STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkshore Estates Nursing & Rehab	6125 South Kenwood Chicago, IL 60637

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 02569 Based on interview and record review the facility failed to ensure a resident was free of physical abuse for one (R3) resident in a sample of three. This failure resulted in physical injury to R3's face requiring transfer to a hospital and R3 receiving three sutures to R3's face. Findings include: R3 is a [AGE] year old female with a diagnoses including Bipolar disorder, Schizoaffective disorder, Obesity, Auditory hallucinations and Depression. R3 has a BIMS (Brief Interview for Mental Status) score 15/15. R3 was first admitted to the facility on [DATE]. R3's care plan includes Abuse & or Neglect. Comprehensive assessment reveals a history of suspected abuse, neglect, exploitation, past trauma and/or other factors that may increase my susceptibility to abuse/neglect. The resident demonstrates: Diagnosis of Mental Illness. Date initiated 2/2/24. R4 is a [AGE] year old male with a diagnosis including Schizophrenia, Suicidal ideation's, Bipolar disorder, Anxiety disorder and Auditory hallucinations. R4 was first admitted to the facility on [DATE]. R4 has a BIMS (Brief Interview for Mental Status) score of 15/15. R4's care plan includes behavioral symptoms related to severe mental illness. R4 displays inappropriate behaviors towards staff. Date initiated 7/4/24. Red Pass. R4 present with inappropriate behaviors not able to be redirected by staff. R4 will continue with a Red pass for 30 days. 2nd offense. Date initiated 7/2/24. The following progress note review shows the following behaviors for R4. 7/3/24 social service note: It was reported to this writer that R4 displayed verbal aggression to staff. Writer educated resident on non-tolerance for behaviors and to respect staff at all times. Resident showed understanding and was receptive to education. Behavior tool form could be found in (electronic charting system). S.S (social services) will continue to document as needed. (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	7/4/24 progress note: It was brought to writer attention by CNA (certified nursing assistant) doing rounds that resident was in a female residents room while they were sleeping and refused to leave when asked by the CNA. Resident became agitated and began screaming. Writer asked resident to remain calm and attempted to redirect but resident began screaming at writer stating that he does not have to listen to anyone. Psychiatric tech was called and resident went to room where he remained for the rest of shift. Staff will continue to monitor. The facility final incident report dated 7/11/24 shows the following: After a thorough investigation, which included interviewing all possible witnesses, the following was concluded: Resident R4 and resident R3 were sitting together in the smoking patio along with other residents and the supervising Psychiactric Technician (V30). They were having a conversation. Both residents are alert and oriented. The conversation led to R4 becoming displeased and he made contact with the side of R3's face. Staff immediately separated them and placed them both on 1:1 monitoring. Both R4 and R3 were sent to the hospital for further evaluation. R3 returned to the facility after receiving treatment for right upper cheek laceration which included three sutures. R5 remains out of the facility and will not be returning to the facility. Police took no further actions. R3 received emotional support and well being checks from social services. She does not have any concerns and stated she feels safe and comfortable in the facility. R3 had no mental anguish or emotional distress. Care plan reviewed and updated. MD and family made aware of the outcome of the investigation. This serves as the final report. On 7/23/24 at 3:15PM V30 (Psychiatric technician) stated R3 and R4 were having an argument on the patio about R4 being with another female. I went up to them and told them to stop. I turned around and walked away. Shortly after I heard a commotion and looked in their direction. R4 hit R3 in the face with a closed fist. He then started choking her. I went over and stopped the fight. I alerted other staff immediately. On 7/23/24 at 2:30 PM V29 (Physician) stated the force that caused R3 to receive the injury to her face was caused by a forceful blow by a closed fist. This resulted in R3 receiving three sutures to her face. The following progress notes shows the description of incident. 7/11/24 progress note: Writer was made aware that resident got into an altercation with peer. Staff immediately intervened and separated the two. Resident was assessed with injury being present. Resident stated that she feels safe in the facility with 911 being called. MD, DON and sister was notified. Resident is alert and oriented. Resident able to voice all concerns with no complaints of pain at this time. Resident verbally agreed to understanding the bedhold policy. 7/12/24 progress note: Resident (R3) returned from hospital ambulating with steady gait alert and she denies any pain or discomfort at this time. Resident immediately assessed with 3 sutures to upper right cheek with minimal swelling to area with no redness or drainage seen. Resident has 2 small superficial scratches to the front of her neck with no bleeding or swelling to neck area. Writer received verbal report from ER doctor stating that all test with no fractures or dislocations seen. Writer observed in discharge documents that resident was + for trichomonas with her informing writer that she did have a light discharge with no itching involved. Writer informed np of return to facility with current finding's with new order's received and noted with resident aware of current medication order's. Writer spoke with resident sister informing her of return to facility and that resident is safe here in the facility. Resident is stable having lunch with no voiced concern's at this time. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Hospital report dated 7/11/24 shows R3 sustained a 2 centimeter laceration to right upper cheek. Wound closed with three sutures. Facility policy titled Abuse Prevention Program revised 01/2019 states including: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32338 Based on observation, interview and record review, the facility failed to monitor residents on the outside patio of the facility for safety. This failure has the potential to affect 4 residents (R8, R16, R17, R18) who use wheelchairs and are at risk for falls and other unsafe conditions on the patio. Findings include: On 7/22/24 between 10:51am and 11:03am, the surveyor observed residents on the patio while trying to find R8. The surveyor observed R8, R16, R17, R18 and 21 other residents on the patio while some of the residents were smoking. There was no staff watching the residents on the patio. The surveyor spoke with a few residents who helped to identify R8, as R8 did not have the ability to respond to his name. No staff around to help the surveyor to identify residents by name. After about 8 minutes, V25 (Psychiatric Technician) came and helped to identify some residents. Inquired from V25 about the staff responsible for monitoring the residents on the patio while smoking. V25 stated that he (V25) was supposed to be inside to give out the smoking materials and another staff was supposed to be outside on the patio to watch the residents, but he (V25) was not sure who was scheduled to be there on the patio. On 7/23/24 at 1:50pm, V27 (Social Worker) stated There is usually 2 staff monitoring smoking. One staff is not enough. One staff will be by the cigarettes inside, and the other staff will be outside lighting the cigarettes for the residents and watching that everyone is safe. On 7/23/24 at 3:10pm, V3 (Assistant Director of Nursing) was interviewed about lack of supervision of residents on the patio the previous day. V3 stated that V34 (CNA/Certified Nurse Assistant) was supposed to be on the patio to watch R8 and other residents, especially R8 who recently fell on the patio. The surveyor inquired from V3 if there was any staff monitoring the residents on the patio on 6/9/24 when R8 fell on the patio, or was it a similar situation when staff was supposed to be watching residents on the patio and the staff did not show up? V3 responded that there were staff on the patio. On 7/22/24 at 12:30pm, V2 (Director of Nursing) presented the facility's investigation and report of R8's fall dated 6/9/24, that was sent to the State Agency. This report states in part: Based on staff statements and record review, it was determined that the resident slid out of his wheelchair on the patio, falling on the floor, and he sustained a laceration to his right forehead. Resident was sent to the hospital and returned with 3 sutures to his right eyebrow. R8's records reviewed include but are not limited to the following: Face sheet shows that admission diagnoses which include but are not limited to Schizoaffective Disorder, Convulsions, Major Depressive Disorder, Gastrostomy Status, Anemia, Dysphagia, and Cachexia. Fall Risk Review form dated 6/12/24 shows that R8 is at high risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS section C dated 6/11/24 BIMS (Basic Interview for Mental Status) score shows (severe cognitive impairment). Care plan dated 9/11/23 states that R8 is at risk for falls related to diagnoses. R16's records reviewed include but are not limited to the following: Face sheet shows diagnoses which include but are not limited to Acquired Absence of Left Leg Below Knee, Schizoaffective Disorder. Fall Risk Review form dated 5/15/24 shows that R16 is at risk for falls. MDS section C dated 5/16/24 BIMS score shows 10 (moderate cognitive impairment). Care plan dated 9/20/22 states that R16 is at risk for falls related to diagnoses. R17's records reviewed include but are not limited to the following: Face sheet shows diagnoses which include but are not limited to Schizophrenia, Auditory Hallucinations, Visual Hallucinations, Weakness, Depression, and Convulsions. Fall Risk Review form dated 5/29/24 shows that R17 is at risk for falls. MDS section C dated 5/30/24 BIMS score shows 11 (moderate cognitive impairment). Care plan dated 9/12/22 states that R17 is at risk for falls related to diagnoses. R18's records reviewed include but are not limited to the following: Face sheet shows diagnoses which include but are not limited to Cerebral Infarction, Spinal Stenosis, Seizures, Weakness, Bipolar Disorder, and Paranoid Personality Disorder, Fall Risk Review form dated 6/30/24 shows that R18 is at risk for falls. MDS section C dated 6/4/24 BIMS score shows 11 (moderate cognitive impairment). Care plan dated 6/3/24 states that R18 is at risk for falls related to diagnoses. Facility's policy on Standard Supervision and Monitoring states in part: The facility recognizes supervision and guidance to the resident is an essential part of nursing care in which standard approaches are successful in meeting the residents physical and psychosocial needs. Facility's policy titled Guidelines for Smoking states in #9: All residents will be under supervision while smoking. #9A: Residents must remain within eyesight of the smoking monitor no more than eight to ten feet away. Smoking monitors will hold lighters for ignition of cigarettes. #8D: Only trained staff can serve as smoking supervisors for yeah residents not being supervised by a responsible adult family member or adult friend.