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	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Baptist Village	4747 North Canfield Avenue Norridge, IL 60656

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide written notice of the facility's bed-hold policy to the resident and/or resident representative at the time of transfer to the hospital or within 24 hours of transfer for two (R1, R2) of three residents reviewed for hospital transfers; the facility also failed to complete a discharge summary/recapitulation of stay when R1 and R2 did not return to the facility and were discharged from the facility.Findings include:R1's face sheet documented R1 was Medicare Part A on 04/30/26. R1 was transferred to a local hospital on [DATE]. A physician progress note dated 04/30/26 documented, Patient being transferred to the acute hospital for evaluation of abdominal abscess as the abdomen is getting bigger and hardening. She has stable pain in the abdomen without worsening. Review of R1's clinical record revealed no documented bed-hold notice was provided to R1 and/or R1's representative at the time of transfer to the hospital or within 24 hours of transfer. R1 did not return to the facility. R1 discharged to an Assisted Living Facility after hospitalization. Review of R1's clinical record revealed no completed discharge summary/recapitulation of stay following R1's discharge from the facility.R2's face sheet documented R2 was Medicare Part A on 05/11/26. R2 was transferred to a local hospital on [DATE]. A nursing progress note dated 05/11/26 documented, Patient with reports of weakness, patient is unable to transport to wheelchair. Vital signs taken, see vitals for details. MD made aware. Patient to go to [LOCAL HOSPITAL] ER for further evaluation. Review of R2's clinical record revealed no documented bed-hold notice was provided to R2 and/or R2's representative at the time of transfer to the hospital or within 24 hours of transfer. R2 did not return to the facility. Review of R2's clinical record revealed no completed discharge summary/recapitulation of stay following R2's discharge from the facility.06/15/26 at 2:20 PM, V1 (Administrator) confirmed bed-hold notices were not provided for R1 and R2. The Administrator stated the bed-hold notices were not provided because R1 and R2 were Medicare Part A residents. The Administrator stated, according to company policy, the facility does not issue bed-hold notices to residents who are under Medicare Part A.06/15/26 at 2:45 PM, V4 (Social Services Director) said, they normally complete a recapitulation of the resident's stay along with a discharge summary. V4 stated discharge summaries/recapitulations of stay were not completed for R1 and R2 because the discharges were not planned. Surveyor asked if the summaries were completed once they were made aware that the residents were not returning and V4 said, No.The facility policy titled CBV Bed Hold Policy, reviewed/revised 04/15/25, documented the bed-hold policy needs to be given to the resident and representative when they are transferred or discharged . The policy documented the resident/representative needs to receive written notice within 24 hours in a language and manner they understand. The policy also documented the policy excludes residents on a Medicare stay at CBV.The facility policy titled Discharge Planning, reviewed/revised 04/24/26, documented discharge planning is a service and process provided by the facility to every resident. The policy documented discharge planning prepares the resident for the next level of care and includes arrangements for placement in the appropriate care environment with provisions of necessary services. The policy documented a few days prior to discharge, Social (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Services opens the CBV Post-Discharge Plan of Care Form and Discharge Summary/Recapitulation of Stay V3 within PCC. The policy further documented Social Services reminds Activities, Dietary, and Nursing interdisciplinary team members to complete and sign their sections of the forms. The policy also documented the nurse enters a Discharge Summary progress note documenting the resident's status at the time of discharge.