STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	**6125 SOUTH KENWOOD CHICAGO, IL 60637**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation 1682355/ IL85190 - No deficiency 1683264/ IL86220 - F279, F309, F312, F314 and F465	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to develop individualized fall care plan interventions based on the resident's assessed physical limitations. This applies to one of four residents (R3) reviewed for high risk for falls, in a sample of 15.	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	6125 SOUTH KENWOOD CHICAGO, IL 60637

(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) COMPLETION DATE
F 279	Continued From page 1	F 279		

Findings include:

According to an electronic face sheet R3 was admitted to the facility 3/24/14 and had diagnoses including but not limited to: rheumatoid arthritis, abnormal gait/mobility and lack of coordination.

R3's last minimum data set (MDS) assessment dated 4/14/2016 R3 had impaired vision, and required physical assistance from staff members for transfer and ambulation.

According to incident reports R3 had two recorded falls since his admission. On 6/27/2015 at 14:34 (hour) R3 told staff he fell in the washroom yesterday but did not inform anyone. There was no injury recorded.
On 6/17/2016 at 20:56 (hour) R3 with compliant of pain MD (medical doctor) made aware eith new orders for x-ray. Resident stated I fell days ago. Resident acknowledge that he did not pull call string and assisted himself back to bed. this reported stated R3 was not taken to the hospital.

The Physician order chest, ribs and knee x-rays. The x-ray revealed what appears to be a fracture of the left 10th rib posteriorly with no significant displacement. R3 was sent out for further evaluation at a local hospital. The hospital emergency room report dated 6/17/2016 at 02:56 (hours) also documented R3 was treated for a rib fracture. The final diagnosis was documented as a possible rib fracture.

R3's care plan dated 4/13/16 documents R3 was at risk for falls due to visual acuity impairment, requires ADL Assistance for transfers and mobility, decreased strength and endurance and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	6125 SOUTH KENWOOD CHICAGO, IL 60637

(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) COMPLETION DATE
F 279	Continued From page 2 use of anti-psychotropic Meds (medications). The interventions were as follows: gather information on past falls and attempt to determine cause of falls. Anticipate and intervene to prevent future recurrence. Be sure call light is within reach and encourage to use it for assistance as needed. Respond promptly to all requests., Anticipate and meet needs, Complete fall assessment per facility protocol, 6/27/15- educate/ensure proper footwear and 6/17/16 - Patient education on call limit usage. On 6/23/2016 at 10am, the surveyor asked R3 how would call for help from the nurse. R3 stated he would go pull the string in the toilet room. R3 was positioned in a wheelchair while in his room at this time. R3 was asked to activate the call light. R3 turned his wheelchair toward the opposite direction of the toilet room. R3 commented, I know it is one of two of the doors as he pushed his wheelchair on the opposite side of the room. Finally, R3 stopped the wheelchair and did nothing else. E10 (minimum data coordinator/nurse) was in the room at the time. The surveyor at the daily status meeting with E1 (administrator) and E2 (director of nurses) shared the observation of R3 not able to physical use a call light due to his limitation but he is expected to use it to prevent a fall. E1 and E2 did not present any additional documentation regarding this intervention.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	6125 SOUTH KENWOOD CHICAGO, IL 60637

(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) COMPLETION DATE
F 309	Continued From page 3	F 309		

mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to have a staff member report a fall accident/incident involving a resident upon occurrence to immediately asses for possible injury. This applies to one of four residents (R3) at risk for falls, in a sample of 15. As a result, R3 was not assessed and/or treated for a possible rib fracture until a family member (Z1) alerted nursing staff.

Findings included:

According to an electronic face sheet R3 was admitted to the facility 3/24/14 and had diagnoses including but not limited to: rheumatoid arthritis, abnormal gait/mobility and lack of coordination.

R3's last minimum data set (MDS) assessment dated 4/14/2016 R3 had impaired vision, and required physical assistance from staff members for transfer and ambulation.

According to incident reports R3 had two recorded falls since his admission. On 6/27/2015 at 14:34 (hour) R3 told staff he fell in the washroom yesterday but did not inform anyone. There was no injury recorded.
On 6/17/2016 at 20:56 (hour) R3 with compliant of pain MD (medical doctor) made aware eith new orders for x-ray. Resident stated I fell days ago.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	6125 SOUTH KENWOOD CHICAGO, IL 60637

(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) COMPLETION DATE
F 309	Continued From page 4	F 309		

Resident acknowledge that he did not pull call string and assisted himself back to bed. this reported stated R3 was not taken to the hospital.

The Physician order chest, ribs and knee x-rays. The x-ray revealed what appears to be a fracture of the left 10th rib posteriorly with no significant displacement. R3 was sent out for further evaluation at a local hospital. The hospital emergency room report dated 6/17/2016 at 02:56 (hours) also documented R3 was treated for a rib fracture. The final diagnosis was documented as a possible rib fracture.

R3's electronic medication administration record for June 2016 had a pain score of six (6) for June 16, 2016. According to the facility pain score, a score of 6-7 means moderate pain.

During an interview with Z1 (power of attorney/sister) Z1 reported R3 stated he was startled by a staff one day. The staff person wanted to get him up for a shower but he was not completely awake. As this person was trying to take off his clothing it was a struggle and he fell with the staff on top of him. Z1 stated R3 is blind he did not know who the staff was and they (the facility) change staff people. Z1 stated she believe R3 is afraid to tell staff because he is blind.

On 6/21/2016 between 3:52 and 4:02pm, Z2 (family) and Z3 (family) were interviewed via phone regarding details of R3's fall incident for 6/17/2016. According to Z3, R3 told staff on 6/17/16 he was in a struggle with a staff member. He was not sure who. During the struggle R3 went down and the staff fell on top of him. It happened 2-3 weeks prior to reporting it 6/16/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	6125 SOUTH KENWOOD CHICAGO, IL 60637

(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) COMPLETION DATE
F 309	Continued From page 5	F 309		

According to Z2, family members (Z1, Z2 & Z3) were visiting R3 and he reported having pain. Z2 was present when a nurse came into R3's room to check him out. She gave him some medication. He (R3) told the nurse what happened.

On 6/21/2016 at 12:50pm via phone E5 (nurse) acknowledged she was the charge nurse for R3, on duty the morning of 6/16/2016. According to E5 she was told by the MDS coordinator that R3 had pain. When she came to R3's room, three family member were present. E5 stated R3 was changing his story about how he fell. R3 first said he was walking and fell and next he said something fell on him. My concern was to make the resident comfortable.

On 6/21/2016 at the daily status meeting with E1 (administrator) and E2 (director of nurses/DON) the surveyor presented a concerns regarding conflicting information about R3's alleged fall in June 2016. E2 (DON) commented, she was present when the assistant director of nurses questioned R3. E2 stated R3 can tell you what happened he said he fell.

On 6/23/2016 at 9:05am, E10 (MDS coordinator/ Guardian Angel staff) reported he received information from Z1 (family/power of attorney) the day the incident was reported about R3's fall. E10 stated, Z1 told him R3 had fallen. They were in the dining room at the time during the meal. R3 told E10 he had pain on his right side and knee. He stated he fell about 4 days ago. I told the chare nurse about it.

On 6/23/2016 during the 10am hour, R3 stated to the surveyor a facility staff fell on him. R3 could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	6125 SOUTH KENWOOD CHICAGO, IL 60637

(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) COMPLETION DATE
F 309	Continued From page 6 not recall any specific details(how, who what, when or where) about the incident. The facility's abuse prevention program policy & procedure revised date 09/25/2013 contained the following information: Employees are required to immediately report any incident, allegation or suspicion of potential abuse, neglect, misappropriation of resident property, or treatment they observe, hear about, or suspect of the administrator if available or an immediate supervisor who must immediately report it to the administrator. In the absence of the Administrator, reporting can be made to the DON. On the morning of 6/23/2016 E2 (DON) in the presence of E1, reported she re-interviewed R3 about the incident reported 6/17/2016. E2 reported R3 did say at the time of this interview, a staff member fell on top of him. E2 expressed this was the first time they (E1 and E2) heard this information. According to E2, all employee receive an orientation at the time of hire, including a review of the facility's abuse policy and procedures.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	**6125 SOUTH KENWOOD CHICAGO, IL 60637**

(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) COMPLETION DATE
F 312	Continued From page 7	F 312		

Based on observation, record review and interview the facility failed to followed care plan interventions for providing incontinent care and re-positioning for a resident within a two to three hour time period for residents who unable to perform activities daily living (ADL). This applies to four or four residents (R1, R2, R3 and R4) reviewed for ADL care and services, in a sample of 15.

Findings include:

On 6/20/2016 at 10 am, the surveyor entered the 2nd floor nursing unit residents were present in the day room and an activity of morning exercise was noted at that time. R1, R2, R3 and R4 were among the residents presented in this area. At 10:15am, R3 was taken off the floor for therapy. The surveyor followed the personal transporting R3 to a therapy room on the first floor. The surveyor returned to the unit prior to 10:30am to continue observation on the second floor. R3 was returned back to the day room at 11am, via wheelchair and positioned up to a table.

The surveyor observed R1, R2 and R3 in the day room positioned in geriatric chairs. R1, R2, R3 and R4 did not participate in any of the exercise or music playing activities conducted during the 10am and 11:43am. Nurse aides and nurses were noted at 11:30am in the dining room preparing resident for the lunch. The surveyor noted the staff action included re-locating chairs and placing clothing protectors on residents until the food arrived to the floor just before 12 noon. R1, R2, R3 and R4 remained in their chairs throughout the lunch period. R1, R2 and R4 were fed by staff member with a minimum conversation with the residents. After all the residents in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	6125 SOUTH KENWOOD CHICAGO, IL 60637

(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) COMPLETION DATE
F 312	Continued From page 8	F 312		

dining room were fed, staff began to take residents out of the dining room at 1:57pm and line them up in the corridor.

R1, R2, R3 and R4 remained in the corridor positioned in either a geriatric chair or wheelchair until the surveyor request to have staff check for incontinence beginning at 2:25pm. R3 was checked for incontinence per surveyor's request at 2:25pm. R1 was checked for incontinence per surveyor's request at 2:31pm. R4 was checked for incontinence per surveyor's request at 2:39pm. R2 was checked for incontinence per surveyor's request at 2:40pm.

On 6/20/2016 the surveyor made 15 minutes interval observations of R1, R2 and R4 positioned in a geriatric chair between 10am to 2:15pm (over a 4 hour period) without being repositioned, checked for incontinent or toileted by a staff members. The surveyor made 15 minutes interval observations of R3 from 11am to 2:25pm (3 hours and 25 minutes) without being repositioned, checked for incontinence or toileted by a staff member. The surveyor was positioned just outside the dayroom where staff members and residents were visible if exiting out the room.

On 6/20/2016 at 2:02pm the surveyor asked E12 (restorative nurse) for a list for the residents receiving scheduled toileting on the second floor. E12 commented she did not think anyone was receiving this service but would check. E12 also, commented the facility had a check and change policy if a resident did not have a toileting program. E12 explained this when the staff would check on an incontinent resident every two hours or as needed. E12 also commented the nurse aides documents it in electronic system. E12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	**6125 SOUTH KENWOOD CHICAGO, IL 60637**

(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) COMPLETION DATE
F 312	Continued From page 9	F 312		

refer to it as the POC system.

-An electronic face sheet indicated R1 was admitted to the facility on 6/10/2013 with an history of transient ischemic attack and cerebral infarction.

According to R1's last minimum data set (MDS) assessment dated 5/01/2016 R1 needs physical assistance for transfer, mobility and hygiene. R1's range of motion is impaired on both side for the upper and lower extremities. R1 was always incontinent of bowel and bladder.

R1's current care plan dated 6/20/2016 documents R1 has bladder and bowel incontinence. The goal is the resident will be kept clean, dry and odor free with regular toileting following the check and change toileting plan through next review 9/20/2016. The intervention included but not limited to:Follow the check and change program at minimum of every 2-3 hours. Next, the care plan identified R1 with a poor sitting balance and unable to maintain an upright position when up in the wheelchair due to poor trunk control and sitting balance. The goal was for use of geriatric chair when out of bed to provide trunk support/ stability/ comfort over the next 90 day. The interventions included but not limited to: Reposition resident ever 2-3 hour and as needed and check and change resident every 2-3 hours and as needed.

-An electronic face sheet indicated R2 was admitted to the facility on 01/14/2009 and had diagnoses including but not limited to dementia, Alzheimer's disease and lack of coordination

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	**6125 SOUTH KENWOOD CHICAGO, IL 60637**

(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) COMPLETION DATE
F 312	Continued From page 10	F 312		

According to R2's last minimum data set (MDS) assessment dated 04/12/ 2016 R2 needs physical assistance for transfer, mobility and hygiene. R2 was frequently incontinent of both bowel and bladder.

R2's current care plan dated 4/12/2016 documents for self care deficit: R2 requires assist with ADL to maintain highest possible level of functioning. Interventions included but not limited to: ensure proper positioning while in bed/ chair. Turn and reposition every 2 hours.

-An electronic face sheet indicated R3 was admitted to the facility 3/24/2014. R3's diagnoses including but not limited to: rheumatoid arthritis, abnormal gait/mobility and lack of coordination.

R3's last minimum data set (MDS) assessment dated 4/14/2016 indicated R3 had impaired vision, required physical assistance from staff members for transfer, ambulation and hygiene and was frequently incontinent of bowel and bladder.

R3's current care plan dated 4/14/2016 documents for self care deficit: R3 requires assist with ADL to maintain highest possible level of functioning. Interventions included but not limited to: ensure proper positioning while in bed/ chair. Turn and reposition every 2 hours. The only place R3's incontinence was indicated was under the resident's risk for alteration in skin integrity with a date of 4/13/16 and none of the intervention address what services R3 would receive for incontinence care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	6125 SOUTH KENWOOD CHICAGO, IL 60637

(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) COMPLETION DATE
F 312	Continued From page 11 -An electronic face sheet indicated R4 was admitted to the facility 3/24/2014. R3's diagnoses including but not limited to: rheumatoid arthritis, abnormal gait/mobility and lack of coordination. R4's last minimum data set (MDS) assessment dated 5/10/2016 indicated R4 had required physical assistance from staff members for transfer and hygiene and R4 was frequently incontinent of bowel and bladder. R4's current care plan dated 5/10/2016 documents for self care deficit: R4 requires assist with ADL to maintain highest possible level of functioning. Interventions included but not limited to: ensure proper positioning while in bed/ chair. Turn and reposition every 2 hours. Also the care plan indicated R4 was always incontinent of bowel and bladder. The goal is the resident will be kept clean, dry and odor free with regular toileting following the check and change toileting plan through next review. The intervention included but not limited to: Follow the check and change program at minimum of every 2-3 hours. On 6/23/2016 the surveyor requested for the facility policy governing the care of incontinent residents. E2 (DON) presented a policy and procedure for Brief/incontinence product usage. E2 commented this is what we have. When questioned about the check and change programs as outline in some residents' care plans E2 denied any knowledge of this policy.	F 312		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	6125 SOUTH KENWOOD CHICAGO, IL 60637

(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) COMPLETION DATE
F 314	Continued From page 12	F 314		

resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation and record review the facility failed to turn or reposition residents to relieve pressure on body areas at risk for development pressure ulcer. This applies to four of four residents (R1, R2, R3 and R4) assessed at risk for the development of a pressure ulcer, in a sample of 15.

Findings include:

On 6/20/2016 at 10 am, the surveyor entered the 2nd floor nursing unit residents were present in the day room and an activity of morning exercise was noted at that time. R1, R2, R3 and R4 were among the residents presented in this area. At 10:15am, R3 was taken off the floor for therapy. The surveyor followed the personal transporting R3 to a therapy room on the first floor. The surveyor returned to the unit prior to 10:30am to continue observation on the second floor. R3 was returned back to the day room at 11am, via wheelchair and positioned up to a table.

The surveyor observed R1, R2 and R3 in the day room positioned in geriatric chairs. R1, R2, R3 and R4 did not participate in any of the exercise or music playing activities conducted during the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	6125 SOUTH KENWOOD CHICAGO, IL 60637

(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) COMPLETION DATE
F 314	Continued From page 13	F 314		

10am and 11:43am. Nurse aides and nurses were noted at 11:30am in the dining room preparing resident for the lunch. The surveyor noted the staff action included re-locating chairs and placing clothing protectors on residents until the food arrived to the floor just before 12 noon. R1, R2, R3 and R4 remained in their chairs throughout the lunch period. R1, R2 and R4 were fed by staff member with a minimum conversation with the residents. After all the residents in the dining room were fed, staff began to take residents out of the dining room at 1:57pm and line them up in the corridor.

R1, R2, R3 and R4 remained in the corridor positioned in either a geriatric chair or wheelchair until the surveyor request to have staff check for incontinence beginning at 2:25pm. R3 was reposition when checked for incontinence per surveyor's request at 2:25pm. R1 was repositioned when checked for incontinence per surveyor's request at 2:31pm. R4 was repositioned when checked for incontinence per surveyor's request at 2:39pm. R2 was checked for incontinence per surveyor's request at 2:40pm.

On 6/20/2016 the surveyor made 15 minutes interval observations of R1, R2 and R4 positioned in a geriatric chair between 10am to 2:15pm (over a 4 hour period) without being repositioned, checked for incontinent or toileted by a staff members. The surveyor made 15 minutes interval observations of R3 from 11am to 2:25pm (3 hours and 25 minutes period) without being repositioned by a staff member. The surveyor was positioned just outside the dayroom where staff members and residents were visible if exiting out the room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	**6125 SOUTH KENWOOD CHICAGO, IL 60637**

(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) COMPLETION DATE
F 314	Continued From page 14	F 314		

-An electronic face sheet indicated R1 was admitted to the facility on 6/10/2013 with an history of transient ischemic attack and cerebral infarction.

According to R1's last minimum data set (MDS) assessment dated 5/01/2016 R1 needs physical assistance for transfer, mobility and hygiene. R1's range of motion is impaired on both side for the upper and lower extremities.

R1's current care plan dated 6/20/2016 identified R1 is at risk for alteration in skin integrity due incontinence and diabetes. The interventions for this problem included but not limit to reposition resident frequently when in bed, chair, geriatric chair or wheelchair. Also, R1 was identified with a poor sitting balance and unable to maintain an upright position when up in the wheelchair due to poor trunk control and sitting balance. The interventions included but not limited to: Reposition resident ever 2-3 hour and as needed.

-An electronic face sheet indicated R2 was admitted to the facility on 01/14/2009 and had diagnoses including but not limited to dementia, Alzheimer's disease and lack of coordination

According to R2's last minimum data set (MDS) assessment dated 04/12/ 2016 R2 needs physical assistance for transfer, mobility and hygiene.

R2's current care plan dated 4/12/2016 identified R2 is at risk for alteration in skin integrity due dementia. The interventions for this problem included but not limit to reposition resident frequently when in bed, chair, geriatric chair or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	6125 SOUTH KENWOOD CHICAGO, IL 60637

(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) COMPLETION DATE
F 314	Continued From page 15	F 314		

wheelchair. Also, the care plan documents for self care deficit interventions included but not limited to: ensure proper positioning while in bed/ chair. Turn and reposition every 2 hours.

-An electronic face sheet indicated R3 was admitted to the facility 3/24/2014. R3's diagnoses including but not limited to: rheumatoid arthritis, abnormal gait/mobility and lack of coordination.

R3's last minimum data set (MDS) assessment dated 4/14/2016 indicated R3 had impaired vision, required physical assistance from staff members for transfer, ambulation and hygiene.

R3's current care plan dated 4/14/2016 identified R3 at risk for alteration in skin integrity due incontinence and decrease mobility. The interventions for this problem included but not limit to Reposition resident frequently when in bed, chair, geriatric chair or wheelchair. Also, the care plan documents for self care deficit interventions included but not limited to: ensure proper positioning while in bed/ chair. Turn and reposition every 2 hours.

-An electronic face sheet indicated R4 was admitted to the facility 3/24/2014. R3's diagnoses including but not limited to: rheumatoid arthritis, abnormal gait/mobility and lack of coordination.

R4's last minimum data set (MDS) assessment dated 5/10/2016 indicated R4 required physical assistance from staff members for transfer and mobility.

R4's current care plan dated 5/10/2016 identified R1 is at risk for alteration in skin integrity due

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	6125 SOUTH KENWOOD CHICAGO, IL 60637

(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) COMPLETION DATE
F 314	Continued From page 16 incontinence and dementia. The interventions for this problem included but not limit to Reposition resident frequently when in bed, chair, geriatric chair or wheelchair. The care plan for self care interventions included but not limited to: ensure proper positioning while in bed/ chair. Turn and reposition every 2 hours. On 6/23/2016 the surveyor requested for the facility policy governing the care of incontinent residents. E2 (DON) presented a policy and procedure for Brief/incontinence product usage. E2 commented this is what we have. When questioned about the check and change programs as outline in some residents' care plans E2 denied any knowledge of this policy.	F 314		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to have wall and floor surfaces clean and maintain with a good appearance, to have resident's furnishings and window curtains in good repair, maintain good appearance of ceiling tiles, and have resident's equipment stored cleaned or protected from contamination until in use. This has the potential to affect 224 of 224 residents in the facility Findings include:	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	**6125 SOUTH KENWOOD CHICAGO, IL 60637**

(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) COMPLETION DATE
F 465	Continued From page 17	F 465		

On 6/20/16 between 9:10am and 9:55am, the surveyor conducted an environmental tour accompanied by E4 (housekeeper director).
The following observation were made during the environmental tour:
The 2nd floor -north side hallway had sticky floor
Rooms 221 & 220 multi-paper debris on floor (bowl, condiment packages could be identified)
Rooms 201, 202, 212, 211, 213, 215, 216, 218, 219, 220, 221, 222, 223, 224 had dirty build up at or around the room entry way and along the floors at the based of the walls.

The 4th floor -east side hallway had multiple wall surfaces in disrepair. The handrail by the elevator was missing and the wall was patched but the repair not completed. The wall paper near the oxygen storage room was torn away from the wall. The 4th floor north hallway had multiple yellowish stain on the walls on both side of the hall. Rooms 411, 413, 420, and 422 had torn window curtains. Rooms 421 and 424 had window curtains hang down. Parts of the curtain were not on curtain hooks. Room 420 had a chester drawer missing near bed#4 and the closet door was off the track. In the 4th floor day room, the majority of the dropped ceiling tiles were discolored. There were a few replaced with bright white tiles and the other tiles were either brown or yellowish in color. The exhaust vent had build up dust and dirt. The floor around the parameter of the day room had build-up dirt.

All resident's rooms on the 5th floor had unclean floor areas at the entry way and areas surrounding the parameter of the rooms. Room 513 with multiple beds had no privacy curtain hanging. Room 514 had a wall (where the head

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145938	A. BUILDING _____ B. WING _____	C 06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKSHORE ESTATES NURSING & REHAB	**6125 SOUTH KENWOOD CHICAGO, IL 60637**

(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) COMPLETION DATE
F 465	Continued From page 18 of beds was positioned) in disrepair. Work was started to repair the wall but not completed. Room 506 had torn and dirty window curtains hanging. In the 5th floor day room there was a total of 19 chairs with seat that had multiple cracks in the surface. All the chairs in the day room, which is use for resident's dining, had multiple dirty and food stain on the legs of the chairs. Food and paper debris were present under the tables in the day room. Also, noted was a french fry. The wall in which the air condition was mounted was in need of repair. On the 6th floor, no resident room was occupied. According to E4 the facility is utilizing the floor to service dialysis patient/residents, equipment storage and resident's personal belonging storage. On the 6th floor east corridor contained multiple wheelchairs, geriatric chairs, walkers, a mechanical lift and other equipment. upon examination The wheelchairs and geriatric chairs had multiple amounts of food and paper debris. None of the equipment was protected from spillage or dust build-up	F 465		