hours to ensure that the fall interventions are in place and to ensure that all needs are met such as toileting. It is important to not only document but investigate all falls.On 1/20/26 at 2:25 pm, V16 (LPN/ Licensed Practical Nurse) stated the following, If there is an unwitnessed fall, we (nurses) assess the patient for injuries, notify the nurse practitioner or doctor, and monitor the patient. If the patient hits their head or had an unwitnessed fall, the doctor will give an order to send the patient out for further evaluation to make sure that there are no fractures or injuries. We also do neurological checks for 72 hours after the fall.On 1/21/26 at 10:30 am, V9 (LPN) stated the following, When I came into work at 7:00 pm on 10/18/25, I was informed by V7 (CNA) that R1 complained of pain. I went to assess R1 in the room and observed a bruise on the side of her leg. Her (R1's) roommate told me about R1's fall that had occurred on the previous night. I called the doctor and received orders to send R1 out to the hospital for further evaluation. I'm not familiar with the nurse that worked the previous night shift (10/17/25), but the morning nurse that I relieved on 10/18/25 was V8 (Agency Registered Nurse). In report, I was not made aware of any fall, special monitoring or neurological checks for R1. If a fall was reported to me, I would have known to monitor R1 for complications. If an individual has fallen and not able to verbalize and it was unwitnessed, I would expect that the patient is sent out per doctors' order to the hospital for further evaluation.On 1/21/26 at 11:11 am, V8 (Agency RN) stated the following, When I went to work on the 18th (10/18/25), I was not made aware that R1 had fallen on the previous shift. If I had known, I would have completed post fall charting for R1. During the end of my shift, a CNA (Certified Nurse Assistant) called me into the room and stated that R1 had leg pain, and I medicated her before I left. No one mentioned anything about a previous fall.On 1/22/26 at 12:20 pm, V5 (Nurse Manager) stated the following, I recall the night that R1 fell. V6 (CNA/ Certified Nurse Assistant) came to the nurses' station and stated that R1 had a fallen. I told V4 (Agency LPN) about the fall and told her to go to the room to evaluate R1. When I went into the room, I asked if V4 wanted me to call an ambulance and V4 told me that R1 was ok and did not fall. V4 said that R1 had walked to the restroom. As far as I know, she (R1) was able to stand but not able to ambulate. She needed assistance. I don't believe R1 was able to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verbalize what had occurred and I don't recall R1's roommate stating what had happened because I left the room. After V6 cleaned R1, she was placed in a geriatric chair outside of her room and placed on 1:1 observation with V6. I don't think that V4 had done an incident report that night because she stated that R1 did not fall.On 1/22/26 at 12:47 pm, V6 (CNA) stated the following, I was doing rounds at around 1:15 am and noticed that R1 was not in bed. I then saw her (R1) laying on the floor in the bathroom. I yelled and told V4 and V5 and they both came to the room. She (R1) was a fairly new resident, and I wasn't really familiar with her abilities. R1 had stated that she had walked to the bathroom. V4 came in and asked how she got on the floor. I don't recall what R1 stated but I proceeded to clean her up and got her off of the floor. I then placed her in a geriatric chair in the hallway so that she could be monitored. I did not feel comfortable putting her back in bed because she was a fall risk. I recall V4 taking R1's blood pressure, but R1 was not sent to the hospital that night. I'm not sure if the incident was reported at that time because V4 stated that R1 did not fall. We as CNAs don't document falls we only report to the nurse.Section GG- Functional Abilities documents the following: R1 requires moderate assistance with transfers; R1 uses a wheelchair.R1's Care Plan dated 9/01/25 documents, R1 is at risk for falling related to history of falls.Nursing Progress note authored by V9 (LPN) and dated 10/19/25 documents the following: Writer (V9) was informed by R1's roommate that R1 was found on the bathroom floor of their room on 10/17/25 at 1:30 am.Nursing Progress note dated 10/19/25 documents the following fall event recorded as a late entry by V4; On 10/18/25 at 1:40 am, Writer (V4) was called to room and observed R1 sitting on the bathroom floor. R1 denied falling and stated that she was trying to clean herself. V4 (Agency LPN) was unreachable during investigation. Facility Incident Report Form dated 10/19/25 documents the following: on 10/18/25, R1 sustained a fall; on 10/19/25 R1 was noted with complaints of right leg pain; on 10/19/25 R1 admitted to hospital with sepsis and fracture of right clavicle.Facility Staff Schedule dated 10/17/25 documents, V4, V5 and V6 scheduled to work 7 pm- 7 am. Facility Staff Schedule dated 10/18/25 documents, V9 scheduled to work 7 pm- 7 am.R1's Hospital documentation dated 10/19/25 documents the following: R1 admitted to hospital for fall with clavicle fracture; X-ray to right shoulder shows redemonstration of a comminuted, displaced fracture of the distal third of the clavicle. Facility policy titled, Accident and Incident Investigation Guidelines documents the following: A nurse should begin the initial investigation of the incident, as soon as possible by determining if an injury occurred, performing appropriate assessments and providing emergency care and seeking medical intervention when necessary. Facility policy titled, Falls- Clinical Protocol documents the following: the physician will identify medical conditions affecting fall risk and the risk for significant complications of falls such as, increased fracture risk with osteoporosis or increased risk of bleeding in someone taking an anticoagulant.