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	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 45346 Based on observation, interviews and record review, the facility failed to maintain confidentiality of personal and medical information for two residents (R225 and R69) out of the 54 residents reviewed for privacy and confidentiality of records. Findings include: 1. On 4/28/2025 at 10:05am R225 observed in room, lying in the bed. R225 stated I came to this facility on Thursday (4/24/2025) from the hospital. Observed a white band on R225 's left wrist. R225 stated this is the band I had at the hospital. R225 stated none of the staff have asked me if I wanted the band removed. Observed the following information documented on R225 's white wrist band: MRN# (medical record number), AD (admitted): 04/13/2025, and R225's date of birth. R225's Face sheet which documents in part, last qualifying hospital stay: 04/13/2025-04/24/2025. 2. On 4/28/2025 at 10:35am R69 observed lying in bed watching television. Observed a white band on R69's right wrist. R69 stated I went to the hospital about two months ago. R69 stated this is the band I got in the hospital. Observed the following information documented on R69's white band: Name, DOB (date of birth), admitted : 3/19/25, MD (medical doctor's name). R69's Face sheet which documents in part, last qualifying hospital stay: 3/19/2025-03/26/2025. On 4/28/2025 at 10:45am V15 (RN/Registered Nurse) stated the nurses are responsible for removing the hospital bands when the resident is admitted back into the facility. V15 stated the purpose of removing the band is due to HIPPAA (Health Insurance Portability and Accountability Act) concerns. On 4/30/2025 at 12:05pm V2(DON/Director of Nursing) stated there is no time frame for the removal of a resident's hospital band once the resident is admitted into this facility. V2 stated the resident must request for the hospital band to be removed. V2 stated the hospital bands usually have the resident's name, date of birth, and clinical number on them. V2 stated the purpose of removing the resident's hospital band once the resident is admitted back into this facility is to prevent giving out the resident's information. V2 stated this (resident continuing to wear the hospital band once admitted back into the nursing facility) is a HIPPA (Health Insurance Portability and Accountability Act) issue. (continued on next page)

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
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities policy presented by the facility, which documents in part, you have a right to privacy and confidentiality of your personal and medical records. Your medical and personal care are private.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51772 Based on observation, interview, and record review the facility failed to ensure resident was free of confinement to bed with all four side rails up. This failure has the potential to affect 1 resident (R40) of 1 resident reviewed in a sample size of 54 residents. Findings include: R40 Face Sheet documents a diagnosis of Hypertension, Psychotic Disturbance, Schizophrenia, and Gastro-esophageal reflux disease. On 4/28/2025 at 11:09 AM, R40 was noted lying in bed with all four side rails up. R40's Physician Order Sheet dated 3/29/2025 -4/29/2025 does not document an active order for a restraint. R40's Physician Order Sheet dated 3/29/25 - 4/29/25 documents an active order with a start date of 11/25/2024 with an end date of Open Ended, documents Half Side Rails to bed for mobility. Special Instructions: half side rails x 2 as a enable for mobility and repositioning while in bed. R40's Minimum Data Set, dated dated dated [DATE], Section C documents in part, A Brief Interview Mental Status (BIMS) score of 6 out of 15 which is indicative of cognitive impairment. R40's Minimum Data Set, dated dated dated [DATE], Section P documents in part, Physical Restraints side rails are used daily. R40's Care Plan dated 4/15/2025 documents no restraint problem. R40s Care Plan dated 4/15/2025 was updated for a problem for half side rails with a start date of 4/30/2025. On 04/29/25 at 11:41 AM, R26, (Registered Nurse-(RN), stated R40 will try and climb out of bed. V26 stated R40 can fall and hurt herself with all 4 side rails up. V26 verified R40 has an active order for half side rails up for bed mobility while in bed. On 4/30/2025 at 9:55 AM, V45, Certified Nurses Assistant-(CNA) stated Yes, all 4 side rails were up when (R40) was in bed. V45 stated V45 was unaware of why all 4 side rails were up on R40's bed and the surveyor will have to ask V23, (Licensed Practical Nurse-(LPN). V45 stated I don't think they are supposed to be up. 04/30/25 at 10:42 AM, V23, (Licensed Practical Nurse-(LPN) stated One side rail should be down. I use it for safety, the one side rail by the window ledge at the foot of the bed. V23 verified the physicians order sheet documents an order for half side rails. Facilities Policy titled Physical Restraint Policy dated February 2014 documents the following: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Purpose: To achieve a restraint free environment to improve or maintain quality of life and processes re implemented to pursue this goal. Restraints shall not be used for the purpose of punishment of for staff convenience. Periodic assessments shall address the resident's status in an effort to reduce or eliminate restraints whenever possible and assure the least restrictive method is used which allows the resident to function at their highest practicable level. Definitions: Physical restraints are any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot easily remove and that restricts freedom of movement or normal access to one's body. A physician order for a restraint will be valid for thirty (30) days. After 30 days, the Restraint Observation must be completed to determine if the restraint is required further. Physician orders for restraint shall be complete and specifically define the type, reason, duration, and justification for use.

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49572 Based on interview and record review, the facility failed to refer residents with possible serious mental disorders for Screening and Resident Review to the appropriate state-designated authority for further assessment as required. This failure affects 2 residents (R106 and R110) reviewed for pre-admission screening in the sample list of 54 residents. Findings include: 1. R106's face sheet documents, in part, admitted : 07/05/2024 01:48 PM (latest return); 05/11/2023 02:34 PM (current). R106's face sheet documents R106's diagnoses that include but are not limited to schizophrenia (date diagnosed [DATE]). R106's care plan, edited date 3/31/25, documents, in part, (R106) has displayed aggression and was recently involved in an incident with another peer where he was NOT the aggressor. This may be potentially related to his mental health issues of Delusional Disorder and Personality Disorder. [NAME] can also at times exhibit verbally inappropriate behaviors towards staff/peers. Review of R106's Notice of PASRR (Pre-Admission Screening and Resident Review) Level I Screen Outcome, dated 4/3/23, documents, in part, PASRR Level 1 Determination: No Level II Required - No SMI (serious mental illness)/ID (intellectual disability). Evidence shows R106 was diagnosed with a serious mental illness (schizophrenia) after R10's Level I PASARR was completed. This requires another PASARR submission which was not done by the facility. 2. R110's face sheet documents, in part, admitted : 09/30/2024 05:27 PM (latest return); 07/09/2024 02:21 PM (current). R110's face sheet documents R110's diagnoses that include but are not limited to schizophrenia (date diagnosed [DATE]). R110's active order, start date 4/11/25, documents, in part, quetiapine 50 mg once a morning and quetiapine 100 mg at bedtime. R110's care plan, edited date 4/15/25, documents, in part, (R110) has a diagnosis of schizophrenia delirium to psychological condition. Review of R110's Notice of PASRR Level I Screen Outcome, dated 7/4/24, documents, in part, PASRR Level 1 Determination: No Level II Required - No SMI (serious mental illness)/ID (intellectual disability). Evidence shows R110 was diagnosed with a serious mental illness (schizophrenia) after R110's Level I PASARR was completed. This requires another PASARR submission which was not done by the facility. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/25, surveyor asked for the employee responsible for the completion of PASARRs and V1 (Administrator) referred V25 (Business Office Manager/Admission Director). On 4/29/25 at 10:41am, V25 (Business Office Manager/Admission Director) said, I am not the only one responsible for the PASARRs. (V3 (SSD/Social Services Director)) has a part too. (R106) and (R110) don't have a PASARR 2 because the PASARR 1 shows that they (R106 and R110) didn't need one. They (R106 and R110) were diagnosed with schizophrenia after the initial PASARR was done. I have to check to see if they (R106 and R110) would need another PASARR submitted. Yes, everyone needs an initial PASARR screening. Before the resident come here, the place the resident is coming from submits the PASARR and we (facility) get the results. It (PASARR) tell us (facility) if the resident is appropriate for our facility. I don't know. This (PASARRs) is new to me. PASARRs identify if our facility is an appropriate setting for the incoming resident. PASARR II identifies residents that have dementia, schizophrenia, things like that. I give (V3) the information on the resident and V3 enters the information. I think certain diagnoses would trigger a PASARR II to be done. (V3) and myself collaborate. On 4/30/25 at 10:40am, V3 (SSD/Social Services Director) said, I don't collaborate with anyone for the PASARRs. The only thing I do is put in the information from the MATRIX to determine if the level of nursing care is appropriate. PASARR II is for psychosis and IOP (Identified Offenders Program). PASARR II is for diagnoses like schizophrenia and Bipolar. New diagnoses of schizophrenia and Bipolar would need a new submission for a PASARR II if a PASARR was already done. On 4/30/25 at 11:36am, V25 (Business Office Manager/Admission Director) said, I did speak with (agency that completes PASARR screenings) and they had me submit for (R106) and (R110) to have new PASARR screenings done due to their diagnoses. Facility policy titled, PASSAR Guideline, revised date 11/2017, documents, in part, The objective of the PASARR guideline is to ensure that individuals with mental illness and intellectual disabilities receive the care and services that they need in the most appropriate setting. The PASARR will be evaluated annually and upon any significant change for those individuals identified. PROCEDURE 1. Admission and Readmission The facility will participate in or complete the Level I screen for all potential admissions regardless of payer source to determine if the individual meets the criterion for mental disorder (SMI/SMD), intellectual disability (ID) or related condition. b. Based upon the Level I screen, if an individual is determined to meet the above criterion, the facility will not admit an individual, the facility will refer the potential admission to the State PASARR representative for the Level II screening process. c. Upon completion of the Level II screen, the facility will review the screen recommendations and determine the facility's ability to provide the specialized services outlined. Admission decision will be determined and notification to the State PASARR representative, resident and resident representative will be completed. d. Readmission i. The PASARR screening process will not apply to those identified individuals, who after being admitted to the facility, were transferred for an acute care stay . iv. The facility will refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or related condition for a level II review upon a significant change in status assessment to the State PASARR representative . Facility policy titled, Residents' Rights for People in Long-term Care Facilities, revision date 3/17, documents, in part, safety and good care. Your facility must provide services to keep your physical and mental health, and sense of satisfaction. Your facility must make reasonable arrangements to meet your needs and choices.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49572 Based on interview and record review, the facility failed to ensure preadmission screening assessments were completed as needed for residents identified to have a mental illness. This failure affects 4 residents (R10, R33, R40, and R46) reviewed for pre-admission screening in the sample list of 54 residents. Findings include: 1. R10's face sheet documents, in part, admitted : 12/27/2024 05:15 PM (latest return); 09/21/2015 06:47 PM (current). R10's face sheet documents R10's diagnoses that include but are not limited to schizophrenia (date diagnosed [DATE]). R10's active order, start date 1/7/24, documents, in part, risperidone (antipsychotic) 2mg (milligram) orally twice a day. Review of R10's health records do not show that a Level I Pre-Admission Screening and Resident Review (PASARR) was completed for R10. 2. R33's face sheet documents, in part, admitted : 02/11/2023 06:53 PM (latest return); 07/07/2010 12:01 AM (current). R33's face sheet documents R33's diagnoses that include but are not limited to schizophrenia (date diagnosed [DATE]) and other schizoaffective disorders (date diagnosed [DATE]). R33's active orders documents, in part, risperidone (antipsychotic) start date 3/14/25, 0.25mg at bedtime. Review of R33's health records do not show that a Level I Pre-Admission Screening and Resident Review (PASARR) was completed for R33. On 4/29/25, surveyor asked for the employee responsible for the completion of PASARRs and V1 (Administrator) referred V25 (Business Office Manager/Admission Director). On 4/29/25 at 10:41am, V25 (Business Office Manager/Admission Director) said, I am not the only one responsible for the PASARRs. (V3 (SSD/Social Services Director)) has a part too. (R10) and (R33) never had an initial PASARR done. Not sure why. Yes, everyone needs an initial PASARR screening. Before the resident come here, the place the resident is coming from submits the PASARR and we (facility) get the results. It (PASARR) tell us (facility) if the resident is appropriate for our facility. I don't know. This (PASARRs) is new to me. PASARRs identify if our facility is an appropriate setting for the incoming resident. PASARR II identifies residents that have dementia, schizophrenia, things like that. I give (V3) the information on the resident and (V3) enters the information. I think certain diagnoses would trigger a PASARR II to be done. (V3) and myself collaborate. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/30/25 at 10:40am, V3 (SSD/Social Services Director) said, I (V3) don't collaborate with anyone for the PASARRs. The only thing I (V3) do is put in the information from the MATRIX to determine if the level of nursing care is appropriate. PASARR II is for psychosis and IOP (Identified Offenders Program). PASARR II is for diagnoses like schizophrenia and Bipolar. New diagnoses of schizophrenia and Bipolar would need a new submission for a PASARR II if a PASARR was already done. On 4/30/25 at 11:36am, V25 (Business Office Manager/Admission Director) said, I (V25) did speak with (agency that completes PASARR screenings) and they had me submit for R10 and R33 to have PASARR screenings done. Facility policy titled, PASSAR Guideline, revised date 11/2017, documents, in part, The objective of the PASARR guideline is to ensure that individuals with mental illness and intellectual disabilities receive the care and services that they need in the most appropriate setting. The PASARR will be evaluated annually and upon any significant change for those individuals identified. PROCEDURE 1. Admission and Readmission The facility will participate in or complete the Level I screen for all potential admissions regardless of payer source to determine if the individual meets the criterion for mental disorder (SMI/SMD), intellectual disability (ID) or related condition. b. Based upon the Level I screen, if an individual is determined to meet the above criterion, the facility will not admit an individual, the facility will refer the potential admission to the State PASARR representative for the Level II screening process. c. Upon completion of the Level II screen, the facility will review the screen recommendations and determine the facility's ability to provide the specialized services outlined. Admission decision will be determined and notification to the State PASARR representative, resident and resident representative will be completed. d. Readmission i. The PASARR screening process will not apply to those identified individuals, who after being admitted to the facility, were transferred for an acute care stay . iv. The facility will refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or related condition for a level II review upon a significant change in status assessment to the State PASARR representative . Facility policy titled, Residents' Rights for People in Long-term Care Facilities, revision date 3/17, documents, in part, safety and good care. Your facility must provide services to keep your physical and mental health, and sense of satisfaction. Your facility must make reasonable arrangements to meet your needs and choices. 51772 3. R40's Face Sheet documents a diagnosis of Hypertension, Major Depressive Disorder, Dementia, Psychotic Disturbance, Schizophrenia, and Gastro-esophageal reflux disease. R40's Minimum Data Set, dated dated dated [DATE], Section C documents in part, A Brief Interview Mental Status score of 6 which is indicative of cognitive impairment. R40's Minimum Data Set, dated dated dated [DATE], Section D Mood documents in part, a Mood Total Severity Score of 12 which is indicative of Moderate Depression. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/30/25 at 10:40 AM, V25, (Business Office Manager-(BOM) stated V25 called Maximus about R40 regarding a Preadmission Screening and Resident Review (PASARR) because R40's admitted was in 2008 when the requirement was just an Omnibus Budget Reconciliation Act of 1987. V25 stated Maximus informed V25 that a (PASARR) should have been submitted when Maximus took over. V25 stated that nobody ever submitted it to Maximus, so V25 submitted R40's PASARR. V25 stated V25 enters the data and then social service enters the resident's history. V25 stated now V25 knows that when a resident have a psychiatric diagnosis, the PASARR Level I will trigger a PASARR Level II. On 04/30/25 at 11:11 AM, V3, (Social Services Director-(SSD), stated the business office does the Preadmission Screening and Resident Review (PASARR). V3 stated Yes, every resident should have a PASARR completed if the resident has a mental health diagnosis. V3 stated when residents go out to the hospital, residents may be diagnosed with a new mental health diagnosis. V3 stated in the case of a new mental health diagnosis, V25, (Business Office Manager-(BOM) completes the PASARR and both V3 and V25 play a part tag teaming on it. V3 affirmed R40 should have a PASARR I and a PASARR II. 45346 4. On 04/29/2025 at 10:30am surveyor requested R46's PASARR (Preadmission Screening and Resident Review) from the facility staff. On 04/29/2025 at 10:55am V25(Business Office Manager/ Admissions Director) stated I work with the Social Services Director to do the PASARRs for residents. V25 stated the PASARR is used to identify what type of facility the resident goes to, to make sure the resident is in the appropriate setting. V25 stated R46 came to this facility in 2019, R46 did not have a PASARR. V25 stated I spoke with the state agency representative regarding R46's PASARR. The state agency representative informed me to start a PASARR Level I for (R46).

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45346 Based on observation and interview, the facility failed to have signage posted identifying a resident who has oxygen in use in the resident's room to prevent a possible hazard. This affected one resident (R69) in a total sample of 54 residents. Findings include: On 04/28/2025 at 10:355am observed nasal cannula in R69's nares, with tubing leading to an oxygen concentrator machine next to R69's bed. The oxygen concentrator machine was set to deliver oxygen at two liters per minute. R69 stated I have been on oxygen for three months now. There was no Oxygen in Use sign posted on the outside of R69's door indicating that oxygen was in use in R69's room. On 4/28/2025 at 10:45am V15 (RN/Registered Nurse) stated R69 is on as needed oxygen. V15 was asked what would indicate that R69 was receiving oxygen. V15 stated when you enter the room you see the concentrator machine. V15 stated a sign would be on R69' s door before entering the room. V15 stated the sign is missing from R69's door. V15 stated the purpose of the sign is for safety reasons. V15 stated IP (infection preventionist) is responsible for placing the oxygen sign on the door. On 4/30/2025 at 12:03pm V2(DON/Director of Nursing) stated if a resident is receiving oxygen therapy, then yes, a sign is to be posted on the resident's room door. V2 stated the nurse is responsible for placing the oxygen in use sign on the resident's room door. V2 stated the purpose of the oxygen in use sign is to let people know that the oxygen is flammable. V2 stated if someone is smoking near a room where oxygen is in use, this can cause a fire. R69's diagnosis includes, but are not limited to, bilateral primary osteoarthritis of knee, hypertensive heart disease with heart failure, other asthma, chronic obstructive pulmonary disease, unspecified, muscle wasting and atrophy, not elsewhere classified, right lower leg, muscle wasting and atrophy, not elsewhere classified, left lower leg, chronic kidney disease, unspecified, and dyspnea, unspecified. R69 has a Brief Interview for Mental Status (BIMS) dated 04/01/2025 which documents R69 has a BIMS score of 14, indicating R69's cognition is intact. R69's most current Physician Order Report (03/30/2025-04/30/2025) documents in part, O2(oxygen) at 2-liter PRN (as needed). R69's care plan documents in part, Problem: R69 has ineffective breathing pattern R/T (related to) dyspnea. Approach: Administer oxygen. Observe oxygen precautions. On 04/30/2025 reviewed the facility's policy dated 05/2023 and titled Oxygen Therapy, which documents in part, Underneath Equipment 4. Oxygen in use sign. Underneath Safety Factors: 1. Must have Oxygen in Use sign posted in space that is visible prior to actually entering room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/30/2025 reviewed the facility's undated policy, titled Smoking Policy, which documents in part, No Smoking signs will be posted by the oxygen storage rooms and by the door of any resident who is receiving oxygen.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50728 Based on interview and record review, the facility failed to complete performance evaluations for certified nursing assistants and failed to ensure 12-hours of in-servicing was completed for certified nursing assistants annually. This failure affects all 127 residents that reside within the facility. Findings include: Record review of facility provided census (4/28/2025) documents that 127 residents reside in the facility. On 5/1/2025 at 9:51 AM, annual performance evaluations and documentation of in-servicing for the last year was requested for V18 (Certified Nursing Assistant/CNA) and V27 CNA. No annual performance evaluation documentation was received prior to the end of the survey. The facility provided in-servicing documents titled CNA (Certified Nursing Assistant) Competency Checklist for V18 and V27 does not document training/in-servicing, nor the hours (time) it took to complete this competency. On 5/1/2025 at 1:26 PM, V4 (Registered Nurse, Infection Preventionist/Quality Assurance Nurse) affirmed that V4 is responsible for educating and in-servicing the staff within the facility. V4 stated that V4 was told by V1 (Assistant Administrator) that the facility does not complete performance evaluations because of the union contract but that the surveyor would have to verify with V1. V4 stated that V4 was unsure how many hours of in-servicing certified nursing assistants were required annually and stated, I think maybe 20 or so?. V4 affirmed that the process for training CNAs is a skills fair where they come in to get checked off on skills competency. V4 stated that the skills fair takes about 6 hours or so. Additional in-servicing documents were requested to verify how many hours of in-servicing V18 and V27 received within the last year. V4 stated, I don't think we have any documentation on our in-service forms that document how long each training occurred. V1 stated to V4, we need to start tracking that from now on. No further in-servicing records were provided during the survey that affirms V18 or V27 received at least 12 hours of in-servicing within the last year. On 5/1/2025 at 1:49 PM, V1 (Assistant Administrator) affirmed that the facility does not complete performance evaluations for certified nursing assistants. V1 explained, due to the union contract, we are unable to complete performance evaluations. All pay increases have already been decided in the contract. On 5/1/2025 at 3:47 PM, V1 stated that there is no facility policy for annual performance reviews for certified nursing assistants. The facility assessment dated [DATE] documents in part, . Required in-service training for nurse aides. In-service training must: - Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year . - address areas of weakness as determined in nurse's aides performance reviews and facility assessment and may address the special needs of residents as determined by facility staff .

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	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 50728 Based on observation, interview and record review, the facility failed to post required staffing information in a high visibility area. This failure affects all 127 residents that reside within the facility. Findings include: The facility census for 4/28/2025 documents 127 residents reside within the facility. On 4/28/2025 at 11:19 AM, surveyor requested the daily staffing posting for the facility. V1 (Assistant Administrator) grabbed a document (titled Nursing Schedule) that was observed on top of the ledge of the 1st floor nurse's station, facing the ceiling (not visible to residents). V1 affirmed this was the document that the facility uses to post the staffing information. V2 (Director of Nursing) affirmed that this posting is kept at the nurse's station. The facility provided document from V1 titled, Nursing Schedule (dated 4/28/2025), does not document the following required information: A) Facility Name B) The total number and the actual hours worked by registered nurses, licensed practical nurses, and certified nursing assistants directly responsible for resident care per shift C) Resident census. Facility policy titled Posting Direct Care Daily Staffing Numbers documents in part, Policy Statement Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents . At the beginning of each shift facility shall post the nurse staffing data as required by state and federal regulations.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45346 Based on observation, interview, and record review the facility failed to ensure two licensed personnel conducted a physical inventory of controlled substances at each change of shift. This failure has the potential to affect 4 out of 18 residents who are prescribed controlled substances from the second-floor long hall medication cart. Findings include: On 04/29/2025 at 1:26 pm, review of the 2nd Floor long hall medication cart with V15 (RN/Registered Nurse) surveyor observed the Controlled Substances Check Form for April 2025. The Nurse's Initials On box was left blank for April 17, 2025 (3-11 shift). The Nurse's Initials Off box was left blank for April 17, 2025(11-7 shift). The Nurse's Initials Off box was left blank for April 20, 2025 (11-7 shift). The Nurse's Initials On box was left blank for April 21, 2025 (3-11 shift). The Nurse's Initials On box was left blank for April 23, 2025(3-11 shift). The Nurse's Initials On box was left blank for April 26, 2025 (3-11 shift). The Nurse's Initials Off box was left blank for April 26, 2025 (11-7 shift). The Nurse's Initials On box was left blank for April 27, 2025(7-3 shift). The Nurse's Initials On box was left blank for April 27, 2025 (3-11 shift). The Nurse's Initials Off box was left blank for April 27, 2025 (3-11 shift). The Nurse's Initials Off box was left blank for April 27, 2025(11-7 shift). The Nurse's Initials On box was left blank for April 28, 2025 (3-11 shift). The Nurse's Initials Off box was left blank for April 28, 2025 (11-7 shift). The blank spaces on the facility's-Controlled Substances Check Form indicate the controlled substances were not reconciled at the end and beginning of the shift on the specified days. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/2025 at 1:26pm V15 stated the shift-to-shift controlled substances check form is used by the nurses to count the narcotics. V15 stated two nurses are to count the narcotics together, the nurse going off the shift and the nurse coming on the shift. V15 stated both nurses are to make sure the count of the narcotics is correct and document their initials on the form if the narcotic count is correct. On 4/30/2025 at 12:07am V2 (DON/Director of Nursing) stated the Controlled Substances Check Form is used to verify the count for the narcotics is correct. V2 stated the nurse coming on shift and the nurse leaving the shift are to count the narcotics together and sign off on the Controlled Substances Check Form that the count of the narcotics is correct. V2 stated it is my expectation that two nurses (the incoming nurse and the outgoing nurse) are counting the narcotics and initialing the Controlled Substances Check Form indicating that the count of the narcotics is correct. The facility's policy dated 05/24 and titled Controlled Drug Policy and Procedure which documents in part, 1. Controlled drugs, as determined by the facility, are counted every shift by the nurse reporting on duty with the nurse reporting off-duty. 3. The controlled drug checklist must be signed by the nurse coming on duty and going off duty to verify that the count of all controlled drugs is correct, if used at facility discretion. The facility's undated Registered Nurse job description which documents in part, underneath Duties/ Responsibilities/Function: 11. Ensure that appropriate documentation/charting is completed as required and in accordance with established policies and procedures. 14. Ensure that narcotic records are accurate for your shift. Immediately notify the DON/ADON (Director of Nursing/Assistant Director of Nursing) of any identified drug discrepancies. The facility's undated Licensed Practical Nurse job description which documents in part, underneath Duties/ Responsibilities/Function: 10. Ensure that appropriate documentation/charting is completed as required and in accordance with established policies and procedures. 13. Ensure that narcotic records are accurate for your shift. Immediately notify the DON/ADON (Director of Nursing/Assistant Director of Nursing) of any identified drug discrepancies.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067 Based on interview and record review, the facility failed to ensure that all kitchen staff have active food handler certifications to provide safe and competent food and sanitation service to residents which has the potential to affect all 127 residents receiving oral diets in the facility. Findings include: On [DATE] at 2:25 pm, this surveyor requested V16 (Cook), V21 (Dietary Aide), V29 (Dietary Aide), and V31's (Dietary Aide) food handler certifications. V13 confirmed in viewing the kitchen employee schedule ([DATE]) provided to survey team that there are 10 kitchen employees (excluding V13) working all shifts in the facility kitchen. On [DATE] at 10:00 am, V13 stated that V13 requested the food handler certifications from V21, and (V21) hasn't responded and (V29) started (V29's certification test) today but can't pay for it until tomorrow. On [DATE] at 11:15 am, V13 stated that of the 4 kitchen staffs' (V16, V21, V29 and V31) food handler certificates not yet presented to this surveyor, both V16 and V31 were taking the food handler tests today. V13 stated that V16 and V31 informed V13 that both of their previous food handler certificates were expired. V13 stated that it's the kitchen employees' responsibility to maintain a current food handler certification. V13 stated that in different facility kitchens that V13 has worked in, all kitchen staffs' food handler certificates are posted in the kitchen. V13 stated that the dietary manager can then see when they are expiring and can give reminders to the staff. V13 stated, But they are not posted here (facility). V13 stated that the kitchen staff must have an active food handler certification; It's part of their union hand book to be certified to work in the facility. V13 stated that the importance of having an active food handler certification is so they (kitchen staff) will know what they can and can't do for cross contamination. To know what the law is. This is these people's (residents') home. We are making their food in the kitchen, and it can affect any resident eating from this kitchen. On [DATE] at 1:18 pm, V13 stated that the kitchen staffs' roles are broken up by the title and shift of cook and dietary aides. V13 stated that there are two shifts for cooks, one that starts the early shift at 5:00 am, which is V16; and the other cook's shift is 11:30 am to 8:00 pm. V13 stated that dietary aides have shifts from 6:00 am to 2:30 pm, 6:30 am to 3:00 pm, 11:30 am to 8:00 pm, and 4:00 to 8:00 pm. V13 stated that they have on cook working on each of the two cook shifts. V13 stated that two dietary aides work between the two early shifts (6 am-2:30 pm; 6:30 am-3:00 pm); two dietary aides work on the 11:30 am to 8:00 pm shift and one dietary aide from the 4:00 to 8:00 pm on 3 to 4 days a week. V13 stated, We need at least the 2 dietary aides and one cook per shift. V13 presented this surveyor with the kitchen job descriptions saying that the shifts listed are for the dietary aides, and the other one is for the cook. On [DATE] at 1:51 pm, V13 presented copy of V31's food handler certificate which was completed on [DATE]. V13 stated, (V31) did it today. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 2:15 pm, V13 stated that V13 does not keep or catalog the kitchen staffs' food handler certificates, and that V13 doesn't really know who maintains copies of the kitchen staffs' food handler certificates. V13 stated that this surveyor can check with V1 (Assistant Administrator) for the remaining kitchen staffs' food handler certificates. On [DATE] at 9:19 am, when requesting for food handler certificates for V16, V21, V29 and V31 prior to [DATE], V1 (Assistant Administrator) stated that V1 was going to speak with V13 about the food handler certificates. On [DATE] at 10:48 am, this surveyor received V16's food handler certificate, dated [DATE]. On [DATE] at 11:26 am, this surveyor received V31's food handler certificate, dated [DATE]. On [DATE] at 11:34 am, this surveyor received an email notice from V13 documenting the following, The following employees don't have their Food Handler Certification. (V21)-Dietary Aide. (V29)-Dietary Aide. Employee facility list documents, in part, the hire dates of the following kitchen staff: V16 on [DATE]; V21 on [DATE] (rehire date); V29 on [DATE]; and V31 on [DATE]. V16 (Cook) and V21 (Dietary Aide) certificates document, in part, that their food handler certificates for Employee Food Safety Course and Exam were completed on [DATE]. On [DATE] at 9:57 am, V32 (Registered Dietitian) stated that that the kitchen staff should have, at a minimum, a current food handler certification. V32 stated that the importance of all kitchen staff having a current food handler certification is to ensure the overall residents' safety and having no cross contamination in the kitchen. Facility kitchen employee schedule, dated [DATE], documents, in part that there are 10 kitchen employees (excluding V13, Dietary Manager). During facility kitchen tours on [DATE] and [DATE], this surveyor observed V16, V21 and V31 working, and V29 was scheduled on the 4 - 8 pm shift on [DATE]. Facility list reviewed shows all of the current residents receiving oral diets (dated [DATE]), and V1 (Assistant Administrator) confirmed with survey team that the total resident census is 127 residents. Facility Job Description (undated) titled [NAME] documents, in part, Purpose: The primary purpose of this position is to: Prepare meals in accordance with recipes and written planned menus . Ensure that the kitchen is maintained in a clean, sanitary and orderly fashion. Ensure that 'safe food handling' procedures are being consistently maintained. Maintain all federal, state and local nutritional/dietary regulations . Qualifications & Essential Requirements: . Must possess sanitation certification. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility Job Description (undated) for the Dietary Aide, 6 am to 2:30 pm shift, documents, in part, a timed list of job responsibilities which include set up coffee and start coffee machine, setup juice and milk, start tray line, call the dietary line, help other dietary aides, wash dishes, and sweep and mop. Facility Job Description (undated) for the Dietary Aide, 6:30 am to 3 pm shift, documents, in part, a timed list of job responsibilities which include prepare dessert, help cook on line, setup tray line and milk, call the tray line, help other dietary aides, wash dishes, and sweep and mop. Facility Job Description (undated) for the Dietary Aide, 11:30 am to 8:00 pm shift, documents, in part, a timed list of job responsibilities which include help on line, supplement setup (for 10 am, 2 pm and 7 pm), start dessert (follow all recipe), set up cart for dinner (salt, pepper, sugars), do juice for breakfast, prepare sandwiches for snacks, and setup for dinner meal. Facility Job Description (undated) for the Dietary Aide, 4 pm to 8 pm shift, documents, in part, a timed list of job responsibilities which include pour juice for breakfast (follow menus as to what juice to pour, spread sheet book), help cook on line, wash dishes, and sweep and mop.

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	145829	A. Building B. Wing	05/01/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40067 Based on observation, interview, and record review, the facility failed to label and date an opened refrigerated food item; kitchen staff failed to perform appropriate hand hygiene in the kitchen; failed to sanitize the thermometer probe in between obtaining temperature readings of each hot food item; failed to properly clean food processor equipment; failed to allow food processor equipment to fully air dry before use; failed to ensure that kitchen staffs' personal belongings are not stored on kitchen equipment where resident food is prepared; and failed to ensure that kitchen staffs' food and drink items are not stored in the facility kitchen dedicated for resident food and drinks. These failures affect all 127 residents receiving oral diets in the facility. Findings include: On 4/28/25 at 9:35 am, during the initial tour of the facility kitchen's walk in refrigerator and freezer with V13 (Dietary Manager) and V16 (Cook), a 16.9 fluid ounce bottle of water (frozen) observed on the shelf inside the freezer. When asked if this is a water bottle for resident use, V16 stated, No. It's someone else's. In the walk in refrigerator, an opened package of bologna slices wrapped in clear plastic wrap is observe with no label or date. V16 stated that V16 is not sure when the bologna slices package was opened. Ten water bottles (16.9 fluid ounces) and two ginger ale bottles (20 ounce bottles) are observed on a shelf inside the walk in refrigerator. When asked who's water and soda bottles are these, V13 stated, Employees. Next to the water and soda bottles on the shelf, a gray grocery sack is observed. V13 retrieved this sack from the shelf and opened the grocery sack revealing an opened package of polish beef sausages (identified by V13). When asked is this for the residents' menu, V13 stated, No, it's someone's (staff) lunch. V13 stated that staff's food should not be stored in the residents' kitchen refrigerator. On 4/28/25 at 9:53 am, clean plate covers are observed stacked on the main food preparation (prep) table in the center of the kitchen. At the end of this food prep table (closest to the dishwasher room), an employee's cellular phone is observed connected to a phone charger cable plugged into the outlet at the end of the food prep table. This employee phone is next to the clean plate covers. On 4/28/25 at 11:45 am, the same employee's cellular phone is observed again on the food prep table connected to phone charger next to the clean plate covers. Also, a set of keys with 2 car fobs (on a key ring with a lanyard) is observed next to the phone. On 4/28/25 at 11:46 am, V16 (Cook) observed plating residents' lunch plates on tray line service at the main food prep table. V16, with gloved hands, is observed taking V16's left hand, and with the back of V16's left gloved hand, wipes V16's perspiration on V16's forehead. V16 then continues to plate the macaroni with meat sauce and hamburgers on buns on the resident lunch plates. No hand hygiene and glove change are performed by V16. (continued on next page)

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	145829	A. Building B. Wing	05/01/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/28/25 at 12:48 pm, a condiment tray (open cart on wheels with bins of salt, peppers, sugars, and sweeteners) observed parked at end of the main food prep table. A blue tumbler cup with an open clear lid is observed on this cart. V19 (Cook) observed preparing peanut butter and jelly sandwiches and bologna sandwiches on the kitchen prep table. When asked whose tumbler cup is this, V19 stated, I (V19) don't know. V19 then calls out to the kitchen staff, Whose cup is on the cart? V21 (Dietary Aide) said that it was V20's (Dietary Aide) cup, and V21 walked over to remove V20's tumbler cup from the condiment cart out of the kitchen. V19 stated, No one should be drinking in here (the kitchen). On 4/28/25 at 12:49 pm, this surveyor pointed to the cellular phone and car keys observed on the same kitchen table that V19 is preparing food sandwiches on, asking whose personal items are these? V19 stated that V19 doesn't know whose they are. When asked are these personal items to be stored in the kitchen on the food prep table and the condiment cart, V19 stated, Not that I am aware of. On 4/29/25 at 9:21 am, for the puree food preparation, V16 (Cook) is observed with food supplies on the main kitchen prep table near the food processor and the covered meat slicer. V16 stated that V16 is going to be making pureed beef steaks and creamed corn. A music speaker, white and gray in color and cylindrical in shape, is observed on the kitchen prep table in between the food processor and the meat slicer. Another cellular phone is observed on top of the meat slicer ledge and is connected to a charging cable plugged into the outlet on the opposite end (closest to the 3 compartment sink) of the main kitchen prep table. V16 observed preparing the pureed beef patties in the food processor, and V16 transfers the pudding like consistency of pureed beef steak patties from the food processor base into a clean pan. On 4/29/25 at 9:26 am, V16 observed taking the used food processor base, cover and blade over to the small sink next to the oven and rinsed the food processor equipment under the running water. V16 then walked the 3 food processor items over to the 3 compartment sink and placed the blade in the wash compartment, next the rinse compartment and lastly the sanitize compartment. V16 placed the food processor blade on the counter next to the small sink to air dry. V16 returned to the wash basin of the 3 compartment sink, washed and scrubbed the food processor base and lid, and then moved the 2 items to the rinse compartment. V16 placed both items in the sanitizer compartment to dwell. V16 then removed paper towels from the dispenser to dry off V16's hands. V16 observed touching and moving the gray garbage can lid covering the garbage can to place the used paper towel in the garbage can. V16 did not perform hand hygiene after touching the garbage can lid. V16 next retrieved the food processor base and cover from dwelling inside the sanitize 3 compartment sink. While holding onto to the food processor base and cover, V16 shook these items in front of V16's body and picked up the blade from the small sink counter. V16 walked back over to the main food prep table where V16 assembled the base with the blade inside, and visible moisture droplets are observed on the food processor base. In addition, 2 pieces of beef steak patties residue is observed on the food processor base. V16 removed the creamed corn from the oven and ladled scoops of creamed corn into the dirty food processor base. V16 continued the puree preparation of the creamed corn via the same food processor equipment. After creamed corn puree preparation was completed, V16's cellular phone, which is on top of the covered meat slicer ledge, rings, and V16 answers the phone call. (continued on next page)

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	145829	A. Building B. Wing	05/01/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/29/25 at 11:30 am, V16 is observed with an electric thermometer preparing to obtain temperatures of the hot foods assembled on the main kitchen table. V16 pulls the foil covers back from hot food items and begins taking food temperatures. V16 inserts the thermometer probe into the mashed potatoes which read 200 degrees Fahrenheit. V16 removes the thermometer probe from the mashed potatoes and does not sanitize the probe with alcohol pads. V16 then inserts the same thermometer probe into a beef patty for a reading of 185.6 degrees Fahrenheit. V16 removes the thermometer probe and residual white mashed potatoes are visible on the beef steak patty where V16 inserted the same electric thermometer. V16 stated that V16 uses the alcohol pads to clean off the thermometer probe so there's no cross contamination. V16 stated, I (V16) don't want each food going into a different food. V16 gave example of not wanting beef steak patty to go into this or that pointing to the mashed potatoes or creamed corn, despite mashed potato residual being visible on a beef steak patty. (continued on next page)

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	145829	A. Building B. Wing	05/01/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/30/25 at 11:15 am, V13 (Dietary Manager) stated that kitchen staff are supposed to wash their hands, after put on their hair nets, enter the kitchen and go over and wash their hands. Anytime they go in and out of the kitchen, touch their nose or face with fingers. It doesn't matter how many times they go in and out of the kitchen, they have to wash their hands. V13 stated that if kitchen staff are wearing gloves, are serving food on the tray line, and wipe their sweat from their forehead with the gloved hand, then they must take off the gloves and wash their hands. Use paper towel and let hands dry and put on new gloves. V13 stated that purpose of kitchen staff performing hand hygiene is to keep hands sanitized and to keep down cross contamination so not everyone will get sick. V13 stated that after kitchen staff are touching their face with a gloved hand during tray line or touching the garbage lid and not washing their hands, Well that's just nasty and is cross contamination. V13 stated that kitchen staff should not keep their personal items, such as cellular phones, music speakers, keys, or drinking cups, in the kitchen. V13 stated that kitchen staffs' personal items are not supposed to be around food. This is where we prepare food for the residents. Their (staffs') personal items are not to be in there (kitchen) at all. V13 stated that it is not acceptable for kitchen staff to have personal items in the kitchen, not on the condiment cart, not on the prep table with everything that's in there. No. V13 stated that V13 will in-service kitchen staff, but they should know. When asked when should a food item that is opened and is refrigerated, what should be labeled on the plastic wrap covering, and V13 stated, The date when it's opened and when it expires. It depends on the item. V13 stated that if a food item is refrigerated and remains in refrigerator past the expiration date, then if it's served to residents, it can have a possible bad effect, food poisoning, diarrhea. When asked about the employees water and soda bottles observed in the refrigerator and freezer on 4/28/25, V13 stated that V13 normally comes in and checks the refrigerators on Monday mornings. V13 stated that V13 had just came in to the kitchen on Monday, when survey team entered, and wasn't able to do the check of the refrigerator and freezer. V13 stated that V13 will normally remove everything from Friday, Saturday and Sundays. Everyone don't do it, and I can't speak for them. I throw out the staff's stuff in the garbage. V13 stated that the polish beef sausage in the grocery bag in the refrigerator observed on 4/28/25 is not on the menu to be served to the residents. V13 stated, That wasn't supposed to be there. It was an employees' (food). V13 stated that kitchen staff can't keep their food in there (kitchen refrigerator). It's for the residents. It's not for the staffs' food. V13 stated that the process of kitchen staff obtaining temperatures of hot foods before tray line service is to open and use an alcohol wipe on the thermometer probe; allow to air dry; place the probe into one food item; read the electric thermometer; remove the probe; and clean and sanitize the thermometer probe with a fresh alcohol wipe; and allow to air dry before moving to the next food item. V13 stated that the purpose of using alcohol to clean the thermometer probe in between each food item is to keep it sanitized and not have food cross over to contaminate the other food. It's common practice. V13 stated that the process for the 3 compartment sink is there are separate wash, rinse and sanitize compartments. V13 stated that the kitchen staff are to remove food off the pan or equipment and scrub the item in the wash basin with warm water. V13 stated that the item is then placed in the rinse basin after washing and finally immersed in the sanitizing basin to dwell. V13 stated that the sanitizing compartment is a combination of bleach and water. V13 stated, Then (staff) put it on the counter by sink and let it sit there completely air dry. Do not dry with a towel. V13 stated that the purpose of allowing the pan or equipment to air dry completely and not use a towel to dry it, V13 stated that they don't want to transfer food products or lint from the towels onto the clean and sanitized pan. V13 stated that if the item is not completely air dried and there are visible droplets of moisture on the item after the 3 compartment sink process, V13 stated, Those droplets can get into the food. Droplets of bleach water. It would actually be like poisoning. There should be no droplets residual whatsoever after air drying is complete. V13 stated, They (staff) need to wait to let it dry. V13 stated that staff must redo the whole process (3 compartment sink process) from the beginning if food particles are visible on the item after staff washed, rinsed and sanitized it. V13 stated that this would be cross contamination. It's not supposed to happen. (continued on next page)

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	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/1/25 at 9:57 am, V32 (Registered Dietitian) stated that V32 is a contracted registered dietitian for the facility. V32 stated that V32 expects kitchen staff to properly label and contain open foods in the refrigerator when they are removed from their original containers. V32 stated, They are dated and are in container they are able to see through the front. V32 stated, The date they (staff) opened it (food) is what is to be labeled on the plastic wrap of an opened food item. V32 stated that when the kitchen staff are obtaining temperatures of hot foods, the purpose of sanitizing the thermometer probe with alcohol in between each hot food item is to prevent cross contamination. V32 stated that if kitchen staff are touching the garbage can lid with their hands, they should remove their gloves, wash their hands and reglove. Facility list reviewed shows all of the current residents receiving oral diets (dated 4/29/25), and V1 (Assistant Administrator) confirmed with survey team that the total resident census is 127 residents. Facility kitchen menu from 4/27/25 to 5/3/25 titled Week at a Glance for General Week 3 documents, in part, that for lunch on 4/29/25, lunch meal is country fried steak, garlic mashed potatoes, roasted corn, brown gravy and oatmeal raisin cookie. Facility kitchen policy dated November 16, 2017, and titled Safe Food Preparation and Handling documents, in part, Policy: Food will be prepared to conserve maximum nutritive value in a safe and sanitary environment. Policy Specifications: The following safe food preparation and handling practices will be followed: 1. Strict personal hygiene will be followed. Hands will be washed properly, frequently, and at appropriate times. Proper hand washing techniques will be used . If gloves are used, they will be single-use gloves . Regulatory guidelines will be followed. Facility kitchen policy (undated) titled Labeling and Dating Foods documents, in part, Policy: Prepared and packaged foods will be labeled and rotated to decrease the risk of food borne illnesses, provide the highest quality product for the residents and minimize waste. Policy Specifications: . Refrigerator Stores: . Commercially processed foods that have been prepared and packaged by a food processing place will be labeled with the date it is opened. This will be discarded by the 3rd day or by 'Best Used By' date. Facility kitchen policy (undated) titled Storage of Refrigerated Foods documents, in part, Policy: Refrigerated food is stored in a manner that ensures food safety and preservation of nutritive value and quality. Facility kitchen policy (undated) titled Manual Sanitizing in Three-Compartment Sink documents, in part, Policy: A sink with three compartments is used for manually washing, rinsing and sanitizing utensils and equipment that can be submerged. It may also be used for tableware. Procedure: Manufacturer's instruction on the wall poster above the three-compartment sink are followed. Three-Compartment Sink Manufacturer's Poster (undated) titled Three Sink Washing & Sanitizing documents, in part, the Wash Setup, Sanitize Setup, and the Washing Procedures. The Washing Procedures are as follows: 1: Thoroughly pre-scrape food soil into waste receptacle, 2: Place ware into detergent sink and wash with pad or brush, 3: After washing, dip ware into middle sink to thoroughly rinse, 4: After rinsing ware, submerge into sanitizer sink for at least 1 minute, 5: Once sanitized, remove ware from sink and place onto drain board to air dry. (continued on next page)

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	145829	A. Building B. Wing	05/01/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility kitchen policy (undated) titled Sanitizing Food Thermometers documents, in part, Policy: Food thermometers will be sanitized between taking food temperatures. Procedure: When taking food temperatures, use an alcohol swab to sanitized the thermometer in between taking the temperature of each food. Facility Job Description (undated) titled [NAME] documents, in part, Purpose: The primary purpose of this position is to: Prepare meals in accordance with recipes and written planned menus . Ensure that the kitchen is maintained in a clean, sanitary and orderly fashion. Ensure that 'safe food handling' procedures are being consistently maintained. Maintain all federal, state and local nutritional/dietary regulations . Qualifications & Essential Requirements: . Must possess sanitation certification . Duties/Responsibilities/Function: . Follow all dietary policies and procedures. This includes, but is not limited to, Proper sanitation procedures, proper food and chemical storage procedures, proper operation of facility equipment (dishwasher, stove, oven, etc {and the rest}) . cleaning procedures . hand washing and infection control compliance . monitor food preparation and tray line activity to assure that: foods are handled under 'safe food handling' techniques . Follow all safety rules and regulations. Follow all facility policies and procedures . Ensure compliance with infection control standards.

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	145829	A. Building B. Wing	05/01/2025

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 50728 Based on interview and record review, the facility failed to complete an accurate facility assessment. This failure has the potential to affect all 127 residents that reside within the facility. Findings include: The facility provided census (4/28/2025) documents 127 residents reside in the facility. The facility assessment (4/25/25) documents the following inaccuracies, including but not limited to: 1) No staff, resident, or family names that participated in the development of the facility assessment (pg. 6) 2) 803 residents with Heart/Circulation conditions (pg. 8) 3) 447 residents with metabolic conditions (pg. 8) 4) 252 residents that have > 252 diseases (pg. 8) 5) 383 residents were in the facility from 3/1/2025 to 4/1/2025 (pg. 8) 6) (Facility) is unable to care for and/or accept residents with a primary diagnosis of mental illness (pg. 8) when page 7 identifies that the facility has a long term/Psych unit 7) Acuity (Pg. 9) lists the facility as (Another Facility) 8) Identifies that 95% of the facility population has care needs related to urinary incontinence/indwelling catheters (pg. 10) 9) 94% of the facility population has care needs related to impaired nutritional status (pg. 11) 10) 100% of the facility population has care needs related to pressure ulcers (pg. 11) 11) Lists the facility as (Another Facility) and has a 30% of the resident population of Polish decent (pg. 11). 12) Lists the facility as (Another Facility) (pg. 12) 13) Identifies the need for a dementia unit coordinator (pg. 15). There is no dementia unit identified within the facility. 14) The staffing plan identifies the facility as (Another Facility) and identifies that the facility needs 17 Registered Nurses, 8 Licensed Practical Nurses and 53 Certified Nursing Assistants 15) facility assessment does not describe the facility's recruitment and retention of staff initiatives 16) does not describe the facility's contingency staffing plans 17) does not identify QAPI (Quality Assuracnce Performance Improvement) training as required area of training. On 4/29/2025 at 12:11 PM, the facility assessment was reviewed with V1 (Assistant Administrator) and V43 (Nurse Consultant). V1 and V43 affirmed that the IDT (Interdisciplinary Team) participated in the development of the facility assessment. V43 stated that the facility assessment is important because it identifies care needs of the residents within the facility, dictates what the facility can and cannot accept, outlines staffing needs, etc. The inaccuracies identified were reviewed with V1 and V43 and V43 stated, these must be typos. V43 could not explain how or why (Another Facility) name and data was described within the facility assessment. V43 stated the two must have gotten jumbled up. V43 could not give a reason how the facility assessments got jumbled up as the other nursing home is not within their multi-facility oversight. V1 affirmed there was no other facility assessment for (Facility) and no other facility assessments were provided prior to the exit of the survey. Facility policy titled Facility Assessment Tool (undated) documents in part, Requirement Nursing facilities will conduct, document, and annually review a facility wide assessment, which includes both their resident population and the resources the facility needs to care for their residents.

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	145829	A. Building B. Wing	05/01/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067 Based on observation, interview and record review the facility failed to wear personal protective equipment (PPE) while performing gastrotomy (G-tube) care for one resident (R104) on enhanced barrier precautions (EBP). This failure affected one resident (R104) in a total sample size of 54 residents. The facility also failed to do hand hygiene while performing laundry duties. This failure has the potential to affect all 127 residents residing in the facility. Findings include: 1. On 4/28/25 at 10:28 am, R104 observed in bed with a tube feeding pump hanging on a pole with a piston syringe for a G-tube. R104 stated that R104 went back to the hospital recently to have R104's G-tube replaced, and R104 pointed to R104's covered stomach saying that the G-tube is clamped now. An Enhanced Barrier Precautions (EBP) sign is observed visibly posted on R104's room door. On 4/29/25 at 10:41 am, R104 observed in bed with a tube feeding pump hanging on a pole with a piston syringe for a G-tube, and R104's G-tube is clamped. An EBP sign is observed visibly posted on R104's room door. On 4/30/25 at 10:15 am, V15 (Registered Nurse, RN) stated that R104 has a G-tube. This surveyor requested to view R104's G-tube site and for placement check. An EBP sign is observed visibly posted on R104's room door. V15 did not put on a gown prior to R104's G-tube care. With gloves on, V15 pulled back R104's shirt and touched R104's G-tube dressing to show that it was intact. V15 removed the piston syringe from the plastic bag, removed the cap from R104's G-tube, and connected the piston syringe into R104's open G-tube port. V15 pulled back on the piston syringe for a gastric residual check for placement which revealed approximately 30 milliliters of stomach contents. While holding the G-tube connecting port and piston syringe with one hand, V15 removed the plunger from within the piston syringe with the other hand which opened the end of the syringe to allow for R104's gastric contents to flow slowly by gravity first into R104's G-tube and next into R104's stomach. V15 then disconnected the piston syringe from R104's G-tube connecting port and clamped R104's G-tube. V15 stated that R104's tube feedings and G-tube dressing change are done on the night shift. As V15 doffed gloves upon exiting R104's room, this surveyor pointed to R104's Enhanced Barrier Precautions sign. V15 stated that the purpose of residents on EBP is to protect the patient from us (staff). V15 stated that EBP applies to residents who have openings such as residents with G-tubes, indwelling urine catheters, and open wounds, and when staff are performing care related to these sites, staff wear gowns and gloves, despite V15 not donning a gown. V15 stated that wearing the gown and gloves will prevent transfer of contamination of microbes from V15's person, who provides care to other residents, and transferring the unknown microbes to the residents who have body openings like G-tubes. (continued on next page)

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	145829	A. Building B. Wing	05/01/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/30/25 at 10:57 am, V4 (Infection Preventionist, Quality Assurance, RN) stated that the purpose of EBP is to protect them (residents) from us (staff). We use protection (PPE) on us for them (residents). V4 stated that EBP is for residents who receive treatments to open wounds, has a G-tube, indwelling catheter or surgical sites. V4 stated that EBP is for anywhere where microbes can get in. Transferred from person to person, from staff who is providing care to residents. V4 stated that EBP constitutes staff wearing a gown and gloves when performing direct care to these residents. When asked if a nurse is caring for a G-tube resident and opens the G-tube to check for G-tube placement, what PPE does the nurse need to be wearing, and V4 stated, Gown and gloves. The nurse needs to have the stuff on. Because that's going to expose contaminants to that area. We (staff) are considered dirty and contaminated. They (staff) should have PPE when they are messing with catheters or G-tubes. It can be possible harm to the patient by introducing microbes which cause infection. Facility sign posted on R104's door (undated) titled Enhanced Barrier Precautions documents, in part, Stop . Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities: . Device care or use: . feeding tube. R104's Face Sheet documents, in part, diagnoses of gastrostomy status, hypertensive hear disease, elevated white blood cell count, hypo-osmolality and hyponatremia, intestinal obstruction, chronic kidney disease, nausea with vomiting, anemia, hyperlipidemia, pelvic varices, and acquired absence of right leg above the knee. R104's Minimum Data Set (MDS), dated [DATE], documents, in part, that R104's Brief Interview for Mental Status (BIMS) score is 9 which indicates that R104 has moderate cognitive impairment. R104's Swallowing/Nutritional Status documents, in part, that R104 has a feeding tube (G-tube). R104's Physician Order Report, dated 4/28/25, documents, in part, an active orders (from 3/25/25) of enteral feeding general flush with water (150 milliliters, ml) every shift, and Jevity 1.2 at 75 ml/hour from 6 pm to 6 am. R104's Care Plan, start date of 2/7/25 and edited date of 2/13/25, documents, in part, a problem of R104 has a diagnosis of gastrostomy status with an approach of check placement and patency of feeding tube every 8 hours. Facility list (undated) titled Enhanced Barrier Precaution documents, in part, that R104 is on the EBP list which was provided to the survey team by V4 (Infection Preventionist/Quality Assurance Registered Nurse, RN). (continued on next page)

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	05/01/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility policy dated 4/28/24 and titled Enhanced Barrier Precautions Policy documents, in part, Policy: Enhanced Barrier Precautions (EBP) is designed to reduce transmission of multidrug-resistant organisms (MDROs) and Extensively drug-resistant organisms (XDROs) in nursing homes. It is the policy of this facility that Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implement during high-contact resident care activities when caring for residents that have an increased risk of acquiring a multidrug-resistant organism (MDRO) such as a resident with wounds, indwelling medical devices or residents with infection or colonization with an MDRO or XDRO. Overview: The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of MDROs to employees hands and clothing during cares, beyond situations in which staff anticipate exposure to blood or body fluids . Procedure: 1. Standard Precautions should always be applied to all residents at all times. 2. In addition to Standard Precautions, residents will be assessed to determine whether Contact Precautions or Enhanced Barrier Precautions will be implemented . 9. Personal Protective equipment is required for all staff providing high-contact resident care activities to include . vii. Device care or use: . feeding tube . 19. Enhanced Barrier Precautions are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device. Facility Job Description (undated) titled RN documents, in part Purpose: The primary purpose of this position is to: . Provide licensed nursing care to residents on assigned unit in accordance with current federal, state and local standards, guidelines and regulations . Duties/Responsibilities/Function: . 24. Ensure compliance with infection control standards. 50662 2. On 04/29/25 at 11:07am V11 (Housekeeping Supervisor) observed pushing soiled linen cart into the soiled linen area of the laundry room with his bare hands. V11 then observed removing items from the washing machine and touching multiple surfaces without performing hand hygiene. Observed soiled linen in the laundry chute that was not contained in a bag. On 04/29/25 at 11:07am V11 (Housekeeping Supervisor) stated that he should have performed hand hygiene after pushing the soiled linen cart and touching the clean items. V11 stated that the items that he removed from the washing machine were clean items and that he should not have touched them without washing his hands. V11 stated that soiled linen should not be in the laundry chute without a bag. V11 stated that the soiled linen should be contained in a bag to prevent contamination of other items. On 04/29/25 at 1:14pm V4 (Infection Preventionist/IP) stated that hand hygiene should be performed when moving from a dirty task to a clean task. V4 stated that the soiled linen cart is considered dirty, and hand hygiene should be performed after touching the cart. Facility's policy titled Handling of Contaminated Linen Policy dated 02/2014 documents in part, Policy To protect employees and residents from cross-contamination while handling contaminated linen .Policy Specifications: .2. Contaminated linen will be placed in a biohazard bag. (continued on next page)

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	05/01/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility's policy titled Hand-Washing/Hand Hygiene Policy dated 03/2020 documents in part, Policy: It is the policy of the facility to assure staff practice recognized hand washing/hand hygiene procedures as a primary means to prevent the spread of infections among residents, personnel, and visitors. Alcohol based hand rubs can be used for hand hygiene when hands are not visibly soiled or contaminated with blood or bodily fluids . Policy Specifications: 1. All personnel shall be educated on recognized hand washing/hand hygiene procedures and shall follow such procedures .4. When hands are not visibly soiled, employees may use an alcohol-based hand rub containing at least 60% alcohol in all of the following situations . j. After handling used dressing, potentially contaminated equipment . l. After contact with potentially infectious material.

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	145829	A. Building B. Wing	05/01/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 50662 Based on interview and record review, the facility failed to follow policies and procedures for immunization of residents against pneumococcal disease in accordance with national standards of practice. The facility failed to vaccinate eligible residents with the pneumococcal vaccine. The facility failed to document the refusal and/or the benefits and side effects in the resident's electronic medical records. This deficient practice affected 9 residents (R21, R25, R33, R39, R64, R68, R69, R102, R115) sampled in a total sample size of 54 and has the potential to affect all eligible residents that reside at the facility. Findings include: Review of records for R21, R25, R33, R39, R64, R68, R69, R102, and R115 from admitted s to 04/30/25 have no findings of documentation of pneumococcal vaccine offering or education of the vaccine. Review of physician orders for R21, R25, R33, R39, R64, R68, R69, R102 and R115 from admission to 04/30/25 show no orders for pneumococcal vaccination. Immunization records for R21, R25, R33, R39, R64, R68, R69, R102 and R115 has no current pneumococcal vaccination listed. On 04/29/25 at 11:30am V4 (Infection Preventionist/IP) stated that pneumococcal vaccines are offered to residents upon admission and during influenza season. V4 stated that she does not have proof of offering the residents the pneumococcal vaccine besides the undated and incomplete consent forms. V4 stated that she does not usually document the resident's refusal for vaccination in the resident's chart. V4 stated that she does not know why she did not add the date or finish filling out the vaccination forms. Facility's policy titled Pneumococcal Vaccine dated 11/2009 documents in part, All residents will be offered the Pneumovax (Pneumococcal vaccine) to aid in preventing pneumococcal infections .Policy Interpretation and Implementation .1. Prior to or upon admission, residents will be assessed for eligibility to receive the Pneumovax (pneumococcal vaccine), and when indicated, will be offered the vaccination withing thirty days of admission to the facility unless medically contraindicated for the resident has already been vaccinated .3. Pneumococcal vaccinations will be administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician approved pneumococcal vaccination protocol. 4. Residents/representatives have the rights to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination. (continued on next page)

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	145829	A. Building B. Wing	05/01/2025

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility's policy titled Infection Control Policy dated 06/2020 documents in part, Objective: The facility's written program is for the implementation of systems that provide a safe, sanitary and comfortable environment and helps prevent the development and transmission of communicable diseases and infections. The facility's infection control program include: 1. A system for preventing, identifying, reporting, investigating, and controlling infections and communicable disease for residents, staff, visitors and other individuals providing services based upon the facilities assessment in conjunction with hazards and vulnerability analysis that is consistent with national standards. Policy is reviewed annually . 15. The facility maintains procedures for managing outbreaks of infection and pandemics. The facility will follow guidance as provided by the Local Health Department, State Regulatory and/or Communicable disease division, CMS (Centers for Medicare and Medicaid Services) and CDC (Centers for Disease Control) . 19. The facility maintains a program of immunizations for residents to include pneumonia and influenza immunization programs . 24. The facility appoints an Infection preventionist (IP) who is responsible for coordinating the infection control program . a. The IP will be an advocate for each resident to monitor that standards of practice to prevent and control infections is carried out.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 50662 Based on observation and interview the facility failed to clean the lint screen thoroughly to provide a safe environment for the residents. This failure has the potential to affect all 127 residents that reside in the facility. Findings include: On 04/29/25 at 11:07am, a large amount of lint is observed in all three of the dryers covering the lint trap catcher and the base of the dryers located in the facility's laundry area. Also observed a large amount of lint on the floor surrounding the three dryers. On 04/29/25 at 11:07am V11 (Housekeeping Supervisor) stated that he cleans the lint traps every three days. V11 stated that there is a loose wire in one of the dryers and the repair guy is coming to fix the wire. V11 stated that he is unable to physically move the dryers to clean around them and will do so when the repair guy comes to fix the dryer. V11 stated that it is important to clean the dryer's lint traps and surrounding areas because they are fire hazards and could cause a fire. On 05/01/25 at 12:56pm V1 (Assistant Administrator) sent an email that stating, There is no policy for the Lint Traps and there is no specific policy for the laundry area.

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	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 50728 Based on interview and record review, the facility failed to ensure all staff were trained on Quality Assurance (QA)and Performance Improvement (QAPI). This failure affects all 127 residents that reside within the facility. Findings include: Record review of facility provided census (4/28/2025) documents that 127 residents reside in the facility. On 4/28/2025 at 10:52 AM, V44 (Housekeeper) stated that V44 did not know what QAPI was and had never received training on QAPI. On 4/28/2025 at 11:14, V26 (Registered Nurse) stated that V26 was unsure what QAPI or QA was. V26 could not recall when the last time V26 was in-serviced on QAPI. On 4/29/2025 at 12:11, V1 (Assistant Administrator) stated, we do train on QAPI, like we just got done training everyone on handwashing. The line staff get training on hire. When asked if the floor staff get trained on QAPI, V1 replied they don't participate in the QAPI meeting. V43 (Nurse Consultant) and V1 (Administrator) were unsure if it was a requirement that all staff receive QAPI training. V43 stated, I will have to check on that. On 4/30/2025 at 10:32 AM, V4 (Registered Nurse, Infection Preventionist/QA Nurse) affirmed that V4 is responsible for the QAPI programming in the facility. V4 affirmed that the purpose of QAPI is to improve systems and identify/correct deficient practices within the facility. V4 stated that the facility had not completed all staff QAPI training but was currently working on it. V4 provided a document titled IN-SERVICE TRAINING REPORT that indicated QAPI training began on 4/29/2025, after the survey had begun. Record review of facility assessment (4/16/2025) does not identify that the staff require training on quality assurance and performance improvement (QAPI).