STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145853	A. BUILDING _____ B. WING _____	C 03/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL BAPTIST VILLAGE	**4747 NORTH CANFIELD AVENUE NORRIDGE, IL 60656**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 12 5) Accident/ Incident reporting policy and procedure will be revised and will be handled by the DON and ADON. 6) Regular interviews and spot checks to ensure that staff understand the abuse and incident policy and procedure will be done by the Asst. Administrator as part of the Quality Assurance process.	F 226		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.3240a) 300.3240b) 300.3240e) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145853	A. BUILDING _____ B. WING _____	C 03/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL BAPTIST VILLAGE	**4747 NORTH CANFIELD AVENUE NORRIDGE, IL 60656**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 13 3-611 of the Act) These Regulations were not met as evidenced by: Based on observation, interviews, and record review, the facility failed to report and investigate suspicions and allegations of suspected abuse involving 7 residents (R1, 2, 3, 4, 5, 6, and 7) against a staff member (E4) who provides direct care to these residents. Since no reporting and investigation was done, the facility also failed to protect residents from the alleged perpetrator who continued to work as a direct care provider for all of the resident units in the facility. The facility also failed to investigate thoroughly incidents of unknown origin involving R8 and R9. . Findings include: 1) R3 has diagnoses of Dementia, Depression, and Osteoarthritis. On 2/24/09 at around 2:30 PM, R3 was observed in her bed with 1 large bruise approximately 6 x 8 cm on her right inner thigh and 2 small bruises on top of the large bruise about 1.5 x 1.5 cm in size each. The large bruise extends to the inner posterior thigh and is also visible if viewed from R3's back. R3 was observed as alert but confused and does not communicate needs verbally. When Z1 was interviewed on 2/24/09, Z1 said that in the afternoon of 2/19/09, she saw R3's bruises at the right inner thigh when she came to the facility. Z1 said that when she told E6 (3-11 nurse) that Z1 wanted to show E6 something, E6	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145853	A. BUILDING _____ B. WING _____	C 03/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL BAPTIST VILLAGE	**4747 NORTH CANFIELD AVENUE NORRIDGE, IL 60656**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 14 said that E5 (7-3 nurse) already told E6 about R3's bruises. According to E6's 2/24/09 interview, E6 told Z1 that the bruises could be from sitting on the facility chair armrest as R3 is off balance and has poor vision according to E6. Per R3's incident report dated 2/20/09 and per interview of E4 (7-3 CNA) and E5 (7-3 nurse), R3's right thigh bruises were initially discovered by E4 on 2/19/09 between 7:00 AM - 7:30 AM and were reported to E5 that morning. E5 did not look at R3's bruises immediately until later in the middle of the day when R3 was toileted. According to E10 (11-7 CNA), prior to E4's discovery of R3's right thigh bruises, E10 toileted R3 and did not see the bruise on R3 during the 11-7 shift. Per record review, R3's 2/19/09 incident report was only written by E5 on 2/20/09, the day after it was initially found. Review of R3's facility's abuse investigation showed that this incident was not investigated until 2/20/09, only after it was written by E5. Both E2 (Asst. Administrator) and E3 (Director of Nursing) confirmed that indeed this was only investigated on 2/20/09 after E3 was made aware of R3's bruises and Z1's presence in the facility the night before and of Z1's inquiry about possible abuse as the cause of R3's bruising. However, when E6 was interviewed on 2/24/09, E6 said that as early 10:30 PM of 2/19/09, Z1 already indicated that Z1 thinks that R3's bruise was from staff mishandling R3. Yet, no investigation nor incident report or initial abuse investigation was made after this conversation between Z1 and E6. Instead, E6 encouraged Z1 to talk to the 11-7 nurse to inquire further about	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145853	A. BUILDING _____ B. WING _____	C 03/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL BAPTIST VILLAGE	**4747 NORTH CANFIELD AVENUE NORRIDGE, IL 60656**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 15	F9999		

the bruise. No call was made to E2 or E3, who normally investigates abuse allegations, until 2/20/09. Added to this, when E4 was interviewed on 2/25/09, even E4 suspected that R3's bruises look like a hand mark as the 2 small bruises above the large bruise could possibly be finger marks.

Per Z1, R3 also sustained a bruise on her left hand weeks ago that the staff just attributed to blood draws. When a photograph of R3's left hand bruise was reviewed, the extent of the circular bruise was noted from the middle of the back of the left hand extending to the distal edge of R3's left hand. Review of R3's record and incident report showed no evidence that this bruise was charted or investigated. Added to this, R3's bruise was found in the middle of the month by Z1 in February 2009, and R3's last blood draw from the laboratory was more than 2 months prior on 12/2/08, as confirmed by Z3 from the laboratory. The presence of this hand bruise was confirmed and also attributed to blood draw by E4 during 2/25/09 interview. E5 also verified that she also saw the bruise on R3's hand a week prior to the right thigh bruise, which E5 also said could be from a blood draw. When facility's record was reviewed, this bruise was neither recorded in the nurses notes nor was it investigated as part of incidents or injuries of unknown origin that could be from physical abuse. Instead, as stated above, staff attributed this to a blood draw without verifying if R3 indeed had her blood drawn that week. E2 who normally investigates abuse allegations was not aware of this bruise.

Added to the above, Z1 also indicated that R3 also had bruises on her back which she found

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145853	A. BUILDING _____ B. WING _____	C 03/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL BAPTIST VILLAGE	**4747 NORTH CANFIELD AVENUE NORRIDGE, IL 60656**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 16 and showed to E4 on 2/17/09. E4 confirmed this during interview and said he did not tell anyone about it afterwards, as according to E4, Z1 had already notified the 3-11 nurse about it. Z1 mentioned that she actually saw the bruises initially a week before 2/17/09. During 2/24/09 interview, E6 confirmed that Z1 also showed her (E6) and E14 (3-11 CNA) what Z1 said was a bruise on R3's back. E6 said the bruise was a reddish to brownish discoloration about 1/2 the size of E6's thumbnail (about 1 cm) on R3's left side of the back. E6 said that E14 said it could have been from the toilet handle when R3 sits on the toilet. E6 also said that Z1 indicated to her that it was bigger a week before. Review of R3's record showed no evidence that this bruise was charted by E6, nor was there any evidence that this bruise of unknown origin was investigated by the facility. Furthermore, there is no incident report regarding this back bruise. When Z1 was interviewed further, Z1 said that on Sunday night of 2/22/09, a staff member E7 (3-11 CNA) approached Z1 and said that E7 suspects that E4 caused R3's right thigh to bruise as E7 indicated to Z1 that E4 is abusive to residents under his care. Z1 continued that E7 told her that a week prior to 2/17/09, E7 was in the shower room with another resident and heard E4 was upset and was yelling at R3 in another shower stall, followed by a noise that she thought was from R3 and her shower chair being thrown against the shower wall. Z1 said that E7 said that R3 started screaming after that. Z1 also added that E7 also told her that E4 also hit and caused bruises on R1 and other residents in the facility. According to Z1, E7 has not reported these incidents to anyone in the facility because E7 said the facility knew about what E4 was doing to	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145853	A. BUILDING _____ B. WING _____	C 03/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL BAPTIST VILLAGE	**4747 NORTH CANFIELD AVENUE NORRIDGE, IL 60656**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 17 these residents, yet they just don't care. Finally, Z1 mentioned that E7 said that she (E7) is going to tell the administration about these on 2/23/09. During 2/25/09 phone interview, E7 confirmed that she is very suspicious of E4 for a long time now. E7 said that a week before 2/17/09, she was in the shower room while E4 was showering R3, when she heard a loud bang followed by R3's screaming and crying badly. E7 likened the loud bang to the sound of a shower chair pushed hard to the shower wall. E7 said that R3 was screaming and mumbling like she was in pain. E7 said she did not tell anyone at the facility about it. E7 continued that E4 gets frustrated with the residents and was seen pushing their wheelchairs really fast and yelling at them. E7 also said she heard E4 yelling at R4 before while in the shower room and when R4 came out, E7 said R4 was crying. E7 said during this incident, E7 heard a loud smack and R4 was just moaning and crying. E7 also added that another resident R1 had bruises on her face 2 to 3 months ago, and that R1 told the staff that E4 did it. E7 mentioned that she told E16 (nurse) that she (E7) was suspicious of E4. E7 also continued that even a week after the bruises were initially noted on R1's face, R1 was still talking about it and even said that she (R1) told the nurse about it but they did not do anything about the allegation. Per E7, she also saw E4 a couple months ago put a napkin all the way on R2's mouth and yanked it out hard while removing the food in his mouth. R2 was not choking during the time. And lastly, E7 also indicated that one morning, E7 found R5 really upset and about to cry in her (R5's) room. According to E7, R5 said that E4 came to R5's room and told R5 to stop calling every 5 minutes and told R5 that E4 hates R5. R5 was so upset	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145853	A. BUILDING _____ B. WING _____	C 03/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL BAPTIST VILLAGE	**4747 NORTH CANFIELD AVENUE NORRIDGE, IL 60656**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 18	F9999		

that according to E7, R5 called Z2 and even had E7 talk to Z2. E7 verified that she never reported these observations and allegations to the administrative staff of the facility like E2 or E3. R5 who is alert and oriented x3 verified this, and even added that E4 told her that the call light is only for emergency, proceeded to take one of R5's sweaters, and threw it on the floor, and told R5 that he hates her. R5 was able to identify E4 as the staff that R5 was talking about when R5 was shown E4's photocopied ID card.

When E7's allegation was checked, it was confirmed by another staff E8 (from Activity Department). E8 said that several months ago, she saw E4 shove his whole hand inside R2's mouth to remove the food that R2 pocketed in his mouth. There was no emergency like R2 was choking from pocketing the food during the time of observation. E8 also confirmed that she saw R1 with bruises on the face at the end of summer in 2008 and that E8 heard R1 saying that it was E4 who hit R1 and left her with bruises. E7 even said that E15 (nurse) was at the nurse's station when R1 verbalized that E4 hit R1 and bruised her face. According to E8, E15 responded by saying, "You'll never know, there are bad people in this world." E7 confirmed that during this time, E4 continued working as a direct caregiver on the 1st floor where R1 was and the rest of residents who have dementia. E8 said that when R1 is assigned to E4, R1 seems terrified of E4 and just stops talking. With other CNAs, E8 said that R1 normally screams all the time for assistance. E8 added that when toileting R6 around summer time, E8 observed also that there was just loud banging inside the toilet by the dining room while E4 is toileting R6. E8 admitted that she did not tell anyone about it because according to E8, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145853	A. BUILDING _____ B. WING _____	C 03/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL BAPTIST VILLAGE	**4747 NORTH CANFIELD AVENUE NORRIDGE, IL 60656**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 19 facility nurses are aware of R1's allegation, yet nothing is being done about it. When E14 (3-11 CNA) was interviewed on 2/25/09 at 3:40 PM, E14 admitted that about 4 - 5 months ago, E14 also observed 3 bruises on R1's upper lip. E14 said that R1 told E14 that the bruises hurt and that a man came in and hit R1 in the face. E14 continued that when she asked R1 who hit her, R1 without prompting from E14 said that it was E4. According to E14, when she looked at the schedule to check who worked with R1 during the previous 7-3 shift, E14 learned that it was E4 who took care of R1 during the morning shift. E14 said that when she brought another staff (E13 - 3-11 CNA) to look at R1, R1 repeated to E14 and E13 that E4 hit R1. This was confirmed by E13 during interview. E14 said she told R1's nurse E15 that evening . When E15 (nurse) was interviewed, E15 denied knowing about R1's bruises and also denied E14's account that E14 told her about R1's bruises on the face/lip. Furthermore, E15 also denied E8's observation that she heard R1 saying a staff hit R1. On the other hand, when E16 (nurse) was asked on 2/25/09 at 11:55 AM, E16 confirmed E7's statement by saying that in November 2008, E7 or another CNA reported to her (E16) that R1 had a bruise on her face. E16 said that the bruise was small, but E16 said that she filled out an incident report of unknown origin. E16 said that when she assessed R1, R1 said that a man came in at night and hit R1. During interview, E4 confirmed he works at night if he is needed by the facility. E16 also admitted that E7 told E16 in the hallway that it might be E4 because E7 thought E4 hurts residents. According to E16, she told E7 that if	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145853	A. BUILDING _____ B. WING _____	C 03/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL BAPTIST VILLAGE	**4747 NORTH CANFIELD AVENUE NORRIDGE, IL 60656**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 20	F9999		

E7 feels that way, she should talk to E3. For her part, E16 said that since it was indicated in the blue incident form to call the ADON or the DON if the cause of the incident is unknown, E16 tried to notify the ADON. However, E16 said that the ADON had already left at that time, so the ADON was not notified at all. E16 also admitted that she did not notify E3 (DON). E16 said that looking back at the situation, she should have called E3 regarding R1's bruise. E16 also said that she told the other nurse in the unit who looked at R1's bruise and said she felt it was very small.

When R1's record was reviewed, there was no indication that any of the staff charted R1's facial bruises nor was there any evidence that the facility conducted an investigation surrounding R1's facial bruises. The incident report that E16 said she wrote cannot be found during this survey.

Similarly, when E12 (11-7 nurse) was interviewed on 2/27/09 at 1:30 PM, E12 said that she heard from the nurses and CNAs just months after E4 started 3 years ago as a CNA, that E4 has a mean streak. On a personal level, E12 said that one night, E12 witnessed E4 grab R7's shoulders and shake R7 while telling her to stay on her (R7) back. E12 said that E4 was changing R7's diapers and wanted R7 to stay on her back during the process. According to E12, R7 kept on trying to roll to her left side as R7 was in pain during this because R7 has spinal stenosis. Per E12, she did not report this incident but told E4 not to do what E4 did. E12 said that E4 looked mad when he shook R7 because R7 would not cooperate with E4.

According to E2 (Assistant Administrator) when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145853	A. BUILDING _____ B. WING _____	C 03/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL BAPTIST VILLAGE	**4747 NORTH CANFIELD AVENUE NORRIDGE, IL 60656**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 21 she looked at all the abuse investigations that she did, the allegation of abuse made by R1 against E4 was not investigated, as no staff came forward to report this. The bruise on R3's left hand and back were also not reported and investigated by the facility, nor was the suspicious bruise on R3's right inner thigh investigated and reported in a timely manner. The alleged perpetrator for R3 was also E4. Similarly, suspicions of abuse observed and heard against E4 involving R2, R4, R5, R6, and R7 were also not reported, recorded, and investigated by the facility. No reporting of several allegation of abuse was made by several department staff members (Nurses - E5, E6, E12, E15, and E16; CNAs - E4 and E7; Activity - E8). These allegations, observations, and suspicious bruising were observed by staff as early as the end of summer. E2 also said that these staff including E7 and E8 had abuse training in the past but never reported any of their suspicion or allegation of abuse against E4 to the administration. Review of E4's file showed that despite the above allegations against E4, E4 was never reprimanded, investigated, removed from direct care pending the result of investigation of abuse allegation against E4. During 2/25/09 interview, it was found out that aside from working on 7-3 shift on the 1st floor (Dementia floor), E4 also works overtime on 11-7 shift on the only other floor in the facility as a CNA. E4 was only removed from duty on 2/24/09 when local police officers and state police came in the facility after Z1 reported an allegation of abuse against E4. Prior to that, since allegations were not reported and investigated and alleged perpetrator was not removed from direct care, residents on both 1st	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145853	A. BUILDING _____ B. WING _____	C 03/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL BAPTIST VILLAGE	**4747 NORTH CANFIELD AVENUE NORRIDGE, IL 60656**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 22 and 2nd floor, especially those who are unable to verbalize needs, are not protected from possible abusive practices. Per facility's Abuse Policy and Procedure, "All employees are required to report any knowledge of potential and actual resident mistreatment to their supervisor or to the Director of Resident Services. In the event that the employee's supervisor and the Director of Resident services are not available, employees must notify the charge nurse on duty if the concern involves immediate danger to the resident. All supervisors will immediately inform the Director of Resident Services or the Executive Director of all reports of potential mistreatment. Upon learning of the report, the Director of Resident Services and other person(s) appointed by the Executive Director will initiate an incident investigation ." Other examples of facility not investigating injury of unknown origin were as follows: 1) R8 was observed with a bruise on the left thigh on 11/6/08 during shower. According to R8's incident, R8 complained of pain when bruise was touched by staff. Review of the incident report showed no evidence that an investigation was conducted to determine the cause of the bruising. No staff interviews were done regarding this incident. Instead, per incident report it was attributed to Coumadin as a factor that may have contributed to this bruise. Review of R8's Prothrombin time and INR however showed that there was no PT/ INR for the month of October, and a November 21, 2008 draw showed a low INR of only 1.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145853	A. BUILDING _____ B. WING _____	C 03/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL BAPTIST VILLAGE	**4747 NORTH CANFIELD AVENUE NORRIDGE, IL 60656**

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 23 2) R9 was observed with a left hand bruise that extended up to 3 fingers on 9/26/08. Per R9's record, there was no incident prior to the discovery of the bruise. Yet, per incident report, this bruising which later on was x-rayed and found with fracture was attributed to R9 hitting her left hand on the bed rail while R9 was in bed. R9 was not witnessed banging her left hand on the bedrail per nurse and no evidence of an investigation was noted to determine the cause of bruising and fracture to R9's hand. (A)	F9999		