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 01/19/2024

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 Facility Reported Incident Investigations FRI of 12/14/23/IL168384 FRI of 12/30/23/IL168681 .	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3240e) 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 b) The facility shall provide the necessary care and services to attain or maintain the highest	S9999		

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S9999	Continued From page 1 practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3240 Abuse and Neglect e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These requirements were not met as evidenced by: Based on interview and record review, the facility failed to follow their abuse policy to protect resident's right to be free from resident-to-resident abuse for two of five residents (R2, R4) these failures resulted in 1) R2 sustaining facial fractures after R2 was struck by a peer and 2) R4 experiencing back stiffness after R4 was struck by a peer. Findings include: 1) R2's medical record (Face Sheet, Minimum Data Set) documents R2 is a cognitively intact 60 year old re-admitted to the facility on 12.21.2023	S9999		

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with diagnoses including but not limited to: Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Major depressive disorder, Maxillary fracture, left side, subsequent encounter for fracture with routine healing, Fracture of orbit, unspecified, subsequent encounter for fracture with routine healing.

Final Incident Report of 12.20.2023 documents in part, staff reported that (R3) hit (R2) in the hallway. (R3) did not deny accusations against him. (R2) had injuries to his face.

12.14.2023 After Visit Summary documents in part:
You were seen today for fractures to the face.
-Reason for visit: Assault victim
-Diagnoses: Closed fracture of left side of maxilla, Closed fracture of orbital wall

1.17.2024 at 10:38 AM, V5 (LPN-Licensed Practical Nurse) via telephone. V5 said she remembered the incident involving R2 and R3. V5 said, I was inside the Nursing Office (at the time of the incident) when one of the CNAs (V8) alerted me that two residents were fighting. V8 said "hey, there are two guys fighting." I came out of the office and saw R2 on the floor shielding himself, R3 was doing most of the hitting. According to V8, R2 was the aggressor, he pushed R3. I assessed both residents; R2 had facial bruising and edema, R3 had no visible injury. Both residents were sent to the ED for evaluation and treatment. Yes, this is resident to resident abuse, I notified the Administrator.

1.17.2024 at 11:45 AM, V8 (CNA-Certified Nursing Assistant) said via telephone. I was coming into work. I didn't see the beginning of it, I

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came in on it. I saw R3 hit R2 in the face. I don't know who started it.

12/14/2023 11:06 PM Resident was in physical altercation with another Resident. Both residents seems to be intoxicated. Both residents sent to ER for evaluation. Police report made. Administrator, DON made aware.

12/15/2023 02:30 PM Resident returned from (local hospital). Resident was treated for Orbital and Maxillofacial fractures. Left eye swollen and red.

R2 and R3 were not in the facility during the investigation.

2) R4's medical record (Face Sheet, MDS-Minimum Data Set) documents R4 is a severely cognitively impaired 67-year-old re-admitted to the facility on 11.28.2023 with diagnoses including but not limited to: Parkinsonism, Other schizophrenia, Type 2 diabetes mellitus with diabetic nephropathy, Morbid (severe) obesity due to excess calories, Body mass index [BMI] 40.0-44.9, adult.

Final Incident Report of 12.20.2023 documents in part, staff reported (R5) hit (R4) in the hallway unprovoked. (R4) stated (R5) hit him in the back because he was moving slow in the hallway. (R5) stated he (was) frustrated and when (R4) would not move he bump(ed) him with the clothing cart on the back of his wheelchair.

1.16.2024 at 2:31 PM, R4 said, when I was going out the door, he (R5) thought I was in his way, he couldn't get around me, he fell in my lap then he hit me in the back. Yes, I got hurt, I have back pain (points to right side). They sent me to the

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hospital to get checked out.

1.17.2024 at 11:20 AM, V6 (LPN-Licensed Practical Nurse) said, "it was reported to me by another resident (R6) that he (R5) hit R4; R4 confirmed that R5 hit him. I spoke with R5; he denied the allegation. He (R5) was irate, his behavior was escalating; I notified Social Service to do a 1:1. Yes, that's abuse because he (R5) put his hands on R4.

1.17.2024 at 11:26 AM, V7 (LPN-Licensed Practical Nurse) said via telephone, "they (residents) came to tell us that R4 was pushed and hit in the back (of R4's wheelchair) by R5. R4 confirmed that the other resident (R5) hit him at the back (of wheelchair). I assessed R4, there was no visible injury, R4 was not complaining of pain. I reported the incident to the Administrator. Yes, that's physical abuse because he's (R5) is trying to make the other person uncomfortable, it was deliberate.

1.18.2024 at 12:38 PM, R6 said (regarding incident involving R4 and R5), R4 was in his wheelchair waiting to go outside to smoke. I guess R4 wasn't moving fast enough for R5, R5 forcefully pushed a cart into the back of R4's wheelchair then punched R4 in the right shoulder.

12/13/2023 07:45 PM, It was reported by staff that resident was hit at the back by another resident. Upon interview, (R4) confirmed that the other resident hit him at the back while at the padio (patio) while in his wheelchair. No physical injuries seen on (R4). No change in condition noted. Administrator notified. Nursing will continue to monitor resident.

12/14/2023 03:12 PM, Well Being Check: Staff

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S9999	Continued From page 5 met with this resident concerning his feelings about the physical altercation with another resident on 12/13/2023. 1:1 counseling with this resident. This writer asked this resident is he feels safe in this facility. Resident responded with "yes" also reporting being a little stiff. Staff will continue to assist and monitor for any changes in his condition. R5 was not in the facility during the investigation. Abuse Prevention Policy revised 10.2022 -This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment - Abuse means any physical or mental injury or sexual assault infliction upon a resident -Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, mental anguish to a resident. (B)	S9999		