

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146018	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER Little Village Nrsg & Rhb Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>32338</p> <p>Based on observation interview and record review, the facility failed to ensure that a resident was free of physical and verbal abuse from staff. This failure affected one of three residents reviewed for abuse.</p> <p>Findings include:</p> <p>On 10/21/24 at 11:35am, R3 was asked what happened between him and the staff V11(CNA/Certified Nurse Assistant). R3 stated It was at nighttime, and I couldn't sleep. I asked him(V11) to give me some ice, he yelled at me and then he hit me on the cheek and said he would beat me to death. Inquired from R3 about any emotional effect this had on him(R3) and if anyone witnessed what happened. R3 responded that he(R3) felt okay and felt safe in the facility because the staff was fired immediately and never came back to work. R3 added that no staff witnessed the incident, and no staff has ever hit him before at the facility, and he did not have any fears that it could happen again.</p> <p>V11's employee records show that V11 was suspended first and later terminated, after investigation.</p> <p>R3 has a BIMS (basic interview for mental status) score of 14(cognitively intact).</p> <p>On 10/21/24 at 11:21 AM, V5 (R3's family and Power of attorney/POA) was interviewed and stated I am his brother and POA and I work here as a Restorative Aide. The Administrator notified me that my brother told them that (V11) yelled at him and hit him. He told me that he and the CNA had a verbal altercation, and the CNA put his hands on him. My brother has no reason to lie about it. I believe him.</p> <p>On 10/21/24 at 12pm, V10(Administrator) presented the facility's initial and final incident reports sent to the State, dated 7/26/24 and 8/1/24 respectively, regarding the allegation that V11(CNA) physically abused R3. These reports stated that R3 alleged that he(R3) was sitting in another resident's wheelchair and V11 asked him to get up out of the chair, and V11 hit his face. V10 also presented the facility's investigations and witness statements dated 7/26/24 as follows:</p> <p>Witness statements from V12 (Restorative Nurse) and V13(LPN/Licensed Practical Nurse) show that R3 immediately reported to V12 and V13 that V11 hit him on the face.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Witness statements from V14(CNA) states that R3 was running away from V11 and saying that V11 should keep his hands off him(R3).</p> <p>Witness statements on the day of the alleged incident (7/26/24), from R10 with BIMS (basic interview for mental status) score of 12(mild cognitive impairment), shows that R10 observed V11 hitting R3 in the face and V11 told R3 he will whip his ass and R3 started to defend himself.</p> <p>On 10/23/24 at 11:58am, R10 was interviewed about what happened, and R10 stated that he remembers that he saw the staff hit R3 but it was a long time ago. R10 added I told them but I don't know if they did anything about it.</p> <p>R3's progress notes date 7/26/24 at 7:20am written by V13(LPN) states in part: This resident reported to this writer that a CNA slapped him on the left side of his face and slapped him on his left shoulder. Immediately a safe place was provided for the resident and the CNA was sent home pending investigation. Upon further investigation resident stated he was in the back hallway when it happened, he stated the CNA backed him in a corner and there was no witnesses around. Body assessment performed, no injuries noted to those areas, no redness, bruising, swelling or open areas noted to the skin, he denies being hit anywhere else, denies pain or discomfort. The resident was upset and hyper verbal but was able to be redirected. Administrator made aware of the incident, POA made aware and the doctor made aware with instructions to monitor.</p> <p>The Surveyor made several attempts to reach V11 without success. However, the statement dated 7/26/24, written by V11, was presented by the Administrator. In this statement, V11 denied the abuse allegation. V11 stated that's R3 was aggressive towards him(V11) when he was redirecting him out of the other resident's wheelchair. The report further stated that V11 is no longer employed at the facility, and all staff were given Inservice regarding the facility's abuse policy.</p> <p>On 10/21/24 at 1:13pm, V10 stated We had to terminate him(V11) to keep the residents safe. After the incident, I personally in-serviced all staff about Abuse Prevention, and they all took tests and had to pass the test to be put on the schedule. Total of 71 staff members were in-serviced and passed the test between 5/30/24 through 5/31/24 and 8/12/24 through 8/30/24. (V11) attended an abuse in-service on 5/30/24.</p> <p>At this time, V10 presented the following additional documentation as dated below:</p> <p>4/1/24 - V11 was suspended for discourteous behavior.</p> <p>4/8/24 - Administrator did in-service about Customer Service with V11.</p> <p>12/27/23 - Administrator did Code of Conduct In-service on Abuse with V11.</p> <p>5/30/24-5/31/24 - All Staff Inservices on Abuse.</p> <p>8/12/24-8/30/24 - All Staff Inservices on Abuse.</p> <p>Other records reviewed include:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>V11's Employee Timecard which shows that V11 did not come back to work after the incident of 7/26/24.</p> <p>V11's Employee File which shows that V11 attended in services on abuse prevention, and that V11 was suspended on 4/1/24 for discourteous behavior.</p> <p>Records of Abuse Prevention In-Services for Nurses and CNAs.</p> <p>Records of Abuse In-services for other staff members.</p> <p>On 10/21/24 at 1:30pm, V3(Social Services Director) stated that R3 was given one to one counseling after the alleged incident and several times on the days following the incident.</p> <p>On 10/22/24 at 10:22am, records of Social Workers note that documented psychosocial support and other notes were reviewed. R3's updated care plan was also reviewed.</p> <p>Facility's Abuse Policy with latest review on 1/18/24 states in part This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse</p>		