| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0052837 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/25/2025 |
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| KENWOOD VLGE NRSG AND RHB CTR | 4505 SOUTH DREXEL , CHICAGO, Illinois, 60653 |

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| S0000 | Initial Comments<br><br>Complaint Investigation:<br><br>2586561/2564700 | S0000 | | 08/05/2025 |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br><br>300.1010h)<br><br>300.1210b)<br><br>300.1210d)3)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1010 Medical Care Policies<br><br>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.<br><br>Section 300.1210 General Requirements for Nursing and | S9999 | | 08/05/2025 |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| S9999 | Continued from page 1<br>Personal Care<br><br>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.<br><br>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:<br><br>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.<br><br>These Requirements were not met as evidenced by:<br><br>Based on interviews and record reviews the facility failed to evaluate and address a resident’s continued poor appetite for adequate nutrition and hydration, failed to follow the dietary’s recommendation, and failed to consistently implement interventions, monitor the effectiveness of interventions and revising them as necessary for one (R1) out of four residents reviewed for nutritional services. These failures resulted in R1 being hospitalized due to hypovolemic shock, malnutrition, and dehydration.<br><br>Findings Include:<br><br>R1’s clinical records revealed R1 was admitted in the facility on 6/23/25 and was discharged home on 7/9/25. R1’s listed diagnoses include but not limited to cerebral infarction, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, unspecified severe protein-calorie malnutrition, dysphagia pharyngoesophageal phase, and major depressive disorder. R1’s minimum data set dated 6/30/25 shows a BIMS (Brief Interview for Mental Status) score of 14, which indicates R1 was cognitively intact, and was total dependent on staff’s assistance for her activities of daily living (including eating).<br>R1’s weight record shows 88.3 pounds on 6/23/25. No other weights recorded for the entire stay of R1 in the facility. R1’s physician orders reads in part: General diet (ordered on 6/24/25) and House Supplement 1 carton three times a day (ordered on 6/25/25). | S9999 | | |

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| S9999 | Continued from page 2<br><br>R1's progress notes dated 6/26/25 to 7/9/25 revealed no documentation of any follow-up notification to V20 (R1's Physician) or V10 (Registered Dietitian/RD) about R1's consuming 25% or less of her meals. R1's vitals report revealed R1's amount eaten for breakfast, lunch, and dinner (25% or less):<br><br>6/24/25: 1-25% for dinner<br><br>6/26/25: 1-25% for dinner<br><br>6/29/25: 1-25% for dinner<br><br>7/2/25: None eaten for breakfast<br><br>7/3/25: 1-25% for breakfast and lunch<br><br>7/5/25: 1-25% for breakfast and lunch<br><br>7/6/25: 1-25% for breakfast and lunch<br><br>7/7/25: 1-25% for breakfast and lunch<br><br>7/8/25: 1-25% for breakfast and lunch<br><br>R1's progress notes dated 6/25/25 at 11:41 AM documented by V10 reads in part: "RD new admission referral for this 78 y/o female. Admitted 6/23/25. DX/PMH [Diagnoses/Primary Medical History] including but not limited to cerebral infarction, COPD, T2DM, chronic respiratory failure with hypoxia, severe protein-calorie malnutrition, MDD, dysphagia, glaucoma, anxiety DO, bilateral primary osteoarthritis of knee, hypertensive heart disease without HF, rheumatoid arthritis, spinal stenosis, radiculopathy, retention of urine, GERD, pain in left hip, central retinal vein occlusion, brachial plexus DO, Vitamin D deficiency. Reviewed orders. NKA per EMR. Diet: general. Per progress notes, no teeth observed, no dentures, noted decreased vision in both eyes. Per EMR, PO intake 6/23-6/25 was variable 26-100% of meals, with 1 meal 1-25%. Weight on 6/23 was 88.3 [pounds], Ht: 64" (per hospital records), BMI 15.2-underweight. Wt [Weight] stability/gain beneficial d/t [due to] underweight status. Skin intact per wound report. Per progress notes, two healed/closed pressures ulcers on the left and right ankle. No edema noted. No GI problems. No recent labs. Estimated needs using IBW (55kg): 1650-1925kcals/day (30-35kcals/kg), 55g protein/day (1.0g protein/kg), 1650-1925mL/day (1ml/kcal). Recommend SLP [Speech Language Pathologist] referral for appropriate diet consistency d/t no teeth and house supplement/med pass 1 carton TID [three times a day] to | S9999 | | |

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| S9999 | Continued from page 3<br>promote wt stability/gain, Refer to RD as needed."<br><br>R1's progress notes dated 7/4/25 at 5:32 PM documented by V34 (Licensed Practical Nurse) reads in part: R1 "had inadequate meal intake and consumed 750cc fluids. Total assist with ADL's provided by staff and all care provided in resident room."<br><br>R1's hospital records (7/11/25 to 7/14/25) documented in part: [R1] "recently completed 2 week stay at [Nursing Home Facility Name] for respite care, [V33 (R1's Daughter)] is primary caregiver. On return home patient [R1] was noted by daughter [V33] to be altered with slurred speech. Admitted with AMS [Altered Mental Status], hypotension and elevated lactic acid thought initially to be due to urosepsis however urine culture grew mixed flora. Therefore, shock due entirely to hypovolemia. Stroke workup negative for acute stroke. [R1] (90 pounds) received 7L [liters] of IV [Intravenous] fluids for resuscitation guided by lactic acid levels and bedside IVC ultrasound without signs of volume overload. Hypovolemic shock is determined to be from lack of PO [by mouth] intake of food and water during stay at nursing home for respite care. [R1] report she did not receive food or water during her time at nursing home."<br><br>On 7/23/25 at 10:56 AM, V11 (Licensed Practical Nurse) stated she was one of the regular nurses who took care of R1 in the facility. V11 stated R1 barely talked, total dependent, and was on general diet changed to mechanical soft because R1 was pocketing her food. V11 stated R1 ate at least 50% of her meals but there were days R1 ate less. V11 stated she did not inform V20 (R1's Physician) because R1 had poor appetite since the first day R1 was admitted in the facility. V11 stated that R1 was not on calorie count, R1 was on one-on-one feeding and not on any supplements. V11 stated she provides the residents water during medication pass.<br><br>On 7/23/25 at 11:03 AM, V12 (Restorative Aide) stated, R1 came as total assist. R1 was on Geriatric chair. R1's arms and legs were already contracted when she came. V12 stated that R1 was a picky eater and sometimes R1 would refuse to eat. V12 stated that she told the nurse but can't remember who the nurse. When R1 refuses, V12 stated they would offer substitute soup or a sandwich and would eat a little bit of that.<br><br>On 7/23/25 at 11:32 AM, V13 (Certified Nursing Assistant) stated, "If residents don't eat, I don't offer them alternatives. Kitchen staff come around with what food options they can have the day before. They give them what they ordered. I took care of R1. She | S9999 | | |

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| S9999 | Continued from page 4<br>would eat her meals at least half. Sometimes she would have just a couple of bites. She was a picky eater. I tried to give her a little more of what she likes. She was not offered substitute because I think she can only eat certain foods. I didn't tell the nurse about R1 because she's been having poor appetite since she came here to us."<br><br>On 7/24/25 at 1:05 PM, V4 (Certified Nursing Assistant/CNA) stated she was of the CNAs that regularly took care of R1. V4 stated some days R1 would eat 50% and other days R1 would eat very little. V4 stated, "If [R1] would not eat I tell the nurse and they give her a supplement. She [R1] was not offered alternatives just milk shakes. I offer water in the beginning of my shift and in between meals and when they asked. [R1] was offered water, and she can talk and can tell you if she's hungry or thirsty."<br><br>On 7/24/25 at 1:41 PM, V7 (Agency Registered Nurse) stated that R1 had poor appetite. V7 stated that sometimes R1 would not eat. Sometimes R1 would eat just a little bit.<br><br>On 7/24/25 at 9:07 AM, a phone interview was conducted with V10 (Registered Dietitian). V10 stated that on 6/25/25, she recommended speech referral to evaluate R1 for difficulty chewing because R1 had no teeth and no dentures. R1 also had poor appetite and underweight. V10 stated having no teeth could contribute to R1's poor appetite. V10 stated she recommended house supplement three times a day. V10 stated she was not notified of R1's continued poor appetite and was eating less than 25% most of her meals. V10 stated she would have ordered additional supplements, calorie count, and weekly weights. V10 stated she recommended speech therapy to work on R1's appropriate diet texture and consistency. V10 stated that with the right diet, R1 would have better appetite that matches her needs, weight stability and no weight loss. V10 stated R1 was not provided speech therapy services because V10 can't find any reports from speech. V10 further stated that if residents do not like the food and refuse to eat, staff should offer alternatives and substitutes, and it should always be available with each meal. V10 stated that having dehydration and acute malnutrition with shock could not happen in just two days. It could happen after a week of not drinking and not eating enough.<br><br>On 7/24/25 at 9:29 AM, V17 (Director of Rehab) stated that speech therapy [ST] sees residents with cognition issues and dysphagia, and for dietary referrals for diet texture and consistency. ST works on what is | S9999 | | |

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| S9999 | Continued from page 5<br>appropriate for the resident. They work on mastication, rate of chewing, if there is food left over in the mouth if they are pocketing. V17 stated that she did not receive any referral about R1. V17 stated that if she sees any referral or if she was notified, ST would evaluate the resident within 24-48 hours. V17 stated R1 was not screened or evaluated by speech therapy. V17 stated she has no documentation about speech services provided for R1. V17 stated R1 was only provided skilled occupational therapy during R1's stay at the facility.<br><br>On 7/24/25 at 10:34 AM, V34 (Licensed Practical Nurse) stated that she took care of R1 on 7/4/25. Breakfast, lunch, and dinner R1 only ate about 50-60%. R1's good with her fluids. R1 did not want to eat. The CNAs are supposed to inform the nurses if the resident did not eat or did not want to eat. If it's a pattern nurses could contact the dietitian and the doctor. V34 stated she did not inform V20 of R1's poor appetite because R1 was already seen by V10.<br><br>On 7/24/25 at 2:52 PM, a phone interview was conducted with V35 (R1's Hospital Physician). V35 stated, R1 "was admitted in the hospital on 7/11/25 and was discharged on 7/14/25. [V33] brought her [R1] in after getting her [R1] back from the nursing home the day before. She [R1] was not as alert and not answering questions as typically did. She [R1] had severe electrolytes imbalance, had kidney injury with elevated lactic acid level which indicated she [R1] was in shock. Initially we thought it was UTI [Urinary Tract Infection], but nothing came back with infection. She [R1] did not have UTI. She [R1] was dehydrated based on her labs and required large amount of fluids compared to her body weight to correct her kidney injury and electrolytes. She [R1] was able to eat and back to her normal mental status after we gave her the fluids. She [R1] told us that she was not given foods and fluids at the nursing facility. She weighed 90 pounds when she came in the hospital. That was documented on the 11th before she [R1] received the fluids. She [R1] required 7 liters of fluids total during her hospitalization. That amount of fluid was indicative that she [R1] was not provided enough hydration and nutrition for a longer period of time. That can't happen it just two days. To be hypovolemic, severely dehydrated and with acute malnutrition with shock to happen it could take longer than 2 days. It's a matter of days but not 2 days. If she [R1] was seen by speech therapy at the nursing home that would help identify what's an appropriate diet and fluids for her."<br><br>On 7/25/25 at 10:55 AM, a phone interview was conducted | S9999 | | |

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| S9999 | Continued from page 6<br>with V20 (R1's Physician). V20 stated that he expects nursing to contact and notify him if his residents are not eating or having poor appetite. V20 stated he was not made aware of R1's poor appetite or eating less than 25% some of her meals in the nursing home. V20 stated that the nursing staff at the facility are pretty good of notifying him about his residents' change in condition. V20 stated dehydration and malnutrition with shock do not happen in the span of 2 days and it could result from 3 or more days of not eating or drinking.<br><br>The facility's "Hydration" policy dated 2005 documents in part: the physician will manage fluid and electrolyte imbalance, and associated risks, appropriately and in a timely manner. The physician will help monitor the development, progression, or resolution of fluid and electrolyte imbalance in at-risk individuals. Adjust treatments on specific information relevant to that individual.<br><br>The facility's "Passing Meal Trays" policy (no date) documents in part: Nursing will offer alternates to residents who refuse their food or request a substitute. Nursing will advise dietary of such requests.<br><br>The facility's "DIETARY SERVICES" policy (no date) documents in part: It is the policy of this facility to provide a quality dietetic service using high standards of sanitation that meet the daily nutritional needs of the residents. Each resident's nutrition and hydration status is assessed and monitored. Residents shall be observed to determine acceptance of the diet. Should residents refuse foods served, or eat less than 50% of the total meal, appropriate substitutes of similar nutritive value will be offered.<br><br>(A) | S9999 | | |