STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145829	A. Building B. Wing	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kensington Place Nrsg & Rehab	3405 South Michigan Avenue Chicago, IL 60616

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 - Few	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** 41356 Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse by staff for one resident (R1) and failed to protect a resident's right to be free from physical abuse by another resident for two residents (R2 and R3) reviewed for abuse in the sample of 5 residents. Findings include: 1. R1 is [AGE] years old, initially admitted in the facility on 1/15/2024, with diagnosis of schizoaffective disorder, major depressive disorder, psychosis. The facility reported incident dated 6/16/2024, docuemnts V3 (Housekeeper) went into the soiled utility room that R1 followed and went inside the same soiled utility room that V3 went into. V4 (Licensed Practical Nurse/LPN) observing that R1 followed V3, attempted to redirect R1 but the door was closed. When the door finally opened, V4 saw R1 on the floor and overheard V3 being verbally inappropriate to R1. R1's progress notes dated 6/16/2024 at 7:55 AM by V4 (LPN), docuemnts R1 sustained scratches on her left hand. Per written witness statements of the following staff: V3 (Housekeeper) documents that she went inside soiled utility room to get bucket when R1 followed her the door closed. And the space between her and R1 was close, so she put the mop and bucket between them. R1 tripped over the mop and bucket. She denies physically touching R1 and admit being verbally inappropriate with R1. V4, documents: R1 followed V3 into the utility room. The door of the utility room was locked. V4 knock hard and loud, then when the door begin to open R1 was on the floor in a sitting position and V3 was standing using profanity to R1. V4 stated to V3 that she cannot talk to a resident like that, V3 said a few more words, then walked away. R1's care plan dated 2/15/2024 by V12 (Social Worker) under dementia, R1 exhibits moderate to severe cognitive impairment. R1 displays inattention, confusion and disorientation, and periods of impaired judgment. R1's impaired judgments are potentially related to R1's psychiatric diagnosis or deficits. (continued on next page)

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/2024 at 1:49 PM, V8 (Social Service Director) stated that R1 followed V3 (Housekeeper) into the soiled utility room and used inappropriate language to R1. V8 said that V3 used words to R1 like (BXXXH) and that V4 (Licensed Practical Nurse) can elaborate more because V4 heard what V3 said. V8 stated that what V3 said to R1 was verbal abuse and that is the reason why V3 was terminated. Per facility's employee report, V3 was suspended on 6/16/2024 at 8:00 AM. It documents staff (V3) was sent home pending abuse allegation. By facility policy staff has to be sent home immediately pending an investigation. Employee report dated 6/21/2024 at 12:00 PM, documents that after pending investigation, staff (V3) was found to have abuse a resident (R1). Therefore, staff was discharged at that point, staff (V3) was notified that day. V8 then provided witness written statements that documents as follows: V4 (Licensed Practical Nurse) documents that V3 from the elevator went to soiled utility room followed by R1. She (V4) tried to redirect R1, but the door was closed and locked. When the door finally opened, R1 was sitting on the floor, V3 was standing and using profanity to R1. V4 said to V3 that she (V3) cannot talk to resident (R1) like that, V3 stated few words to R1 and then walk away. Per R1's progress notes by V4 dated 6/16/2024, R1 sustained scratches on her left hand. V3 (Housekeeper) documents that she went inside soiled utility room to get bucket when R1 followed her the door closed. And the space between her and R1 was close, so she put the mop and bucket between then. R1 tripped over the mop and bucket. She denies physically touching R1 and admit being verbally inappropriate with R1. V3 was called multiple times for an interview, left number for V3 to call but no call was received. On 7/3/2024 at 4:16 PM, V4 (LPN) stated that V3 went inside the soiled utility room and was followed by R1. The door closed and was locked and was not able to reach by V4. Per V4, she tried to bang the door multiple times. And when it finally opened, V3 was standing and R1 was sitting on the floor. V4 was using profanity words towards R1 mother XXXXXX, you BXXXX get away of my mother XXXXXX face. Per V4 she told V3 that she cannot talk to residents like that, you cannot use curse words to R1. V3 continue to use profanity words and left still cursing. Earlier on 7/3/2024 at 1:36 PM, V1 (Assistant Administrator) stated that V3 was fired because of verbal abuse to R1. Per V1 residents may have medical diagnosis to act inappropriately but staff are trained to act appropriately. And that the facility is continuing effort to train staff and provide procedure for staff to follow when facing difficult situations with residents. 2. R3 is [AGE] years old, initially admitted in the facility on 9/19/2018 with the following diagnosis schizophrenia, hallucinations, conduct disorder, bipolar disorder, and depressive disorder. R2 is [AGE] years old, initially admitted in the facility on 9/20/2018 with the following diagnosis chronic obstructive pulmonary disease (COPD), anxiety disorder. Facility reported incident dated 6/19/2024 involving R2 and R3 are as follows: Incident description by V4 (Licensed Practical Nurse) documents that on 6/19/2023 at 11:42 AM, it was reported to staff by a resident that R2 and R3 engaged in a physical altercation that occurred on 6/18/2024. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Per description of occurrence documentation, on 6/19/2024 11:42 AM, it was reported to staff by a resident alleging that R1 and R2 engaged in a physical altercation that occurred on 6/18/2024. Under occurrence resolution documentation, staff observing (R3) approach R2 while he was sitting in the dining room. (R3) became verbally inappropriate to R2 and threw water at him unprovoked. R2 got up and engaged in a physical altercation with (R3). On 7/3/2024 at 10:25 AM V1, Administrative Assistant/AA, identified the staff and resident involved in the Facility Reported Incident as follows: R4 was the resident who informed V8 (Social Service Director-SSD) about the incident between R2 and R3. V8 informed V4 (Licensed Practical Nurse-LPN). And V13 (Certified Nursing Assistant) was the staff who witnessed R2 and R3 incident. On 7/3/2024 at12:15 PM, V4 (LPN) confirmed that she wrote a report after V8 (SSD) informed her about the altercation between R2 and R3. At 12:23 PM, R4 was seen alert and able to verbalize his thoughts within topic during conversation. R4 stated that R3 threw water on the face of R2. R2 got up and hit R3. Both R2 and R3 are screaming at each other. R4 said, R3 was like pissed-off with R2. On 7/3/2024 at 12:44 PM, V5 (LPN) stated that R3 was sent to the hospital due to R3's behavior all day. On 7/3/2024 at 1:02 PM, V13 (CNA) stated that R3 walked pass her, went to R2 and threw water on his face. R2 then jumped up and hit R3. V13 stated that R2 hit the head area of R3 when R2 went to R3 and started swinging at her (R3). Aggression between R2 and R3 stopped on their own and R3 went back to her room. Per V13, the nurse when it happened was V5. V5 was informed by her (V13) that R3 threw water on the face of R2. V5 did not do any assessment and just went to the nursing room after being informed. Per V13 she called security via her cellphone. V7 (Social Worker) answered the phone instead of the security. V7 went up to the room of R3. Another nurse V14 (Licensed Practical Nurse) who was in the elevator spoke to V5 about what happened. Then both V5 and V14 gave R3 an injection to calm her down. V13 stated she cannot remember the specific date it happened, but it was Tuesday. Per R3's physician order, R3 has an order for Haloperidol 5 milligram per milliliter intramuscular injection to be given as needed every six (6) hours. On 7/3/2024 at 1:36 PM, V1 (Assistant Administrator) stated that staff should follow reporting and notification process. Per V1 the incident when R3 threw water to R2's face, and R2 a male resident hitting a female resident is considered abuse and the facility will continue to address those issues. Abuse policy dated 1/18/2024, reads: This facility affirms the right of our residents to be free from abuse. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrence of abuse of residents.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41356 Based on the interview and record review, the facility failed to report abuse in a timely manner for two residents (R2 and R3) reviewed for abuse out of the sample of 5 residents. R3 is [AGE] years old, initially admitted in the facility on 9/19/2018 with the following diagnosis schizophrenia, hallucinations, conduct disorder, bipolar disorder, and depressive disorder. R2 is [AGE] years old, initially admitted in the facility on 9/20/2018 with the following diagnosis chronic obstructive pulmonary disease (COPD), anxiety disorder. Facility reported incident dated 6/19/2024 involving R2 and R3 are as follows: Incident description by V4 (Licensed Practical Nurse) documents that on 6/19/2023 at 11:42 AM, it was reported to staff by a resident that R2 and R3 engaged in a physical altercation that occurred on 6/18/2024. Per description of occurrence documentation, on 6/19/2024 11:42 AM, it was reported to staff by a resident alleging that R3 and R2 engaged in a physical altercation that occurred on 6/18/2024. R3 was currently hospitalized for psychiatric evaluation. Actual incident happened on 6/18/2024 which was not reported until the next day 6/19/2024. Occurrence resolution documentation reviewed and documents that staff observed R3 approaching R2 while R2 was sitting in the dining room. R3 became verbally inappropriate to R2 and throw water at R2 unprovoked. R2 got up and engaged in a physical altercation with R3. On 7/3/2024 at 10:25 AM V1, Administrative Assistant/AA, identified the staff and resident involved in the Facility Reported Incident as follows: R4 was the resident who informed V8 (Social Service Director- SSD) about the incident between R2 and R3. V8 informed V4 (Licensed Practical Nurse- LPN). And V13 (Certified Nursing Assistant -CNA) was the staff who witnessed R2 and R3 incident. On 7/3/2024 at12:15 PM, V4 (LPN) confirmed that she wrote a report after V8 (SSD) informed her about the altercation between R2 and R3. At 12:23 PM, R4 was seen alert and able to verbalize his thoughts within topic during conversation. R4 stated that R3 threw water on the face of R2. R2 got up and hit R3. Both R2 and R3 are screaming at each other. R4 said, R3 was like pissed-off with R2. On 7/3/2024 at 12:44 PM, V5 (LPN) stated that it was a Certified Nursing Assistant (CNA) who informed her about the incident between R2 and R3. Per V5 she cannot remember the name of the CNA or the exact date. And that she was informed the next day after the incident between R2 and R3 happened. V5 confirmed that V13 was her CAN and that CNAs should inform the nurse every time an incident between residents happens. V5 stated that R3 was sent to the hospital due to R3's behavior all day. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/3/2024 at 1:02 PM, V13 (CNA) stated that R3 walked pass her, went to R2 and threw water on his face. R2 then jumped up and hit R3. V13 stated that R2 hit the head area of R3 when R2 went to R3 and started swinging at her (R3). Aggression between R2 and R3 stopped on their own and R3 went back to her room. Per V13, the nurse when it happened was V5. V5 was informed by her (V13) that R3 threw water on the face of R2. V5 did not do any assessment and just went to the nursing room after being informed. Per V13 she called security via her cellphone. V7 (Social Worker) answered the phone instead of the security. V7 went up to the room of R3. Another nurse V14 (Licensed Practical Nurse) who was in the elevator spoke to V5 about what happened. Then both V5 and V14 gave R3 an injection to calm her down. V13 stated she cannot remember the specific date it happened, but it was Tuesday. Per R3's physician order, R3 has an order for Haloperidol 5 milligram per milliliter intramuscular injection to be given as needed every six (6) hours. On 7/3/2024 at 1:14 PM, V8 (SSD) stated that he was informed by R4 about the incident between R2 and R3 and it was the first the time he (V8) knew about the incident. Per V8, he informed V4 (LPN) that wrote on the facility reported incident. V8 was informed that multiple staff knew about the incident including (V5 -LPN, V13-CNA who witnessed the incident, V7 Social Worker, and V14-LPN). V8 also was shown the written statement of V13 provided by V1 (AA). V8 stated, staff should let me, or the abuse coordinator know right away. I do the abuse in-service to staff multiple times. And I always tell the staff to report abuse right away. I need to do another in-service again. For me throwing water on the face of a resident is abuse. Reporting abuse that happened to us help handle the situation not to further escalate. On 7/3/2024 at 1:36 PM, V1 (AA) stated that staff should follow reporting and notification process. Per V1 the incident when R3 threw water to R2's face, and R2 a male resident hitting a female resident (R3) is considered abuse and the facility will continue to address those issues. Under Internal Reporting Requirements and Identification of Allegations, employees are required to report any incident, allegation or suspicion of potential abuse of resident they observed, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or to a compliance officer. In the absence of the administrator, reporting can be made to an individual who has been designated to act in the administrator's absence.