STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007140	A. BUILDING: _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE VILLAGE NRSG & RHB CTR	2320 SOUTH LAWNDALE CHICAGO, IL 60623

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S 000	Initial Comments Investigation of Facility Reported Incidents of: 01/25/2025 / IL187207 02/15/2025 / IL187533	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210d)6) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision	S9999		

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S9999	Continued From page 1 and assistance to prevent accidents. These Requirements were not met as evidenced by: Based on interview and record review the facility failed to ensure that 4 of 4 residents (R1, R2, R5, and R6) were free from physical abuse. The facility also failed to develop and implement appropriate measures to ensure adequate supervision is afforded to two residents R1 and R2 reviewed for physical abuse. This failure affected R1, R2, R5, and R6 who had verbal altercation that resulted in R1 injury and bleeding to mouth and R6 injuries resulting in stitches to eyebrow and injury to forehead. This has the potential to affect all 103 residents residing in the facility. Findings include: On 02/27/25 at 12:44pm, R1 was observed in the room sitting on the bed. The surveyor asked R1 about the incident of 01/25/25. R1 stated that "I (R1) can't remember what happened, but (R2) and I (R1) had a misunderstanding. I (R1) did not steal anything from (R2). (R2) hit me and punched me in my face and my mouth. I (R1) was bleeding from my mouth." On 2/27/25 at 12:55pm, R2 was observed in the room. when the surveyor asked about the incident of 01/25/25, R2 stated "R1 was drunk and was taking my pop drinking them. I (R2) came to the nurse's station and told them (staff) about it, and they did nothing. When I (R2) went back to the room (R1) was still drinking my Pop. I (R2) pushed (R1) down on the bed and held (R1) because (R1) was stealing from me."	S9999		

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R1's medical record showed V17's documentation in the progress note dated 01/25/25 timed 10pm indicated that R1 noted to be fighting with roommate (referring to R2). Roommate (R2) hit (R1) in the face and the mouth with moderate bleeding noted from R1's mouth.

According to facility investigation witness statement dated 1/31/25, V18 stated that on 1/25/25 R2 came to the front desk and reported that R1 was stealing R2's food and this was reported to V17 (Nurse). V17 went to the resident's room and came out and said R1 and R2 were fine. V18 made V17 aware that R1 was drunk and V17 went back into the office (referring to medication room used as the nurse's office). V18 (Receptionist) stated R2 came back to the nurse's station and said someone needs to come and get R1. V18 stated that while sitting at the nurse's station she heard them fighting (referring to R1 and R2). V18's witness statement documentation showed that V17 was first notified at 7:30pm.

According to V17's witness statement, V17 documented in part that at 7:00pm she was notified that two residents R1 and R2 that "something is going on with these 2 (referring to R1 and R2)." V17 did not separate the resident R1 and R2 from each other. At 9:30pm V18 documented that R1 had unsteady gait and suspected alcohol intoxication. V17 documented that R1 had bleeding from the mouth.

On 03/04/25 at 12:25pm, R5 stated that "R6 and I shared the same bathroom. R6 is always urinating on the floor and everywhere. On the day of the incident I tried to let R6 know that (R6)

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must clean it up because R6 always leaves the place dirty, and I end up cleaning it." When asked whether the housekeeper/staff know about these concerns. R5 stated "Yes, because they clean it all the time and R6 will dirty it again and again. And nobody (referring to staff) does nothing about it. I (R5) have reported it but (R6) kept (urinating) on the floor, I feel like (R6) is saying whatever I (R6) do you are going to clean it up. R5 stated that I am a grown man, and no one is going to be treating me like that. R6 punch me in my face so I hit (R6) hard. A fight broke out and R6 started bleeding in the face."

At 1:20pm, R6 was observed with three wound closure strips on the right eyebrow and approximately 2 inches of healing wound to the forehead. When the surveyor asked about what happened to R6's face. R6 stated that "I fought with (R5). (R5) is not my boss, (R5) thinks he can fight, and I (R6) showed him. (R5) keeps putting everything that is wrong on me, and (R5) hit me, and I (R6) hit him back."

R1's medical record Face Sheet showed that R1 was admitted to the facility on 06/03/2024 with a diagnosis list that includes but not limited to chronic obstructive pulmonary disease unspecified, schizoaffective disorder, bipolar type, alcohol abuse uncomplicated Type 2 diabetes mellitus with hyperglycemia. R1 was sent to the local hospital on 1/15/25 and the discharge record showed that R1 was treated for alcohol intoxication.

R2's medical record Face Sheet showed that R2 was admitted to the facility on 11/15/2024 with diagnosis list that includes but not limited to Type 2 diabetes mellitus with hyperglycemia, non-pressure chronic ulcer of other part of left

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foot with unspecified severity left foot.

R5's medical record Face Sheet showed that R5 was admitted originally to the facility on 08/14/2024 with latest admission date of 02/21/25. Diagnosis list includes but not limited to Major depressive disorder, drug induced subacute dyskinesia, schizoaffective disorder, acquired absence of eye-right eye, and blindness one eye unspecified eye-right eye.

R6's medical record Face Sheet showed that R6 was admitted to the facility on 01/03/2025 with diagnosis list that includes but not limited to chronic obstructive pulmonary disease unspecified, schizoaffective disorder, bipolar type, alcohol abuse uncomplicated Type 2 diabetes mellitus with hyperglycemia.

On 03/04/25 at 2:15pm, V2 stated that she expected the licensed nurses to separate the residents immediately when there is a suspicion of any abuse. In the case of R1 and R2 the nurse (V17) should have separated the residents before the altercation escalated into actual physical abuse. V2 stated that hitting and holding down of resident by another resident is a form of physical abuse and should not happen. V2 stated that both R1 and R2 should have been separated and placed on 1:1 supervision.

On 03/12/25 at 1:49pm, V1 (Administrator) stated that "she (V1) expected the nurse to first separate the residents, assess them, and depending on the type of altercation put the resident on 1:1 supervision, call the medical doctor (physician) and both residents must be sent out. The nurse should call me (V1) the abuse coordinator. V1 stated that when (V18) informed the nurse (referring to V17 LPN), she did what she was

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supposed to do it is not her (V18) responsibility to separate the residents. R1 just had a tooth extraction maybe the alcohol caused R1 to bleed because R2 said I (R2) did not hit R1 from my interview." When asked whether pushing and holding down another resident and physical contact holding another resident down in a physical altercation, is that appropriate behavior. V1 stated "no, it is not allowed that is like restraining a person." The surveyor then asks are residents allowed to restrain another resident. V1 stated "No".

During this investigation both V17 and V18 cannot be reached by the surveyor. Both V1 (Administrator) and (V2 DON (Director of Nurse's) tried to reach the staff without success.

The facility did not provide any supervision policy.

The facility policy on Abuse with reviewed date 1/18/2024 documented that the facility affirms the right of our (facility) residents to be free from abuse. the policy under definitions documented in part that abuse is the willful infliction of injury and the term "willful "means the individual must have acted deliberately not that the individual must have intended to inflict injury or harm. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means. Physical abuse listed includes but not limited to hitting, slapping, and controlling behavior through corporal punishment.

(B)