| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145829 | A. Building<br>B. Wing | 10/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Kensington Place Nrsg & Rehab | 3405 South Michigan Avenue<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44314<br><br>Based on interview and record review, the facility failed to protect a resident from physical abuse. This failure affected one resident (R1) of seven residents reviewed for abuse.<br><br>Findings Include:<br><br>Facility's Investigation Report (dated 09/13/2024) notes, on 09/06/2024, (R1) engaged in an altercation with (R2), staff immediately intervened and separated the residents. Body assessment conducted. (R1) was noted with a laceration. MD (Medical Doctor) aware and emergency contacts made aware. (Local Police Department) contacted, administration. (R1) stated she was sitting down at a table eating her snacks and watching television while in the 3rd floor dining room when (R2) approached her and became aggressive. She indicated no precipitating factors that led to the altercation. Residents who witnessed the incident stated (R1) was sitting at the table when (R2) suddenly engaged in an altercation with (R1) for no reason. Staff interviews indicated overhearing yelling and observed (R1) and (R2) engage in an altercation. They immediately separated both residents to different areas of the dining room. Staff questioned (R2) what triggered her behavior, however, (R2) exhibited paranoid delusions related to others' intents towards her. Body assessment conducted. (R1) was noted with a superficial skin laceration to forehead. Area was cleansed and treatment was given. (R2) was petitioned to community hospital for psychiatric evaluation where she was admitted . (R1) was sent to a community for evaluation, she returned the same day.<br><br>Facility's Abuse Policy (revised 10/2022) notes: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents.<br><br>R1's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Atherosclerotic heart disease of native coronary artery without angina pectoris, Acute respiratory failure with hypoxia, Epilepsy, unspecified, not intractable, with status epilepticus, Paranoid schizophrenia, Pure hyperglyceridemia, Dysphagia, unspecified, Bipolar disorder, unspecified, Major depressive disorder, recurrent, mild, Type 2 diabetes mellitus without complications, Gastro-esophageal reflux disease without esophagitis.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Care plan (dated 09/16/2024) documents that R1 is potentially at risk for abuse/neglect related to continued, anxious, repetitive requests as well as delusional thinking and aggressive behavior. She was recently involved in an incident in which she was not the initial aggressor. This may be related to her various psychiatric diagnosis including bipolar disorder and Schizophrenia. R2 has a diagnosis of major depressive disorder, recurrent mild.<br><br>MDS (Minimum Data Set) section C (dated 09/12/2024) documents that R1 has a BIMS (Brief Interview for Mental Status) score of 15, indicating that R1's cognition is intact.<br><br>R2's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: hypertensive heart disease without heart failure, other schizophrenia, hypothyroidism, unspecified, delusional disorders, decreased white blood cell count, unspecified, other symptoms and signs involving appearance and behavior.<br><br>Care plan (dated 09/17/2024) documents that R2 has a history of aggressive behaviors per hospital paperwork. In addition, she was recently involved in an incident with another peer; she was the initial aggressor. This is potentially secondary to history of delusional behavior and her psychiatric diagnosis. R2 has a history of aggressive behaviors per hospital paperwork.<br><br>On 10/05/2024, at 10:34 AM, V6 (Psychiatric Rehabilitation Services Director) stated, On 09/06/2024, (R1) was sitting in the 3rd floor community room eating her snacks. While (R1) was eating her snacks, (R2) approached (R1) and became verbally aggressive. (R2) hit (R1) on her head. (R1) had a superficial skin laceration on her forehead from (R2)'s attack. (R1) did not provoke (R2) in any way. There was no reason why (R2) physically attacked (R1). (R2) attacked (R1) without being provoked because (R2) was symptomatic due to her psychosis. (R2) has paranoid schizophrenia and became symptomatic immediately when (R2) admitted to the facility as a new resident. (R2) was only in the facility for about 45 minutes before she walked up to (R1) and attacked her for no reason without being provoked. Staff intervened right away and separated the residents. The nurse on duty assessed (R1) and noticed that (R1) had a laceration from the attack. The nurse on duty cleansed the area and treatment was provided to (R1)'s forehead. (R2) was petitioned and was sent to the hospital for psychiatric evaluation. (R2) was admitted as inpatient in a psychiatric unit. (R1) was sent out to the hospital for medical evaluation and returned the same day. (R2) was a new resident to the facility and within the first hour of admission, (R2) attacked (R1).<br><br>On 10/05/2024, at 10:55 AM, R1 was observed lying down in her bed. R1 was observed to be comfortable within her environment. R1 stated, On 09/23/2024, I was sitting in the dining room and eating my potatoes chips and (R2) started fighting with me and pulled my wig off. (R2) started fighting with me. I did not do anything to (R2) at all. (R2) physically attacked me and hit me for no reason. (R2) and I did not have any argument or anything. (R2) just came up to me and started hitting me. (R2) started eating my potato chips and drinking my pop. Staff broke the fight up between me and (R2). I was sent to the hospital after the fight. I did not do anything to provoke (R2). I feel safe here in the facility. Staff broke the fight up right away and I was sent to the hospital. There was no prior argument between me and (R2) before the physical altercation occurred. I am not afraid to be here. I'm not afraid of (R2).<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 10/05/2024, at 11:06 AM, R2 was observed in her room, sitting on the edge of her bed. R2 was observed to be calm and cooperative. R2 stated, I don't remember having an altercation with anybody. I don't know who (R1) is, and I don't remember attacking her. I can't recall having a physical altercation with anyone. I feel safe here.<br><br>On 10/05/2024, at 12:19 PM, V10 (Psychiatric Rehabilitation Services Coordinator) stated, On 09/06/2024, I was in the medication room which is right by the dining room. I heard the screaming coming from the dining room. I immediately ran into the dining room. I saw (R2) on top of (R1). (R1) was sitting down in the dining room and (R2) was standing over (R1) hitting and scratching (R1). (R1) was trying to defend herself, while (R2) was hitting (R1). I immediately intervened and attempted to break up the altercation. V11 (certified nursing assistant) also assisted with separating the residents. (R1) had scratches in her forehead and (R1) was bleeding from the physical altercation. (R1) was sent to the hospital for medical evaluation because of the physical altercation. (R1) said that she felt after the altercation and she was sent for evaluation. (R2) was sent out to the hospital for psychiatric evaluation. (R1) is not an aggressive resident and there was no prior incident between the two residents that provoked the altercation. (R2) was admitted to the facility for only about an hour. (R2) was new to the facility and within the first hour (R2) attacked (R1).<br><br>On 10/05/2024, at 12:41 PM, V12 (Registered Nurse) stated, On 09/06/2024, I was at the desk around 5:45 PM. (R2) came out of the room. She entered the dining room and saw (R1) sitting at the dining room table. (R2) walked up to (R1) and struck (R1), while (R1) was eating her dinner. (R2) struck (R1) twice on the face. The first time (R2) struck (R1) on her head and the second time she struck (R1) on the face. (R2) also removed the wig off (R1) and threw it on the floor. (V11, Certified Nursing Aassistant/CNA) immediately intervened and separated (R1) and (R2). (R2) was placed in her room and a certified nursing assistant stayed with (R2) to provide 1 to 1 behavior monitoring. I went to assess (R1) who remained in the dining room. I saw that (R1) had superficial scratches and (R1) was bleeding from three different sites on her forehead. I cleansed the area with normal saline and applied the pressure dressing. I checked (R1)'s vital signs and I made (R1)'s personal contact notified of the incident. (R1) and (R2)'s physician gave the order for (R1) to be sent to the hospital via 911 for medical clearance. (R1)'s physician wanted (R1) to go to the nearest hospital due to (R1) being hit in the head. The physician gave the order for (R2) to be sent to a different hospital for psychiatric evaluation via petition. (R2) was a new admission to the facility. (R2) was in the facility only for about 45 minutes before (R2) attacked (R1). (R2) was delirious and was saying things that did not make sense and she attacked (R1) without being provoked. (R2) just walked right up to (R1) and struck (R1). When the hospital gave the facility report on (R2) before she arrived at this facility, the nurse never mentioned that (R2) was capable of physical aggression without any warning and without being provoked. (R1) returned to the facility the same day.<br><br>On 10/05/2024, at 3:20 PM, V11 (CNA) stated, On 09/06/2024, I was inside a resident room doing patient care and I heard shouting. I ran out of the resident room and ran into the dining room. I separated (R1) and (R2) immediately. (R2) was punching (R1). I separated the two residents immediately. (R2) was placed in her room on 1 to 1 monitoring. (R1) was assessed by the nurse. (R1) and (R2) were both sent out to the hospital.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R1's Progress Notes (dated 09/06/2024) documents, Resident in dining room eating dinner. Peer walked up and pull resident's wig off. The resident struck another resident multiple times. Resident separated by staff was put on 1on 1 monitoring. MD notified. An order was given to send resident back to the closest hospital. Further assessment notes superficial skin laceration to front forehead. No active bleeding to the area. The area was cleansed with normal saline and covered with a dry dressing.<br><br>R1's Progress Notes (dated 09/06/2024) documents, 911 called. Resident stated she felt dizzy. Resident transferred to community hospital.<br><br>R2's Progress Note (dated 09/06/2024) documents, Resident come to dining room. Resident started to strike peer numerous of times. Peer sustained facial laceration. Resident separated by staff and escorted to room. Resident placed on 1 to 1 monitoring.<br><br>R2's Progress Note (dated 09/06/2024) documents, Resident was involved in an altercation with another resident. Resident was the aggressor. Intervention: Staff intervened and separated the residents. Social services spoke with resident to make sure she was okay and attempted to process on what triggered her reaction. Resident stated she's tired of people and she felt the resident deserved what she got. Resident maintained on 1:1 monitoring until arrival of the ambulance. Resident was sent out to the hospital. Resident Response: Resident stated she's tired of people and she felt the resident deserved what she got. Resident was delusional. Plan: Social services will continue to monitor resident behavior. |