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	06/04/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility staff failed to report an allegation of abuse to the administrator for one of three residents (R1) in a total sample of four. Findings include: On 6.3.2025, at 1:17 PM, V1 (Administrator) said, the incident happened on 5.10.2025. Two residents R1 and R2 got into it. It wasn't initially a reportable incident because no resident was injured and there was no mental distress of either resident. He (V3) stated CNA-Certified Nursing Assistant) came in and hit him in the face. R1 did not reference R2. On 6.3.2025, at 1:32 PM, V3 (CNA-Certified Nursing Assistant) said, I did not hit R1. V3's written statement of 5.12.2025, documents in part, V3 observed R1 and R2 involved in an altercation, intervened by separating the residents; V3 reported the incident to the nurse. On 6.4.2025, at 12:17 PM, V10 (PRSC- Psychiatric Rehabilitation Services Coordinator), said it was towards the end of my shift (5.10.2025). They called me down to the 3rd floor, because there was an incident that was going on. By the time I got down there it was over. R1 couldn't tell me what happened. At first, he didn't want to talk to me. All he would tell me was that there was an altercation between him and R2. When I came back on Monday (5.12.2025), an investigation was in progress. I reported it to V12 (Social Service Director). We reported it to V1 on Monday. On 6.4.2025, at 12:38 PM, V11 (Psych Tech) said, I didn't report it (the altercation between R1 and R2) because it was over when I got up there. On 6.4.2025, at 1:24 PM, V12 (Social Service Director) said, I was told about the altercation between R1 and R2 on Monday (5.12.2025). I found out from V1 In the morning meeting (Administrator) that it was a reportable (incident) for behavior. It should be reported to the abuse coordinator. On 6.4.2025, at 2:19 PM, via telephone, V9 (CNA-Certified Nursing Assistant) said, I would let the charge nurse know about any abuse. V8 (RN-Registered Nurse) was the charge nurse that shift. She knew, she reported it (the incident) to V2 (DON-Director of Nursing). (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6.4.2025, at 3:05 PM, V2 (DON-Director of Nursing) said, R1 and R2 had a verbal altercation and V3 intervened. It wasn't reported to me that either of the residents hit each other. None of my staff reported anything to me about the alleged incident of 5.10.2025. I didn't find out about the incident until Monday or Tuesday. I was never told it was physical contact. Abuse is reported to the administrator immediately. He's the abuse coordinator. They don't have to report it (abuse) to me, they should report it to V1. On 6.4.2025, at 3:27 PM, V13 (Nurse Supervisor) said, honestly, I did not hear anything until V1 questioned me on 5.12.2025. V1 asked me if I heard about an incident involving V3 and R1. R1 stated that V3 allegedly punched R1 in the face. If a resident hits another I need to know immediately. If residents have a verbal altercation, staff should let me know immediately. I would immediately let V1 know. Facility incident report (initial of 5.10.2025) documents in part, V3 made contact with resident (R1). Addendum: It is alleged that residents (R1) and (R2) made contact with each other. Conclusion: V3 did not make contact with R1. V3 responded to a disagreement between R1 and R2. The allegation was not substantiated. Facility incident report (initial of 5.12.2025) documents part, V3 made contact with resident R1. Facsimile cover sheet documents both initial reports were faxed to the Illinois Department of Public Health on 5.12.2025 Abuse Prevention Program Policy and Procedure (Revised 3.26.12) documents in part: -V. Identification of Allegations/Internal Reporting Requirements Employees are required to immediately report any incident, allegation or suspicion of potential abuse, neglect, exploitation misappropriation of resident property, mistreatment, or a crime against a resident they observe, hear about, or suspect to the Administrator if available or an immediate supervisor who must immediately report it to the Administrator. In the absence of the Administrator, reporting can be made to the DON. Supervisors shall immediately inform the Administrator or in the absence of the Administrator, the DON of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, misappropriation of property, mistreatment, or crime against a resident. Procedure: Any alleged violations involving mistreatment, abuse, neglect, exploration (exploitation), misappropriation of resident property, any injuries of an unknown origin, or reasonable suspicion of a crime against a resident MUST be reported to the Administrator or Director of Nursing. The Administrator is the Abuse Coordinator of the facility. Additionally, the person(s) observing an incident of resident abuse or suspecting resident abuse must IMMEDIATELY report such incidents to the Charge Nurse who will immediately report the allegation to the Administrator, regardless of the time lapse since the incident occurred. The Charge Nurse will immediately report the incident to the Administrator or to the DON during the Administrator's absence. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This report shall be made immediately, but no later than two hours after the allegation is made. If the events that (cause) the allegation involve abuse or resulted in serious bodily injury, or not less than 24 hours if the events that cause the allegation do not involve abuse and did not result in serious bodily injury.