

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6007140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 11/08/2023
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NAME OF PROVIDER OR SUPPLIER  LITTLE VILLAGE NRSG & RHB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 2320 SOUTH LAWDALE CHICAGO, IL 60623
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S 000	Initial Comments  Complaint Investigation 2388837/IL165833 2388672/IL165629	S 000		
S9999	Final Observations  Statement of Licensure Violations  300.610a) 300.1210a) 300.1210b) 300.3240c) 300.3240g)  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  a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
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S9999	<p>Continued From page 1</p> <p>applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest 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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act)</p> <p>g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interviews and record reviews, the facility failed to follow their policy to protect the resident's right to be free from [A] verbal abuse by staff members for two (R83 and R242) residents, this failure resulted in R83 and R242 feeling scared when they come across the accused staff members, [B] mental abuse by staff to two residents (R83, R88) in sample of 18 reviewed for abuse. This failure resulted in R88 feeling humiliated and fearful of retaliation, and R83 feeling depressed, crying, and increase in anxiety.</p> <p>Findings Include:</p> <p>1. On 11/07/2023 at 1:17 PM, R242 stated that staff members are very rude to residents. R242 stated that there were these receptionists who cursed at residents and did not treat them with respect. This made us feel like we couldn't say anything. It felt like we were in prison.</p> <p>R242's written witness statement (10/20/2023) documents in part: V18 is verbally abusive to him and other residents. V18 would yell at them and is mean.</p> <p>2. On 11/07/23 at 09:19 AM, reviewed document titled Reportable Event which documents in part on 10/19/23 @ 5:33 PM reportable event occurred involving resident and employee and it was brought to the administrator's attention that some of the staff members have not been acting in a professional manner. Reviewed signed document by R88 on 10/20/23 which documents</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>in part that smoking monitors are rude and talk to them like a kid. Document stated R88 could not give names of smoking monitors.</p> <p>On 11/07/23 at 10:25 AM, R88 stated that he is a smoker and that all of the smoking monitors are rude. R88 stated the smoking monitors talk to the residents in a disrespectful and mean manner. R88 stated "I don't like the way they talk to me" and "I get spoken to like I'm a child and this makes me feel humiliated." R88 stated he is fearful to speak up for himself because he's worried the staff will take R88's cigarettes away. R88 stated he does not know the names of the smoking monitors and that it is not one specific staff member.</p> <p>On 11/07/23 at 10:04 AM, V1 (Administrator) stated many of the residents living at the facility have mental health issues and that staff should speak to the residents in a respectful and professional manner. V1 stated residents should not feel intimidated by staff or fearful of speaking up to the staff. V1 stated this facility is the resident's home and that the residents should feel safe here.</p> <p>R88's diagnosis included but not limited to Bipolar Disorder, Major Depressive Disorder with Recurrent Severe Psychotic Symptoms, and Generalized Anxiety Disorder.</p> <p>R88's MDS (Minimum Data Set) dated 10/09/23 BIMS (Brief Interview for Mental Status) score is 15/15 indicating intact cognition.</p> <p>R88's psychosocial well-being care plan goal dated 10/13/23 documents in part R88 will be free of abuse/neglect.</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>3. On 11/05/2023 at 10:30 AM, R83 stated that V18 (Former Receptionist) was very rude to her and that she would curse at other residents. V18 stated that she would yell at me all the time. V18 stated this would bring me anxiety and I would be scared to go out of my room. I just didn't want to cross paths with her.</p> <p>R83's written witness statement (10/20/2023) documents in part. V18 (Former Receptionist) is mean to her and other residents. She refused to get up and give her or other residents ice. V18 was rude to her and yelled at her.</p> <p>Reviewed R83's clinical record documents in part R83 was admitted to the facility on 5/2/23, with the medical diagnosis of hypertensive heart disease, depressive disorder, gastritis, anxiety disorders and insomnia. R83's face sheets, medical diagnosis, physician order sheets, minimum data set (MDS) Brief Interview Mental Status score of [15] indicates R83 is cognitively intact, alert/oriented x3, care plans, medication administration record, treatment administration record, community pass assessments and progress notes. There were no progress notes from 10/1/23 thru 10/18/23, no documentation during the time frame.</p> <p>On 11/5/23 at 10:38 AM, R83 stated, "In order for me to leave the facility on my community pass, the nurse and the social worker must sign the pass, and the pass is given to the receptionist before I'm able to leave the facility. On 10/19/23, I went to my nurse, and she signed my pass, then I went to V14 [Social Worker] and he signed my pass. Then I took my signed pass to the receptionist to sign out and leave. V18 [Former Receptionist] told me that I could not leave the facility, because my pass privileges were</p>	S9999		
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S9999	Continued From page 5  restricted. I spoke with V1 [Administrator] she informed me that V13 [Social Service Director] placed my independent community pass on restriction for 30 days because I went out on pass on 10/13/23 and returned to the facility and staff smelled marijuana on me a week ago. On 10/13/23, I went out on pass, and when I came back into the facility and signed back in and went to my room. No one said anything to me that I smelled like marijuana. Later, that same day [10/19/23], V14 came to me with a "The Behavior Intervention Program Counseling Form" dated 10/19/23 read [ Resident [R83] was suspected to be under the influence of a substance while in the facility.] I signed that form, because V14 told me I had to sign it. I asked V14 why a week later that I was notified staff accused me of smelling like marijuana, V14 told me that V13 [Social Service Director] told him to place me on a 30-day pass restriction. On 10/13/23 no one, no nurse, no social worker said one word to me or asked me to give a urine sample for a toxicology drug screen. The first time anyone talked to me was on 10/19/23. Right before 10/19/23, V1 [Administrator] found a type of letter in the bathroom that named me as the writer, making accusations against the facility staff committing abuse. The letter V1 showed me was typed on a form. I told V1 to get out my room with that mess, how could I type and print off a letter on a form. I believe V1 got angry with me because she felt I typed the letter, but I did not. I feel V1 placed me on pass restriction because of the letter that someone placed under her bathroom door. I've been up every night, not able to sleep, crying because I feel like I'm in prison on false charges. I feel so depressed, and my anxiety has increased."  R83 provided surveyor copy of "The Behavior	S9999		

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S9999	<p>Continued From page 6</p> <p>Intervention Program Counseling Form" dated 10/19/23 read: [ Resident [R83] was suspected to be under the influence of a substance while in the facility [Attachment-A]</p> <p>On 11/5/23 at 12:15 PM, V14 [Social Worker] stated, "I've been working here since January 2023. I was told by a few certified nurse assistants (CNA) that R83 smelled like marijuana when she came back from pass on 10/13/23. On 10/13/23, I asked V19 [Social Service Aide] to assist me with obtaining a urine toxicology screening from R83 because R83 and V19 were both females. I stood outside R83's room when V19 asked R83 for a urine sample and explained the reason. R83 refused to give urine. Then I presented R83 with the "Behavior Intervention Program Counseling Form", and R83 and I signed the form. The form read: [Resident [R83] was suspected to be under the influence of a substance while in the facility.] and noted restriction will be from 10/13/23 thru 11/13/23. R83 and I signed the form. On the form it was dated for 10/19/23, but it was for the incident on 10/13/23. I presented the form on 10/19/23, because that was when V13 [Social Service Director] came up with R83's interventions. R83 should have been medically assessed, and it was all based on hearsay, I did not agree that R83 should be on pass restriction."</p> <p>On 11/5/23 at 1:36 PM, V13 [Social Service Director] stated, "I was informed by a case manager that R83 came back from community pass smelling like marijuana. V18 [Former Receptionist] told V19 [Social Service Aide] then told me. This was R83's first offense, and she does not have a history of drug use. R83 was placed on a 30-day community pass restriction. The Behavior Intervention Program Counseling</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>Form dated 10/19/23 reads in part- [ Resident [R83] was suspected to be under the influence of a substance while in the facility. Resident [R83] refused a urine toxicology screening and admitted to social service staff related to using marijuana. Intervention: Resident [R83] educated and counseled on the negative effects of using illegal substances and taking prescription medications. Staff reinforced the facility substance abuse policy and placed on a behavior intervention program." ]</p> <p>[Surveyor asked V13, why the "The Behavior Intervention Program Counseling Form" dated 10/19/23 with R83 and V14's signatures have added information and surveyor showed V13 the copy of the original form. (Attachment B)]</p> <p>On 11/5/23 at 1:45 PM, V13 stated, "I added to the original "The Behavior Intervention Program Counseling Form" dated 10/19/23, that V14 presented to R83. I wrote: Resident [R83] refused a urine toxicology screening and admitted to social service staff related to using marijuana. Intervention: Resident [R83] educated and counseled on the negative effects of using illegal substances and taking prescription medications. Staff reinforced the facility substance abuse policy and placed on a behavior intervention program. I did not know R83 got a copy of the form, wow. I updated the form after R83 signed the form, and no R83 was not aware. I did not know that I could not update R83's signed medical form without her knowing or agreeing to the change of the additional information. R83 is currently on pass restriction from 10/13/23 until 11/13/23, the only person that could override the policy is the administrator [V1]. The Behavior Intervention Program Counseling Form is a part of R83 medical record. R83 should have been</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>presented with the Behavior Intervention Program Counseling Form on 10/13/23, the day of the occurrence. I do not remember why R83 was given the form on 10/19/23."</p> <p>On 11/6/23 at 9:51 AM, V1 [Administrator] stated, "V2 [Director of Nursing] was sitting at the receptionist desk when R83 returned from community pass on 10/13/23. V14 was made aware and R83 was offered a urinary toxicology drug screen test, R83 declined. At that time R83 was made aware that her community pass was restricted for 30 days. V2 [Director of Nursing], V14 [Social Worker], V13 [Social Service Director], nor V19 [Social Service Aide did not document that R38 smelled like marijuana. The appropriate protocol for a resident who is suspected of being under the influence of drugs or alcohol would be to notify their physician, ask the physician if there is any medication should be held, ask the resident to take a toxicology urine test, inform social services, monitor vital signs, frequent monitoring, and start wellbeing checks for 72-hours. V13 should have completed a new "Behavior Intervention Program Counseling Form" and asked R83 to sign the updated form. V13 was not to add information to the form that was signed by R83 and V14, without R83 and V14 consents, doing so is falsifying the document. Someone found a typed letter under the bathroom door, naming R83 and other residents referencing allegations against some staff and the state was going to be notified. Regarding the letter, R83 said, she did not have anything to do with the letter."</p> <p>On 11/6/23 at 2:00 PM, V1 stated, "V13 was suspended for falsifying R83's document. The facility failed to document and handle things timely with R83, I will have social service</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>re-evaluate R83 for a community pass now and end her restriction."</p> <p>On 11/7/23 at 11:10 AM, V2 [Director of Nursing] stated, "I was sitting at the reception desk working on the nursing staff schedule, when R83 came back in the facility from community pass. R83 smelled like a strong odor of marijuana. I don't remember doing much of anything. It was an assumption that the marijuana came in with her, but I was not sure. I did not call the physician, take R83's vital signs or make any frequent rounds on R83. I did not notify R83's nurse. My focus was completing the nursing staff schedule."</p> <p>On 11/7/23 at 11:45 AM, R83 came to the conference room crying and stated, "V14 just came to my room and tried to get me to sign another Behavior Intervention Program Counseling Form, that said I admitted to using marijuana on 10/13/23, and I refused a urine toxicology test. I told V14 I would not sign that form, because it is not true. I was not smoking marijuana, and I was not offered to take a urinary toxicology drug test. V14 is stressing me out, they are picking on me, causing me to feel bad and my anxiety is through the roof. They keep picking on me because I called the state and filed a complaint. V13, V14, and V1 think I'm stupid. I knew not to sign the paper, that I know it is not true. I cannot take any more harassment from any of them V13, V14, and V1. I was feeling better, I have one more week of restriction. Now, they are messing with my mental, I feel so bad, full of anxiety. I am scared that V1, V13 and V14 will retaliate against me for filing a complaint with IDPH and telling you the truth. I'm not sure why they will not leave me alone. V14 told me that V13 told him to have me sign the new form."</p>	S9999		
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S9999	Continued From page 10  On 11/7/23 at 12:00 PM, V1 stated, "V28 [Nurse Consultant] asked V14 to have R83 sign the new updated form. Because the old form was not written correctly, they want to make sure R83 had a copy with her signature. If R83 would have signed the new form, with the exact wording from V13, then V13 wouldn't have falsified R83's document, but that was not our intent."  On 11/7/23 at 12:10 PM, V14 stated, "I re-wrote the Behavior Intervention Program Counseling Form, and asked R83 to sign the new form with the updated interventions. No one told me to ask R83 to sign information over all on a new form, using V13's exact words, so R83 would understand her interventions. I was trying to clear everything up. R83 refused to sign the new form, because R83 said the information on the new form was false." [Copy of The Behavior Intervention Program Counseling Form presented to R83 on 11/7/23 noted as [Attachment C]  On 11/7/23 at 12:40 PM, V28 [Nurse Consultant] stated, "I asked V14 to go and talk with R83 and give her the corrected document with the interventions. To assist with correction process. My intent was to cause R83 any emotional distress."  Facility's Final Incident Report Form (10/25/2023) documents in part: Investigation has been completed. In the conclusion of the investigation staff member V18 was accused by several residents of verbal abuse. Based on the negative verbal interviews, V18 will not be continuing her employment at this facility.  Policy: Documents in part:	S9999		

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S9999	<p>Continued From page 11</p> <p>Abuse Prevention Policy dated 2/2017 -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.</p> <p>Policy: Documented in part Resident Rights: -Resident has the right to be informed of their rights and all the rules and regulations governing resident conduct and responsibilities -A facility must not prohibit or in any way discourage a resident from communicating with federal, state surveyors -Resident has the right to be informed, participate in their treatment -Resident has the right to be informed in advance of changes in their plan of care</p> <p>(B)</p>	S9999		
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