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| 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 03/13/2025 |
| 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.

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| (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 - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30279</p> <p>Based on interview and record review the facility failed to ensure that 4 of 4 residents (R1, R2, R5, and R6) were free from physical abuse. This failure affected R1, R2, R5, and R6 who had verbal altercation that resulted in R1 injury and bleeding to mouth and R6 injuries resulting in stitches to eyebrow and injury to forehead. This has the potential to affect all 103 residents residing in the facility.</p> <p>Findings include:</p> <p>On 02/27/25 at 12:44pm, R1 observed in the room sitting on the bed. The surveyor asked R1 about the incident of 01/25/25. R1 stated that I (R1) can't remember what happened, but (R2) and I (R1) had a misunderstanding. I (R1) did not steal anything from (R2). (R2) hit me and punched me in my face and my mouth. I (R1) was bleeding from my mouth.</p> <p>On 2/27/25 at 12:55pm, R2 was observed in the room. when the surveyor asked about the incident of 01/25/25, R2 stated R1 was drunk and was taking my pop drinking them. R2 stated that I (R2) came to the nurse's station and told them (staff) about it, and they did nothing. R2 stated that when I (R2) went back to the room (R1) was still drinking my Pop. R2 stated that I (R2) pushed (R1) down on the bed and held (R1) because (R1) was stealing from me.</p> <p>R1 medical record showed V17's documentation in the progress note date 01/25/25 timed 10pm that indicated that R1 noted fighting with roommate (referring to R2). Roommate (R2) hit (R1) in the face and the mouth with moderate bleeding noted from R1's mouth.</p> <p>On 03/04/25 at 12:25pm, R5 stated that R6 and I shared the same bathroom. R6 is always urinating on the floor and everywhere. R5 stated that on the day of the incident I tried to let R6 know that (R6) must clean it up because R6 always leaves the place dirty, and I end up clean it. When asked whether the housekeeper/staff know about these concerns. R5 stated Yes, because they clean it all the time and R6 will dirty it again and again. And nobody (referring to staff) does nothing about it. I (R5) have reported it but (R6) kept (urinating) on the floor, I feel like (R6) is saying whatever I (R6) do you are going to clean it up. R5 stated that I am a grown man, and no one is going to be treating me like hat. R6 punch me in my face so I hit (R6) hard. A fight broke out and R6 started bleeding in 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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>At 1:20pm, R6 observed with three wound closure strips on the right eyebrow and approximately 2 inches of healing wound to the fore head. When the surveyor asked about what happened to R6's face. R6 stated that I fought with (R5). (R5) is not my boss, (R5) thinks he can fight, and I (R6) showed him. (R5) keeps putting everything that is wrong on me, and (R5) hit me, and I (R6) hit him back.</p> <p>R1 medical record Face Sheet showed that R1 was admitted to the facility on [DATE] with diagnosis list that includes but not limited to chronic obstructive pulmonary disease unspecified, schizoaffective disorder, bipolar type, alcohol abuse uncomplicated Type 2 diabetesmellitus with hyperglycemia.</p> <p>R2 medical record Face Sheet showed that R1 was admitted to the facility on [DATE] with diagnosis list that includes but not limited to Type 2 diabetes mellitus with hyperglycemia, non-pressure chronic ulcer of other part of left foot with unspecified severity -left foot.</p> <p>R5 medical record Face Sheet showed that R1 was admitted originally to the facility on [DATE] with latest admitted [DATE]. Diagnosis list includes but not limited to Major depressive disorder, drug induced subacute dyskinesia, schizoaffective disorder, acquired absence of eye-right eye, and blindness one eye unspecified eye-right eye.</p> <p>R6 medical record Face Sheet showed that R1 was admitted to the facility on [DATE] with diagnosis list that includes but not limited to chronic obstructive pulmonary disease unspecified, schizoaffective disorder, bipolar type, alcohol abuse uncomplicated Type 2 diabetes mellitus with hyperglycemia.</p> <p>On 03/04/25 at 2:15pm, V2 stated that she expected the licensed nurses to separate the resident immediately when there is a suspicion of any abuse. In the case of R1 and R2 the nurse (V17) should have separated the residents before the altercation escalated into actual physical abuse. V2 stated hitting, holding down of resident by another resident is a form of physical abuse and should not happen. V2 stated that both R1 and R2 should have been separated and placed on 1:1 supervision.</p> <p>On 03/12/25 at 1:49pm, V1 (Administrator) stated that she (V1) expected the nurse to first separate the residents, assess them, and depending on the type of altercation put the resident on 1:1 supervision, call the medical doctor (physician) and both residents must be sent out. The nurse should call me the abuse coordinator. V1 stated that when (V18) informed the nurse (referring to V17 LPN), she did what she was supposed to do it is not her (V18) responsibility to separate the resident. R1 just had tooth extraction may be the alcohol caused R1 to bleed because R2 said I did not hit R2 from my interview. When asked whether pushing and holding down another resident a physical contact holding another resident down in a physical altercation, is that appropriate behavior. V1 stated no, it is not allowed that is like restraining a person. The surveyor then asks are residents allowed to restrain another resident. V1 stated No.</p> <p>The facility policy on Abuse with reviewed date 1/18/2024 documented that the facility affirms the right of our (facility) residents to be free from abuse. the policy under definitions documented in part that abuse is the willful infliction of injury and the term willful means the individual must have acted deliberately not that the individual must have intended to inflict injury or harm. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means. Physical abuse listed includes but not limited to hitting, slapping, and controlling behavior through corporal punishment.</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30279</p> <p>Based on interview and record review the facility failed to develop and implement appropriate measures to ensure adequate supervision is afforded to two residents R1 and R2 reviewed for physical abuse. This failure affected R1 and R2 who had an altercation that resulted into physical abuse and R1 injury to mouth and has the potential to affect all 103 residents residing in the facility.</p> <p>Finding include:</p> <p>R1 medical record Face Sheet showed that R1 was admitted to the facility on [DATE] with diagnosis list that includes but not limited to chronic obstructive pulmonary disease unspecified, schizoaffective disorder, bipolar type, alcohol abuse uncomplicated Type2 diabetes mellitus with hyperglycemia. R1 was sent to the local hospital on 1/15/25 and the discharge record showed that R1 was treated for alcohol intoxication.</p> <p>R2 medical record Face Sheet showed that R1 was admitted to the facility on [DATE] with diagnosis list that includes but not limited to Type 2 diabetes mellitus with hyperglycemia, non-pressure chronic ulcer of other part of left foot with unspecified severity left foot.</p> <p>According to facility investigation witness statement presented dated 1/31/25, V18 stated that on 1/25/25 R2 came to the front desk and reported that R1 was stealing R2's food and this was reported to V17 (Nurse). V17 went to the resident's room and came out and said R1 and R2 were fine. V18 made V17 aware that R1 was drunk and V17 went back into the office (referring to medication room used as the nurse's office). V18 (Receptionist) stated R2 came back to the nurse's station and said someone needs to come and get R1. V18 stated that while sitting at the nurse's station she heard them fighting (referring to R1 and R2). V18 witness statement documentation showed that V17 was first notified at 7:30pm.</p> <p>According to the V17's witness statement V17 documented in part that at 7:00pm she was notified that the two residents R1 and R2 that something is going on with these 2 (referring to R1 and R2). V17 did not separate the resident R1 and R2 from each other. At 9:30am V18 documented that R1 had unsteady gait and suspected alcohol intoxication. V17 documented that R1 had bleeding from the mouth.</p> <p>R1 medical record showed V17's documentation in the progress note date 01/25/25 timed 10pm indicated that R1 noted fighting with roommate (referring to R2). Roommate (R2) hit (R1) in the face and the mouth with moderate bleeding noted from R1's mouth.</p> <p>On 03/04/25 at 2:15pm, V2 stated that she expected the licensed nurses to separate the resident immediately when there is a suspicion of any abuse. in case of R1 and R2 the nurse (V17) should have separated the residents before the altercation escalated into actual physical abuse. V2 stated hitting, holding down of resident by another resident is a form of physical abuse and should not happen. V2 stated that both R1 and R2 should have been separated and placed on 1:1 supervision.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>On 03/12/25 at 1:49pm, V1 (Administrator) stated that she (V1) expected the nurse to first separate the residents, assess them, and depending on the type of altercation put the resident on 1:1 supervision, call the medical doctor (physician) and both residents must be sent out. The nurse of cause should call me the abuse coordinator. V1 stated that when (V18) inform the nurse (referring to V17 LPN), she did what she was supposed to do it is not her (V18) responsibility to separate the resident. R1 just had tooth extraction may be the alcohol caused R1 to bleed because R2 said I did not hit R2 from my interview. When asked whether pushing and holding down another resident a physical contact holding another resident down in a physical altercation, is that appropriate behavior. V1 stated no, it is not allowed that is like restraining a person. The surveyor then asks are residents allowed to restrain another resident. V1 stated No.</p> <p>During this investigation both V17 and V18 cannot be reached by the surveyor. Both V1 (Administrator) and (V2 DON (Director of Nurse's) tried to reach the staff without success.</p> <p>The facility did not provide any supervision policy.</p> <p>The facility policy on Abuse with reviewed date 1/18/2024 documented that the facility affirms the right of our (facility) residents to be free from abuse. the policy under definitions documented in part that abuse is the willful infliction of injury and the term willful means the individual must have acted deliberately not that the individual must have intended to inflict injury or harm. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means. Physical abuse listed includes but not limited to hitting, slapping, and controlling behavior through corporal punishment.</p> | | |