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	12/28/2024

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 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. 43351 Based on interview and record review, the facility failed to follow their own policy in reporting incident and accident. This failure affected 1 (R1) resident reviewed for reporting of incident and accident in the total sample of 3 residents. Finding include: R1 ' s (11/04/2024) Initial and Final reportable documented, in part Description of Occurrence. Res(ident) sent to Hosp(ital) ER (emergency room) for 3-4 inche(es) laceration to inner R(right) leg. Occurrence Resolution. Res(ident) received 10 stiches to inner R leg; to be removed in 10 days. On 12/27/2024, at 1:33 PM, V8 (Nurse Supervisor) stated I work 3:00 PM-11:00 PM shift. I stayed over that night. (V4-Licensed Practice Nurse) came and asked me if I could go upstairs to assess (R1) due to an open area on his right leg. When I assessed him, there was a long and deep laceration on his leg; it was like he got cut on something. In my opinion, he (R1) needed stitches. On 12/27/2024 at 1:43 PM, this surveyor read to V8, R1's (11/04/2024) Initial and Final reports' Description of the Occurrence and the Occurrence Resolution. V8 stated it is a complete initial and final reports. I did not interview anyone. Nobody else knew what happened. I asked him (R1) 3 times and he said he did not know. If I am not mistaken we did ask the roommate. He (the roommate) said he did not know. I did not want to be smart*** because I was not the nurse on duty at that time. I followed the protocol. I was asked to give my opinion and I gave my opinion. I would think the nurse would do the incident report. On 12/27/2024 at 12:55 PM, V2 (Director of Nursing/DON) stated it is a self-reported incident by the resident. If it happened during my shift, I (V2) or (V7 - Assistant DON) would do the initial report. If (V8 -Nurse Supervisor) is here she would do the reportable. The initial report should include what occurred and a summary of what happened, and that's it. On 12/27/2024 at 12:59 PM, V2 stated the final report should include what occurred and what is the ending result; when he was sent to the hospital what was the findings and the plan of care upon his return. That's it. (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

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	12/28/2024

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Kensington Place Nrsg & Rehab	3405 South Michigan Avenue Chicago, IL 60616

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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 12/27/2024 at 1:02 PM, V2 stated I have spoken with resident myself and he (R1) told me that he cut his inner leg on the wheelchair; he was sitting on his bed and attempted to prop his leg on the wheelchair. I had maintenance check the wheelchair. He could not find any sharp parts on the wheelchair so we gave him a new wheelchair. This information was not included in the final report. I don't know, maybe it should be included. The IDT (Inter Departmental Team) referral was we gave him (R1) a new wheelchair. This information was also not included in the final report. His (R1) reportable should not be done at one time. I just have to teach (V8). She has done reportables a lot of times. She (V8) was not understanding it right. I think she thought the initial and final reports should be submitted within 2 hours. On 12/27/2024 at 3:13 PM, this surveyor handed V3 (Assistant Administrator) R1's 11/04/2024 reportable sent to the State Agency for review and stated (V8) did the initial and final reports together. There is only one set of paper. The description of occurrence says the resident was sent to hospital ER (emergency room) for 3-4-inch laceration to inner right leg and the cccurrence resolution says the resident received 10 stiches to inner right leg and the stitches are to be removed in 10 days. It did not show how it happened and where it happened. It stated nothing about the wheelchair. It is not written that we provided him (R1) with a new wheelchair. It did not even say that the old wheelchair was switched out with a new one. She did not write the reports completely. She should have not included the final report with the initial report yet. She (V8) did not write that it happened while the resident was transferring to the wheelchair. Even though (V8) did not write it in the initial, it could have been written on the final report. The initial and final reports did not include the intervention that we removed the wheelchair and changed with a new one. On 12/27/2024 at 3:38 PM, V3 stated his (R1) reportable needs to mention that staff were interviewed, and the roommate was interviewed, where it happened and how it happened; and the plan that we removed the old wheelchair and replaced it with another wheelchair. On 12/27/2024 at 3:43PM, V3 (Assistant Administrator) stated in summary (R1)'s initial and final reports were not completed appropriately. There should be 2 separate reports: initial and final reports. R1's facesheet documented that R1's Diagnoses: (include but not limited to) chronic obstructive pulmonary disease, schizophrenia, atherosclerotic heart disease of native coronary artery without angina pectoris, Type 2 diabetes mellitus, Restlessness and agitation, Neuralgia and neuritis, Hypertensive heart disease with heart failure, Cellulitis of unspecified part of limb. R1's (10/08/2024) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 14. Indicating R1's mental status as cognitively intact. The (10/11/2019) RN Supervisor job Description documented, in part SUMMARY: The primary purpose of this position is to supervise the day-to-day nursing activities of the facility during your tour of duty. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing, to ensure that the highest degree of quality care is maintained at all times. ESSENTIAL DUTIES AND RESPONSIBILITIES: Complete accident/incident reports as necessary. Perform administrative duties such as completing reports as necessary. (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	The (undated) Accident/Incident Process and Reporting Policy and Procedure documented, in part Policy: Policy of this facility is that each incident involving a resident shall be documented. All incidents are treated in the same manner. Incidents Accidents will be investigated for state and federal regulations. Incidents are identified as any event or occurrence out of the ordinary, including such events, but not limited to, the following: any injury. 1.c. The nurse will complete all sections of the form, including. Incident date, time, location; Description of the incident; witnesses to the incident; Description of any injury and treatment provided, Interdisciplinary team recommendations. The supervisor and nurse will initiate the investigation process and begin interviewing witnesses. The resident will be the first individual interviewed where feasible.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43351 Based on interview and record review, the facility failed to ensure an incident was investigated thoroughly. This failure affected 1 (R1) resident reviewed for incident and accident investigation in the total sample of 3 residents. Findings include: The (12/27/2024) email correspondence with V2 (Director of Nursing) and V3 (Assistant Administrator) documented, in part Kindly provide scanned copy of the investigation packet for (R1)'s incident on 11/04/2024. R1's (11/04/2024) investigation packet only include R1's witness statement taken by V10 (Wound Care Nurse). The (11/03/2024) 3:00 PM to 11:00 PM, shift daily assignment sheet documented that V9 (Certified Nursing Assistant) was assigned to R1. The (11/03/2024) 11:00 PM to 7:00 AM, shift daily assignment sheet documented that V4 (Licensed Practice Nurse) and V11 (Certified Nursing Assistant) were assigned to R1. On 12/28/2024 at 12:47 PM, V9 (Certified Nursing Assistant) stated no one interviewed me and no one told me to write a witness statement regarding his (R1) incident on 11/04/2024. On 12/28/2024 at 1:17 PM, V11 (Certified Nursing Assistant) stated I remember that night. His (R1) roommate (R2) came out to the nurses station and told us he (R1) needed to see us. When we got to his room, he did not want anything. He just wanted to see the nurse (V4 - LPN). (R2) came back and said (R1) needed assistance. We (V4 and V11) went back and there was blood everywhere. We were asking him (R1), but he was incoherent, we could not make out what he was saying. We checked him and we noticed a [NAME] of blood coming from above his right ankle. The nurse got all the material to put pressure on his leg. She called the ambulance. First, we could not understand what he was saying, then he said he hit his leg on the wheelchair. The roommate was asked and he said he did not know. (R1) was sent out to the hospital. After the shift, I went home. I did not see the big bosses or the administration. Nobody called me and informed me I have to write a witness statement. I would have written a witness statement if I were told. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/27/2024 at 12:32 PM, V4 (Licensed Practice Nurse) stated first I made rounds at around 11:00 PM. He (R1) was in bed. I don't know to be exact, his roommate (R2) came to the nurse's station and stated (R1) wanted you. I got up, went to the room, and asked him. He said nothing. I came out of the room. About 15-20 minutes, (R2) came back to the nurses station and said (R1) is bleeding. I went back to the room and there was blood everywhere, on his bed and on his sheet. I checked him and saw a laceration on his leg. I had to stop the bleeding. As I am working on his bleeding, I asked him and his roommate what happened? His roommate shrugged his shoulder up and he (R1) did not say anything. I got the nurse supervisor (V8-Nurse Supervisor) I told her I wanted her opinion. We both looked and she (V8) said yeah, he's going to need sutures. I called the doctor and the ambulance, and we got him out. (R1) was pointing around the room, to the wall and to his wheelchair. The supervisor talked to me. I told her exactly what I told you. I don't recall if she (V8) asked me to write a witness. I did not interview anyone or ask anyone to write a witness statement. On 12/27/2024 at 1:33 PM, V8 (Nurse Supervisor) stated I work 3:00 PM-11:00 PM shift. I stayed over that night. (V4) came and asked me if I could go upstairs to assess (R1) due to open area on his right leg. When I assessed him, there was long and deep laceration on his leg it was like he got cut on something. In my opinion, he (R1) needed stitches. On 12/27/2024 at 1:43 PM, V8 stated no, I did not interview anyone. Nobody else knew what happened. I asked (R1) 3 times and he said he did not know. If I am not mistaken we did ask the roommate. The roommate said he did not know. I did not write it in the witness statement form. I did not want to be smart*** because I was not the nurse on duty at that time. I followed the protocol. I was asked to give my opinion and I gave my opinion. I would think the nurse would do the incident report, and I do the charting. I, the CNA (V11), and the nurse (V4) went inside his room. I have no clue if any witness statements were written. On 12/27/2024 at 3:29 PM, this surveyor handed to V3 (Assistant Administrator) R1's (11/04/2024) incident investigation packet. V3 stated there were no witness statement other than R1's statement taken by (V10 - Wound Care Nurse). There's no statement from the roommate (R2) and the 2 CNAs (V9 and V11) who were assigned to him (R1) on 11/3/2024, evening and night shifts. The investigation packet should have the roommate's statement and the 2 CNAs statements. This is nothing new. We do this every day. I don't know why she (V8) dropped the ball on this one. R1's facesheet documented that R1's Diagnoses: (include but not limited to) chronic obstructive pulmonary disease, schizophrenia, atherosclerotic heart disease of native coronary artery without angina pectoris, Type 2 diabetes mellitus, restlessness and agitation, Nneuralgia and neuritis, hypertensive heart disease with heart failure, cellulitis of unspecified part of limb. R1's (10/08/2024) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 14. Indicating R1's mental status as cognitively intact. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The (10/11/2019) RN Supervisor job Description documented, in part SUMMARY: The primary purpose of this position is to supervise the day-to-day nursing activities of the facility during your tour of duty. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, and as may be required by the Director of Nursing, to ensure that the highest degree of quality care is maintained at all times. ESSENTIAL DUTIES AND RESPONSIBILITIES: Complete accident/incident reports as necessary. Perform administrative duties such as completing reports as necessary. The (undated) Accident/Incident Process and Reporting Policy and Procedure documented, in part Policy: Policy of this facility is that each incident involving a resident shall be documented. All incidents are treated in the same manner. Incidents Accidents will be investigated for state and federal regulations. Incidents are identified as any event or occurrence out of the ordinary, including such events, but not limited to, the following: any injury. 1.c. The nurse will complete all sections of the form, including. Incident date, time, location; Description of the incident; witnesses to the incident; Description of any injury and treatment provided, Interdisciplinary team recommendations. The supervisor and nurse will initiate the investigation process and begin interviewing witnesses. The resident will be the first individual interviewed where feasible. J. Tips for interviewing witnesses and staff: Interview as soon as possible after the incident. The (10/2020) Investigation Process documented, in part Purpose: The investigation Process is utilized following any event resulting in an actual or potential injury to a resident. The investigation process assists the interdisciplinary team to develop plans or programs to prevent further incident. Procedure: 1. Determine if anyone witnessed the incident and can explain what occurred. 2. Assist the witness to write and sign the statement. 3. Interview the resident depending on cognition and memory. 4. Note resident comments in the investigation document. 7. Interview staff and residents.