

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  01/30/2026
NAME OF PROVIDER OR SUPPLIER  Park View Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and records review, the facility failed to ensure three (R4, R6, R13) of seven residents reviewed remained free from physical and mental abuse in a sample of 14. Findings include: 1. Facility Reported Incident Report, sent to Illinois Department of Public Health (IDPH), initial dated 10/24/2025, final dated 10/29/2025, related to R4 and R6 documents: Based on the known facts from medical records review and interviews, the following conclusions have been determined about the original allegation: Abuse is substantiated. On 01/29/2026 at 2:20PM, V1 (Administrator) stated on 10/24/2025, V1 was notified by nursing staff (no names provided), R4 was verbally aggressive and loud towards R6, telling R6 to turn off his music playing from R6's phone. R6 pushed R4 on R4's face for being verbally aggressive towards him. R4's provider gave orders for R4 to be sent to the hospital for aggressive behavior. R4 refused, police were called, R4 was sent to a psychiatric hospital for evaluation related to aggressive behavior. V1 stated staff are supposed to keep residents safe and free of any form of abuse. V1 further stated verbal aggression and pushing are a form of abuse. V1 conducted investigations on what happened and concluded abuse happened between R4 and R6. R4 is a [AGE] year-old individual whose current face sheet documents R4 medical conditions to include but not limited to depression, unspecified, schizophrenia, unspecified, alcohol use, unspecified with intoxication, unspecified. MDS (Minimum Data Set) section C, dated 12/16/25, documents R4's Brief Interview for Mental Status (BIMS) as 15/15, indicating R4 has intact cognitive abilities. R4 is a closed record and was not residing in the facility during this investigation. R4's nursing progress note, dated 10/24/2025, documents R4 stated to staff his roommate (R6) pushed him. V6 (Licensed Practical Nurse) heard R4 in the hallway having a verbal disagreement with co residents. Residents became aggressive, agitated, and combative. R6 is a [AGE] year-old individual whose current face sheet documents R6 medical conditions to include but not limited to: bipolar disorder, unspecified, type 2 diabetes mellitus without complications. MDS (Minimum Data Set) section C, dated 12/3/25, documents R6's Brief Interview for Mental Status (BIMS) as 15/15, indicating R6 has intact cognitive abilities. On 01/27/2026 at 12:08PM, R6 stated he got into a confrontation with R4 when R4 tried to snatch R6's phone as R6 was listening to music, stating the phone was his (R4's). R6 pushed R4 away and told him to get away from him. R6 stated he and R4 cursed each other. Staff came and separated them. R4 was moved out of the room he shared with R6. R6's progress notes, dated 10/24/2025, documents R6 told V6 (Licensed Practical Nurse) that he pushed R4 because R4 came on R6's side of the room and threatened to break his phone and started verbally abusing him. Police notified. Chicago Police made aware of incident. On 01/28/2026 at 12:36PM, V8 (Licensed Practical Nurse-LPN) stated on 10/24/2025, she heard a disagreement between R4 and R6. R6 told V8 that he had pushed R4 after R4 threatened R6 and told him he was going to break his phone. R6 stated R4 she went to check to check what was going on. R4 stated R6 he was playing music on his phone, and it was not loud. R6 stated R4 was verbally abusing R6. V8 went</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  145765	Facility ID:  145765  If continuation sheet Page 1 of 2

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>to R4 and R6's room and heard R6's music at a normal sound, it was not loud at all. V8 stated she notified police who come to the facility to investigate. On 01/28/2026 at 3:40PM, V12 (Social Services Director) stated the incident between R4 and R6 occurred on 10/24/2025. V12 works only one Sunday of the month; V12 learned about the altercation on 10/27/2025 when he returned to work. V12 stated R4 and R6 used to be roommates. V12 stated he was informed by nursing (Does not remember who) that R6 had reported there was a verbal confrontation between R4 and R6. R4 was yelling and cursing at R6, R4 was approaching R6, so R6 pushed R4 away from him. V12 stated R4 and R6 were separated, R4 sent to the hospital for further evaluation. R6 was moved to another room. Both R4 and R6 are ambulatory and do not use assistive devices. V12 stated its not ok for residents to push each other. Residents are supposed to be monitored by staff and interventions taken before residents' resident issues can escalate to aggression. V12 stated when R6 pushed R4, that is a form of abuse. R4 abused R6 when R4 cursed at R6. V12 stated staff are responsible of making sure residents are safe in the facility. V12 stated he met with R6 on 10/27/2025 and R6 stated he did not like being verbally abused by R4. V12 stated R4 was sent to the hospital on [DATE] and come back on 11/13/2025. V12 met with R4 on 11/17/2025. R4 stated he did not like it when R6 pushed him. V12 further said residents should feel safe in the facility since it's their home. Social services progress, note dated 11/17/2025, documents R4 returned to the facility after being sent out to a near hospital for getting into a physical altercation on 10/24/2025 with R6. 2.R13's current face sheet documents R13 medical conditions to include but not limited to: deaf nonspeaking, not elsewhere classified, unspecified psychosis not due to a substance or known physiological condition, schizophrenia, unspecified. MDS (Minimum Data Set) section C -Cognitive abilities, dated 10/27/25, 1/15/26, Brief Interview for Mental Status (BIMS) is not scored/documented. On 01/28/2026 at 4:17PM, V8 (Licensed Practical Nurse) stated R13 is deaf and communicates staff with staff writing down questions that include yes or no. R13 reads the questions and answers by writing down the answers or shaking his head yes or no. R13 read questions asking him if he has been hit by R4. R13 nodded his head yes that R4 hit him, but he did not hit R4. R4 nodded yes that he was afraid and hurt when R4 hit him. R13 feels safe at the facility. R13's nursing progress notes, dated 1/2/2026, documents R4 stated R13 kicked him on the left leg. Abuse Prevention Program-Policy, dated 1/20, documents: -Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means. -Verbal abuse is the use of oral, written, of gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance regardless of an individual's age, ability to comprehend or disability.</p>		