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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145765	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect the residents rights to be free from physical abuse by residents. This failure affected 3 (R4, R6, and R12) residents and resulted in R6 sustaining a nasal bone fracture and subdural hematoma. Findings Include: 1.R6's Face Sheet, dated 1/23/2026, documents diagnoses of but not limited to Traumatic Subdural Hemorrhage without Loss of Consciousness, Subsequent Encounter, Unspecified Injury of Head-Subsequent Encounter, Fracture of Nasal Bones-Subsequent Encounter for Fracture with Routine Healing, Acute Embolism and Thrombosis of Unspecified Vein, Schizophrenia, and bipolar disorder. R6's Minimum Data Set Section C, dated 11/19/2025, documents a BIMS (Brief Interview Mental Status) Score is 15, which indicates an intact cognition. R6's Care Plan, dated 11/20/2025, documents a focus for Nasal Bone Fracture, dated 1/22/2026; Potential for complications related to subdural hematoma-Acute Head Injury dated 1/22/2025; and resident's comprehensive assessment reveals history of suspected abuse and or neglect or factors that may increase his susceptibility of abuse- Incident 1/18/2026 R6 was involved in a physical altercation with a co-peer R9, initial date initiated 6/23/2025 and date revised on 1/21/2026. IDPH (Illinois Department of Public Health) Reportable, dated 1/18/2026, documents the initial incident report was made to IDPH at 5:18 am, and the IDPH Final Incident Report, dated 1/23/2026 at 1:04 pm, documents abuse was substantiated. R6's Progress Note, dated 1/18/2026 at 4:46 pm, documents, admitted at (local) Hospital with the Diagnosis of Subdual Hematoma. R6's Discharge Summary from (local) Hospital, dated 1/21/2026, documents, Page #22-23, Small focal left frontal subarachnoid clot appears new or more evident.There is left periorbital and pre-septal soft tissue swelling. Left ocular lens replacement. There is a right nasal bone fracture evident. R6's Progress Note, dated 1/21/2026 6:49 pm, documents, resident returned to the facility from the hospital at 1600 hours via ambulance on a stretcher. Hospital discharge diagnoses include subdural hematoma and stenosis of the left carotid artery. Upon arrival, resident noted to have left eye markedly reddened with visible blood and clotted blood present around the surrounding tissues. Facial appearance consistent with recent trauma. Resident level of consciousness assessed; resident awake and responsive at time of admission. Vital signs obtained upon arrival and documented. No active external bleeding noted at this time. Resident denied pain at this time. Family and attending physician (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 0600 Level of Harm - Actual harm Residents Affected - Few	have been notified of resident return. Hospital discharge paperwork reviewed; medication reconciled per doctor's instructions. Resident is comfortably on bed, call light within reach. Continues monitoring planned with emphasis on neurological status, vision changes, pain and safety. R9's Face Sheet, dated 1/23/2026, documents diagnoses of but not limited to Undifferentiated Somatoform Disorder, Anxiety Disorder-Unspecified, Insomnia-Unspecified, and Schizophrenia-Unspecified. R9's Minimum Data Set Section C, dated 10/25/2025, documents a BIMS (Brief Interview Mental Status) Score is 15, which indicates an intact cognition. R9's Minimum Data Set Section E, dated October 27, 2025, documents behaviors of hallucinations and delusions but no physical behavior directed towards others. R9's Care Plan, dated 10/28/2025, documents a focus of the resident displays socially inappropriate & maladaptive behavior related to: A mental illness diagnosis(es)., Anger, agitated depression., Feeling inadequate, inferior., Feeling vulnerable, powerless. Date Initiated: 11/15/2023. R9's Care Plan, dated 10/28/2025, documents a focus of the resident expresses maladaptive behavioral symptoms related to: A diagnosis of chronic mental illness., Disorganized, chaotic and/or decompensating behavior (e.g., poor contact with reality, hallucinations, delusions)., The resident's problems/symptoms are manifested by: Hallucinations (Specify- auditory, visual, tactile, olfactory, taste, command hallucinations), The resident's problems/symptoms are manifested by: Delusions (Specify paranoid, grandiose, irrational/bizarre thoughts, inability to perceive reality Date Initiated: 11/15/2023. R9's Progress Noted, dated 1/18/2026 at 10:07 pm, documents physician notified and Note Text: Staff informed the writer regarding resident's behavior. Resident hit another resident. It resulted to injuries of (R6), ending up in ICU. The resident's behavior which is volatile and explosive post danger to other residents. He was sent out to St [NAME] Hospital and was given notice of involuntary discharge. R9's Progress Note, dated 1/18/2026 at 4:24 pm, documents Note Text: admitted to the Hospital with the Diagnosis of Schizophrenia. On 1/18/2026 at 12:07 pm, R6 stated he went to R9's room to borrow a cigarette lighter so that he could take a smoke. R6 stated R9 told him that he (R9) did not have a lighter. R6 stated he went back to his room and a few minutes later R9 entered his room. R6 stated R9 asked R6 where his cigarettes were. R6 stated he informed R9 he did not have R9's cigarettes. R6 stated R9 punched him in the face, and he fell on his bed. R6 stated R9 continued to punch him repeatedly with a closed fist but can't recall how many times R9 punched him. R6 stated he never lost consciousness. R6 stated he feels safe in the facility since R9 has been discharged . R6 stated he sees his Social Worker and Therapist regarding the incident. R6 stated the Abuse Coordinator is V1 (Administrator) and he knows how to report abuse to V1 and the Ombudsmen. On 1/23/26 at 12:42 PM, V12 (Psychiatric Rehabilitation Services Coordinator-(PRSC) stated he heard about the physical altercation incident between R6 and R9 as manager on duty that Sunday morning, in which R6 was already hospitalized . V12 stated R6 received counseling regarding the physical altercation and injury he sustained on 1/18/2026. V12 stated R6 stated he felt safe in the facility. V12 stated when there is a physical altercation, both residents involved are separated and further (continued on next page)

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

guidance is obtained, and the family is informed. V12 stated R9 had two prior incidents with another peer, though not as severe as the incident with R9 and R6. V12 stated R9 was involuntarily discharged from the facility because of his behavior.

On 1/23/2026 at 1:59 pm, V17 (Registered Nurse) stated he was at the nursing station completing documentation when he heard a loud noise. V17 stated he rushed down the hallway and notice R9 leaving out or R6's room. V17 stated as he entered R6's room he noticed R6 lying on the bed with his face covered in blood. V17 stated R6 informed him that R9 came into his room and began punching him (R6) in the face. V17 stated R9 had broken some shelves in the nursing station on the third floor in the past but R9 has improved his behavior since then. V17 stated when residents exhibit aggressive behavior they are placed on one-on-one monitoring and a psychiatric evaluation may be needed. V17 stated R8 was not on one-on-one monitoring at the time of the altercation.

On 1/23/2026 at 2:30 pm, V20 (Certified Nurse's Assistant) stated most of the time, R9 is in bed sleeping and when he wants something he asks politely. V20 stated other staff had stated R9 displayed aggressive behavior on the second floor in the past. V20 stated when residents exhibit aggressive behavior, the staff is trained in Crisis Prevention Intervention (CPI) to de-escalate the resident. V20 stated the staff who works the night shift should be monitoring the hallway during throughout the night to make sure residents aren't wandering in other residents' rooms when they are sleeping.

On 1/23/2026 at 3:02 pm, V2 (Assistant Administrator) stated she heard about the incident between R6 and R9. V2 stated she was surprised R9 had a physical altercation with another resident because when R9 has outbursts he usually will go outside or come and talk to V2 or V12 (Psychiatric Rehabilitation Services Coordinator-(PRSC). V2 stated R9 is redirectable, and staff are supposed to monitor the hallways throughout the night to ensure residents are not wandering in other residents' room. V2 stated the purpose of staff monitoring the hallway is to make sure residents are safe. V2 stated residents does not have a smoking time at 3 o'clock or 4 o'clock am.

On 01/23/2026 at 3:13pm, V1 (Administrator) stated it is not expected of residents to be physically abused by another resident while they are at the facility because the facility must keep the residents safe. V1 stated she is the Abuse Coordinator.

On 1/23/2026 at 4:41 pm, V22 (Medical Doctor) stated he was informed of the altercation between R6 and R9 and reviewed R6's record but did not recall all of the specifics. V22 stated his normal practice is to send the resident who exhibits aggressive combative behavior to the hospital for a psychiatric evaluation and send the affected resident to the hospital for a medical evaluation. V22 stated the facility is not a psychiatric long term care facility although the facility has a mix of resident with more behavioral health need than other facilities. V22 stated abuse is not an expectation and behaviors should be managed to maintain safety.

2.R4's admission Record documented R4's diagnoses (include but not limited to) schizophrenia, hypertension, and unsteadiness on feet.

R4's (01/20/2026) Minimum Data Set documented, Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 15., indicating R4's mental status as cognitively intact.

R5's admission Record documented R5's diagnoses (include but not limited to) schizophrenia, asthma, and schizoaffective disorder.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R5's (09/05/2025) Minimum Data Set documented, Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 03., indicating R5's mental status as severely impaired. R5's census list documented R5 was admitted to the facility on [DATE] on the second floor and was discharge on [DATE]. R5 was sent to the hospital on [DATE]. R4's (11/06/2025) Final Incident Investigation Report Form documented, Based on the known facts from medical record review and interviews, the following conclusions have been determined about the original allegation: [X] Abuse is [x]SUBSTANT1ATED, as follows. On 11/06/25, (V15 – Licensed Practical Nurse/ LPN) reported to administration a resident (R4) was STRUCK in the face by another resident (R5). Upon further investigation it was determined (R4) exited the dining room and was sitting in the hallway when (R5) walked out of her room and struck him in the face with her hand, unprovoked. R4's (11/06/2025) Progress note documented, Resident was sitting in the hallway when another resident came out of her room and suddenly smacked the resident on the face. Writer responded to the incident immediately by assessing the resident. No redness or swelling noted at this time. Authored by: (V13) LPN. R4's (11/07/2025) Counselling Session documented, It was reported to Social Services Director that resident was hit by co-peer (R5) on 11-6-25. On 01/23/2026 at 3:25pm, V13 (Licensed Practice Nurse) stated she was the nurse working on 11/06/2025 when the incident between them (R4 and R5) happened. V13 stated she was getting medication for a resident when she heard R4 yelling stop hitting me. V13 stated she saw R5 standing close to R4 making a fist. V13 stated she separated the two residents. V13 stated R4 reported to her that R5 hit him (R4) in the face. V13 stated she called the police and notified the psych doctor and the primary care physician. The importance of calling the psych doctor is to get an order to send resident for psych evaluation. It is not an expectation for resident to be abused by another resident. Residents have rights to live free from abuse. 3.R12's admission Record documented R12's diagnoses (include but not limited to) osteoarthritis, hypertension, and psychosis. R12's (11/03/2025) Minimum Data Set documented, Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 15., indicating R12's mental status as cognitively intact. R12's (11/04/2025) Final Incident Investigation Report Form documented, Based on the known facts from medical record review and interviews, the following conclusions have been determined about the original allegation: [X] Abuse Is [x]SUBSTANTIATED as follows (summarize facts obtained during investigation): On 11/4/2025 resident (R12) alleged she was struck in the face by another (R5). Upon further investigation it was determined that while (R12) was inside the public restroom (R5) was walking past. When the restroom door opened (R5) was startled and started swinging her arms and struck (R12) in the face. Staff present on the unit intervened immediately and separated the residents. The resident's physician was made aware of the allegation. Subsequently, (R5) was sent to the hospital for evaluation per physician orders. R5's (Date Range: 10/31/2025 – 11/10/2025) Progress notes documented, 11/04/2025. The nurse was on the phone by the nursing station and suddenly She heard (R12) saying don't hit me. (R12) is (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	just outside the nurse station, (R5) is by the door of the bathroom which is beside the nurse station. She ran immediately and she saw (R5) picking up her bag and she went inside the bathroom. (R12) is around 1 meter away from (R5). When she asked (R12) where she was hit she said on her face. Authored by: V14 LPN. 11/04/2025 Counselling Session. It was reported to Social Services Director that resident allegedly hit co-peer (R12). Authored by: V12 PRSD. 11/06/2025. (R5) without event or provocation hit co peer on his face. Staff immediately attempting to remove (R5) from the area using verbal cues and positioning their bodies between the residents. (R5) then became physically aggressive towards staff attempting to kick, punch and spit on them. Authored by: V3 DON. There was no physician notification when R5 hit R12. On 01/24/2026 at 12:44pm, V11 (Infection Preventionist/RN) stated she worked the floor on 11/04/2025 during the 3pm-11pm shift. She was on the phone with a hospital, sending a resident out, when she heard (R12) say don't hit me. She asked R12 where she got hit and R12 said she was hit on the face. On 01/23/2026, R4 and R12 both stated they did not remember the incidents. On 01/23/2026 at 11:45am, V1 (Administrator) stated she substantiated both allegations of physical abuse between R4 and R5 and between R12 and R5 based on the nature of the incidents and statements from the residents. If the allegations of abuse are substantiated it means abuse happened. On 01/23/2026 at 3:13pm, V1(Administrator) stated, It is not expected of residents to be physically abused by another resident while they are at the facility because the facility has to keep the residents safe. The (undated) Residents' Rights for People in Long-Term Care Facilities documented, As a long-term care resident in the State, you are guaranteed certain rights, protections and privileges according to State and Federal laws. Your rights to safety. You must not be abused physically, neglected, or exploited by anyone-financially, physically, verbally, mentally or sexually. Your facility must provide services to keep your physical and mental health at their highest practicable levels. The (undated) Abuse Prevention Program Policy documented, Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. DEFINITIONS: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental mean. Abuse is also the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident's physician of allegation of abuse. This failure affected 2 (R5, and R12) residents reviewed for abuse in the total sample of 16 residents.Findings include: 1.R12's admission Record documented R12's diagnoses (include but not limited to) osteoarthritis, hypertension, and psychosis. R12's (11/03/2025) Minimum Data Set documented, Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 15., indicating R12's mental status as cognitively intact. R12's census list documented R12's actual admission date was on 06/01/2015 and has been residing on the second floor since 06/28/2022. R12's (11/04/2025) Final Incident Investigation Report Form documented, Based on the known facts from medical record review and interviews, the following conclusions have been determined about the original allegation: [X] Abuse Is [x]SUBSTANTIATED as follows (summarize facts obtained during investigation): On 11/4/2025 resident (R12) alleged she was struck in the face by another (R5). Upon further investigation it was determined that while (R12) was inside the public restroom (R5) was walking past. When the restroom door opened (R5) was startled and started swinging her arms and struck (R12) in the face. Staff present on the unit intervened immediately and separated the residents. The resident's physician was made aware of the allegation. Subsequently, (R5) was sent to the hospital for evaluation per physician orders. R12's (11/01/2025 - 11/15/2025) Progress Notes documented, in part 11/04/2025. The nurse was on the phone by the nursing station and suddenly She heard (R12) saying don't hit me. (R12) is just outside the nurse station, (R5) is by the door of the bathroom which is beside the nurse station. She ran immediately and she saw (R5) picking up her bag and she went inside the bathroom. (R12) is around 1 meter away from (R5). When she asked (R12) where she was hit she said on her face. Authored by: V14 LPN. 11/04/2025. Counselling Session. It was reported to Social Services Director that resident (R5) allegedly hit co-peer (R12). Authored by: V12 (PRSD). On 01/24/2026 at 12:44pm, V11 (Infection Preventionist/RN) stated she worked the floor on 11/04/2025 during the 3pm-11pm shift. She was on the phone with a hospital, sending a resident out, when she heard R12 say don't hit me. She asked her where she got hit and she said she was hit in the face. V11 stated she already called the police and informed (V1 - Administrator) that she was busy, and she would not be able to complete the abuse protocol for R5 and R12. V11 stated she (V1) instructed (V14 - Licensed Practical Nurse/LPN) to complete the abuse protocol. Abuse protocol includes calling the family and doctor for both alleged victim and perpetrator. The importance of calling the doctor of the alleged victim is to inform the doctor of the incident, to get an order to send for medical evaluation, or to monitor the resident at the facility. The importance of calling the doctor of the alleged perpetrator is to inform the doctor of what happened, get an order to send the resident for psych evaluation, or get an order to place resident on supervision 1:1. V11 stated she did not call the family and doctor of both alleged victim and perpetrator. On 01/24/2026 at 12:57pm, V14 (Licensed Practice Nurse) stated she did not receive an instruction from V1 to complete the abuse protocol for R5 and R12. V14 stated she did not call the family or doctor of both residents. On 01/23/2026 at 11:11am, V12 (PRSC (Psychiatric Rehabilitation Services Director) stated he documented on the progress note that R12 was hit by R5 on 11/04/2025. If a resident made an allegation of physical abuse, the psychiatrist should be called. V12 stated he was not 100% sure if the psychiatrist was called. V12 stated the reason why the psychiatrist should be called because the resident was physically aggressive toward a resident, and they can order to send to the perpetrator to the hospital for psych evaluation. If the nurse did call the psychiatrist, then the nurse should document it in the electronic health record.On 01/23/2026 at 11:16am, V12, PRSD, stated (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no notification was done for the psychiatrist. R5's physical aggression towards R4 on 11/06/2025 could have been prevented if the nurse called the psychiatrist when she allegedly hit her R12 on 11/04/2025. On 01/23/2026 at 11:45am, V1 stated it was reported to her by R12 that she was hit by another resident, and she submitted a reportable to IDPH (Illinois Department of Public Health). V1 stated, Anytime the residents were struck by another resident, the facility has to immediately start abuse protocol. Abuse protocol includes separating the individuals, putting them on behavior monitoring, and notifying physician and emergency contact person. Nursing staff are expected to document the notifications in electronic health record, and to follow the physician's order, if they have order to send to psych facility for psych evaluation or for medication adjustment. If not documented, if means the staff failed to follow abuse protocol. Doctor should be notified immediately. Right away. V1 stated the allegation of physical abuse between R4 and R5 on 11/06/2025 could have been prevented if the doctor was notified when R5 hit R12 on 11/04/2025.On 01/23/2026 at 3:13pm, V1(Administrator) reviewed R12's 11/04/2025 reportable which read Subsequently, (R5) was sent to the hospital for evaluation per physician orders. V1 also reviewed R5's census list which indicated R5 was not sent to the hospital on [DATE]. V1 stated, Staff should be calling the doctor to get an order to send the alleged perpetrator to the hospital for psych evaluation. That is part of the facility abuse protocol.On 01/24/2026 at 2:10am, V1 (Administrator) stated she spoke with the nurse (V14 - LPN) on the phone and was notified there is an abuse allegation between R5 and R12 and instructed V14 and to follow abuse protocol. V1 stated the abuse protocol includes separating both residents, calling the primary contact of both residents, calling the physician of both residents, and calling the police. V1 stated the purpose of calling the doctor of both residents is to get an order; maybe to put the resident on close monitoring or give PRN (as needed) medication or to send the residents out. V1 stated if notification of the doctor was not documented, it means it did not happen. The (undated) Abuse Prevention Program Policy documented, in part Residents have the right to be free from abuse. DEFINITIONS: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental mean. Abuse is also the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. Abuse Prevention Program Facility Procedures. V. Protection of ResidentsThe facility will take steps to prevent mistreatment while the investigation is underway. Residents who allegedly mistreated another resident will be removed from contact with other residents during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. IV. INVESTIGATIONAs soon as possible after an allegation of abuse, neglect, mistreatment, misappropriation ofresident property, or exploitation, the administrator or designee will initiate an investigation intothe allegation which may include the following elements: Physicians will be notified of any incident, and any medical treatment will be done as ordered. V. Reporting & RESPONSE. A. Representative and Physician. The administrator or designee will notify the resident's representative and physician of the alleged incident and the investigation.