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	12/18/2025

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

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record reviews, the facility failed to follow their policy and provide an adequate number of staff to meet resident needs based on their facility assessment. This has the potential to affect all 99 residents residing in the facility. Findings include: CMS (Centers for Medicare & Medicaid Services) PBJ (Payroll Based Journal) Report for facility's Fiscal Quarter 4 2025 (July 1 - September 30) documents in part that the facility triggered for excessively low weekend staffing. Facility Assessment 2025 (last reviewed by the facility on 11/19/2025) documents in part a staffing of two nurses per shift, five CNAs (Certified Nurse Aides) for morning shift, four CNAs during evening shift, and four CNAs during night shift. On 12/17/2025 at 9:42 AM, V3 (Assistant Director of Nursing) stated that V2 (Director of Nursing) oversees nursing schedules. When V2 is off, V3 oversees the schedules such as during the time of the survey. V3 stated the facility should have two nurses per shift. When it comes to CNA (Certified Nurse Aide) staffing, the facility should have six CNAs during the day shift, four to five during the evening shift, and a minimum of four CNAs during the night shift. Facility provided a handful of 2025 assignment sheets. There were multiple assignment sheets that did not meet CNA staffing levels. These included 7/1, 7/4-7/8, 7/10-7/12, 7/16, 7/18, 7/21, 7/26, 7/27, and 7/30 for fiscal quarter 4. For the current fiscal quarter (1), the facility did not meet CNA staffing levels on 10/1, 10/4-10/6, 10/9, 10/11, 10/12, 10/14, 10/16-10/19, 10/21, 10/25, 10/26, 10/28, 10/29, 11/1, 11/2, 11/4, 11/5, 11/7-11/10, 11/12, 11/15-11/17, 11/19, 11/22, 11/23, 11/29, 11/30, 12/6, 12/13, and 12/14. During the same interview, V3 stated the circled staff names were the staff that did not report to work for whatever reason. V3 stated what's provided and written on the assignment sheets were for the most part the staff that worked the units during the given days. V3 stated facility usually asks previous shift staff to volunteer to work overtime or later shifts to come early to cover missing spots, but it's not always the case. Asked facility to provide staff timecards to prove adequate staffing. None provided at the completion of the survey. Facility's (1/8/2021) Staffing Policy documents in part: It is the policy of this facility to provide an adequate number of staff to successfully implement resident functions to meet resident needs.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record reviews, the facility failed to ensure there was a RN (Registered Nurse) that worked eight consecutive hours daily. This has the potential to affect all 99 residents that reside in the facility. Findings include: CMS (Centers for Medicare & Medicaid Services) PBJ (Payroll Based Journal) Report for facility's Fiscal Quarter 4 2025 (July 1 - September 30) documents in part that the facility triggered for four or more days within the quarter with no RN (Registered Nurse) hours. The infraction dates were for 7/04/2025, 7/12/2025, 7/13/2025, and 7/26/2025. 7/04/2025 assignment sheet did not list a RN working. 7/12/2025, 7/13/2025, and 7/26/2025 assignment sheets listed V3 (Assistant Director of Nursing) as the manager on duty. Requested V3's timecards for proof of RN hours worked. On 12/15/2025 at 3:01 PM, V1 (Administrator) stated the facility should have a RN for 8 consecutive hours a day. V1 stated they did not have a RN during the discussed days in July because people called off. Facility's 1/08/2021 Staffing Policy documents in part: A Registered Nurse will be scheduled seven days a week at least one continuous (8) eight hour shift.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to follow proper sanitation and food storage practices as evidenced by a.) Food not properly labeled, and b.) staff personal items in the food preparation area. These deficient practices have the potential to affect all 99 residents receiving food prepared for the nursing skilled facility.Findings include:On 12/15/25 at 9:20 AM, During initial kitchen tour V15 [Dietary Manager] observed two large cans of string beans with no open dates, no discard dates, no expiration dates on the cans. V15 stated, Once the box was open and the cans were placed on the shelf it should have been labeled. If dietary staff prepare food, not knowing how long the food has been on the shelf it could potentially cause a foodborne illness.On 12/15/25 at 9:30 AM, V15 and surveyor observed car keys in the food preparation area. Noted raw uncooked, uncovered cookies on the food preparation table. V15 stated, Those car keys belong to V25 [Dietary Aide]. Employee personal items should not be stored in the dietary kitchen to prevent cross contamination.On 12/15/25 at 9:35 AM, V25 [Dietary Aide] stated, The car keys belong to me. I should have placed them in my locker, I forgot. My car keys should not be stored on the food preparation area; it could potentially cause cross contamination.Reviewed the facility's In-Service Record dated 12/15/25: Personal itemsAll personal items must be in your lockers no in the kitchen such as car keys and coats.Policy documented in part:Labeling and Dating Foods {No date}Cans and items will be labeled with the date received when unpacked from cases.Personal Property:You will be assigned a locker for your personal possessions.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to a.) ensure medications had the proper label, b.) ensure medications were labeled and dated after opening, c.) ensure medications requiring refrigeration were refrigerated, d.) ensure insulin pens were stored in a bag to prevent cross contamination and e.) discard discontinued medications in 2 of 2 medication carts reviewed for medication labeling and storage.Findings Include: On [DATE] at 11:01 AM medication cart B was reviewed with V14 (Licensed Practical Nurse). R40's Albuterol Sulfate 90 mcg aerosol inhaler was observed in the medication cart with no open date. Surveyor asked V14 if the inhaler should be labeled with an open date. V14 responded, for these I am not sure. An Albuterol inhaler was observed in a bag with no name or label. R22's Albuterol 90 mcg aerosol inhaler was observed in the medication cart with no open date. R25's Albuterol 90 mcg aerosol inhaler and Humulin R25's sliding scale insulin vial was observed in the medication cart with no open date. V14 stated the insulin should be labeled with an opened date. I think the insulin is good for 30 - 60 days. days. R102's Lispro insulin pen 8 units three times a day was observed in a cup, not in an individual bag stored with R14's and R27's insulin pens in the medication cart. The insulin pens were not stored in a bag and had no open date or label. R102's name was written on the insulin pen with a marker. R27's Glargine insulin pen was observed in the cup, not in an individual bag stored with R14's and R102's insulin pens in the medication cart. There was no order found for the insulin pen. R14's Basaglar insulin pen 8 units daily was observed in the cup, not in an individual bag stored with R27's and R102's insulin pens. V14 stated, the insulin pens should be in individual bags because of infection. On [DATE] at 01:18 PM medication cart A was reviewed with V12 (Licensed Practical Nurse). R47's Latanoprost Ophthalmic solution dispensed on [DATE] was observed in the medication cart unopened with a label indicating refrigerate. R28's Lantus insulin pen was observed in the medication cart unlabeled with no open date or bag. V12 stated the insulin pen should be labeled and dated with the expiration date and date it was opened. The insulin pen should be in a bag to prevent cross contamination.On [DATE] at 09:13 AM V3 (Assistant Director of Nursing) stated Labeling and storage, the resident name and date opened should be on the medication. The Albuterol inhalers are good for 30 days after being opened. The insulin vials once opened should have the resident name, date opened and expires 28 days from the open date. If the insulin and albuterol is given after the expiration date it is inappropriate and there is a potential the expired medication may be inactive if expired. Insulin pens are kept in the medication cart, labeled and dated. I thought all of the insulin pens were stored together once opened. If the insulin pens are not stored in separate bags there is a contamination risk. If the eye drops are stored in the medication cart and should be refrigerated, they should be tossed and reordered. Once the eye drops were received, they should have been refrigerated. There is a potential eye drops can be inactive so it was inappropriate, and the resident needed the right medicine. The residents name should not be written on the medication with a marker. If the medication is not properly labeled the nurse should get rid of it and order a new one. The inhaler with no name or label should have been discarded and another should have been ordered. The discontinued insulin pen should have been discarded.Policy:Titled Storage of Medications reviewed 01/25 document in part: Medications and biologicals are store safely, securely and properly, following manufacturer's recommendations or those of the supplier. 5. Medications requiring refrigeration or temperature between 2 degrees Centigrade (36 degrees Fahrenheit) or 8 degrees Centigrade (46 degrees Fahrenheit) are kept in a refrigerator with a thermometer to allow temperature monitoring.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to follow their policy to a.) ensure medications was handled in a sanitary manner for 1 (R11) resident, b.) ensure reusable medical equipment was cleaned and disinfected between resident use for 4 (R11, R58, R94, R98) residents, c.) perform hand hygiene between 2 (R2, R58) residents contact, d.) store insulin pens to prevent cross contamination for 4 (R14, R27, R28, R102) residents and e.) ensure infection control protocols related to linen handling were followed for 1 (R5) out of 4 residents reviewed for linen handling out of a sample of 21.Findings include: On [DATE] at 10:45 AM, surveyor observed R5 in his room. Surveyor observed dirty towel and gown on the floor behind the door. R5 stated that he threw those there last night. On [DATE] at 10:50 AM, surveyor asked V8 (Certified Nursing Assistant) to come into R5's room. V8 noticed R5's dirty towel and gown on the floor. V8 picked up the dirty gown and towel and placed it in the dirty linen bin. V8 stated that dirty linen should not be on the floor. On [DATE] at 11:30 AM, V6 (Infection Preventionist) stated that dirty linen should not be on the floor due to contamination and spread of infection. On [DATE] at 11:00 AM, V3 (Assistant Director of Nursing) stated that no linen should be on the floor. V3 stated that dirty linen should not be on the floor due to spread of infection. Facility's laundry services policy (01/2019) documents in part: The laundry staff shall store, process and transport all linen and resident personal laundry in accordance with procedures which ensure safety and sanitary conditions to prevent the spread of infections. On [DATE] at 09:07 AM V12 (Licensed Practical Nurse) said to R11 first I am going to take your blood pressure. V12 entered R11 room and placed the blood pressure cuff on R11's right arm to check R11's blood pressure and oxygen saturation with the pulse oximeter. V12 exited R11's room, returned to the medication cart placed the blood pressure cuff and pulse oximeter on top of the medication cart without performing hand hygiene or cleaning and disinfecting the blood pressure cuff and pulse oximeter. V12 removed R11's medication from the medication cart and began preparing R11 medications in a medication cup. Surveyor asked the number of pills in the medication cup. V12 began counting and transferring R11 pills to another medication cup using her finger to push the pills from one medication cup to the other. V12 then said there are 11 pills. On [DATE] at 09:19 AM R58 approached the medication cart. V12 (Licensed Practical Nurse) placed the wrist blood pressure cuff on R58's right wrist while standing at medication cart. V12 stated, R58's blood pressure is 132/95. V12 placed the wrist blood pressure cuff on top of the medication cart without cleaning and disinfecting it. On [DATE] at 09:27 AM V13 (Licensed Practical Nurse Orientee) retrieved the wrist blood pressure cuff from the top of the medication cart then rechecked R58 blood pressure placing the wrist blood pressure cuff on R58's left wrist. V13 stated I am an orientee and this is my first day. R58's blood pressure is 127/67 pulse 83. V13 then placed the wrist blood pressure cuff on top of the medication cart without performing hand hygiene or cleaning and disinfecting the wrist blood pressure cuff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 09:29 AM R94 approached the medication cart. V12 (Licensed Practical Nurse) place the wrist blood pressure cuff on R94's left wrist. V12 stated R94's blood pressure is 147/93 pulse100. V12 removed and placed the wrist blood pressure cuff on top of the medication cart without cleaning and disinfecting it. On [DATE] at 09:34 PM V13 (Licensed Practical Nurse Orientee) Donned a gown, face shield and gloves then entered R2's room with V13 without performing hand hygiene between the R2 and R58. On [DATE] at 09:44 AM R98 approached the medication cart with the use of a walker. V12 (Licensed Practical Nurse) said to R98, I am going to take your blood pressure. V12 placed the wrist blood pressure cuff on R98's left wrist while standing at the medication cart. V12 said R98's blood pressure is 119/86 then placed the wrist blood pressure cuff on top of the medication cart without cleaning and disinfecting it. On [DATE] at 09:48 AM surveyor asked V12 (Licensed Practical Nurse) what she should have done when taking the resident vital signs. V12 responded, I should have sanitized the blood pressure cuff and pulse oximeter between each resident to prevent cross contamination. V13 (Licensed Practical Nurse) said and in house infections. On [DATE] at 09:50 AM surveyor asked V13 (Licensed Practical Nurse) what she should have done between resident contact. V13 responded, I should have use hand sanitizer or hand hygiene to prevent cross contamination. On [DATE] at 11:01 AM medication cart B was reviewed with V14 (Licensed Practical Nurse). R102's Lispro insulin pen 8 units three times a day was observed in a cup, not in an individual bag stored with R14's and R27's insulin pens in the medication cart. The insulin pens were not stored in a bag and had no open date or label. R27's Glargine insulin pen was observed in the cup, not in an individual bag stored with R14's and R102's insulin pens in the medication cart. R14's Basaglar insulin pen 8 units daily was observed in the cup, not in an individual bag stored with R27's and R102's insulin pens. V14 stated, the insulin pens should be in individual bags because of infection. On [DATE] at 01:18 PM the medication cart A was reviewed with V12 (Licensed Practical Nurse). R28's Lantus insulin pen was observed in the medication cart unlabeled with no open date or bag to prevent cross contamination. V12 stated the insulin pen should be in a bag to prevent cross contamination. On [DATE] at 09:13 AM V3 (Assistant Director of Nursing) stated The blood pressure monitor and pulse oximeter should be cleaned with disinfectant wipes after each use. If they are not cleaned there is a potential for infection control, and it prevents the spread of infectious material. Hand hygiene is done between all interactions with residents, anytime you are touching a client or going in and out of the resident rooms. When counting the resident pills, it should be accounted for by signing for one pill at a time. You are not supposed to touch the pills at all. The pills should not be touched because of infection and contamination. We reordering medication when it gets to the last row on the medication card. When medication is missing, they are reordered stat. The medications should be reordered before they run out. If the medications are missed there is a potential it will affect the blood levels. The residents need their medications because bad things can happen to the resident if they will miss a medication dose. if the medication is not there and we should order it stat. The pharmacy can send the medications the same day or we can check the convenience box to see if it is available in there. If the resident miss their Metformin there is a potential for hyperglycemia, it can affect the residents (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood sugar or the resident having to go out to the hospital. When there is a missed medication, you circle the initials on the MAR (Medication Administration Report). If a medication is missed it should be ordered immediately, inform the doctor as well and they should document. If it is not documented, it is not done. Labeling and storage, the resident name and date opened should be on the medication. The Albuterol inhalers are good for 30 days after open. Insulin vials once opened should have the resident name, date opened and expires 28 days from the open date. If the insulin and albuterol is given after the expiration date it is inappropriate there is a potential the expired medication may be inactive expired. Insulin pens are kept in the medication cart, labeled and dated. I thought all of the insulin pens were store together once opened. If the insulin pens are not stored in separate bags there is a contamination risk. If the eye drops are stored in the medication cart and should be refrigerated, they should be tossed and reordered. Once received the eye drops should have been refrigerated. There is a potential eye drop can be inactive, so it was inappropriate, and the resident needed the right medicine. The residents name should not be written on the medication. If the medication is not properly labeled the nurse should get rid of it and order a new one. The inhaler with no name or label should have been discarded and another should have been ordered. The discontinued insulin pen should have been discarded. The Controlled Substance Check Form should be done and signed shift to shift, nurse to nurse every day. The nurse should check to see if any new narcotics have come, and the sheet should still be signed. The admitting nurse does the initial base line care plan, and it is up to the care plan coordinator to take it from there. During admission the baseline care plan is for the initial care and connect dots with initial care. Policy: Titled Handwashing/Hand Hygiene Policy effective date: 03/20 document in part: It is the policy of the facility to assure staff practice recognized handwashing/hand hygiene procedures a primary means to prevent the spread of infections among residents, personnel, and visitors. Alcohol based hand rubs (ABHR) can be used for hand hygiene when hands are not visibly soiled or contaminated with blood or body fluids. 1. All personnel shall be educated on recognized handwashing/hand hygiene procedures and shall follow such procedures. 4. When hands are not visibly soiled, employees may use an alcohol-bases hand rub containing at least 60% alcohol in all of the following situations: a. before direct contact with residents. b. after direct contact with a resident but prior to direct contact with another resident. c. before donning gloves. e. before preparing and handling medications. i. after contact with a resident's intact skin. k. after contact with objects such as medical devices or equipment in the immediate vicinity of a resident that may be potentially contaminated. m. after removing gloves. Titled Cleaning and Disinfection of Reusable Equipment reviewed 01/25 document in part: Reusable medical equipment can transfer germs between residents if it is not cleaned and disinfected correctly. This policy establishes clear expectations for cleaning and disinfecting reusable equipment to reduce the risk of infection and protect resident, staff and visitors. All reusable equipment used in resident care areas must be cleaned and disinfected between residents using facility-approved products. Reusable equipment is cleaned and disinfected after each resident use and before it is used on another resident. Staff follow manufacturer instructions for disinfectant use, including required contact time so the disinfectant works effectively. Examples of reusable equipment include blood Titled Infection Control Policy reviewed 01/25 document in part: The facility's written program is for the implementation of systems that provide a safe, sanitary and comfortable environment and helps prevent the development and transmission of communicable diseases and infections. 6. Hand hygiene is utilized to reduce the spread of germs to residents and the risk of the Health Care provider's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	colonization of infection by germs acquired from a resident. The facility utilizes hand hygiene via hand washing and alcohol-based hand sanitizers. 17. The facility maintains policies and procedures that address storage and handling of linen.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to follow their policy to ensure call light is within reach for 1 (R73) out of 3 residents reviewed for call lights in a sample of 24. Findings Include:On 12/15/2025 at 10:12 AM, surveyor observed R73 in his bed in his room. R73's call light is not within reach. R73 stated that he doesn't get out of bed on his own. R73 stated that he doesn't know where his call light is. On 12/15/2025 at 10:14 AM, surveyor asked V9 (Certified Nursing Assistant) to come into the room. When V9 came into R73's room, surveyor asked V9 where is R73's call light. V9 stated that R73's call light is by the wall. V9 stated that R73's call light should be clipped to his bed. Surveyor observed V9 clip R73's call light to his bed. V9 stated that R73 cannot get out of bed by himself. V9 stated that R73's call light should be within reach so R73 can call for help and make his needs known to avoid falls. On 12/16/2025 at 11:48 AM, surveyor observed R73's call light not within reach of the resident. On 12/17/2025 at 11:00 AM, V3 (Assistant Director of Nursing) stated that all resident call lights are to be within reach. V3 stated that call lights are to be within reach for residents to make their needs known and avoid falls. R73's fall care plan documents in part: Keep call light within reach. Round every two hours. Facility's call light policy (08/2008) documents in part: When residents are in bed, be sure the call light is within reach of the resident.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain a Physician's order with the code status for three (R8, R71, R111) residents reviewed for Advance Directives in a total sample of 21 residents reviewed. Findings Include: R8's Facesheet documents that R8 was admitted to the facility on [DATE]. R8's Facesheet documents that there are no advanced directives selected for this resident. R8's Physician Orders Sheet/POS does not document a physician order for an advanced directive. R71's Facesheet documents that R71 was admitted to the facility on [DATE]. R71's Facesheet documents that there are no advanced directives selected for this resident. R71's Physician Orders Sheet/POS does not document a physician order for an advanced directive. R111's Facesheet documents that R111 was admitted to the facility on [DATE]. R111's Facesheet documents that there are no advanced directives selected for this resident. R111's Physician Orders Sheet/POS does not document a physician order for an advanced directive. On [DATE] at 10:08 AM, V16 (Social Services Aide) states upon admission, residents are informed about advanced directives and asked what their decision is regarding their medical care. V16 states the resident then signs a POLST/Physician/Practitioner Orders for Life-Sustaining Treatment form documenting their code status and it is provided to the physician to sign for it to be valid. V16 states it is important for the advance directives to be documented so the nurses and the rest of the team know the code status of the resident in case of an emergency. V16 states during an emergency, the POLST form lets the staff know whether to do CPR/Cardiopulmonary Resuscitation for a Full Code or DNR/Do Not Resuscitate. V16 states there is a book that contains the resident's POLST forms and is kept at the nurse's station. V16 states the POLST forms for every resident in the facility should be located in this book. V16 states whenever there is an emergency and residents are sent to the hospital, a copy of the resident's POLST form is obtained from the book by the nurses to send with the resident. On [DATE] at 10:45AM, V16 provides surveyor with a book titled Resident DNR/do not resuscitate & Full Code List. V16 states all resident code statuses should be inside of the book. Record review of facility's Resident DNR/do not resuscitate & Full Code List book shows there are no POLST forms found for R8, R71, and R111.Facility policy dated 01/2020 titled, Advance Directives documents in part, 6. Copies of written advance directive documents will be filed/uploaded in the resident's clinical record. 8. Will initiate the necessary processed to modify the status changes in the resident's record, including contact of the resident's attending physician so that appropriate orders to reflect these status changes are secured. 12. The POLST form is the physician order.

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	146018	A. Building B. Wing	12/18/2025

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to provide a home like environment for one (R17) in a total sample of 21 residents residing in the facility.The Findings include:On 12/15/2025 at 11:19 AM, Surveyor observed R17 eating a sandwich while watching television. R17 is alert and oriented to person, place and time. R17 seemed comfortable and free of pain. Surveyor smelled a foul odor coming from R17's bedroom. Surveyor observed the bathroom toilet; it was filthy with dried out feces' residue. Surveyor observed urine stains and spills around the toilet seat. The sink and floor both looked dirty, the entire bathroom looked unsanitary.On 12/15/2025 at 11:20 AM, R17 stated he is concerned with housekeeping not cleaning his room. R17 stated he cleans his own room and bathroom because the housekeeping team won't do it. R17 stated he has not seen housekeeping coming in his room for a few days. Surveyor asked R17 when the last time was the bathroom was cleaned. R17 stated he has not cleaned the bathroom for a few days because he ran out of gloves. R17 stated he does not even bother asking for assistance because no one ever comes to clean.On 12/16/2025 at 11:30 AM, Surveyor observed R17's bathroom's, there was dried out feces' residue inside the toilet. Surveyor observed urine stains and spills around the toilet seat. Surveyor asked R17 if housekeeping has come in to clean his room. R17 stated no one has cleaned his bathroom or mopped the floors. Surveyor asked R17 if he is comfortable being under these circumstances. R17 stated he does not like his room being dirty and will usually clean his room and make his own bed.On 12/16/2025 at 11:32 AM, V17 (Housekeeping Aide) stated she assists in changing the resident beds twice a week. V17 stated if the resident refused at the time of me coming in to change the linens, V17 will come back later. Surveyor asked V17 what can potentially happen if the linen is not cleaned. V17 stated they will sleep in dirty sheets and not be comfortable.On 12/16/2025 at 11:45 AM, V18 (Housekeeper) stated he is assigned a hallway, and is responsible to cleaning the resident rooms. V18 stated he ensures the resident room is mopped and swept. V18 stated he cleans the bathroom toilet and sink every day. V18 stated the last time he cleaned R17's room was Friday. V18 stated he was off over the weekend, and on Monday. V18 stated today is his first day back on the job, and he is working his way throughout the hallway.On 12/17/2025 at 8:57 AM, V22 (Housekeeping) stated he is responsible for making sure that the resident's room is clean every day. V22 stated the bathrooms, toilets, sink, cabinets, windows, floors should be cleaned daily. Surveyor asked V22 if residents are responsible for cleaning their own bathrooms. V22 stated housekeeping should make sure that the residents' bathrooms are cleaned daily. Surveyor asked V22 what can potentially happen if the resident's bathroom is not cleaned daily. V22 stated if bathroom is not cleaned daily, the residents are at risk for infection.On 12/17/2025 at 9:03 AM, V21 (Housekeeping Director) stated there is only one floor in this facility, however they are split into hallways. V21 stated there are three housekeepers, one in each hallway. V21 stated the housekeeping team is responsible for making sure that all resident rooms are cleaned every day. V21 stated the housekeeper is responsible for cleaning the bathrooms, toilets, sinks, sweeping, mopping, taking out the trash, cleaning the walls, windows, etc. V21 stated on the weekends he will staff one housekeeper in the morning shift and one housekeeper in the afternoon shift. Surveyor asked V21 if the resident is responsible for cleaning their own bathroom and room. V21 stated the housekeeping team should be cleaning the bathrooms and rooms. Surveyor asked what can potentially happen if the resident room and bathroom is not clean. V21 stated it will make the resident question if this is a place where he wants to be, because he won't feel comfortable living under these conditions, it is not a homelike environment. Policy titled Housekeeping Policy Services with review date of 01/2025 documents in part It is the policy of this facility to maintain a clean, order free, comfortable and orderly environments in all healthcare and public areas, which meet the sanitation needs of the facility and resident's rights for a safe, clean, comfortable home-like environment. The department (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shall routinely clean the environment of care, using accepted practices, to keep the facility free from offensive odors, the accumulation of dust, rubbish, dirt, and hazards.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a baseline care plan was developed within 48 hours of admission for one (R109) resident reviewed for baseline care plans in a sample of 21.Findings Include:R109 was admitted to the facility on [DATE] with diagnosis not limited to Fracture of Unspecified Part of Neck of Left Femur, Asthma, Low Back Pain, Chronic Pain, Schizoaffective Disorder, Presence of other Bone and Tendon Implants.Progress note dated 12/10/25 12:57 PM document in part: Progress Note R109 arrived at 12:03 pm. R109 was admitted to the hospital for a fall where he (R109) sustained a left hip fracture and has 3 sutures intact and open to air. R109 is alert to name, place and time. R109 has a hx (history) of Asthma, Chronic lower back pain and Schizophrenia. R109 is continent with use of urinal and bed pan, uses a wheelchair for locomotion and is weight bearing as tolerated. R109 has an abrasion to his left knee and bruising to left thigh post fall. R109 is an active smoker. On 12/15/25 02:36 PM an email was sent to V1 (Administrator) by the surveyor requesting R109's care plan.On 12/15/25 the surveyor was presented with an undated document that documents in part: R109's ARD (Assessment Reference Date) is 12/16/25. It has not been completed yet. On 12/15/25 the surveyor was presented with a document titled Observation Detail List Report: Initial/Baseline Care Plan with an observation date: 12/15/25 02:53 PM, date recorded: 12/15/25 02:53 PM, date completed 12/15/25 02:53 PM Description: Admission. On 12/16/25 at 10:59 AM V12 (Licensed Practical Nurse) stated I admitted R109 on the 12/10/25. As a new nurse they never told us that we had to start the baseline care plan. I started R109's baseline care plan yesterday 12/15/25. If I had known I would have started the baseline care plan on admission.On 12/17/25 at 09:13 AM V3 (Assistant Director of Nursing) stated The admitting nurse does the initial base line care plan, and it is up to the care plan coordinator to take it from there. During admission the baseline care plan is for the initial care and connect dots with initial care.Policy:Titled Care Plan Standard Guidelines reviewed 11/14/25 document in part: All resident/client will be evaluated for individual risk factors which may increase the chance of hospitalization. All potential conditions that could increase the chance of hospitalization should be identified for care planning needs. The resident care plan will incorporate risk factors identified in preadmission, assessment, hospital records and admission evaluations. 1. The interdisciplinary team will collect and record data within 24 hours for the admission baseline Care Plan. 7. The care plan will be reviewed throughout the resident's stay upon admission, quarterly and with changes in condition. Baseline Care Plan: It is the practice of this facility to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective person-centered care of the resident that meet professional standards of quality care. The baseline care plan will: 1. Be developed within 48 hours of a resident's admission: 2. Include the minimum healthcare information necessary to properly care for a resident including, not limited to: a. Initial goals based on admission orders. b. Physician orders. c. Dietary orders. d. Therapy services. e, Social services. f. PASARR (Preadmission Screening and Resident Review), if applicable.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide scheduled showers for a resident that requires partial/moderate assistance with Activities of Daily Living/ADL care. This failure affects one (R71) resident in a total sample of 21 residents reviewed for ADL care. Findings include:On 12/15/2025 at 12:53PM, R71 observed sitting on his bed with a red walking stick lying next to him. R71 states he is blind and is unable to see. R71 states he has concerns with getting his scheduled showers in the facility. R71 states he is scheduled to receive a shower in the facility twice a week on Mondays and Thursdays. R71 states on his shower days, the staff does not always come to get him and take him for his shower. R71 states when he asks staff about his shower, they tell him they will return, but no one returns to give him his scheduled shower. R71 states he did not receive a shower this past Thursday on 12/11/2025. R71's Facesheet documents that R71 has diagnoses not limited to: Legal blindness.R71's MDS/Minimum Data Set, dated [DATE] documents that R71 requires partial/moderate assistance with bathing/showers in the facility and uses a cane to ambulate.R71'S shower schedule documents that R71 is scheduled to receive a shower in the facility twice a week on Mondays and Thursdays. On 12/15/2025 at 1:22PM, V10 (CNA Supervisor) states the resident's shower schedule and shower sheets are kept in a binder located at the nurses' station. V10 states the CNAs/Certified Nursing Assistants are responsible for providing residents their showers on their scheduled days. V10 states after a resident receives their shower, the nurse on duty performs a skin check and sign the shower sheet acknowledging that the resident received their scheduled shower. V10 states all residents in the facility should be receiving a scheduled shower at least twice a week and as needed. V10 states if a resident refuses a shower, it is also documented on the resident's shower sheet. V10 states if a resident's shower is not documented, then the resident's shower was not provided. V10 located at the nurses' station and provides surveyor with R71's shower sheets dated 11/2025 and 12/2025. R71's shower sheets dated 11/2025 documents that R71 did not receive his schedule shower on the following dates: 11/03/2025, 11/27/2025.R71's shower sheets dated 12/2025 documents that R71 did not receive his schedule shower on the following dates: 12/04/2025, 12/11/2025.R71's care plan documents in part R71 requires training and skill practice in dressing/grooming 6-7 days a week to prevent decline related to impaired vision. R71 is at risk for falling related to diagnosis of legal blindness. Facility policy dated 08/2002 titled Shower/Tub Bath documents in part, The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. 7. Transport the resident to the bath area. 14. Assist the resident into the tub or shower. The following information should be recorded on the resident's ADL record and/or in the resident's medical record, if indicated: 1. The date and time the shower/tub bath was performed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review the facility failed to follow their policy to ensure the narcotic count was completed at the beginning and end of each shift and failed to sign the controlled drug count record at the beginning and end of each shift for 1 of 2 medication cart narcotic logs reviewed.Findings Include:On 12/15/25 at 11:01 AM medication cart B was reviewed with V14 (Licensed Practical Nurse). During review of the Controlled Substances, November 2025 and December 2025 Controlled Substance Check Form there were observed with multiple blank boxes. V14 stated, there were no narcotics before 2 days ago and we did not have any narcotics before that because the doctor does not prescribe narcotics. On 12/15/25 at 01:18 PM the medication cart A was reviewed with V12 (Licensed Practical Nurse). On 12/17/25 at 09:13 AM V3 (Assistant Director of Nursing) stated The Controlled Substance Check Form should be done and signed shift to shift, nurse to nurse every day. The nurse should check to see if any new narcotics have come, and the sheet should still be signed.Policy:Titled Controlled Drug policy and Procedure reviewed 01/25 document in part: 2. The inventory of the controlled drugs must be recorded on the narcotic records and signed for accuracy of count. 3. The controlled drug checklist must be signed by the nurse coming on duty and going off duty to verify that the count of all controlled drugs is correct.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review the facility failed to ensure a medication error rate of less than 5%, by making 2 errors out of 31 attempts with an error rate of 6.45%. This deficient practice was identified for 2 (R11, R58) of 4 residents observed for medication administration.Findings Include:R11 was admitted to the facility with diagnosis not limited to Hypertensive Heart Disease with Heart Failure, Biventricular Heart Failure, Congestive Heart Failure, Dementia, Unspecified Severity, with Moo Disturbance, Bradycardia and Presence of Cardiac Pacemaker.R11's Care Plan document in part: Problem: Category: Cognitive Loss/Dementia. R11 has memory/recall problems, forgetting vital information towards her plan of care. BIMS (Brief Interview of Mental Status) score 3, indicating cognitively impaired.On 12/15/25 at 09:07 AM V12 (Licensed Practical Nurse) stated said to first I am going to take your blood pressure. V12 entered R11's room and placed the blood pressure cuff on R11's right arm and checked R11's oxygen saturation with the pulse oximeter. V12 exited R11's room, returned to the medication cart. V12 removed R11's medication from the medication cart and began preparing R11 medications in a medication cup. Surveyor asked the number of pills in the medication cup. V12 began counting and transferring R11's pills to another medication cup then said there are 11 pills. V12 reentered R11's room and administered her medications.1. 1. Allopurinol 100 mg daily2. 2. Amlodipine 10 mg daily3. 3. Losartan 25 mg daily4. 4. Metoprolol 25 mg daily 5. Divalproex 500mg Twice a day6. 6. Risperidone 1 mg every 12 hours7. 7. Eliquis 5 mg every 12 hours8. 8. Memantine 10 mg Twice a day9. 9. Metformin 500 mg daily 10. Ferosul 325 mg daily 11. Amiodarone 200 mg daily 12. Aricept 10 mg daily (V12 circled the entry as not given on the Medication flow sheet. There is no documentation of doctor notification).R58 has diagnosis not limited to Schizoaffective Disorders Diabetes Mellitus, Other Conduct Disorders and Schizophrenia.R58's Care Plan document in part: Problem: R58 has dietary restrictions and need for metformin related to type 2 diabetes mellitus.On 12/15/25 at 09:19 AM R58 approached the medication cart. V12 began preparing R58's medications. V12 stated, I have to check the closet to see if R58's Metformin is in there, otherwise I have to reorder it. V12 proceeded down the hallway, returned to the medication cart and said, I have to reorder the Metformin.On 12/15/25 at 09:27 AM V12 (Licensed Practical Nurse) prepared then administered R58's medications stating there are 9 pills in the medication cup.1 13. Cetirizine HCL 10 mg daily 14. Aspirin 81 mg daily1 15. Clozapine 100 mg + 25 mg daily 16. Divalproex 500 mg twice a day 17. Docusate Sodium 100 mg twice a day 18. Metoprolol 50 mg every 12 hours 19. Ferosul 325 mg twice a day 20. Famotidine 20 mg daily 21. Metformin 850 mg twice a day (V12 circled the entry as not given on the Medication flow sheet. There is no documentation of doctor notification). 22. Fluphenazine Decanoate solution 25 mg/ml 1 ml injection once a day on the 15th of the month. On 12/16/25 at 10:59 AM surveyor asked V12 (Licensed Practical Nurse) at any time yesterday (12/15/25) did she back track and administer any medications to the residents that were observed by the surveyor during the medication administration. V12 stated I did not backtrack and give any additional medications after the observation. R58's metformin came on the night shift and I gave it this morning. I notified the doctor but did not make a note. Medications are reordered when they get to the last roll on the medication card.Review of R11 and R58 progress note has no documentation of physician notification for the missed medications.Review of the Convenience Box List of medications had no Metformin listed.On 12/17/25 at 09:13 AM V3 (Assistant Director of Nursing) stated We reordering medication when it gets to the last row on the medication card. When medication is missing, they are reordered stat. The medications should be reordered before they run out. If the medications are missed there is a potential it will affect the blood levels. The residents need their medications because bad things can happen to the resident if they miss a medication dose. If the medication is not there and we should order it stat. The pharmacy can send the medications the same day or we can check the convenience box to see if the medication is available in there. If the resident miss their Metformin there is a potential for (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hyperglycemia, it can affect the residents blood sugar or the resident having to go out to the hospital. When there is a missed medication, you circle the initials on the MAR (Medication Administration Report). If a medication is missed it should be ordered immediately, inform the doctor as well and they should document. If it is not documented, it is not done.Policy:Titled Administration of Medication revised 05/17 document in part: 1. Residents shall receive their medications on a timely basis and in accordance with our established policies. 3. Medications may not be prepared in advance and must be administered within one (1) hour of scheduled administration time.Titled Medication and Treatment Orders revised 11/17 document in part: 11. Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than 3 days prior to the last dosage being administered to ensure that refills are readily available.