

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145752	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2025
NAME OF PROVIDER OR SUPPLIER Forest View Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 535 South Elm Itasca, IL 60143	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide the necessary monitoring and supervision for a resident with a history of suicidal ideation and a history of obtaining knives. The facility also failed to have a system in place to accurately screen residents for suicide risk in a timely manner, and ensure residents with suicide risk were identified, and interventions were put in place. This failure resulted in R1 sustaining self-inflicted stab wounds and expiring at the facility from apparent suicide. This failure resulted in Immediate Jeopardy when the facility lacked interventions and processes to protect a resident with a history of suicidal ideation from keeping sharp knives in his room and sustaining self-inflicted stab wounds and expiring from apparent suicide. The Immediate Jeopardy began on [DATE], at approximately 6:00 AM when R1 was found expired in his bed by facility staff with stab wounds to his chest. The Administrator was notified of the IJ on [DATE], at 3:14 PM. This applies to 14 of 14 residents (R1, R5 - R17) reviewed for suicidal ideation in the sample of 17. The findings include:1. The EMR (Electronic Medical Record) shows R1 was a [AGE] year-old male resident admitted to the facility on [DATE]. The EMR continues to show R1 expired at the facility on [DATE]. R1 had multiple diagnoses including heart failure, non-traumatic subacute subdural hemorrhage, aortic stenosis, hypertensive heart disease, morbid obesity, Type 2 diabetes, atrial fibrillation, major depressive disorder, pyloric stenosis, right shoulder osteoarthritis, acute respiratory failure, history of venous thrombosis, and acute kidney failure.R1's MDS (Minimum Data Set) dated [DATE] shows R1 was cognitively intact, required supervision with eating, substantial/maximal assistance with oral and personal hygiene, and was dependent on facility staff for all other ADLs (Activities of Daily Living). R1 was always incontinent of bowel and bladder. R1's MDS continues to show R1 was feeling down, depressed, or hopeless, and had trouble sleeping nearly every day.The EMR shows R1's hospital paperwork dated [DATE], shows multiple active problems including suicidal ideation.The facility's final incident report submitted to the State Agency on [DATE] shows, On [DATE] at approximately 5:45 AM, staff discovered [R1] unresponsive and without vital signs. Blood was observed on his body and the floor beneath his bed. Emergency medical services (911) were immediately contacted, and [R1] was pronounced dead at 6:45 AM. A comprehensive investigation was completed, including staff interviews, medical record review, and collaboration with law enforcement and the coroner's office. Based on the findings: there is no evidence of foul play. The findings are consistent with self-harm, and the cause of death has been determined to be suicide. On [DATE] at 10:18 AM, V6 (RN-Registered Nurse) said, I had [R1] the night of the incident. I checked on [R1] two times. I didn't notice anything wrong with him. I went in there to check his blood sugar around 5:30 or 6:00 AM and when I went in there, I was shocked. I saw [R1's] mouth open, and the oxygen tubing wasn't in his nose, and I was thinking he passed away from removing the oxygen. I couldn't check his blood sugar because he was pale and cyanotic. There was a lot of blood, and when we opened the sheets, I was panicking looking at the blood. I couldn't even see where it was coming from, and I was thinking it looked like a crime or something. I opened the blanket and there was blood by the incontinence brief. Blood was everywhere, and then when I moved to the other side by the window, I was about to collapse because I was so scared from the amount of blood on the floor. Then the other CNA (Certified Nursing Assistant) was searching and found two knives and there were blood stains on the knives. I called 911 and [V2] (DON-Director of Nursing). There was a lot of blood on his chest. I was scared to touch him, and I could see it coming from the left side of his chest. I asked the roommate if he noticed something. Last year, I had him and they said I had to send him out because he was going to kill himself with a plastic bag. We had him on one-to-one supervision, and then we searched, and we found knives. We removed the knives from his room, and he was mad at me for taking his things. I was surprised the hospital sent him back when that happened. I did not wake [R1] up on the night of [DATE] because he would get mad at me if I would wake him up. His roommate gets mad too. There's a person who visits, his friend. Maybe [R1] bought the knives or asked the lady to bring him knives. He likes to cut his fruits. On [DATE] at 1:57 PM, V3 (CNA) said, I was doing my last rounds on my unit on [DATE]. I saw [V7] (CNA) coming towards me, and he said [R1] passed away. I wasn't aware of how he had passed, and when I saw the blood on him, I saw two knives on the bedside table. They were wrapped in white paper towels. There were two knives. One with a black handle with a stainless-steel pointed tip, and then there was a smaller knife, and it was a light blue color and it was also pointed. [R1] was covered with blood on his chest and down his left-hand side of his body, and there was a puddle of blood on the floor. I wasn't able to see the</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on interview and record review, the administration failed to provide oversight and leadership to ensure staff is qualified to work as a Social Service Director. The administration also failed to ensure self-harm/suicide risk screening assessments were completed accurately, timely, and individualized and measurable care plan interventions were put in place for residents identified at risk for suicide. This applies to all 130 residents living in the facility. The findings include: The Facility Data sheet dated October 24, 2025, shows the facility census as 130 residents. Concerns were identified regarding the accuracy, timeliness, and individualized care plan interventions for multiple residents screened by V12 (SSD-Social Service Director) for self-harm/suicide risk, including R1, R5, R6, R7, R8, R9, R10, R11, R12, R13, and R17. On October 30, 2025, at 3:00 PM, V12's employment record showed on July 19, 2021, V12 was hired as the facility's full-time Social Service Director. V12's employment record shows V12 has completed four years of high school education. V12 did not have any college education listed in her employment record. The facility's Job Description for the position title of Director of Social Services shows the education requirements for the position of Director of Social Services as either a bachelor's degree in psychology or sociology, a B.A. (Bachelor of Arts) or M.A. (Master of Arts) in social work, or a Licensed Clinical Social Worker's Certificate. The facility does not have documentation to show V12 had any of the required education or certificates as shown in her job description. On January 10, 2022, V12 signed the form entitled Job Description for the position title of Director of Social Services. The form V12 signed shows, I have read this job description and fully understand the requirements set forth therein. On October 30, 2025, at 3:30 PM, V1 (Administrator) said he is not sure if V12 (SSD- Social Service Director) has all the required qualifications to work as the Social Service Director.</p>

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<p>F 0850</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Hire a qualified full-time social worker in a facility with more than 120 beds.</p> <p>Based on interview and record review, the facility failed to employ a qualified social worker on a full-time basis. This applies to all 130 residents residing in the facility. The findings include: The Facility Data sheet dated October 24, 2025, shows the facility census as 130 residents. On October 30, 2025, at 3:30 PM, V1 (Administrator) said he is not sure if V12 (SSD- Social Service Director) has all the required qualifications to work as the facility's Social Service Director. On October 30, 2025, at 3:00 PM, V12's employment record shows on July 19, 2021, V12 was hired as the facility's full-time Social Service Director. V12's employment record shows V12 has completed four years of high school education. V12 did not have any college education listed in her employment record. The facility's Job Description for the position title of Director of Social Services shows the education requirements for the position of Director of Social Services as either a bachelor's degree in psychology or sociology, a B.A. (Bachelor of Arts) or M.A. (Master of Arts) in social work, or a Licensed Clinical Social Worker's Certificate. The facility does not have documentation to show V12 had any of the required education or certificates as shown in her job description. On January 10, 2022, V12 signed the form entitled Job Description for the position title of Director of Social Services. The form V12 signed shows, I have read this job description and fully understand the requirements set forth therein. On November 3, 2025, at 2:37 PM, V18 (Medical Director) said, I was not aware [V12] (SSD) does not have the qualifications necessary to be the Social Service Director. You cannot hire someone without the right qualifications. The facility should have followed the regulations and the job description. I did not know this.</p>		