

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2024
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NAME OF PROVIDER OR SUPPLIER PARKSHORE ESTATES NURSING & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 6125 SOUTH KENWOOD CHICAGO, IL 60637
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S 000	Initial Comments Complaint Investigations: 2485680/IL175747 2485272/IL175207 2485250/IL175178 Investigation of Facility Reported Incident of 07/11/24 / IL175814	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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.	S9999		

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

TITLE

(X6) DATE
08/15/24

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S9999	<p>Continued From page 1</p> <p>These requirements were not met as evidenced by:</p> <p>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.</p> <p>Findings include:</p> <p>R3 is a 30 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 2/1/24.</p> <p>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.</p> <p>R4 is a 35 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 6/21/24. R4 has a BIMS (Brief Interview for Mental Status) score of 15/15.</p> <p>R4's care plan includes behavioral symptoms related to severe mental illness. R4 displays inappropriate behaviors towards staff. Date initiated 7/4/24.</p> <p>Red Pass. R4 present with inappropriate</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>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.</p> <p>The following progress note review shows the following behaviors for R4.</p> <p>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.</p> <p>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.</p> <p>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 Psychiatric Technician (V30). They were having a conversation. Both residents are alert and oriented. The conversation led to R4 becoming</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The following progress notes shows the description of incident.</p> <p>7/11/24 progress note: Writer was made aware that resident got into an altercation with peer.</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>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.</p> <p>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.</p> <p>Hospital report dated 7/11/24 shows R3 sustained a 2 centimeter laceration to right upper cheek. Wound closed with three sutures.</p> <p>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</p>	S9999		

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S9999	Continued From page 5 property and a crime against a resident in the facility. (B)	S9999		