STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145752	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest View Rehab & Nursing Center	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident with a history of elopement was appropriately assessed and/or monitored to prevent elopement, failed to identify and assess residents who actively seek exits or display elopement behaviors, failed to ensure all exit doors/windows were secured/monitored, failed to promptly/effectively respond to triggered door alarms and perform a resident head count, and failed to maintain a current list of residents at risk for elopement at the front door exit per facility policy and resident care plans. The Immediate Jeopardy began on 11/4/25 at approximately 10:20 PM when R1 removed window lock hardware, tied bed sheets together, and repelled out of a second-floor window of the facility with temperatures at approximately 55-56 degrees Fahrenheit. R1 was found the morning of 11/7/25 approximately 10 miles away in the parking lot of an assisted living facility from which R1 previously eloped. The failure also had the likely serious adverse outcome of additional residents eloping from the facility. The Administrator was notified of the Immediate Jeopardy on 11/12/25 at 2:00 PM. The surveyor confirmed by observation, interview and record review that the Immediate Jeopardy was removed on 11/13/25 at 12:32 PM, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the plan of correction. This failure applies to 10 of 10 residents (R1-R10) reviewed for elopement in a sample of 10.The findings include: 1. Face sheet, printed 11/13/25, shows R1 was admitted to the facility on [DATE] and R1's diagnoses included an unspecified injury of the head, mild cognitive impairment, chronic kidney disease stage 3, congestive heart failure, dysphagia, unsteadiness on feet, weakness, need for assistance with personal care, and cardiac pacemaker. Pre-admission hospital records, dated 10/7/25, shows R1 left his assisted living facility alone at 4:00 AM with a cart and then hit his head against a concrete wall. The note shows R1 was seen by psychiatry during his hospitalization who deemed R1 to be lacking in decisional capacity.Hospital Record Psychiatry Consult Note, dated 10/5/25, shows, [Patient] presently lacks medical decision-making capacity. He is fully oriented at time of evaluation but is unable to discuss anything about treatment or disposition plan for him since he's been in the hospital. He has poor insight and does not have an appropriate understanding of his limitations in his ability to care for himself independently and believes that he can care for himself completely independently, expressing desire to go to work on a farm in southern Illinois. Patient unable to appropriately discuss his chronic medical issues or the medications he typically takes. He denies having been diagnosed with anything psychiatrically though his friend reported past [diagnosis] of bipolar disorder. Patient is tangential and hyperverbal during evaluation. Suspect mild cognitive decline/early dementia. Patient has primary neurocognitive disorder. Facility Wander Risk Assessment, dated 10/14/25, shows R1 was at high risk for wandering.Elopement risk assessment dated [DATE] and completed by V5 (LPN- Licensed Practical Nurse), shows R1 was assessed as not exhibiting wandering or pacing behaviors, as having the ability to be mobile without assistance from staff, and as having no history of elopement in the prior three months.On 11/7/25 at 11:02 AM, V5 (LPN - Licensed Practical Nurse) stated on 10/12/25 at approximately 9:30 PM R1 packed all his belongings, placed them by the locked exit of the memory care unit, and stated he wanted to leave. V5 stated he attempted to redirect R1 but was unable to do so. V5 stated he called R1's physician and obtained an order for Haldol to calm R1 down but R1 remained upset he was on the memory care unit and wanted to leave. V5 stated he reported the incident to V2 (Director of Nursing) and V16 (Assistant Director of Nursing) as well as the next shift nurse V6 (RN-Registered Nurse). Progress notes, dated 10/12/25 and written by V5, show R1 attempted to elope after packing his belongings and putting them by the door of the locked memory care unit. The note shows R1 was provided a new order for Haldol as needed due to agitation and sitting at the nursing station with all of his belongings.Behavior Monitoring records, dated 10/12/25, failed to show R1 had any wandering or elopement behaviors.On 11/7/25 at 1:28 PM, V6 (Registered Nurse) stated she was notified at approximately 12:30 AM on 11/5/25 by V10 (CNA) that R1's window was open, R1's window lock was removed, and the window could open 1.5 feet. V6 stated there were sheets tied into a rope with knots and one end of the sheet rope was attached to the foot of the bedside drawer which was located close to the open window. V6 stated the rope of sheets led to the ground. V6 stated R1's personal possessions were removed from the room and there were pillows placed under R1's bed linens resembling a body sleeping in the bed. V6 stated there were no alarms alarming in the facility at the time she observed R1 was no longer in his room. V6 stated she was not aware that R1 had a history of elopement from his prior facility or that he

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interview and record review, the facility failed to employ a qualified full time Social Services Director. This applies to all 129 residents residing in the facility. The findings include:Facility Daily Census, dated 11/5/25, shows the facility census was 129 residents.Application for Employment, dated 6/25/21, shows V3 (Director of Social Work) applied for the Social Service Director position. The application shows V3's highest level of education attained was a high school diploma.Employment offer letter, dated 7/2/21, shows the facility offered V3 the position of Social Services Director and V3 accepted the position on 7/2/21. Director of Social Services Job Description, signed by V3 (Director of Social Services) on 1/10/23, shows the education and experience required for the position includes either a bachelor's degree in psychology or sociology; a Bachelors or Master of Arts in Social Work, or a Licensed Clinical Social Worker's Certificate. On 11/13/25 at 10:30 AM with V19 (Consultant) and V2 (Director of Nursing), V1 (Administrator) stated V3 (Social Services Director) continued to work at the facility as the Social Services Director while the facility was recruiting for a new, qualified Social Services Director. V1 stated V3 remained in the role of Social Services Director since she was identified as not being qualified for the position during a prior complaint survey. V1 stated V3 would remain as Social Services Director until a new, qualified Director was hired.