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	05/13/2026

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 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** Based on interview and record review the facility failed to ensure the resident's care plan was revised to address ongoing medication refusal and escalating aggressive behaviors; and failed to implement effective, individualized interventions, resulting in the need for psychiatric transfer for one resident (R6). This failure affects 1 of 3 residents reviewed for care planning. Findings include: R6's face sheets shows that R6 has diagnosis which includes but not limited to: bipolar disorder, psychosis not due to a substance or known physiological condition, schizoaffective disorder, and insomnia. R6's Brief Interview for Mental Status (BIMS) dated 4/13/26 shows a score of 14 which indicated that R6 is cognitively intact. On 5/5/26 at 10:56 am, V7 (Licensed Practical Nurse, LPN) stated on 3/22/26 during morning shift medication pass she offered R6 her morning medication and R6 refused. V7 then explain when a resident refuses medication the psychiatrist is informed after 3 days of missed medications and that this was the third day of R6 refusing her medication. V7 further explained that R6 usually sits in the hallway loud and disturbing other residents and on 03/22/26 R6 and another resident was having a verbal altercation with another resident. V7 then stated that both residents were yelling at each other and V7 then separated the residents by escorting the other resident out of the room and to the common area. V7 then explained that she informed V1 (Administrator) that they were not compatible as roommates and V1 then instructed V7 to call both physicians and let them know regarding both residents' behaviors. V7 then stated that upon V7 informing R6's physician regarding her behavior with the other resident V7 also informed R6's physician that R6 had been refusing her medications for the past 3 days and the psychiatrist informed V7 to petition R6 to the local hospital for an evaluation. V6 explained that she carried out the psychiatrist order, gave report to the local hospital, arranged transportation and informed R6 family that R6 would be transferring to the local hospital for a psychiatric evaluation. V7 then stated that V9 (R6's Family Member) was upset and stated that when she spoke with V9, he stated, Hold on I will be in the facility in 10 minutes. V7 stated that she then informed V9 that R6's transportation was already arranged and on the way to pick up R6 to transport R6 to the local hospital and V9 then replied that he was still coming into the facility. V7 further explained when V9 arrived at the facility R6 was no longer in the facility and was transported to the local hospital. V7 stated that V9 then demanded to speak with a supervisor on duty, questioned why R6 was being sent out to the local hospital and asked why the facility did not wait on V9 to arrive before sending R6 to the local hospital. V7 then explained that she informed V9 that R6 was sent out for noncompliance with medication and aggressive behaviors and V9 then responded by expressing that he did not want to speak with V7 and wanted to speak with the V1 (Administrator). V7 then explained she left the room with V9 to speak with V3 (Assistant Director of Nursing, ADON). V7 then explained that when R6 returned back to the facility after a few days she was still not complaint with medication and aggressive behaviors and was sent back to the local hospital for another psychiatric evaluation and has not returned to the facility. V7 stated that usually when a resident is having a behavior social service is contacted however when R6 had an aggressive behavior on 3/22/26 it was a weekend, and social services was not in the facility. V6 then explained (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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On 5/5/26 at 11:57 am, V8 (Social Service Aide) stated that she has worked at the facility for forty years in the social service department. V8 stated that she recalls R6 at the facility and that R6 was noncompliant with her medication, ADL's (Activities of Daily), smoking, conduct of behavior (verbally aggressive, socially inappropriate disrupting, yelling, screaming, hollering during the day and night), keeping her peers up, response to hallucinations, disorganized thinking, and wanting to establish her own routine. V8 stated, R6 is very difficult to say the least and is considered demanding. V8 then stated that when a resident refuses their medication they have so many days to refuse before the resident has to go to the hospital and the physician is notified. V8 also stated when R6 refuses medication V8 will counsel R6 consisting of asking R6 why she refused her medications, and that R6 would reply stating, I don't want to, and GOD told me that I don't need the medication. V8 also stated that sometimes R6 would respond by telling V8 to get out her face and to leave her alone. V8 stated that when a resident refuses medication they are encouraged to take the medication and are educated regarding the benefits of following medication regimen and health. V8 then explained when a resident has a behavior occurrence the resident's care plan is updated by social service department with an intervention implemented/updated in the resident's care plan. V8 also stated that there is a progress note that should be written regarding the behavior occurrence in the resident medical record and that the facility is currently short staff in the social service department. V8 stated that social service is not in the facility on the weekends and V8 is not aware of what happens to the residents who have a behavior occur over the weekend if social service is needed for a resident. On 5/5/26 at 12:27 pm, V2 (Director of Nursing, DON) stated that R6 was non compliant with any of her care and that R6's behaviors has escalated over the past few years. V2 explained that the first day that R6 returns from the local hospital for behaviors she is complaint with her medication and then after R6 will stop taking her medications. V2 further explained that when a resident refuses medication after three days the psychiatrist is informed, and the physician is called for non-psychiatric medications daily however R6 was only taking a vitamin so R6's physician was not called for medications being missed. V2 stated that a residents behavior occurrence should be documented in the nurse's progress notes and social service is responsible for creating a behavior event for the occurrence. V2 then explained that when there is a behavior event the resident's behavior should be updated on the residents care plan quarterly. Then V2 stated that when the resident has a behavior leading to the resident involuntary discharge an intervention should be implemented, and the intervention should be documented in the resident's care plan. V2 then explained that the facility has exhaust interventions for R6 and that the social service department is responsible for the residents behavior care plan being updated at the facility.On 5/11/26 at 12:41 pm, V3 (Assistant Director of Nursing, ADON) stated the he is familiar with R6 regularly had behaviors where her baseline consisted of R6 yelling and arguing with other residents. V3 stated that interventions implemented for R6's behaviors were constantly redirecting her, placing R6 one on one, room changes, involving the family to assist with calming R6 down. V3 stated that on 03/22/26 V3 was the manager on duty at the facility, the floor nurse V7 (Licensed Practical Nurse, LPN) called V3 to the unit and informed V3 that R6 was arguing with her former roommate. V3 then explained that R6 had been arguing with her roommate earlier that day and V9 (R6's Family Member) helped to calm R6 down and that R6 was arguing with her roommate again. V3 then explained that V7 informed V3 that she had already called R6's psychiatrist and informed him (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that R6 was acting out and unable to be redirected and threatened violence to peers, and that R6 refused medication for the past 3 days and that R6's psychiatrist gave orders to send R6 to the local hospital. V3 then explained that R6 was placed on one to one with staff and the local ambulance arrived at the facility ten minutes later to transport R6 to the local hospital. V3 further explained that V9 (R6's Family Member) arrived at the facility twenty minutes after R6 was transported to the local hospital. V3 stated that V9 (R6's Family Member) was not aware that R6 had been being transported to the local hospital when he arrived. V3 stated that he spoke with V9 (R6's Family Member) he verbalized that he could have done more to calm R6 down before R6 was sent to the local hospital. V3 also stated that V9 also spoke with the V1 (Administrator) who informed V9 to come back the next day. V3 stated that the IDT (Interdisciplinary Team) is responsible for implementing interventions for a residents care plan, the social service department is responsible for updating the residents care plan after a resident has a behavior occurrence and is sent to the local hospital. Every time there is behavior occurrence, and the resident's interventions are not effective the residents intervention should be updated in the care plan. If the resident does not have effective interventions in place the resident can have safety issues. On 5/11/26 at 2:16 pm, V15 (Social Service Director) stated that a resident's care plan is updated annually, quarterly and if there is a behavior with the resident. V15 then explained that the residents care plan should be revised when the resident has a behavior and the interventions in place are not effective. V3 explained that the resident's care plan shows what steps should be taken and followed for the residents plan of care if the resident has a behavior. V3 then explained if a resident's care plan is not updated the resident can have safety issues and the behavior can continue. R6's Resident Census shows the following census report for R6 being transferred to the local hospital for behaviors:hospital leave on 01/19/26 and returned to the facility on [DATE]hospital leave 01/31/26 and returned on 02/11/26hospital leave 03/22/26 and returned 04/03/26hospital leave 04/21/26 and discharged [DATE] R6's progress note from January 19, 2026, through March 22, 2026, shows repeated documentation of aggressive behaviors, refusal of medications and care as well as R6 being sent to the local hospital without any revisions to R6's care plan interventions. R6's Behavior care plan reviewed and shows no documented evidence of the care plan being updated following the residents change in condition after being transferred to the local hospital for behaviors on 1/19/26, 1/31/26, and 3/22/26.R6's care plan Problem start dated 1/14/26: Category: Behavioral Symptoms: R6 exhibits verbal aggressive behavior directed towards others i.e. (example) (cursing, yelling, to the point of disrupting others. History of physical aggressive behavioral symptoms directed towards others as evidenced by grabbing others, slapping others, and pushing others. Can be related to several factors, alteration in thought pattern (hallucinations). Diagnosis: Conduct Behavior (Aggression/Agitation). Schizoaffective Disorder, Psychosis. R6 was involved in a physical altercation with another resident on 3/25/23 . Problem Start Date 01/14/26: Category: Behavioral Symptoms: R6 has a history of non-compliance with following treatment plan (medicine). Refusing medicine, compliance with overall treatment plan. R/T (related to) poor judgment and insight. Thought pattern (delusions). Diagnosis: Conduct Disorder, non -compliance with medication regime. Schizoaffective Disorder, Bipolar Disorder. R6's Medication Administration Record (MAR) dated 03/01/26 - 03/31/26 shows that R6 refused 03/12/26, 03/13/26, 03/14/26, 03/15/26, 03/18/26, 03/19/26, 03/21/26, 03/22/26. The facility's policy dated 01/25/26 and titled Change in a Residents Condition or Status documents, in part: Objective: 1. Our facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's condition and/or status. Procedure: 6. If a significant change in a resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted by the assessment coordinator. The facility's policy dated 4/2017 and titled Comprehensive Care Plans documents, in part: to develop a comprehensive, person-centered plan of care, consistent with the resident's rights, that includes measurable objective and timeframes to meet the resident's medical, nursing, and mental and psychosocial needs. Procedure: 3. The comprehensive care plan will include: b. Areas of (continued on next page)

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