(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLI AND PLAN OF CORRECTION IDENTIFICATION NU			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED			
		A. BUILDING:			С				
IL6007140		B. WING		01/31/2025					
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
LITTLE	LITTLE VILLAGE NRSG & RHB CTR 2320 SOUTH LAWNDALE CHICAGO, IL 60623								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED SC IDENTIFYING INFOR	CIES BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
S 000	Initial Comments			S 000					
	Complaint Investiga	ation							
	2580337/IL184449								
S9999	Final Observations			S9999					
	Statement of Licens 300.3300e)3) 300.3300l)	sure Violation:							
	Section 300.3300	Transfer or Discha	rge						
	e) For transfer or discharge made under subsection (d), the notice of transfer or discharge shall be made as soon as practicable before the transfer or discharge. The notice required by subsection (d) of this Section shall be on a form prescribed by the Department and shall contain all of the following:								
	3) A statement in no which reads:	ot less than 12-poi	nt type,						
	"You have a right to to transfer or dischashould not have to a request for a hear Public Health within notice. If you request a request for a hear public Health within notice. If you request a request for a fixed property of the sering that time. If the sering is not in you be transferred or discontinuous and the serior of 30 day original notice of the form to appeal the serior of serior or discontinuous and the serior of the serior	arge you. If you the leave this facility, you fing with the Depart 10 days after recest a hearing, it will after your request, transferred or discharged prior to the following receipt the transfer or discharged prior to the transfer or discharged or disc	ink you you may file rtment of eiving this I be held not and you charged ing the rally will not he t of the arge. A						

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

Electronically Signed 02/22/25

TITLE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6007140	B. WING			C 31/2025
	PROVIDER OR SUPPLIER	2320 SQU	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
\$9999	request a hearing is questions, call the Ithe State Long Term telephone numbers 3-403(c) of the Act) I) A resident subject discharge from a farm or if the resident is a have the opportunit with the Department receipt of the writtensfer or discharge 3-410 of the Act) These requirements by: Based on interview failed to follow their for one resident (Rareviewed for transfer failure resulted in Rareviewed for transfer failure and subseque community three danotice. R1 progress note or reads: Ambulance a became aggressive she does not have a drunk while on pass state and that she have a state	s attached. If you have any Department of Public Health or In Care Ombudsman at the listed below."; (Section	S9999			
		om note dated 12/25/24 reads:				

Illinois Department of Public Health

STATE FORM RSGK11 If continuation sheet 2 of 5

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6007140	B. WING			C 31/2025
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	-	
LITTLE	VILLAGE NRSG & RH	B CTR	OUTH LAWNDA 6O, IL 60623	LE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S9999	with petition. Per Enstaff said she was a patient is cooperatinadmission to psychand Intoxication. R1 progress note direads: Writer talks psych NP of reside Resident has been alcohol program for given an immediate the process. Reside with a stamped envappeal on the enverence Residents inform the facility that she will belongings. Writer ombudsman reside R1's Notice of involutionand opportunity for residents sheet dat of whether the facility federal regulations to appeal the decision you. If you think you facility, you may file the Illinois Department days after receiving following the hearing generally you will no prior to the expiration of the original Notice R1's Hospital reconscheduled for disches psychiatrist. Patient hallucinations, deni	mergency Medical Support aggressive earlier. On arrival ve and calm. She is upset unit. Diagnosis Depression atted 12/31/2024 03:58 PM to resident psychiatrist and then the behaviors at this facility. non-compliance to go to an or her addiction. Resident was a discharge and was explained ent received the original IVD velope with the address for lope to be mail to IDPH. The marketer to inform the have someone to pick up her email DPH, and the ent IVD. untary transfer or discharge hearing for nursing home ed 12/31/24 reads: regardless ity's proposed action is under or state law, you have the right ion to transfer or discharge u should not have to leave this a Request for a Hearing with ent of Public Health within 10 this notice. If the decision ag is not in your favor, on the transferred or discharge on of 30 days following receipt the of Transfer or Discharge. In did dated 1/2/25 reads patient learge by attending	d d d d d d d d			

Illinois Department of Public Health

STATE FORM RSGK11 If continuation sheet 3 of 5

PRINTED: 02/28/2025 FORM APPROVED

Illinois Department of Public Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6007140	B. WING			C 31/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
LITTLE	/ILLAGE NRSG & RH	B CTR	JTH LAWNDA	LE			
	I	CHICAGO	D, IL 60623				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 3	S9999				
	was resident at nur return, until nursing discharge. Patient r home, now stated s Patient offered alter	ratment plan provided. Patient sing home and plan was to home provided an involuntary requested to go to nephews' she cannot go to nephew. In the placement but refused to be to friend who is able to oday at 1pm.					
	1/29/25 at 2:30pm (Administrator) to g IVD, (involuntary distated when she ar escorted to R1's roworker. V3 stated swas receiving the IV occasions she was aggressive behavious she gave R1 was the R1 that she had a ristated while at the IV who was in room with the IV occasions R1 to Costated at that time IV stated at that time IV occasions.	iness Office) she stated on she was instructed by V8 or to the hospital to give R1 scharge) paper work. V3 rived at the hospital she was ome by the hospital social she explained to R1 that she VD because on two different intoxicated and displaying or. V3 stated the only forms he IVD and did not explain to ight to appeal the process. V3 hospital told the social worker ith R1 and her that the facility come back to the facility. V3 R1 told her and the hospital the process and the process are process and the process and the process are process are process					
	her reason for givin discharge) was bed outpatient substand was not following stated she believed longer meet R1's not familiar with the IVI the residents right twill educate her her	5 am V8 (Administrator) stated g R1 the IVD (involuntary cause she refused go to the ce abuse program and she come of the facility rules. V8 I that the facility could no eeds. V8 stated was not D process, time frames or of o appeal the IVD. V8 stated reelf going forward on how fill prrectly and allow the IVD					

Illinois Department of Public Health

STATE FORM RSGK11 If continuation sheet 4 of 5

Illinois Department of Public Health

C							
IL6007140 B. WING 01/31/2	2025						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2320 SOUTH LAWNDALE CHICAGO, IL 60623							
(X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE						
S9999 Continued From page 4 process to play out according to the State and Federal Guidelines. (B)							

Illinois Department of Public Health

STATE FORM RSGK11 If continuation sheet 5 of 5