F CORRECTION	(X3) DATE SURV	
	C 02/01/20 1	13
NAME OF PROVIDER OR SUPPLIER ABINGTON OF GLENVIEW		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(5) LETION ATE
Continued From page Protection of resident not comprehend dispondental abuse might have willful and the comental abuse is just the intent was willful, the resident intimidate the remarks. Employees of this fact of abuse, neglect or removed from reside the results of the inversive well by the adm Employees accused misappropriation of puthe shift as a direct of FINAL OBSERVATION LICENSURE VIOLATION 300.610a) 300.3240c) 300.3240d) Section 300.610 Resa (a) The facility which shall happrocedures, governing the facility which shall resident Care Policy least the administrate the medical advisory representatives of nuthe facility. These policy with the Act and all runthese written policies.		
SUMMARY STATE (EACH DEFICIENCY M REGULATORY OR LSC Continued From page Protection of resident not comprehend disp mental abuse might have willful, and the commental abuse is just the intent was willful, the resident intimidate the remarks. Employees of this fact of abuse, neglect or removed from reside the results of the inverseive device by the adm Employees accused misappropriation of paths shift as a direct of FINAL OBSERVATION LICENSURE VIOLATION 300.610a) 300.3240c) 300.3240d) Section 300.610 Resa) The facility which shall have procedures, governing the facility which shall Resident Care Policy least the administrator the medical advisory representatives of nut the facility. These policy is a summary of the shall be procedured to the medical advisory representatives of nut the facility. These policy is summary to the facility. These policy is summary to the shall be procedured and the shall be procedured and the medical advisory representatives of nut the facility. These policy is summary to the facility of the facility.	02/01 /	(X) OMPI

PRINTED: 04/15/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		145683	B. WING			C 02/01/2013		
NAME OF PROVIDER OR SUPPLIER ABINGTON OF GLENVIEW				3	REET ADDRESS, CITY, STATE, ZIP CODE 901 GLENVIEW ROAD GLENVIEW, IL 60025	1 02/	01/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE	
F9999	written, signed and meeting. Section 300.3240 A c) A facility administ abuse or neglect of report the matter by the resident's reprethe Act) d) A facility administ becomes aware of a shall also report the (Section 3-610 of the This regulation was following: Based on record refailed to keep one residents reviewed abuse for three day abuse was reported was notified of an ir (private duty care gremain on duty and R1 to possible furth failed to conduct a cabuse to R1 in according include:	is committee, as evidenced by dated minutes of such a subuse and Neglect trator who becomes aware of a resident shall immediately telephone and in writing to sentative. (Section 3-610 of trator, employee, or agent who abuse or neglect of a resident matter to the Department. In e Act) not met as evidenced by the view and interview the facility esident (R1,) out of three for abuse, free from verbal after incident of verbal abuse by Z1 in the facility. The facility incident of verbal abuse by Z1 in provide care to R1 exposing er abuse. The facility also complete investigation of the ordance with their policy.	F99	999				
	dementia. R1's adr	female with a diagnosis of mission MDS (Minimum Data documents that R1 requires						

Facility ID: IL6012595

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CON	E SURVEY MPLETED
		145683				C / 01/2013
NAME OF PROVIDER OR SUPPLIER ABINGTON OF GLENVIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 3901 GLENVIEW ROAD GLENVIEW, IL 60025		
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F9999	locomotion, dressin and bathing. The facility's incided documents that an caregiver telling R1 separate occasions. The facility's investis statement by E2 (A documenting that E that he over heard? "how old are you? You're giving me a this." The statement caregiver was yellin very high tone that On 1/10/13 at 4:35pcompleted the investidentified Z1 (careg E2 stated that Z1 w facility's guest sign was at the facility on E2 stated that 1/8/1 was Z1's last day w stated he did not in nursing assistants to the reason the facilicaring for R1 is been department of Pub questioned her about an employee was at the facility do? E1 stated in the facility do? E1 stated in the facility do?	that she is stupid on two	F99	99		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	COMF	SURVEY PLETED
		145683	B. WING _		02/0	C 01/2013
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					(X5) COMPLETION DATE
F9999	was accused of about the care giver." E1 protects the resider removed " but "a compervision." On 1/11/13 at 11:39 that on 1/3/13, Z1 hat	use? E1 stated "I don't train was asked how the facility at. E1 replied "staff would be caregiver would receive at an, E4 (transporter) stated and stated to R1 "how old are sed that on 1/4/13 after therapy se transported to her room. E4 d to R1 "You're driving me little kid. You're giving me a constated that Z1 started sher visitor "she doesn't want oing crazy. She's always According to E4, R1 was sarted fighting him as he tried stated that R1 was fighting gitated. E4 added that R1 is see when spoken to in a stated that Z1 continued on abusive tone and he was yo and two together." E4 the incident to the E6 (Social added that the facility's policy to upon an abuse allegation is	F999	99		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY MPLETED	
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NAME OF PROVIDER OR SUPPLIER ABINGTON OF GLENVIEW			\$	STREET ADDRESS, CITY, STATE, ZIP CODE 3901 GLENVIEW ROAD GLENVIEW, IL 60025	1 02	01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES OF THE PROPRIES OF THE PROVIDER O	ULD BE	(X5) COMPLETION DATE	
F9999	how would the facilicase? E6 stated "lagain, we will make building." On 1/11/13 at 1:25p Nurse/LPN) stated worked with R1 on occasions. E5 state approximately 3 or administer R1's me was no one else in When asked what vallegation of abuse of the facility upon tinvestigates." In recaregiver, E5 stated separated ". On 1/11/13 at 1:44p Director, Registered there's an allegation allowed to be involved facility investigates. On 1/11/13 at 2:01p care giver is accuse not be allowed to we the facility's investigates. On 1/11/13 at 2:31p Administrator) was made to R1 constituted on't know if I can accertainly raised con was his mother, he	ty protect the resident in this f something like this happen is sure they are not in our om, E5 (Licensed Practical that since 1/4/13 she has at least two separate ed that she entered the room 4 times during the day to dication. E5 stated "there the room with R1, just Z1". was the facility's policy for an? E5 replied "staff is sent out he complaint and then Z1 elation to the abuser being a d "they still have to be om, E7 (Rehabilitation d Nurse/RN) stated that when he of abuse the abuser is not red in resident care until the om, E8 (RN) stated that if a ed of verbal abuse, they would ork with the resident during gation.	F999	99			

Facility ID: IL6012595

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	ND BLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	employee was accummediately taken of when asked what's a caregiver, E2 repreplace them. The figuidance." The facility's Abuse "Verbal abuse is the gestured language disparaging and defamilies, or within the regardless of their adisability. Accused individuals will be denied unsuresidents during the investigation. Protection of resident not comprehend dismental abuse migh was willful and the mental abuse is just the intent was willful the resident intimidation remarks. Employees of this for abuse, neglect or removed from resident results of the intent was will ful the remarks.	om, E2 stated that if an used of abuse, they would be off duty and investigated. But the policy if the accused was lied "the family may choose to family looks to us for Prevention policy documents: Prevention polic	F999	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COM	TE SURVEY MPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC	ROVIDER'S PLAN OF COR CH CORRECTIVE ACTION S S-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F9999	Employees accused misappropriation of	ge 16 d of possible abuse, neglect or property shall not complete care provider to residents." B	F99	99			