

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146198	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/27/2026
NAME OF PROVIDER OR SUPPLIER All American Vlge Nrsg & Rhb		STREET ADDRESS, CITY, STATE, ZIP CODE 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to affirm the right of their residents to be free from verbal and physical abuse. This failure affected two (R2, R4) out of six residents reviewed for abuse. The deficient practice resulted in actual harm when R4 sustained a left eye injury. Findings Include: R4's clinical records show an admission date of 9/26/24 and discharged on 3/18/26, with included diagnoses but not limited to bipolar disorder and anxiety disorder. R4's Minimum Data Set (MDS) assessment, dated 1/1/26, shows a BIMS (Brief Interview for Mental Status) of 15, which means R4 was cognitively intact and required setup help to supervision with activities of daily living (ADLs). R4's progress notes, dated 3/12/26 at 3:21 PM documented by V8 (Licensed Practical Nurse/LPN), reads: The writer was informed that [R4] had a verbal aggression towards co-peer at 1:35 PM at the Lobby. R4's progress notes, dated 3/18/26 at 1:55 PM documented by V8, reads: The writer was informed that [R4] had a physical altercation with a co-peer. Both residents were immediately separated and placed on one-to-one close monitoring with staff. Head to toe assessment was conducted. [R4] was observed with a small opening area to the left eyebrow. R4's progress notes dated 3/18/26 at 3:33 PM documented by V23 (Registered Nurse/RN), reads: It was noted that resident expressed to leave facility AMA [Against Medical Advice]. Writer educated resident on risks of leaving against medical advice. Resident verbalized understanding of risks and continued to request discharging AMA. Resident was educated to wait and go to the hospital first as he was awaiting (sic) for EMT [Emergency Medical Technician] but he declined stating that he had the right to leave as he chose to. Resident advised medical assistance may be required if conditions worsens (sic) and instructed to call 911 or go to nearest Emergency room. Resident was noted earlier with an superficial open and first aid was rendered. Two steri-strips applied. Steri strips intact. No bleeding noted. Charge nurse assessed resident, area clean and dry, skin intact, resident denied having any pain and/or discomfort. Resident verbalized he felt fine and alright. Resident alert and oriented x 3. Resident took all his belongings. Physician made aware. [V22 (R4's Family Member)] contacted, no response as resident stated she may be at work, so voicemail was left. Resident left the facility with his items, properly dressed for the weather and was informed to seek medical assistance by contacting 911 for help if needed. Resident verbalized understanding and he departed from the facility. Law enforcement was notified of this as well. R2's clinical records show an admission date of 9/18/25 with included diagnoses but not limited to bipolar disorder, unspecified psychosis, and major depressive disorder. R2's MDS assessment dated [DATE] shows a BIMS of 15, cognitively intact and requires setup help to supervision with ADLs. R2's progress notes, dated 3/18/26 at 1:50 PM documented by V20 (LPN), reads: [R2] was involved in an altercation with a peer and immediately separated by staff and placed on one and one observation with staff. Full body assessment was conducted and resident noted with redness to forehead. R2's progress notes dated 3/12/26 at 1:30 PM reads: The writer was informed that [R2] had a verbal aggression towards another resident at 1:30 PM at the Lobby. The facility's first incident report related to R2 and R4 sent to Illinois Department of Public Health (IDPH) documents: Date of incident 3/12/26 at 5:02 PM. [R4] reported (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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R4 stated he was fearful for his life due to another resident [R2] residing in the facility. R4 stated the first incident occurred around March 6 or 7 during activity time in the common area on the first floor. R4 stated R2 was making gestures indicating he wanted to fight; however, R4 did not engage and laughed it off. Later that day, at approximately 3:30 PM while R4 was smoking outside, R2 approached and spat on R4's face. R4 stated V19 (Security) was present and intervened, separating both R2 and R4. R4 stated they were both sent to the hospital for a mental evaluation. R4 stated he did not instigate any physical altercation and did not understand the reason for being sent to the hospital. R4 further stated that after a few days, R4 returned to the facility after being reassured that the situation had been resolved. However, around March 17 or 18, R4 said another incident occurred. R4 stated upon exiting the elevator on the first floor, R4 saw R2 approaching and felt threatened, prompting R4 to swing at R2. R2 then punched R4 repeatedly, resulting in an injury to R4's left eye, which began bleeding. R4 stated V18 (Security), and a kitchen staff intervened. R4 stated the kitchen staff member restrained R4 while another staff member separated R2. R4 stated his wound was cleaned, and the situation was de-escalated. R4 stated ongoing fear for his safety, noting that although he did not reside on the same floor as R2, R4 frequently encountered R2 in common areas. R4 stated that due to continued fear and feeling unsafe within the facility, R4 chose to leave AMA. On 4/26/26 at 10:43 AM, R2 was interviewed. R2 stated he does not remember specific times and dates of the incidents that happened with R4. R2 stated since being admitted in the facility, R4 kept bullying him. R2 stated being called derogatory names by R4, including coo (interpreted as being called [NAME] or goofy). R2 stated a verbal altercation occurred, but R2 does not remember the exact date. R2 denied spitting at R4. R2 stated there was no physical fight that occurred at that time. R2 stated R4 were cursing and calling him names, but staff intervened, and they were both sent to the hospital. R2 stated R4 continued to provoke him on multiple occasions, including attempting to initiate fights when they passed each other. Staff reportedly intervened and separated them each time. R2 indicated R4 would come down to his floor and provoke R2. R2 stated following discharge from the hospital in March, R2 returned to the facility (R2 does not remember exact date) and was in the lobby near the elevator retrieving personal belongings. R2 stated at that time, R4 exited the elevator and swung at R2, striking him in the face and causing a minor bruise on the forehead. R2 stated he defended himself by striking R4 multiple times in the face, resulting in a cut near R4's left eye. R2 stated staff intervened, though R2 could not recall specific staff members involved. R2 stated staff physically separated them both. R2 stated R4 was taken to the social services office, while R2 was taken to the patio area. R2 stated he was sent to the hospital for evaluation. R2 believed R4 left AMA and refused hospital care. R2 reported feeling safe in the facility at the time of the interview. On 4/26/26 at 11:25 AM, V6 (Activity Aide) stated she does not remember the exact date of the incident between R2 and R4, as she was new at the facility at the time. V6 stated being stationed at the front desk and covering for security after lunch when the incident occurred. V6 stated she buzzed the front door open for an individual entering the building, and when she looked back towards the lobby, V6 observed R2 and R4 engaging in a physical altercation. V6 stated R2 and R4 were swinging at each other but could not recall who struck first. V6 stated after staff separated R2 and R4, V6 observed R4 was bleeding from one eye. V6 stated no one else was near her at the front desk, and she called for assistance. V6 stated male staff members responded (continued on next page)		

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