FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: _ COMPLETED C IL6007140 B. WING 05/25/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2320 SOUTH LAWNDALE LITTLE VILLAGE NRSG & RHB CTR CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES (X4)10 PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) S 000 Initial Comments S 000 Investigation of Facility Reported Incident of April 16, 2022/IL146284 S9999 **Final Observations** S9999 Statement of Licensure Violations: 300.610a) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Attachment A Statement of Licensure Violations Based on interview and review of documents the facility failed to ensure residents have the right to

inois Department of Public Health

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health				FORM	FORM APPROVE		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE		(X3) DATE SURVEY		
			A. BUILDING:		1 00%	COMPLETED	
		IL6007140	B. WING		05/	C 05/25/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	-			
LITTLE	/ILLAGE NRSG & RH	DUK	UTH LAWNDA O, IL 60623	ALE			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID ID	PROVIDER'S PLAN OF CO	RECTION (VE)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD RF	(X5) COMPLET DATE	
S9999	Continued From pa	ige 1	S9999				
	residents in a sam	2 of 4 (R1, R2, R3 and R4) ble of 10 by not preventing a leading to injuries to both R1		a a			
	Findings include:						
Ta'	including Schizophi disorder of adult pe Hallucinations and symptoms involving	male resident with a diagnosis renia, Bipolar disorder, rsonality and behavior, delusions and other signs and appearance and behavior- avior. R2 has a BIMs score of		5.5m			
	including Schizoaffe End Stage Renal D	male with a diagnosis active Disorder, Diabetes 2, isease, Heart failure, COPD, hosis of liver and bipolar BIMs score of 13.					
	R1 and R2 were inv Nurses assessed R R2 was assessed w right eye and swelling provided to R1 and for psych evaluation sent to the hospital a stated he entered hi and R2 were inside the told R2 to get out	ort stated on 4/16/22 5:20PM, olved in a physical altercation. 1 with swelling to right hand. ith a small laceration under ing to the face. First aid was R2. R1 was sent to hospital per physician orders. R2 was per physician orders. R1 s own room. R1's roommate the room talking. R1 stated to f the room and R2 "wanted ted he hit R2 in the face.					
ŀ	roommate. R2 state he toid R1 "you owe	R1's room talking to R1's d when R1 entered the room, me 3.50 for the pop." R2 and hit him in the face.					
		ited 4/16/22 5:20PM states		(%) (%) - 15 1860 18			
ois Departi	ment of Public Health		1900				
		•	SSSS OR	GL11	If continuat	ion sheet 2 d	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI	(X3) DATE SURVEY COMPLETED			
IL6007140		2	A. BUILDING:				
		B. WING			05/25/2022		
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE			
LITTLE V	/ILLAGE NRSG & RH	CHICAGO	UTH LAWNDA O, IL 60623	LE		177	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER (EACH CORRI CROSS-REFERI	ULD RE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 2	S9999		· · · · · ·		
	resident involved in resident in peer's ro separated, and safe responded to room	physical altercation w/another om; both residents were by provided at all times. Staff after hearing commotion.	1 1		* -		8
	eye superficial lacer soft tissue swelling bleeding to facial inj	ultiple facial fractures; right ration w/moderate to severe to bilateral orbits. Moderate uries noted but easily ribed blood thinners and no				A 47	
	loc (loss of consciou administered ice par 1:1 provided at all tir	usness). Basic first aid ck applied to facial injuries. mes until EMTs arrived. Patient escorted out via 911.					
	R1 hospital record d Displaced fracture o bone of right hand.	ated 4/16/22 states, f neck of 5th metacarpal				3	
	sustained multiple fa surgical repair and 9 the face, right eye pa	ated 4/16/22 shows R2 acial bone fractures requiring sutures. R2 had edema to artially closed and left eye to the facility on 4/27/22.			240 X		
	room. R2 wanted to hitting each other. I p ended up on the grou	5AM, R1 stated R2 was in my fight me. We both started bunched him in the face. We und. The nurse came in and the hospital. My finger got m.		E	# ## ## ## ## ## ## ## ## ## ## ## ## #		
1	to R1's roommate (R room and started pur to go to the hospital. feel safe here now I	DAM, R2 stated I was talking 5) when R1 came into the nching me in the face. I had I am sore now from the fight. haven't had any other					\$ P
(altercations with R1. On 05/23/22 at 11:20 oom with R2 who water of Public Health	AM, R5 stated I was in my as talking to me. R1 came					

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING: COMPLETED С IL6007140 B. WING 05/25/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2320 SOUTH LAWNDALE LITTLE VILLAGE NRSG & RHB CTR CHICAGO, IL 60623 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) Continued From page 3 S9999 S9999 into the room and told R2 to get out. They both started hitting each other. They ended up on the floor. The nurse came in and broke it up. They both went to the hospital. R1 is still my roommate. I don't see R1 and R2 around each other. That is all I know. V1 (Administrator) stated R1 and R2 got into a fight in R1s room on a Saturday 4/16/22. The Director of Nursing was not at the facility. The two nurses that broke up the fight were agency nurses. I have no way of contacting those nurses for you to interview. We are monitoring R1 and R2. Care plans were revised. There were no earlier indications of R1 and R2 having any issues before the incident. I am the abuse prevention coordinator. I followed the policy. IDPH was notified. The police were notified. R1 went for a psych eval. He also was diagnosed with fracture to finger. R2 was sent to hospital for cut under his eye. At hospital fractures were found to face. The hospital had to do extensive treatment for repair. Both of their care plans were revised. The facility failed to prevent abuse because we had no prior indication that R1 and R2 were going to have an altercation. Facility Abuse Prevention Policy Dated February 2017 states including: This affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment of residents.

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