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	IL6006126	A. BUILDING: _____ B. WING _____	C 03/09/2021

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KENSINGTON PLACE NRSG & REHAB	3405 SOUTH MICHIGAN AVENUE CHICAGO, IL 60616

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S 000	Initial Comments Complaint Investigation: 2180922/IL130891 2181362/IL131379 Statement of Licensure Violations: 300.690 a) 300.690 b) 300.690 c) 300.1210 a) 300.1210 b) 300.1210 d)3) 300.1210 d)4)A) 300.3240 a) 300.3240 b)	S 000		
S9999	Final Observations Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695,	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

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resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:
A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to thoroughly investigate a staff to resident mental and verbal abuse allegation which affected one resident (R4) in the sample. The facility also failed to investigate and report to the State Agency an injury of unknown origin for one

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S9999	Continued From page 3 resident (R1) in the sample. This failure affected R1 and R4 who were reviewed for abuse and injury and has the potential to affect all 114 residents residing at the facility. Findings include: 1.R1's medical records showed that R1 was originally admitted to the facility on 12/12/17 and readmitted to the facility on 2/11/21 after being sent to the hospital on 2/8/21 for changes in mental status. R1 was admitted to the hospital with diagnosis that includes but not limited to slurred speech and altered mental status from 2/8/21 to 2/11/21. R1 was noted with multiple bruises to lower extremities. On 2/17/21, the review of R1's medical records did not show documentation concerning any bruises on R1. On 2/17/21 at 3:00 PM, an interview was conducted with V9 RN (Registered Nurse) in charge of R1. V9 stated that when she got to work and was making her rounds, she noted R1 in bed with slurred speech and R1's eyes were fixed and un-focused. V9 stated R1 was not able to talk. V9 explained that she took R1's vital signs (referring to blood pressure, temperature, pulse and respirations) and she called V10 (Physician). V9 stated V10 ordered for R1 to be sent to the hospital. The surveyor asked V9 if a skin assessment was done before sending R1 to the hospital. V9 replied, I did not do a skin assessment. The surveyor then asked whether V9 noted any skin alteration on R1, and whether R1 had any fall incident on 2/8/21. V9 replied, V11 (Treatment Nurse) worked the 7 AM to 3 PM and she did not report any incident, accident or skin bruising concerning R1 to her.	S9999		

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S9999	Continued From page 4 On 2/17/21, an interview was conducted with V12 CNA (Certified Nurse's Aide) in charge of R1's care. V12 stated (V9 RN) asked her to assist in cleaning (R1) up in getting her ready for hospital transfer, she did not notice any bruises on (R1). On 2/17/21, an interview was conducted with V2 DON (Director of Nurses). V2 stated that none of the facility nurses reported R1 had any bruise and there was no bruising documented in R1's chart. V2 was asked whether any of the nurses made her aware that the local hospital called the facility to inquire how R1 got the bruises to her lower extremities. V2 replied she was not aware. V2 DON acknowledged that any injury of unknown origin should be followed up with an investigation and reported to the State Agency. On 2/17/21, V2 DON attributed the bruising to R1's use of anticoagulant injection but was unable to provide any documentation to show that R1 was being closely monitored for any side effects of anticoagulant. V2 did not present any record of physician notification regarding R1's bruises. The review of R1's plan of care presented did not show how R1 is being monitored for the side effects of anticoagulant medication. R1 has no plan of care regarding skin integrity monitoring. On 2/17/21, the review of R1's physician order report did not show an order for skin assessment upon return to the facility. The last order was dated 3/2/2020. On 2/23/21, the review of R1's hospital H&P (history and physical) document dated 2/9/21 at 3:29 AM, on page 6 showed V15 (Physician) documented that the skin is warm and dry, no rash, there is scattered bruises on lower extremities. The local hospital presented picture	S9999		

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S9999	Continued From page 5 of R1's extremities showing the bruises. On 2/24/21 at 2:23 PM, an interview was conducted with V21 ADON (Assistant Director of Nurses). The surveyor asked about the facility protocol on care plan regarding resident(s) using anticoagulants. V21 replied it should be care planned. V21 then searched the plan of care for R1 in the medical record. V21 then stated, "I did not see any care plan." Then the surveyor asked V21 if a care plan should be initiated. V21 replied Heparin is an anticoagulant so it should be care planned. V21 explained that the care plan will show what the staff should be looking for in monitoring R1 to prevent things like bruising or bleeding. V21 stated it should be documented when any bruising is noted on her (referring to R1's) body. On 2/24/21 at 3:06 PM, an interview was conducted with V11 (Treatment Nurse). V11 stated that she worked the unit on 7 AM to 3 PM shift of 2/8/21. V11 stated R1 was fine until after lunch. V11 explained that she noted normal bruising on R1, on the right and left arm but no bruising was noted on other parts of the body. When the surveyor asked about where this was documented, V11 stated she normally charted on the TAR (Treatment Administration Record). V11 was unable to produce any documentation of these bruises. V11 explained after R1 was readmitted on 2/11/21, there was no order recorded for skin assessment. Because this will be her responsibility, she got the physician order on 2/18/21 (seven days after readmission). V11 was unable to present a TAR for December 2020, January 2021, or February 1, 2021 to February 8, 2021.	S9999		

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On 2/24/21 at 3:20 PM, the surveyor showed both V1 (Administrator) and V21 ADON (Assistant Director of Nurses) R1's hospital emergency room picture of R1's lower extremities. V1 stated, "Yes I can see the bruises and I can see what you mean." V21 stated, "Yes there were bruises on both legs. But none of the nurses charted on seeing it (referring to the bruises.)"

On 2/24/21 at 3:30 PM, the facility was unable to produce a policy on injury of unknown origin or a policy on anticoagulant monitoring/management regarding monitoring of side effects.

On 2/25/21 at 1:52 PM, V10 (Physician) acknowledged that he was not aware of any bruising to R1's lower extremities. V10 explained that for any resident on anticoagulant therapy, they are prone to bruising easily, it is the expectation of the facility's nurses to monitor the resident. V10 stated in part, that bruises above 10 cm and multiple bruises should be reported to the physician and documented. V10 said that R1 should have been being monitored and the bruises should have been reported.

On 3/4/21, V1 Administrator stated the injury of unknown origin policy is incorporated within the abuse policy. V1 stated it should be investigated and reported to the State Agency. V1 then presented the initial State Agency notification that was dated 2/24/21 (eight days after the surveyor notified V2).

2. On 2/19/21, R4 alleged V24 CNA (Certified Nurse Aide) was verbally abusive towards her, calling her inappropriate names.
On 3/4/21 at 10:21 AM, an interview was conducted with V7 LPN (Licensed Practical Nurse). V7 stated on 2/19/21 she was the nurse

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on duty. V7 asked V24 CNA (Certified Nurse Aide) to take the phone to R4 in the room. V7 stated V25 PRSD (Psychiatrist Rehabilitation Services Director) came to the floor later that day informing her that V24 was verbally abusive to R4. When she asked R4 about it, R4 confirmed that V24 cussed her out using four letter words but was unable to recollect the time it happened. V7 explained that she called V21 ADON (Assistant Director of Nurses) to report this allegation. V24 stated V21 ADON replied that V25 already made her aware and V24 has been suspended pending investigation.

On 3/4/21 at 10:31 AM, R4 was noted in the room sitting in bed. R4 was not able to remember the exact date of the 2/19/21 incident. When the surveyor asked R4 how she is being treated in the facility by the staff, R4 started looking down and frequently starring at the room doorway then R4 confirmed that staff was cussing when talking to her. R4 stated, "I don't like it and I was upset". On 3/4/21 the facility presented R4's final report sent to the State Agency dated 3/2/21. The facility occurrence resolution documentation showed that the facility concluded that the allegation cannot be substantiated.

On 3/4/21 at approximately 11:05 AM, the surveyor informed V1 Administrator, V2 DON (Director of Nurses) and V21 ADON (Assistant Director of Nurses) of R4 and V7's LPN (Licensed Practical Nurse) confirmation of the verbal abuse. V1 and V2 replied at the same time that V7 did not let anyone know of this. V1 stated that V7 just admitted to her that V24 CNA was verbally abusive to V4. V1 then stated, new report to the State Agency will be sent and V24 will be suspended again pending another full investigation.

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On 3/8/21, V22 (family) explained that when he called the facility, he heard a male staff over the phone cussing. V22 stated at first, he thought they were residents talking to each other until V7 (LPN) identified that the person cussing was one of the facility staff. V22 stated when R4 came to answer the call, R4 was very upset and cussing at the staff using five letter words (referring to B*****). V22 stated he first called V26 (Restorative Rehab) a family member that is staff at the facility. V26 told V22 to call V25 PRSD (Psychiatrist Rehabilitation Services Director). V22 stated he then called V25 to complain about the incident.
Interview was conducted on 3/9/21 at 12:22 PM with V26. V26 Restorative Rehab explained that V22 (family member) called her stating that he heard over the phone how R4 was verbally abused. V26 stated she was on the way home at the time, so she told V22 to call V25 PRSD.
Review of abuse log showed that V24 CNA was suspended pending investigation. However, the facility did not thoroughly investigate the incident because V24 was allowed to come back to work. The facility concluded the allegation was unsubstantiated.

The facility Abuse Prevention policy was presented with no date. The policy documented in part that residents have the right to be free from any form of abuse and neglect.
The policy defines Neglect as failure to provide goods and services to a resident that are necessary to avoid physical harm, mental anguish, or emotional distress.
The facility job description for RN (Registered Nurse) and LPN (Licensed Practical Nurses) presented listed the primary purpose of these positions that includes but not limited to providing

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S9999	Continued From page 9 licensed nursing care to residents on the assigned unit in accordance with current federal, state and local standards, guidelines and regulations. The Duties/ Responsibilities/Functions listed includes but not limited to ensuring that appropriate documentation/charting is completed as required and in accordance with established policies and procedures. Ensure that all elements of the facility's abuse and neglect policies are maintained. "C"	S9999		