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	11/07/2024

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 - 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** 30279 Based on observation, interviews, and record review the facility failed to protect the resident's right (R2) to be free from physical abuse by another resident (R1) out of six residents reviewed for abuse in the sample. This failure resulted in R2 sustaining a laceration to the right center of the head requiring four sutures to close the wound. Findings include: R1's medical record face sheet documented that R1 was admitted on [DATE] and latest admission was on 10/25/24. Listed diagnoses includes but not limited to type 2 diabetes mellitus with other specified complications, other schizoaffective disorders, and other symptoms and signs involving appearance and behavior. R1's MDS (Minimum Data Set) dated 08/28/24 section C scored R1's BIMS (Brief Interview for Mental Status) as 15 indicating that R1 is cognitively intact. R1 care plan for aggression documented that R1 has history of demonstrating aggressive behaviors that can exacerbate at times due to instability to R1's mental illness. R1 as a history of being physically aggressive at times. R2's face sheet showed documentation that R2 was admitted [DATE] with listed diagnoses that includes but not limited to schizoaffective disorder, psychosis, and major depression disorder, type 2 diabetes mellitus with other specified complications, headaches. R2's medical record care plan for abuse showed R2 is potentially at risk for abuse/neglect secondary to diagnosis of schizoaffective disorder, psychosis, and major depression disorder. R2's (MDS) dated [DATE] scored R2's BIMS as 13 indicating that R2 is cognitively intact. R2's medical record Progress Notes dated 10/18/24 timed 10:58pm showed documentation that R2 returned to the facility, from (local hospital) via ambulance with 4 (four) sutures on the right center of the head. R2's emergency room discharge paper dated 10/18/24 presented showed that R2 was seen and attended to for acute head injury. (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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(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 - Actual harm Residents Affected - Few	On 10/31/24 at 12:46pm, R1 noted in the room sitting on the bed with a liquid filled plastic coffee cup, R1 was unable to recollect what happened on 10/18/24. R1 was just talking about something irrelevant to a question that was asked. On 10/31/24 at 12:48pm, R2 was observed in bed, R2 stated that I did not do anything to (R1). (R1) came to the bathroom and hit me in my head with a shoe and a cup. (R1) wanted to kill me. I was in pain. Blood everywhere. I have been living in this place for 3 years and (R1) wanted to take me out. R1's facility witness statement dated 10/18/24 timed 1:05pm documented in part that R1 stated that R2 was disrespectful and opening things that don't belong to R2, bothering R1, throwing cup of water at R1, and expressing delusional thinking of R2 doing things to her hair and putting things in her scalp. On 10/31/24 at 12:50pm, V6, Licensed Practical Nurse/LPN, stated that I was in the nursing station charting and I heard a loud yelling noise coming from the common bathroom on the 3rd floor. I got up to see (R2) standing by the sink brushing (R2)'s teeth because (R2) had toothpaste on the mouth and holding the hand over the head with blood. There was a plastic coffee cup on the floor in the bathroom. I had (R1) go to the room and (R2) was brought to the nurse's station with (R2)'s head leaking (bleeding) blood with a small laceration noted on top of (R2)'s head. When asked whether V6 heard or saw both resident arguing, V6 stated I was busy with my (assigned) residents. I did not see or hear any verbal arguments. When asked about how often rounds are made, V6 stated that we are supposed to make rounds every two hours. I have my own residents. V6 stated the assigned nurse (referring to V5, LPN) was not on the floor at the time of incident. V6 stated V5 was on lunch break. On 10/31/24 at 2:57pm, V12 ADON (Assistant Director of Nurse's) stated that the incident between R1 and R2 on 10/18/24 is considered as abuse. On 11/06/24 at 2:30pm, V13 (Physician) stated that it is an occurrence in many places with this type of population to act out, start fights. They are psyche patients but don't get me wrong they (residents) need to be monitored and separated from each other. V13 stated, I don't want any laceration, and (R1) hitting (R2) in the head can cause a bleeding into the brain and the patient (resident) die. The facility Abuse policy presented with revised date of 1/18/2024 documented that the facility affirms the right of the residents to be free from abuse. The purpose of the policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, and mistreatment 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** 30279 Based on interview and record review the facility failed to immediately report an allegation of verbal abuse for one resident (R5) out of six residents reviewed for abuse in the sample. Findings include: R5's medical record Face Sheet documented that R5 was admitted on [DATE] with diagnoses list that includes but not limited to Meningitis due to other specified causes, other unspecified anemias, other seizures, abnormality of gait and mobility, muscle wasting, and atrophy not elsewhere classified, other lack of coordination and need assistance with personal care and cognitive communication deficit. R5's medical record Progress notes dated 10/30/24 timed 2:10pm showed that R5 was discharged AMA (Against Medical Advice) with family from the facility. On 10/29/24 at 12:38pm, V3 LPN (Licensed Practical Nurse) stated that she is familiar with R5 and that she is the assigned nurse for R5's care. V3 stated that R5 is ambulatory with assist. V3 stated that R5 was on contact isolation previously and just finished antibiotics, R5 has intermittent confusion, and requires constant redirection. V3 stated that R5 is at risk for fall and most of the time tries to ambulate without assistance. The surveyor asked V3 whether they have been rough, hit, or cursed at R5 at any time? V3 stated I am very stern and (R5) may have taken it offensively thinking that is harsh or rude. Therefore, (R5) refused the medications, so I had to ask my peer (referring to V4, Registered Nurse/RN) to give (R5) medicine and care directly for (R5). (R5) may think that is harsh. The surveyor asked what V3 meant by being stern, V3 stated, very strict and direct that is the way I talk, I never cursed, or pushed (R5). When asked whether V1 (Administrator) and V2 DON (Director of Nurses) was aware that you are not able to care for R5 needs and how long it had been going on, V3 stated it started since day two of (R5)'s admission (referring to 10/20/24) and V2 is aware. R5 was admitted [DATE]. When asked whether this can be an abuse situation, V3 stated abuse is abuse and walked away. On 10/29/24 at 12:40pm, V4 (RN) stated I give (R5) daily medication in the morning shift. Because (R5) complained to me about (V3)'s treatment of (R5). V4 stated that to avoid the confusion, I just took over giving (R5) medication, needs, and concerns. The surveyor asked V4 what she meant by confusion, V4 stated that (R5) complained about (V3)'s tone of voice. Being harsh. V4 stated I think (V3) talks like that but (R5) is complaining about it. The surveyor then asked whether this was reported and V4 stated that she did not report it to either V1 or V2. V4 stated that she did not report it. The surveyor then asked V4 whether in her own professional opinion talking to residents in a harsh manner would be considered a form of abuse. V4 stated Yes, and it can be emotional too. V4 stated I should you have reported it. When V1 and V2 were made aware of this allegation. V1 and V2 said they are not aware of this allegation and stated that V4 should have reported it immediately. (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 10/29/24 at 2:11pm, V2 stated she was not aware of the alleged abuse and that the expectation from the nurses regarding any form of abuse is that V2 expected the nurses to advocate for the patients (Residents). Treat them (referring to residents) with respect. When the surveyor asks about the facility protocol/policy regarding reporting of any allegation of abuse and whether in this situation the staff (V4) should have made her aware. V2 stated that yes, (V3 and V4) should have made me aware. The facility Abuse policy presented with reviewed date 1/18/24 documented under internal reporting requirements and identification of allegations that employees are required to report any incident that includes but not limited to allegation or suspicion of potential abuse to an immediate supervisor who must then immediately report it to the administrator. Under internal investigation the policy documented that any incident or allegation involving abuse will result in investigation. Under external reporting the policy stated in part that when allegation of abuse has been made the administrator or the designees hall notify the Department of Public Health.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30279 Based on interview and record review the facility failed to meet professional standard of medication administration and failed to follow their facility policy on medication administration for one resident (R5) in the sample. This failure affected R5 whose medication was prepared by one nurse but administered by a different nurse putting R5 at risk for medication error. Findings include: On 10/29/24 at 12:38pm, during an interview with V3 LPN (Licensed Practical Nurse), V3 stated that she has not been administering R5's medication since the 2nd day of admission that instead it is V4 (RN) who has been the nurse that has been administering R5's medication. R5's medical record Face Sheet documented that R5 was admitted on [DATE] R5's MAR (Medication Administration Record) dated 10/01/24 to 10/31/24 showed documentation that V3 has been signing out the administration of R5's medication. On 10/31/24 at 12:17pm, when this discrepancy was shown to V2 DON (Director of Nurses), V2 stated both V3 and V4 prepared the medication ordered for R5. It was V4 who gave (administered) the medications to R5, but it was V3 who signed out the medication in the MAR (Medication Administration Record). When asked about the professional standard of medication administration, V2 stated that the nurse that prepared and administered the medication should be the one to sign the MAR. V2 stated that V4 should be nurse who signed the MAR. On 10/31/24 at 1:05pm, V4 stated that she did not sign out the medication for R5, that she watched V3 put the medication in the cup, but she (V4) was the one that gave it. When asked about the professional standard in medication administration and facility policy, V4 stated that she should have been the one who signed it out and prepared them (referring to the medications). The facility policy on Medication Administration with updated date of March 2022 documented that the policy is to authorize licensed nursing personnel RN (Registered Nurse) and LPN (Licensed Practical Nurse). Policy specifications listed includes but not limited to the same licensed nurse who prepares the medications shall also administer those medications to resident for whom they were ordered. Medication shall be recorded on MAR promptly after each administration by individual who administer the drug. This guideline was not followed.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 30279 Based on observation, interview, and record review the facility failed to ensure that medication was locked up safely in the treatment cart when not in use and when not in proximity of the nurse, to prevent tampering and accidental hazard. This failure has the potential to affect all the residents residing on the 1st and 2nd floor of the facility. Findings include: On 10/29/24 at 12:46pm, the 2nd floor treatment cart was observed in the hallway unlocked and unattended to. When this was shown to V4 RN (Registered Nurse) and V4 was asked about the facility policy on medication storage. V4 stated that the cart should be locked. V4 stated we have a treatment nurse who should have locked the cart because I did not see that it was not locked. On 10/29/24 at 12:56pm the 1st floor treatment cart was noted in the hallway with no nurse present and unlocked. At 1:00pm, the surveyor showed that observation to V15 (RN). V15 stated that they (referring to Treatment Nurse) don't normally locked the treatment cart on this floor just in case she (V15) needs to use it. The surveyor then asked what the professional standard of medication storage and cart storage is. V15 stated that it should be locked when not in use. V15 stated that she did not pay any attention to it. V15 stated that the facility policy is that it should be locked when not in use. On 10/29/24 at 2:11pm this observation was brought to V2's (DON) attention and V2 was asked what the facility policy on medication storage and cart storage was. V2 stated that the medication cart should always be locked when not in use and not in visible sight of the nurse. The facility policy on storage of Medications presented with effective date 10/25/24 documented that medications and biologicals are stored safely, securely, and properly. The medication supply is accessible only by the licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30279 Based on interview and record review, the facility failed to schedule sufficient staff to meet the behavioral needs of one resident (R1) out of out of six residents reviewed for sufficient staffing in the sample of six. Findings include: R1's medical record face sheet documented that R1 was admitted on [DATE] and latest admission was on 10/25/24. Listed diagnoses includes but not limited to type 2 diabetes mellitus with other specified complications, other schizoaffective disorders, and other symptoms and signs involving appearance and behavior. R1's MDS (Minimum Data Set) dated 08/28/24 section C scored R1's BIMS (Brief Interview for Mental Status) as 15 indicating that R1 has no cognitive deficit. R1 care plan for aggression documented that R1 has history of demonstrating aggressive behaviors that can exacerbated at times due to instability to R1's mental illness. R1 as a history of being physically aggressive at times. R2's face sheet showed documentation that R2 was admitted [DATE] with listed diagnoses that includes but not limited to schizoaffective disorder, psychosis, and major depression disorder, type2 diabetes mellitus with other specified complications, headaches. R2's medical record care plan for abuse showed R2 is potentially at risk for abuse/neglect secondary to diagnosis of schizoaffective disorder, psychosis, and major depression disorder. According to the facility FRI (Facility Reported Incident) of 10/18/24. R1 hit R2 in the head with a plastic coffee cup while R2 was in the bathroom. As a result, R2 sustained a laceration to the top of the head and was sent to the hospital where R2 received four sutures to the head laceration. R1 was also sent to the local hospital for psyche-evaluation. The facility investigation showed documentation that none of the staff scheduled on the 3rd floor on 10/18/24 witnessed or knew what happened happened between R1 and R2. The assigned licensed nurse for both residents was not on the floor at the time of incident. The was only a CNA in the dining area monitoring other residents. On 10/31/24, review of 10/18/24 daily staffing schedule on 10/18/24 showed there were two nurses and one CNA (Certified Nurses Aide) scheduled to work. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/31/24 at 12:50pm, V6 (Licensed Practical Nurse/LPN) stated that I was in the nursing station charting and I heard a loud yelling noise coming from the common bathroom on the 3rd floor. I got up to see R2 standing by the sink brushing her teeth because she had toothpaste on the mouth and holding her hand over the head with blood. There was a plastic coffee cup on the floor in the bathroom. I had (R1) go to the room and (R2) was brought to the nurse's station with R2's head leaking (bleeding) blood with a small laceration noted on top of (R2)'s head. I was the only nurse on the floor because the other nurse (referring to V5/LPN) was on break and the only CNA on the floor was in the dining area monitoring the residents. When asked how often (V6) makes rounds and she saw both residents going into the bathroom together arguing, V6 stated I was busy with my (assigned) residents. I did not see or hear any verbal arguments. V6 stated that we (referring to staff) are supposed to make rounds every two hours. V6 restated that she has her own residents. On 11/04/24 the facility daily schedule staffing assignment presented dated 10/18/24 showed that two nurse's and one CNA were scheduled to work on the 3rd floor. On 11/04/24 at 1:57pm, V9 CNA (Certified Nurses Aide) stated that on 10/18/24, I (V9) was up there (3rd floor). I was in the day room with the residents. I was the only CNA working that day, normally we have two CNAs. On 11/04/24 at 2:09pm, when the surveyor asked about the staffing on the 3rd floor on and how many CNAs and how many nurses are normally scheduled on the 3rd floor, V2 DON (Director of Nurses) stated that usually two nurses and two CNAs are scheduled on every shift. The surveyor asked how many staff were scheduled on 10/18/24, the day of the incident. V2 stated looking at the schedule two nurses and one CNA. When asked whether that is appropriate staffing in meeting the residents' needs, V2 stated No. When asked about the facility plan for staffing incase the facility is short of staff, V2 stated some of the staff volunteer to work overtime or some are called to work overtime and at times some departmental heads who are nurses/supervisors are used to work on the floor. V2 could not explain or give any answer as to why this wasn't done and documented on 10/18/24. On 11/4/24 at 2:56pm V12 ADON (Assistant Director of Nurses) stated that the staffing for the 3rd floor normally is to have two nurses and two CNAs. On 11/06/24 at 2:30pm, V13 (Physician) stated that it is an occurrence in many places with this type of population to act out start fights, they are psyche patients but don't get me wrong they (residents) need to be monitored and separated from each other. V13 stated I don't want any laceration, and R1 hitting R2 in the head can cause bleeding into the brain and the patient (resident) die. V13 stated this can become very serious. The facility Staffing Guidelines policy presented with revised date 7/17 documented that the primary purpose of this plan is to support the provision of safe patient care and adequate nursing staff.