STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146018	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Village Nrsg & Rhb Ctr	2320 South Lawndale Chicago, IL 60623

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45000 Based on interview and record review, facility failed to affirm the right of the resident to be free from verbal abuse. This deficient practice affects one (R1) of three residents reviewed for abuse. Findings Include: On 08/25/2024 at 9:34AM, R1 was not observed inside of his room. On 08/25/2024 at 9:36AM, V7 (Licensed Practical Nurse/LPN) states she is the nurse responsible for caring for R1 but R1 is not currently in the facility. V7 states R1 was petitioned to be sent out to the hospital for a psychiatric evaluation on 08/22/2024 due to verbal aggression and resistance to redirection. On 08/25/2024 at 2:18PM, V6 (Maintenance Director) states he has been working at the facility for 6.5 years. V6 states V4 (Former Floor Technician) is a former floor technician who was responsible for mopping the facility floors. V6 states he was first made aware of the altercation between R1 and V4 when V6 walked onto the first floor unit and saw V4 huffing and puffing. V6 states V4 looked very angry so he inquired to V4 about what happened. V6 states that V4 informed him that V4 called R1 a motherf***er and told R1 to stop walking on my God d@m* floors because V4 was tired of R1 doing that $h!+ everyday. V6 states V4 told V6 I messed up, I said some things to R1 that I shouldn't have, I know I was wrong. V6 states the facility had just had an in-service on abuse and V4 was present so V4 was aware that his actions towards R1 were wrong. V6 states an investigation was initiated. V6 states himself and V1 (Administrator) called V4 via telephone and V4 admitted to V6 and V1 that he had verbally abused R1. V6 states V4 was then terminated via the telephone call. V6 states V4 should not have verbally abused R1. V6 states V4 (Former Floor Technician) and V5 (Painter) are no longer employed at the facility. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/25/2024 at 2:48PM V4 (Former Floor Technician) states he was mopping the floors in the H Wing of the facility and had a wet floor sign placed on the floors. V4 states R1 began walking on the wet floors and he did not want R1 to fall. V4 states he then asked R1 to move to the other side of the hall where the floors were not wet because V4 did not want to be responsible for R1 falling. V4 states R1 then began cursing at him saying F**k you motherf**ker, you don't tell me where to walk. V4 states he never verbally abused R1 and did not call R1 out of his name. V4 states he said some other things but R1 was not in his presence when he said something so V4 did not consider it to be abuse. V4 does not inform surveyor of what he said when R1 was not in V4's presence when surveyor inquired. V4 states he was terminated because it was said that he abused R1, V4 states that was not the case. V4 states he is not sure if there were any witnesses to what happened. V4 states about 20 minutes after the altercation between himself and R1, his supervisor V6 (Maintenance Director) came to speak to him and told V4 that he was under investigation and had to leave the building. V4 states he never admitted to V6 that he verbally abused R1. V4 states the altercation happened on a Monday and V4 was later called on a Thursday to be informed that he was terminated from the facility. V4 states the facility held a couple of meetings on abuse and discussed what staff should and should not do related to abuse. On 08/25/2024 at 4:48PM, V1 (Administrator) states she is the abuse coordinator at the facility. V1 states she received a call from V6 (Maintenance Director) informing her that V4 (Former Floor Technician) had verbally abused R1 for walking on V4's floors. V1 states she informed V6 to send V4 home and start an investigation. V1 states during the investigation, R1 stated to her that he had informed several staff members that V4 verbally abused him. V1 states herself and V6 interviewed V4 via telephone and V4 admitted to verbally abusing R1. V1 states V4 told her that R1 is a big guy and V4 is a little guy so V4 was scared because R1 walked up to V4. V1 states although V5 (Painter) is no longer employed at the facility, during V1's investigation, V5 admitted to witnessing V4 verbally abuse R1. V1 states she informed V4 via telephone that he was terminated and V4 was not allowed back at the facility. An attempt to contact V5 (Painter) via telephone was made on 08/25/2024 at 5:06PM, voice message left, awaiting call back. Nursing Progress Note dated 06/03/2024 written by V2 (Director of Nursing) documents, R1 reported being involved in a verbal altercation with staff. R1 reported that he was spoken to inappropriately by staff member. R1 assessed for injuries, none noted. R1 continues to be monitored for changes in condition and any signs of distress. R1 family and MD made aware of incident. R1's Face Sheet documents that R1 is a [AGE] year-old male with diagnoses not limited to: Chronic Obstructive Pulmonary Disease, Paranoid Schizophrenia, Hypertensive Heart Disease, Asthma, Type 2 Diabetes Mellitus, Anxiety. Facility reported incident dated 06/03/2024 documents that R1 reported allegations of V4 (Former Floor Technician) being verbally inappropriate with R1 due to R1 walking on the floor. V4 was immediately suspended, pending investigation. Family and physician notified. Investigation initiated and final report sent to health department. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility reported incident witness statement dated 06/06/2024 documents that V4 (Former Floor Technician) admits to being verbally inappropriate with R1 calling R1 b!+** and p*$$*. Facility terminated V4 on 06/06/2024. V4 also admits to having an in-service on abuse and taking a post test related to abuse. Facility reported incident witness statement dated 06/03/2024 documents that V5 (Painter) admits that V4 (Former Floor Technician) cursed at R1 and called him names more than once. V4's (Former Floor Technician) employee file dated 09/15/2022 reviewed. V4's file documents that V4 signed the facility's explanation of the types of abuse acknowledgement form on 09/15/2022. V4's employee file documents no prior records of abuse. V4 was hired on 09/15/2022 and terminated on 06/06/2024. Abuse in service dated 04/11/2024 titled Abuse documents that V4 participated in the abuse in-service with topics to include: Steps to take when abuse is witnessed, the type of code used for staff or resident altercations, and who the abuse officer is. Facility Post Test, undated, titled Physical Aggression with V4 (Former Floor Technician) name written on it documents that V4 is aware of how to respond when a resident is becoming increasingly agitated. Ombudsman Resident Rights for People in Long Term Care Facilities (undated) documents in part, You have the right to .safety and good care. You must not be abused by anyone- physically, verbally, mentally, financially or sexually. Facility policy dated 10/2022 titled Abuse Policy documents in part, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of good and services by staff or mistreatment. Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individuals' age, ability to comprehend, or disability.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45000 Based on interview and record review, the facility failed to revise a care plan for one (R1) of three residents reviewed for care plans. Findings include: On 08/25/2024 at 3:42PM, V14 (Licensed Practical Nurse (LPN)/Former Care Plan Coordinator) states she is the former care plan coordinator and is knowledgeable about the care plan process. V14 states the social services department are responsible for entering abuse care plans for the residents. V14 states an abuse care plan should be documented in the resident's medical record for a resident who is at risk for abuse, is vulnerable, or has actually experienced abuse. On 08/25/2024 at 3:46PM, R1's electronic medical record is deployed on the computer. V14 reviews R1's care plan and states she does not see an abuse care plan documented for R1. V14 states she is vaguely familiar with R1's altercation involving allegations of abuse and R1 should have an abuse care plan. Nursing Progress Note dated 06/03/2024 written by V2 (Director of Nursing) documents, R1 reported being involved in a verbal altercation with staff. R1 reported that he was spoken to inappropriately by staff member. R1 assessed for injuries, none noted. R1 continues to be monitored for changes in condition and any signs of distress. R1 family and MD made aware of incident. R1's Face Sheet documents that R1 is a [AGE] year-old male with diagnoses not limited to: Chronic Obstructive Pulmonary Disease, Paranoid Schizophrenia, Hypertensive Heart Disease, Asthma, Type 2 Diabetes Mellitus, Anxiety. Facility Reported incident dated 06/07/2024 documents that R1's care plan and assessments were reviewed and updated. R1's care plan dated 07/11/2024 documents that R1 is not care planned for risk for abuse or abuse that resulted on 06/03/2024. Facility reported incident witness statement dated 06/06/2024 documents that V4 (Former Floor Technician) admits to being verbally inappropriate with R1 calling R1 b!+** and p*$$*. Facility terminated V4 on 06/06/2024. V4 also admits to having an in-service on abuse the previous week before the incident and taking a test related to abuse. Facility document dated 04/2015 titled Care Plans (Comprehensive) documents in part Policy: An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and/or psychological needs is developed for each resident. 5. Care plans are revised as changes in the resident's condition dictates.