

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 10/25/2022
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of 09/21/2022/IL152031	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a)b) 300.690b) 300.1210b) 300.1210d)6) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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	S9999	Attachment A Statement of Licensure Violations	

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

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>recorded in the progress notes or nurse's notes of that resident.</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:</p> <p>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:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.3210 General</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>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>These Regulations were not met as evidenced by:</p> <p>Based on interviews and record review, the facility failed to ensure two residents (R1 and R2) were free from abuse by failing to prevent physical aggressive behavior between R1 and R2 as a result R1 sustained a closed fracture of left orbital (eye socket) floor. The failure affects 2 (R1 and R2) residents reviewed for abuse.</p> <p>The findings include:</p> <p>On 10/18/22 at 11:26 am R5 states "they (R1 and R2) were fighting with each other. R1 brought R2 to the room by R2's neck and cornered her. Then R2 started punching R1 in the face about 5 times. R1 got up from the wheelchair to get R2 and fell. They were fighting about a lighter. I did not see R1 hitting (R1) her head on the dresser. That is what R1 said, but what really happened was that R2 punched R1's face about 5 times." R5 says she and another roommate assisted R1 back to the wheelchair. R5 said there was no staff there and it happened early in the morning.</p> <p>On 10/18/22 at 11:53 AM, R2 states "R1 grabbed my neck and dragged me to her room, then I started hitting R1 in the face, I hit her on the cheek. R1 was in her wheelchair but she was able to grab my neck. I don't remember the reason we were fighting. After I hit her, she fell. I don't know if she hit the dresser. I went back to</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>my room. She had a fight with another girl (R3) the day before and R1 grabbed her neck too."</p> <p>On 10/19/22 at 10:12 AM, R1 denies being punched in the face and states she fell on her own, but states she had an altercation with R3 and R3 kicked her on R1's legs. R1 states that staff members were aware about the incident between her (R1) and R3 and aware about R3 kicking her (R1) legs. A right leg quarter size discoloration lesion is noted on R1's right shin.</p> <p>On 10/19/22 at 12:03 PM, V11 (Licensed Practical Nurse/LPN) states "I learned about the incident when I came to work that morning. R1 came to me before 7:30 am. When I saw R1 she had this little knot on her forehead. I asked what had happened and R1 said "we got into it."</p> <p>Progress notes (draft) on R2's chart dated 9/21/22 reads: 11:11 am R2 believes a resident stole an item she just purchased from peer and then taken by same peer. R2 went in peer room and tried to take item back which led to a verbal and physical altercation. R2 was counseled and educated on buying and selling item from peers. R2 was receptive to counseling and education.</p> <p>R1's Progress Note dated 9/21/22 reads: Note Text: Writer received the patient back at 8:05PM on the floor from Hospital ER via wheelchair accompanied by 1 ambulance attendant. The patient remains AOX3 but verbally aggressive, uncooperative with staff. VS 97.3 (blood pressure)145/98 (pulse)100 (respirations) 20, 96% room air. Result for CT scan (computerized tomography, or imaging) per report from the hospital nurse reveals closed fracture of left orbital floor.</p>	S9999			

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S9999	<p>Continued From page 4</p> <p>Facility statements from R2, R5, R1 and R1's roommate (not identified). R1's statement does not provide any information about the incident. Facility's investigation does not include any other source of information about the incident besides R1, R2 and R1's roommates' statements and these statements are not consistent with the statements taken by the surveyor during the investigation. There are no staff members' statements even though the facility report in its conclusion reads: staff and residents with knowledge of the incident were interviewed and no one could corroborate the allegation of abuse.</p> <p>There is no evidence that facility did a physical assessment on R1's body to identify possible injuries caused by R3's kick. There is no investigation of the incident between R1 and R3. There are no statements taken from staff or R3 related to R1's allegation of being kicked by R3. In the interview V1 states that he reported the two incidents to the Illinois Department of Public Health, however there is no evidence in the facility investigation that this allegation has been investigated other than a note saying that R1 had reported to them about the physical aggression perpetrated by R3.</p> <p>Facility's policy and procedure title "Abuse Prevention Program" revised on 01/2019 reads: For the purpose of this policy, and to assist staff members in recognizing abuse, the following definitions shall pertain: Physical abuse: hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment.</p> <p>(A)</p>	S9999		