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	05/23/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 40061 Based on interview and record review, the facility failed to keep three residents (R2, R3, R4) free from abuse for three of four residents reviewed for abuse. This failure resulted in R2 losing a dental implant and a tooth, R3 sustaining an upper lip laceration, and R4 complaining of headache after being kicked to the head. Findings include: 1. R1's Resident Face Sheet documents diagnoses of schizoaffective disorder, bipolar type; anxiety disorder; and bipolar disorder. R1's Care Plan documents R1 experiences delusions (8/22/2024). V12's (Psychiatric Rehabilitation Services Coordinator) progress note for R1, dated 1/16/2025 10:31 PM, documents R1 was involved in a physical altercation with co-peer. R1 displayed agitated and aggressive behavior with delusions. Facility's Incident Report Form, dated 1/21/2025, documents an incident between R1 and R2 that occurred on 1/16/2025 at 9:10 PM. During facility's investigation, R2 stated R1 came into R2's room and hit R2 in the face, causing an implant tooth to fall off. R2 stated R1 was deeply delusional. On 5/21/2025 at 11:21 AM, R1 stated, [R2] instigated the fight. R1 stated R2 entered R1's room first trying to look for R5. R1 was unclear as to what happened next, but stated getting angry and following R2 back to R2's room. R1 stated, Whatever compelled me to do it, I punched [R2] in the mouth, and I guess [R2's] tooth fell out. On 5/21/2025 at 11:52 AM and during a follow-up interview at 1:45 PM, R5 stated R5 was hanging out with R1 earlier in the evening in the lobby. R1 and R5 were sitting at a table near the elevator talking about religious, magical, and spiritual stuff. R2 was sitting at a nearby table and told R5 to come sit with R2 instead. R5 stated R1 felt emotional that day and was upset that R5 was spending more time with R2 instead of R1. R5 stated R1 got up and left to go upstairs. R2 and R5 then went to R2's room to hang out. R5 stated, That's when [R1] came into [R2's] room and said something like 'you don't pay kindness with evilness.' Then [R1] punched [R2] in the face. R5 stated R1 punched R2 with a closed fist. (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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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/21/2025 at 2:09 PM, V4 (Certified Nurse Aide) stated V4 was sitting in a chair near the nurses station when R2 stated, [R1] punched me, and I lost my tooth. V4 stated R2 had a little blood near the mouth. V4 recalls providing R2 with paper towel for R2's bleeding mouth and helping R2 locate missing teeth. V4 described R2 being a a little bit in distress. On 5/21/2025 at 3:15 PM, V8 (Nurse) stated V8 was at the nurses station when R2 reported lying in bed talking to another resident when R1 came in and hit R2 in the mouth. V8 stated R2 lost the top front tooth and had a bloody mouth. V8's associated progress note, dated 1/16/2025 10:38 PM, documents R2 had bleeding to oral cavity. V8 stated facility sent R1 to the hospital for psychiatric evaluation, and R2 for medical evaluation. R1's hospital papers for service date of 1/17/2025 documents aggressive behavior. R1 endorsed feeling possessed. R2's hospital discharge instructions, dated 1/17/2025, documents diagnoses of dental injury. R2 received new order for chlorhexidine topical orally two times a day and dental referral. V17's (Psychiatric Rehabilitation Services Coordinator) well-being progress note for R2, dated 1/18/2025 8:10 PM (post hospitalization), documents R2 at times felt self-conscious about R2's own physical appearance due to missing two of R2's teeth. During a telephone interview with V14 (Previous Administrator/Abuse Coordinator) on 5/22/2025 at 12:42 PM, V14 stated R1 was having delusional moments that morning. Just before the incident, R1 heard internal commands and that's when R2 sustained the hit in the mouth that caused the implant to fall out. V14 stated facility is assisting R2 with dental follow-ups. R2's dental paperwork, dated 2/05/2025, documents broken implant to tooth #9. During a telephone interview on 5/23/2025 at 10:03 AM, V16 (Dentist) stated R2 reported getting punched in the face and sustaining dental injury. V16 stated R2 was missing an implant that was in the front, upper mouth (tooth location #9) and a normal tooth next to it (tooth #10). V16 stated R2 has solid bone and gum health. V16 stated it will take quite a bit of force and some pretty serious impact to cause R2's teeth (implant and regular tooth) to come out like that. V16 referred R2 to a periodontist for further evaluation. Once cleared, V16 stated R2 will need a bridge and crown to replace the teeth. 2. Facility's Incident Report Form, dated 5/09/2025, documents R3 and R4 reporting abuse on 5/04/2025 at around 1:20 PM. R3 had small redness to mouth area. On 5/21/2025 at 11:44 AM, R4 stated roommate was R3. R4 returned to the bedroom and found R3 on R4's side of the room holding R4's TV remote control. R3 went back to R3's bed and laid in the bed with R4's remote in hand. R4 came over to R3's side and tried to snatch the remote control off R3's hand, but it fell on the floor. R4 stated, I tried to grab it but [R3] kicked me in the face, so I punched [R3] in the head. I hit [R3] in the head three times for kicking me in my face. R4 stated R4 hitt R3 with a closed fist. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/21/2025 at 11:56 AM, R3 stated R4 liked leaving the TV on even when R4 wasn't in the room. R3 stated the incident started because R3 turned off R4's TV. R4 got mad and punched R3 in the mouth with a closed fist multiple times. R3 pushed R4 off with foot to get R4 away. Once R4 stopped punching, R3 left and told the nurse. R3 stated R3 sustained a bloody lip to the top right side. On 5/22/2025 at 10:06 AM, V6 (Certified Nurse Aide) stated V6 interviewed R3 after the incident. R3 reported R4's TV was loud, so R3 took R4's remote and turned it down. R3 said R4 came into the room shortly after, got mad, and started punching R3 in the face. R3 told V6 R3 kicked R4 during the incident. V6 stated R3 was shook up and mostly scared. During a telephone interview with V10 (Nurse) on 5/22/2025 at 10:37 AM, V10 stated V10 was at the nurses' station when R3 complained R4 struck R3 on the face around the mouth. Upon assessment, V10 noted redness to the upper part of R3's lip. R3's hospital records from 5/04/2025 document small laceration on the mucosal aspect of the upper lip. R4's hospital records from 5/04/2025 document R4 reported being kicked to the right side of the head. R4 complained of a little headache on the right side. On 5/22/2025 at 11:22 AM, V2 (Director of Nursing) stated the facility is responsible for each residents safety in the building. Staff are to prevent abuse through close monitoring and knowing where the residents are and their behaviors. Facility's Resident Rights Guideline (last revised 10/2024) documents residents have the right to be from abuse. Facility's Abuse Prevention Program (01/2025) documents the facility affirms the right of their residents to be free from abuse. The facility therefore prohibits abuse and mistreatment of residents. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.