

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145829	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2025
NAME OF PROVIDER OR SUPPLIER Kensington Place Nrsg & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility failed to protect a resident from physical abuse. This failure affected one resident (R9) of 10 residents reviewed for abuse. This failure resulted in R10 hitting R9 on the face in the dining room, resulting in R9 sustaining superficial scratches to R9's face. Findings Include: R9's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Cerebrovascular disease, type 2 diabetes mellitus without complications, idiopathic peripheral autonomic neuropathy, chronic obstructive pulmonary disease, unspecified, hyperlipidemia, hypertensive heart disease without heart failure, gastro-esophageal reflux disease without esophagitis, history of falling, benign prostatic hyperplasia without lower urinary tract symptoms. Minimum Data Set Section (MDS) section C (dated Sep. 10, 2025) documents that R9 has an Interview for Mental Status (BIMS) score of 12, indicating that R9's cognition is intact. Care plan (dated 07/02/2025) documents that R9 is potentially at risk for abuse/neglect secondary to moderate physical deficits and soft-spoken communication. Recently, he was involved in an incident where he was not the aggressor. R9 is alert and able to verbalize needs. R10's Face Sheet documents resident is a [AGE] year-old with diagnoses including but not limited to: Parkinson's disease without dyskinesia, without mention of fluctuations, schizoaffective disorders, chronic obstructive pulmonary disease, unspecified, bipolar disorder, Hypertensive heart disease with heart failure. Minimum Data Set Section (MDS) section C (dated 10/22/2025) documents that R10 has an Interview for Mental Status (BIMS) score of 13, indicating that R10's cognition is intact. Facility Final Incident Investigation Report (dated 07/08/2025) documents in part: On 07/02/2025 at approximately 3:20PM, R10 was observed to strike R9 while in the basement dining area. Staff intervened and immediately separated the residents. Body assessments conducted for R9 and R10. R10 reported no pain and injury. R9 denied pain but was observed with 2 superficial scratches on face. Emergency contacts for R9 and R10 notified. R9 alleged R10 got out of his wheelchair and became aggressive towards him. R9 alleged he was stationary in the basement dining area when R10 came towards him, stood up from the wheelchair and came at him. R9 denied any precipitating factors. Residents who witnessed the incident indicated that R10 became aggressive towards R9. A resident alleged observing R10 trying to get past in between R9 and another peer who were sitting at the table in the basement dining area. R10 stood up and became aggressive towards R9. Abuse Prevention Policy (revised 10/2022) states in part: 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. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish to a resident. Resident Rights Policy (revised 11/2018) states in part: Your rights to safety- You must not be abused, neglected, or exploited by anyone- financially, physically, verbally, mentally or sexually. On 09/30/2025, surveyor was conducting a facility reported incident related to resident-to-resident abuse, that occurred on 07/02/2025. On 9/30/25 at 2:42 PM, R9 observed sitting in his motorized wheelchair in his room. Surveyor conducted an interview with R9. R9 stated, R10 hit me because R10 was trying to get by. R10 and I were in the cafeteria. I was in my wheelchair. R10 was in his wheelchair. It was not enough space for R10 to get by. R10 put his hand on my chair. I went to move R10's hand. R10 stood up and struck me in the face. I was not injured and R10 was not injured. I did not go to the hospital. R10 went to the hospital for psychiatric evaluation. I feel safe in the facility. On 9/30/25 at 2:34 PM, surveyor conducted an interview with resident, R10. R10 stated, I ain't been fighting with nobody. Ain't nobody hit me. I ain't hit nobody. I stay in my room watching television. I feel safe in the facility. On 12/10/2025 at 10:55AM, V1 (administrator) stated, On 07/02/2025, it was reported that at 3:20PM, R10 was observed hitting R9 in the face, in the dining room. Staff intervened immediately and separated R10 from R9. The nurses completed body assessment on both residents. R10 had no pain or injury. R9 had a superficial scratch on his face. Both R9 and R10's physicians and emergency contacts were made aware of the incident. The police were called, and a report was filed. R10 was petitioned and sent out to the hospital for psychiatric evaluation. R9 was provided first aide for the scratch on his face. The issue started because both residents are in wheelchairs. R10 was trying to get by and could not, and that's how the incident started. R10 became frustrated because he could not get by and struck R9 in the face. R9 and</p>		