STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145337	A. BUILDING _____ B. WING _____	C 11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONZEVILLE PARK NSG & LVG CTR	**3400 SOUTH INDIANA CHICAGO, IL 60616**

(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 514	Continued From page 47 the R2's MAR for insulin and blood sugar monitoring was blank.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.690a) 300.690b) 300.690c) 300.695a)3) 300.695b)3) 300.695c)1)2)3)5) 300.695d) 300.695e) 300.1210b) 300.1210d)3) 300.1220b)2) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145337	A. BUILDING _____ B. WING _____	C 11/09/2012

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F9999	Continued From page 48 resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.695 Contacting Local Law Enforcement a) For the purpose of this Section, the following definitions shall apply: 3) Sexual abuse - sexual penetration, intentional sexual touching or fondling, or sexual exploitation (i.e., use of an individual for another person's sexual gratification, arousal, advantage, or profit). b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 3) Sexual abuse of a resident by a staff member, another resident, or a visitor; c) The facility shall develop and implement a policy concerning local law enforcement notification, including: 1) Ensuring the safety of residents in situations requiring local law enforcement notification; 2) Contacting local law enforcement in situations involving physical abuse of a resident by another resident;	F9999		

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	145337	A. BUILDING _____ B. WING _____	C 11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONZEVILLE PARK NSG & LVG CTR	**3400 SOUTH INDIANA CHICAGO, IL 60616**

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F9999	Continued From page 49 3) Contacting police, fire, ambulance and rescue services in accordance with recommended procedure; 5) Facility investigation of the situation. d) Facility staff shall be trained in implementing the policy developed pursuant to subsection e) The facility shall also comply with other reporting requirements of this Part. 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 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. Restorative measures shall include, at a minimum, the following procedures: 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including:	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145337	A. BUILDING _____ B. WING _____	C 11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONZEVILLE PARK NSG & LVG CTR	**3400 SOUTH INDIANA CHICAGO, IL 60616**

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F9999	Continued From page 50 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements were not met as evidence by: Based on interview and record review, the facility failed to report allegations or suspicions of sexual abuse to supervisor or administrator immediately, failed to immediately investigate allegation of sexual abuse, and failed to protect the resident with Dementia who is unable to verbalize needs and unable to protect herself from alleged perpetrator, for 1 resident (R3) out of 4 residents reviewed for abuse. Based on interview and record review, the facility also failed to follow and implement their abuse policy, by not conducting an internal investigation, no protection of the residents, and no immeidate reporting to the state agency after alleged sexual abuse occurred for 1 of 4 residents (R3), all were reviewed for abuse. Findings include : R3 has diagnoses of Dementia, Contracture of Extremities, and Cerebrovascular Accident. On	F9999		

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	145337	A. BUILDING _____ B. WING _____	C 11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONZEVILLE PARK NSG & LVG CTR	**3400 SOUTH INDIANA CHICAGO, IL 60616**

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F9999	Continued From page 51	F9999		

9/13/12 at 10:30 AM, R3 was observed in the recliner chair, alert but non-verbal and unable to communicate needs, and contracted on all 4 extremities.

R3 ' s Incident Report dated 6/1/12 indicated that at 12:30 PM, Z1 (family member) attempted to open R3 ' s contracted hand and stretch her legs which are also contracted. R3 was also seen always patting R3 ' s arm and legs during the entire visit per this incident report written by E20 (nurse).

On 9/12/12 at 11:40 AM, E5 (Rehab Aide) said that on 6/1/12 before noon time, E5 came in R3 ' s room and saw Z1 (family member) groping R3 ' s breast and patting her private area. E5 said that Z1 stopped when Z1 saw E5. E5 said that she told Z1 to excuse himself because E5 needs to take R3 ' s weight. Z1 sat at the back of the room but did not leave R3 ' s room. E5 said that she reported what she saw to E20 (nurse), and had E21 (Certified Nurse Aide / CNA) and E22 (Certified Nurse Aide / CNA) accompany her (E5) to the room. E5 said that R3 was weighed in the room, then her bed was placed in the hallways as her room is going to be deep-cleaned afterwards. E5 said that when Z1 stood up from where he was sitting in R3 ' s room, he had an erection. E5 said that afterwards, R3 was transferred from her bed to her wheelchair while in the hallway, and therapy department took her. E5 said she left around 1 PM.

On 9/12/12 at 11 AM, E20 (Nurse) denied that E5 reported to her R3 ' s groping by Z1 on 6/1/12 in R3 ' s room. E20 said that on 6/1/12, no staff reported to her any allegation that involves R3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145337	A. BUILDING _____ B. WING _____	C 11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONZEVILLE PARK NSG & LVG CTR	**3400 SOUTH INDIANA CHICAGO, IL 60616**

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F9999	Continued From page 52	F9999		

and Z1 that is sexual in nature.
During above incident, R3 was left unsupervised with Z1 (who was already seen by E5 groping her breast and private area) when she called the nurse. Z1 was not immediately removed from direct contact with R3 to protect R3. E20 also did not remove Z1 from direct contact with R3 after E5 claimed that she reported this incident to E20. Additionally, E1 (Administrator) was also not notified about R3 ' s fondling at this time by E5 nor by E20.

On 9/11/12 at 3:30 PM, E26 CNA/Assistant to Director of Nursing said that on 6/1/12 at around 10 - 10:30 AM, when she came out of the bathroom, she saw Z1 kissing R3 on her mouth with his tongue down her throat. E26 said that R3 was in her bed in the hallway outside R3 ' s room which is being deep-cleaned that day. E26 said that Z1 said that E26 had nothing to do with it and called E26 a bitch. E26 said she screamed for E20 (nurse). E20 denied E26 reporting this to her on 9/11/12. E26 added that Z1 was drunk. E26 said that they had R3 placed in the dayroom after what E26 saw, and that Z1 remained with R3 in the dayroom, despite of what E26 said she reported seeing to E20. E26 also added that although she did not see Z1 grope R3, E21 (CNA) did that afternoon. E26 continued that E4 (CNA) also saw Z1 ' s hand under her diaper.

As E20 denied that E26 reported witnessing Z1 kiss R3 in the mouth with his tongue down her throat, there was no immediate reporting to E1 nor was Z1 immediately separated from R3 or any other residents. R3 was placed in the dayroom with Z1 where R3 was again seen being sexually assaulted by Z1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145337	A. BUILDING _____ B. WING _____	C 11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONZEVILLE PARK NSG & LVG CTR	**3400 SOUTH INDIANA CHICAGO, IL 60616**

(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 53	F9999		

On 9/11/12 at 2:30 PM, E4 (CNA) said that on 6/1/12, she was in the 4th floor dayroom and R3 was in the room, covered with a blanket. Z1 was sitting next to her. E4 said that she noticed Z1 ' s hand on top of her breast area while the other hand on her crotch area. Both hands were under the blanket covering R3. E4 said that Z1 ' s hands were moving under the blanket like Z1 was touching R3' s breast and crotch under the covers. E4 said that R3 was agitated and was muttering profanities. E4 also said that Z1 was kissing her in the mouth. E4 said that when she asked Z1 if everything was okay, Z1 removed his hands and stopped what he was doing. E4 continued that later, Z1 stood up and pushed R3' s recliner chair out of the dayroom to the hallway towards her room. On 9/13/12, R3' s room 413 was noted to be away from the 4th floor day room and cannot be visually monitored as soon as R3 and Z1 were in the hallway past the 4th floor nurses station. E4 said that Z1 had an erection when he stood up. E4 was unsure where exactly Z1 took R3, but said that she assumed they were going to R3 ' s room 413, as Z1 was pushing R3 ' s recliner towards that direction. E4 said that she did not go with Z1 and R3, and remained in the 4th floor dayroom until her 30 minute dayroom watch was over in 5-10 minutes after R3 and Z1 left. Only then that E4 said she left the dayroom and reported the fondling to E23 (Social Service Assistant) after her schedule as dayroom monitor was over. On 9/12/12 at 1 PM, E23 denied receiving a report neither from E4 nor from any staff on 6/1/12 regarding R3 being fondled or kissed by Z1. E4 continued that that after she and a restorative aide put R3 back to bed (which was still in the hallway), she again

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145337	A. BUILDING _____ B. WING _____	C 11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONZEVILLE PARK NSG & LVG CTR	**3400 SOUTH INDIANA CHICAGO, IL 60616**

(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 54	F9999		

witnessed Z1 fondling R3 ' s breast and crotch area under the cover while R3 ' s bed was still in the hallway. E4 said that she reported this to E25 (nurse) although she did not make any attempt to intervene and stop Z1 from further fondling R3. E4 said that E25 went with her towards Z1 and R3, but Z1 stopped what he was doing when he saw E4 and E25 coming. At this time, Z1 insisted that R3 ' s bed be put inside her room from the hallway. E4 said that Z1 went to E1 (Administrator) and E1 gave orders to put R3 ' s bed back inside her room. E4 said that they just tucked R3 ' s blanket on her side to prevent Z1 from putting his hands under the blanket to her breasts and crotch area. E4 said that 30 minutes later (after leaving R3 with Z1 unsupervised again) she came back and noticed that her tucked blanket had been undone. E4 said that it was around the end of her shift so she left the room and told E23 (Social Service Assistant) about it. E23 denied this as written above. E4 said that the next time she came back to work, she was told not to leave R3 alone with Z1.

Additionally there was no written statement from E25 Nurse, prior to her termination why she did not report to E1, Administrator, E2 DON (Director of Nursing), E3 ADON (Assist. Director of Nursing) nor to E27 (Social Worker) this allegation of sexual abuse seen 2x by E4, nor did E25 intervene to protect R3 from Z1 who still allowed to stay with R3 inside her room after this report from E4.

On 9/11/12 at 3:20 PM, E21 (CNA) said that in the afternoon of 6/1/12, she saw Z1 fondling R3 ' s left breast under R3 ' s dress. E21 said that R3 was in bed in the hallway which was across R3 '

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145337	A. BUILDING _____ B. WING _____	C 11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONZEVILLE PARK NSG & LVG CTR	**3400 SOUTH INDIANA CHICAGO, IL 60616**

(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 55	F9999		

s room. E21 said that Z1 was drunk and did not stop what he was doing even though he saw E21. E21 said that she stayed there and screamed for E20 (nurse). E21 said that E20 came over and E21 told her that Z1 was fondling R3 ' s breast. E21 said that Z1 denied it and started cursing E21. E21 then said she left after that because she couldn ' t believe what she saw. E20 denied this as stated above and E21 ' s written statement indicated that it was the other nurse E25 who saw Z1. This abuse observation never reached E1, E2, E3 or E24. There was no indication how the facility protected R3 from Z1 after this.

On 9/12/12 at 2:30 PM, E24 (Assist. Director of Nursing) said that on 6/1/12 after noontime, she saw Z1 rubbing R3 ' s legs in the 4th floor dayroom. E24 said that she instructed E20 Nurse and E4 CNA to monitor R3. E24 also said that she informed E1 about this, and E1 actually came to the floor to talk to Z1. E24 said that an hour later, she came back to the floor to check on R3, and saw her still in the recliner at this time, parked in the hallway outside her room. E24 saw Z1's one hand fondling R3 ' s breast, while his other hand is fondling her vaginal area under the sheet. E24 added that Z1 did not stop what he was doing even though E24 was there with E21, E4 and E5. E24 said that she yelled for Z1 to stop what he was doing and he did, but started yelling and threatening to sue and kill E24. E24 said that R3 looked angry at this time. E24 said that she was joined by E20 and E25. E24 said that Z1 smelled of alcohol at this time. E24 said that Z1 left and did not come back after that. E24 also said she made the administrator aware of the incident she witnessed. E24 added that the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145337	A. BUILDING _____ B. WING _____	C 11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONZEVILLE PARK NSG & LVG CTR	**3400 SOUTH INDIANA CHICAGO, IL 60616**

(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 56	F9999		

were also instructed to do 1:1 with R3, and ensure that she should not be left alone. E24 added that the staff were told that Z1 should not have any sort of contact with R3. However unknown to E24, Z1 did not leave after he was seen fondling R3 in the hallway. As per above interview of E4, after Z1 was seen fondling R3 in the hallways in her bed, R3 ' s bed was transferred inside her room where Z1 was left unsupervised with R3 for at least 30 minutes.

On 9/13/12 at 3 PM, E1 denied that any of the staff reported to him any incident of Z1 kissing R3 with tongue, or Z1 fondling of R3 ' s breast and genital areas. E1 said that on 6/1/12, the staff reported to him that Z1 was rubbing R3 ' s leg and leaning over her in the dayroom. E1 said that he came to the floor and spoke with Z1 although he did not see anything unusual. E1 said that later Z1 requested that R3 be transferred back to bed. E1 said that together with E27 (social worker), he observed Z1 and R3 in her room and there was nothing unusual they noted. E1 said that he sent Z1 out of the building and told him not to come back till Monday after that, because he wants to investigate what was going on, and he (E1) is not there during the weekend when Z1 could come back.
On 9/14/12 at 10:16 AM, Z2 (Nurse Practitioner) said that on 6/1/12, she received a report from staff that Z1 (family member) was touching R3's perineal area under the sheets. Z2 said that no staff witnessed the actual fondling of R3 and so she spoke to Z1 who according to Z2 said that he was just doing R3 ' s Range of Motion exercise and doing her perineal care. Z2 continued that she advised Z1 to let the staff do the perineal care and ROM exercises as R3 is very frail. Z2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145337	A. BUILDING _____ B. WING _____	C 11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONZEVILLE PARK NSG & LVG CTR	**3400 SOUTH INDIANA CHICAGO, IL 60616**

(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 57	F9999		

said that Z1 smelled of alcohol but able to converse with Z1 sensibly and was not falling off the chair during that time. Z2 denied receiving a report from staff later that staff actually saw Z1 stick his tongue down R3 ' s throat or Z1 fondling R3 ' s breast or genital area. Z2 added that if she was told of the observed sexual assault on R3, she would have sent R3 to the hospital immediately for examination, call 911, separate Z1 from R3, and call the police. Z2 also said she cannot remember calling Z3 (R3's attending physician) that day as she really did not hear any report from the facility of the kissing and observed fondling of R3.

Similarly on 9/14/12 at 10:48 AM, Z3 (R3's attending physician) said during phone interview that he recalled that the facility called him that R3 is being sent to the hospital for examination for sexual abuse. R3 ' s nurses notes showed this was on 6/8/12, a week after the actual kissing and fondling of R3 by Z1. Z3 added that prior to that, the facility did not call him to report that the son was observed kissing R3 and fondling her breast or vaginal area. Z3 said that if staff called him about it, he would have sent R3 to the hospital for examination immediately.

R3 ' s nurses note dated 6/1/12 at 10 PM indicated that E28 (3-11 nurse on 6/1/12) wrote that she paged Z3 (R3's attending physican) several times during shift regarding Z1 inappropriately touching R3 but Z3 did not return call. Z4 (Medical Director) was also paged by E28 but also did not call back. On 9/13/12 at 3:30 PM, E28 verified that when she came to work on 6/1/12 on evening shift, it was reported to her to call Z3 as Z1 fondled R3. E28 said that she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145337	A. BUILDING _____ B. WING _____	C 11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRONZEVILLE PARK NSG & LVG CTR	**3400 SOUTH INDIANA CHICAGO, IL 60616**

(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 58 paged Z3 and Z3 did not call back so she paged Z4. E28 said that Z4 also did not call back and she endorsed this to the night shift. There is no indication in R3 ' s record that Z3 or Z4 was made aware of R3 ' s incident of being kissed and fondled. As there was no immediate reporting of the 6/1/12 sexual abuse observation to the supervisors E2 and E24 or E1, the facility did not conduct an immediate investigation of the allegation. The investigation started when E24 observed R3 being fondled by Z1 in the hallway on 6/1/12. On 9/13/12 at 3 PM, E1 said that staff is expected to stop Z1 if he was seen kissing R3 or fondling her breast or genital area in the dayroom. E1 continued that staff is also expected to call the supervisor or the nurse and report what the staff saw, and wait for help, then the alleged perpetrator should be separated from the resident. The resident should not be left alone and unsupervised with the alleged perpetrator per E1 after there is an allegation of sexual abuse. E1 said during this interview that there was no kissing with tongue or fondling of R3 that occurred on 6/1/12. E1 then added that if he had knowledge of kissing with tongue or fondling of breast and genital area of R3 in AM, he would have made Z1 leave the building immediately to protect the resident. (A) 300.610a) 300.1210b)2) 300.1210c)	F9999		