

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6006126	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/15/2022
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NAME OF PROVIDER OR SUPPLIER  KENSINGTON PLACE NRSG & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3405 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616
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S 000	Initial Comments  Investigation of Facility Reported Incident of September 23, 2022/IL152060	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations: 300.3210t) 300.3240b) 300.3240c)</p> <p>Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.</p> <p>Section 300.3240 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to protect the residents' rights to be free from physical abuse for two residents (R2 and R3). The facility also failed to report an allegation of physical abuse of 3 residents reviewed for abuse.</p>	S9999	<p style="text-align: center;"><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	Continued From page 1  Findings include:  R1 was originally admitted to the facility on 4/15/2022. Diagnosis includes but not limited to: Other specified Polyneuropathies, Dementia in other disease without Behavioral disturbance, psychotic disturbance and anxiety, Atherosclerotic Heart Disease on native coronary artery, Weakness, Personal history of COVID 19 (1/12/21), Other psychotic disorder not due to a substance or known physiological condition, Other specified anxiety disorders, Epileptic spasms, Hypertensive Heart Disease, Other Hyperlipidemia, Chronic Kidney Disease, Other specified Anemia, Benign Prostatic Hypertrophy and Chronic Obstructive Pulmonary Disease.  R1's Minimum Data Set (MDS) dated 10/10/2022, Section C- Brief Interview for Mental Status was not conducted because R1 is rarely or never understood and documents that R1's cognitive skills for daily decision making is moderately impaired.  R1's Progress Noted dated 9/23/22 8:29 PM written by V3 (Licensed Practical Nurse/LPN) documents "It was reported by peer to writer resident came into his room and hit him and roommate. No witness to incident no injury noted. Resident denies incident."  On 10/15/2022 at 10:20 AM, V3 (LPN) stated "I was present when the incident happened. It happened in the room. I did not witness it, but it was reported to me by R2. R2 stated that R1 came to his room and hit him (R2) and his roommate (R3). R1's room used to be on the same side of R2, but he got transferred to the other side. R1 still has not acclimated to his new	S9999		

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S9999	<p>Continued From page 2</p> <p>room and keeps looking for his room on the other side of the floor where R2 and R3's rooms are. Up to now, R1 still goes to his old room. R1 used to be (XXX), now he's in (YYY). R1 has had no other incident of hitting anybody. R2 and R3 did not sustain any injuries. I went to see R2 and R3 and assessed them right away and they were both fine. When it was reported to me, I went to assess R2 and R3 and the other nurse prepared the papers for R1 for hospital transfer. R1 was admitted. I asked R1 what happened, and he couldn't tell me. R1 has a diagnosis of dementia. For abuse, is to separate the residents, check out the allegations, do a head-to-toe assessment, notify the abuse coordinator, call the doctor." V3 (LPN) stated that there were no other episodes of physical or verbal aggression involving R1 since the incident of 9/23/22.</p> <p>On 10/15/2022 at 10:43 AM, R3 was observed sitting in his wheelchair inside his room. R3 stated "Some guy came to my room at nighttime and hit me in the face. I didn't get hurt. I don't know why he hit me. I don't know who it was. I feel safe here now. It didn't happen again, that was the first time it happened to me. I like living here. They take good care of me."</p> <p>On 10/15/2022 at 11:02 AM, R2 was observed sitting in his wheelchair, appears irritable, keeps saying "What do you want from me? I need to smoke. I don't want any questions." R2 further stated, "The old man who hit me on 9/23/22, he's still in the building, most of the time he is calm and cool but sometimes he has a burst of anger. Yesterday he hit another person. I don't want to talk about it. I reported it to the nurse. R1 is an old man, he doesn't know what he is doing. I don't want to press any charges, let R1 be. I feel safe overall. I don't want to talk about it. Let the</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>man be. He's an old man. I want to go; I want to go smoke now."</p> <p>Review of R1's progress notes dated 10/14/2022 12:46 PM written by V3 documents "It was reported by peer resident, hit peer in eye staff sitting at nurses' station no incident occurred. Staff continue to monitor. Social service aware of allegation."</p> <p>On 10/15/2022 at 12:00 PM, when asked regarding V3's progress notes about R1 from yesterday, V3 stated, "Yesterday, 10/14/2022 before lunch, I can't remember the exact time, R2 reported to me that R1 had hit another resident in the eye, he didn't say who it was. R2 did not give any details but he just brought up the incident with R1 again and did not provide any details. R1 was sitting in the dining room, day room with the CNAs, within my vision, and I didn't see any altercation happen. I also asked the Certified Nursing Assistant/CNAs that day and they all said they didn't see anything. I didn't report it to the abuse coordinator because there was no abuse which occurred. R1 was in the day room around 11:00 am and R1 went back to his room after lunch. Before 11:00 AM, R1 was in his room. Yesterday, R1 was wandering in the hallways and was going to the back door. I had the CNA bring him back. If I see R1 going into a room that is not his, I intervene right away. But I didn't see him hit anybody."</p> <p>R2 was admitted to the facility on 4/5/2017. R1's diagnosis includes but not limited to : Hereditary and Idiopathic Neuropathy, Other Schizophrenia, Other persistent Atrial Fibrillation, Hypertensive Heart Disease without Heart Failure, Other Hyperlipidemia, Embolism and Thrombosis of other arteries, Other specified Anemias,</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>Gastro-esophageal Reflux Disease, Epileptic Spasms, Alcohol Abuse, Other Bipolar Disorders, Other symptoms and signs involving emotional state, Personal history of COVID-19, Acquired absence of right leg above knee, Acquired absence of other left toe and Weakness.</p> <p>R2's Minimum Data Set (MDS) dated 09/02/2022, Section C- Brief Interview for Mental Status Score is 15 which means that R2 has no cognitive impairments.</p> <p>R3 was admitted to the facility on 11/28/2018. R3's diagnosis include but not limited to: Anoxic Brain Damage, Other Schizophrenia, Epileptic Spasms, Other encephalopathy, Displacement of other gastrointestinal prosthetic devices, disorders of diaphragm, Personal history of COVID-19, Other Hyperlipidemia, Age Related Osteoporosis, Legal blindness, Extrapyrimal and movement disorders.</p> <p>R3's Minimum Data Set (MDS) dated 09/21/2022, Section C- Brief Interview for Mental Status Score is 10 which means that R3 has some cognitive impairments.</p> <p>Facility presented an Initial Report dated 10/15/2022 with time stamped 12:15 PM regarding R1's incident on 10/14/22. The incident was not reported within the required time frames to the state surveying agency.</p> <p>On 10/15/2022 at 12:50 PM, V1, Administrator stated "For any allegations of abuse, I expect staff to inform their supervisor right away or call my cellphone if she is not reachable. The incident yesterday about R1 hitting somebody in the eye was not reported to me. I have in serviced them about reporting allegations of abuse to me right</p>	S9999		

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S9999	Continued From page 5  away so that it can be reported immediately. I will in service staff again."  The facility presented an undated policy titled "Abuse Prevention Policy" which documents in part: Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms.  "B"	S9999		