STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145765	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Rehab Center	5888 North Ridge Chicago, IL 60660

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations, interviews, and record reviews, the facility failed to provide hand splints for one resident (R31) out of a total sample of 25 residents.Findings include:R31's ‘admission Record' documents a primary diagnosis of rheumatoid arthritis.On 9/09/2025 at 12:40 PM, R31 was sitting at the side of the bed. R31 was oriented to person, place, date, and situation. R31's left fingers were closed inward. R31 stated both hands had weakness, but it is worse on the left. R31 stated R31 is able to spread left fingers open with right hand. R31 stated the nurses and Certified Nurse Aides used to apply bilateral hand splints during the day, but not anymore. R31 stated the facility did a deep clean close to a year ago, and R31's hand splints disappeared. R31 suspected staff must have thrown them out by mistake. R31 informed staff, but they never replaced them. R31's ‘Order Summary Report' documents R31 may wear splint to bilateral upper extremities as tolerated and as needed for comfort (active since 10/10/2023).R31's ‘Care Plan Report' documents R31 has orthoses (brace/splint) related to rheumatoid arthritis (revised 4/14/2024). Intervention includes Educate on the importance of wearing splint/brace (revised 10/05/2023) and Monitor splint for cleanliness, need for refitting, repair or fit as needed (revised 10/05/2023).R31's 2025 progress notes prior to the survey did not mention hand splints or braces. No mention of hand braces or splints under the ADL (Activities of Daily Living) tasks in the electronic medical records. On 9/10/2025 at 9:10 AM, V5 (Nurse) stated V5 works with R31 on most days of the week. V5 stated V5 has been taking care of R31 since resident has been residing on the first floor. V5 stated R31 does not have any hand splints. V5 stated R31 had them years ago, but none this year. On 9/10/2025 at 10:03 AM, V7 (Restorative Nurse) stated the facility did not reorder the hand splints/braces until date of the survey. On 9/10/2025 at 10:29 AM, V9 (Certified Nurse Aide-CNA) stated V9 takes care of R31 for most days of the week, since R31 moved to the first floor. V9 stated R31 is not able to hold open the left fingers all the time. V9 stated left fingers are closing inward. V9 stated R31 hasn't had hand splints/braces for more than a year. On 9/10/2025 at 10:38 AM, V10 (Psychiatric Rehabilitation Services Coordinator) stated V10 has worked with R31 for less than half a year. When V10 does morning rounds, V10 hasn't seen R31 with hand splints. On 9/10/2025 at 11:45 AM, V2 (Director of Nursing) stated when making rounds, V2 hasn't seen hand splints/braces on R31. Facility's ‘Splints/Braces/Devices' policy (11/17) documents: Resident with the following conditions, but not limited to, may be eligible for evaluation: (a) weak or absent muscle strength. Nursing/Restorative will document the application of the splint/brace/device on the appropriate facility ADL form.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to follow professional standards and administer medications in a timely manner for two (R11 and R31) out of a total sample of 10 residents reviewed for medication times.Findings include: 1.On 9/09/2025 at approximately 10:20 AM, V6 (Licensed Practical Nurse) prepared R11's morning medications. These included Hydroxyzine Pamoate (given for restless leg syndrome), Lamotrigine (antianxiety), Levetiracetam (anticonvulsant), Metoprolol Succinate Extended Release (for high blood pressure), and Potassium Chloride (for low potassium). At 10:32 AM, V6 stated V6 will not administer the Metoprolol because R11's blood pressure was low. R11 took the other morning medications at 10:32 AM. R11's 'Medication Administration Record (MAR)' documents R11's morning medications are to be given at 9:00 AM. R11's 'Medication Admin Audit Report' documents on 9/03/2025, R11's morning medications were also administered late. R11's received the 9:00 AM medications at 12:08 PM. On 9/04/2025, R11 received the morning medications at 10:57 AM. On 9/08/2025, R11 received the morning medications at 12:40 PM. 2.On 9/09/2025 at 12:44 PM, R31 stated there were incidents a week to two weeks ago in which a new nurse gave R31's evening medications late. R31 stated nurses usually give R31's evening medications an hour after dinner. R31 stated during the mentioned incidents, it was almost 11:00 PM, and R31 still hadn't received the evening medications. R31's current MAR documents R31 is to receive Haloperidol (for agitation) and Vitamin C (supplement) at 5:00 PM. R31 is also to receive Donepezil Hydrochloride (for dementia) at 9:00 PM.R31's 'Medication Admin Audit Report' documents in August, R31 had Naproxen (for pain) and Vitamin C scheduled at 5:00 PM. On 8/06/2025, R31 received the medications at 7:03 PM. On 8/07/2025, R31 received the medications at 6:25 PM. On 8/09/2025, R31 received the medications around 8:28 PM. On 8/12/2025, R31 was no longer receiving Naproxen in the evening; however, R31 remained scheduled to receive Vitamin C at 5:00 PM. On this evening, R31 received it at 9:34 PM. There were multiple evenings afterwards in which staff administered it late (8/13/2025, 8/15/2025 - 8/17/2025, 8/20/2025, 8/21/2025, 8/23/2025 - 8/25/2025).R31's 'Medication Admin Audit Report' also documents in August, R31 had Donepezil Hydrochloride and Haloperidol scheduled at 9:00 PM. On 08/07/2025, R31 received the medications at 10:22 PM. On 8/20/2025, R31 received them at 11:14 PM. R31's 'Medication Admin Audit Report' documents on 8/26/2025, R31's 5:00 PM medications were now Vitamin C and Haloperidol. On this evening, R31 received them late at 8:01 PM. R31 also received them late on 8/27/2025 - 8/29/2025, 9/02/2025 - 9/04/2025, and 9/06/2025 with the latest one being at 8:45 PM on 8/29/2025. On 9/10/2025 at 11:23 AM, V2 (Director of Nursing) stated V24 (outside Social Worker) spoke with facility staff at the end of August to report R31 had complained about late or missing evening medications. V2 stated with some of the new nurses such as V13 and V25, it's possible medications were given late, since the residents were new to them. V2 stated all nurses were in-serviced on medication timeliness to make sure medications are administered within one hour before or one hour after the scheduled time. Facility's 'Medication Administration Policy' (8/15) documents: Medications must be administered in accordance with a physician's order at his/her discretion, e.g., the right resident, right medication, right dosage, right route, and right time.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%. This affected five (R1, R11, R30, R107, R110) out of nine residents during medication administration task. The facility had six errors out of 25 opportunities, resulting in a 24% medication error rate. Findings include:1.R107's 'Order Summary Report' and 'Medication Administration Record' document in part: RisperDAL Oral Tablet (Risperidone) Give 1.25 mg by mouth in the morning related to UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITH OTHER BEHAVIORAL DISTURBANCE.On 9/09/2025 at 9:52 AM, V6 (Nurse) prepared R107's medications. V6 read R107's Medication Administration Record (MAR) on the laptop. V6 stated R107 was scheduled to receive Risperidone (Risperdal) 1.25 MG (Milligram) every morning. V6 pulled out two different unit-dose blister packs/bingo cards for R107's Risperidone. One blister pack read Risperidone Tab 3 MG take 1/2 tablet (1.5 MG) by mouth at bedtime. Each individual slot contained half tablets (1.5 MG dosing). The other blister pack read Risperidone tab 0.25 MG with instructions to take 1 tablet by mouth daily - give [with] 1 MG (total dose = 1.25 MG). V6 popped out two half tablets from the first blister pack (1.5 MG + 1.5 MG = 3 MG) and one 0.25 MG tablet from the other blister pack (totaling 3. 25 MG of Risperidone). V6 popped the three tablets into the medicine cup with all the other morning medications for R107. V6 put away the rest of the medications and started cleaning up the medication cart. V6 stated V6 will administer the medications to R107. V6 was asked to review R107's orders and Risperidone blister packs. After reviewing the order, V6 removed a Risperidone 1/2 tablet (1.5 MG). The total in the cup was now 1.75 MG (1.5 MG + 0.25 MG). At a9:58 AM, V2 (Director of Nursing) was near the nurses' station. V2 motioned for V3 (Infection Preventionist) to assist. V3 instructed V6 to hold Risperidone until V2 and V6 obtained the correct dosage from the electronic medication dispensing system. 2.R11's 'Order Summary Report' and 'Medication Administration Record (MAR)' documents: Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG (Metoprolol Succinate) Give 25 mg by mouth one time a day for [Hypertension] related to ESSENTIAL (PRIMARY) HYPERTENSION. There were no parameters to hold the medication.R11's 'Care Plan Report' documentsR11 is at risk for elevated blood pressure related to hypertension (last revised 1/22/2025). Interventions include to administer medications as ordered by the doctor (initiated 1/22/2025). On 9/09/2025 at 10:20 AM, V6 prepared R11's medications. One of the medications included Metoprolol Succinate ER (Extended Release) 25 MG (blood pressure medicine) and Lamotrigine 200 MG (given for anxiety). At 10:29 AM, V6 went into R11's room and checked R11's blood pressure via an electronic blood pressure machine to R11's right wrist. V2 (Director of Nursing), who was standing at the doorway, stated there was no parameters for the blood pressure medicine. V2 stated it was okay for V6 to administer the Metoprolol. R11's blood pressure was 98/63, with a heart rate of 85 beats per minute. At 10:32 AM, V6 stated V6 will not administer the Metoprolol to R11 because the blood pressure was low. V6 stated, It's for hypertension [high blood pressure] and I don't want [R11] to bottom out. V6 stated V6 will put in a progress note to read that it did not apply. R11 took the other morning medications at 10:32 AM. At 10:37 AM, V6 stated R11's morning medication pass was complete and proceeded to administer medications to other residents. V6 did not call to inform R11's physician about not administering Metoprolol. R11's MAR documents V6 charted '9' under the 9/09/2025 9:00 AM dose meaning Other / See Nurse Notes. R11's orders and MAR also document: LamoTRIgine Oral Tablet 200 MG (Lamotrigine) Give 1 tablet by mouth every 12 hours for antianxiety. The MAR documents it was due at 9:00 AM. V6 administered the medication at 10:32 AM. R11's progress note, dated 9/9/2025, 10:34 AM reads dna hypotension (low blood pressure). V6 stated 'dna' stood for 'did not apply.'On 9/09/2025 at 10:41 AM, V4 (Physician) stated no one called to inform V4 about R11's blood pressure or holding the morning dose of Metoprolol. V4 stated the nurses need to inform V4 when they are holding or not administering a medication because it is a complicated decision. V4 stated V4 will need to trend R11's blood pressures, heart rates, and symptoms in the last three to four days prior to deciding whether to hold the Metoprolol Succinate ER or change it. When asked about R107's Risperidone, V4 stated it 'definitely' would not be good if the nurse increased the dosage and administered more than what was ordered. V4 stated R107 would have increased sedation and systemic slowing.3.R1's 'Order Summary Report' documents Sucralfate Oral Suspension 1 GM (Gram)/10 ML (Sucralfate) Give 10 ml by mouth three times a day related to GASTROINTESTINAL HEMORRHAGE.R1's 'Care Plan Report' documents R1 has gastritis and duodenitis (initiated 9/05/2025). Intervention initiated on 9/05/2025 documents in part to administer medications per physician orders. On 9/10/2025 at 12:03 PM, V13