STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146198	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
All American Vlge Nrsg & Rhb	5448 North Broadway Street Chicago, IL 60640

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 45196 Based on interview and record review, the facility failed to ensure a nurse followed established procedures for documentation in a residents electronic medical record (EMR). This failure affected one resident (R1) out of three residents reviewed for quality of care. Findings include: R1's face sheet shows R1 has diagnoses which includes but not limited to hyperlipidemia, schizoaffective disorder, primary generalized osteo arthritis, legal blindness, unspecified ptosis of bilateral eyelids, central corneal opacity right eye, gastritis unspecified without bleeding, insomnia, and dysphagia. R1's Brief Interview for Mental Status (BIMS), dated 08/21/24, shows R1 does not have a BIMS score, and indicates R1 has memory problems and is severely impaired. R1's progress note, dated 08/21/24 at 1:02 am, authored by V8 (Licensed Practical Nurse, LPN) documents, While making rounds at 11:30 pm noted resident with lethargy. Obtain vital signs (temperature)T 99.9, (pulse) P114, (respiration) R16, (blood pressure) B/P 115/63, (oxygen saturation) SPO2 89%. (R1's) physician made aware with order to send resident to local hospital ER (emergency room). Local ambulance called with (estimated time of arrival) ETA of 3 to 4 hours and suggested 911. 911 was called. Resident was transferred (transferred) to local hospital at 12:55 am. R1's progress note, dated 08/21/24 at 6:50 am, authored by V8 (LPN) documents, Resident was diverted to local hospital and (R1's) physician made aware. Follow up call was made to local hospital ER, this writer was told that nurses are giving report and to call back in an hour time. Endorse to in-coming nurse to follow up resident status. On 08/27/24 at 6:52 am, V8 (Licensed Practical Nurse, LPN) was asked regarding V8's progress note authored on 08/21/24 at 1:02 am that documented V8 sending R1 to the local hospital. V8 stated, I (V8) did not document that. I never worked on the second-floor or with that resident. I do not know that resident. I let (V9, LPN) use my access to get into the computer because she could not get in. Inever assessed that resident. When V8 was asked regarding the facility's policy and procedure for documenting in a residents electronic medical record, V8 stated, It is not professional practice to give another nurse access to document in a residents medical record with my credentials because I can be held liable for the assessment and implicated. I gave it to her (V9) because she needed to get into the computer and couldn't. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146198	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
All American Vlge Nrsg & Rhb	5448 North Broadway Street Chicago, IL 60640

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/24 at 7:05 am, V9 (LPN) was asked regarding the progress note documented with V8's electronic signature on 08/21/24 at 1:02 am. V9 stated, I used (V8's) electronic access to document in (R1's) chart because I could not get into the computer system. V9 was asked regarding the facility's policy and procedure for documenting in a residents electronic medical record. V9 stated, It is not professional practice but, I could not get into the computer, so I asked (V8). I called (V2, Director of Nursing/DON) and made her (V2) aware that I had to use (V8's) access and that I could not get into the computer system. On 08/27/24 at 11:26 am, V2 (Director of Nursing, DON) stated V2 became aware of V9 documenting in R1's medical record with V8's access the day after (08/22/24) R1 was sent to the local hospital, after V2 reviewed R1's medical record. V2 denied V9 informing V2 that V9 documented in R1's medical record with V8's medical record access. V2 stated V2 was reviewing R1's documentation for 08/21/24 and with V8's authored progress note, and was aware V8 did not author the progress notes on 08/21/24, due to V8 never working on the second floor or with R1. V2 stated, Nurses should not be sharing computer access. The nurse caring for the resident should be documenting under their own access and signature. If anything happens to the resident, then the nurse who access was shared will be held accountable. The nurse should have called me (V2) to reset her password. If I am not available then the Assistant Director of Nursing (ADON) should have been called. Nurses are educated regarding not sharing their access (passwords) upon hire to the facility. The facility's policy, dated 2006 and titled Charting and Documentation, documents, Policy Statement: All services provided to the resident, or any changes in the residents medical or mental condition, shall be documented in the residents medical record. Policies Interpretation and implementation: 2. Entries may only be recorded in the resident's clinical record by licensed personnel . in accordance with state law and facility policy . 4. Information documented in the residents clinical record is confidential and may only be released in accordance with state law and facility policy. The facility's policy, dated March 2014 and titled Health Information Management- Resident Information Privacy Protection, documents, Policy: To assure that all resident-identifiable information maintained by the facility shall be confidential and disclosed only to authorized individuals. Policy Specifications: 5. Resident Care: a.) only health care professionals directly involved in the care of an individual resident will have access to that resident's clinical record. The facility's job description titled Charge Staff Nurse documents, Position Purpose: Provide direct nursing care to the residents, and to supervise nursing activities performed by nursing assistants. Administrative Functions: 2. Ensure that all written policies and procedures that govern day-to-day functions of the nursing department are followed. 3. Ensure that the Nursing Service Procedures Manual is followed in rendering nursing care . 6. Perform administrative duties such as completing medical forms, reports, evaluations, charting, etc. as necessary . Charting and Documentation: 2. Chart all accidents or incidents involving the resident. Follow established procedures . 4. Chart nurses' notes in an informative and objective manner that reflects the care provided to the resident, as well as the resident's response to the care. 5. Complete and file required record keeping forms or charts upon the resident's admission, transfer, and/or discharge . 11. Perform routine charting duties as required and in accordance with our established Charting and Documentation Policies and Procedures.