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	02/20/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to provide appropriate supervision for one (R2) resident who was identified at risk for elopement and requires supervision with community access. The findings include: R2's admission record / face sheet shows admission date on 1/12/26, with diagnoses not limited to Acute respiratory failure with hypoxia, Biliary acute pancreatitis without necrosis or infection, Other pulmonary embolism without acute cor pulmonale, Generalized anxiety disorder, Insomnia, Major depressive disorder, Essential (primary) hypertension, Extrapyramidal and movement disorder, Gastro-esophageal reflux disease, Alcohol dependence, Opioid dependence, Other chronic pain, Obstructive and reflux uropathy, History of falling, Muscle weakness (generalized), Other abnormalities of gait and mobility, Unsteadiness on feet, Encephalopathy, Gastrointestinal hemorrhage, and Other psychoactive substance abuse. R2's MDS (Minimum Data Set), dated 1/19/2026, showed R2 cognition was intact. On 2/11/26 At 10:55AM, R2 was up and about, ambulatory, alert and oriented x 3, verbally responsive. He said on 1/14/26, around evening time, it was already dark outside, he left the facility unauthorized. He stated nobody told him that he was in Chicago, and he did not feel safe. He said he had paranoia because of his history of taking drugs. He said he did not feel safe / comfortable in the facility, and he thought somebody was after him, so he exited the facility without telling the staff. R2 said staff were behind him and saying you can't leave the facility. He said it was after dinner when he left the facility. He said the staff were closely monitoring him and were on him because he wanted to leave. R2 said he told staff they couldn't hold him and left the facility. He said he thought there was an alarm going off when he left the facility. He said he was not sure which floor the alarm went off. R2 said he thought there was a female facility staff running after him and probably could not catch him because he was running as fast as he could. He said he did not realize that he was Chicago, and it was very cold outside, raining ice / snowy. He said he was wearing the same type of clothes he is wearing today when he left the facility. He said he was wearing a sweater, pants, and shoes with no socks. Observed R2 wearing gray sweater, pants, and shoes. R2 said his sweater was not a winter jacket and should have had a coat over it. He said he walked outside of the facility for a while and when he noticed that he was hit by ice / snow, he felt very cold. He said he was walking and running a little bit. R2 said he was maybe a couple blocks or about a half mile away from the facility and saw an apartment building. He said he sat in the lobby of the apartment building to shelter because he felt very cold already. R2 said he was not in the proper state of mind. He said he felt his mind was telling him that people around him were trying to hurt him and wanted to leave the facility. R2 said he was walking and running for about an hour in the cold. He said he probably was running as fast as he could to leave the facility. R2 said he was in the lobby of the apartment maybe for more than 2 hours to shelter, then a random person helped him and called the police. He said 2 policemen came, called an ambulance, and he was brought to the hospital. R2 said there was some bruising on his left foot, pain medicine (Tylenol) was (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

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	02/20/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	given, compression wrap was applied on his foot, and nonskid socks were provided in the hospital. R2 said he stayed in the ER for about 2 hours. He said female staff from the facility came and brought him back to the facility. R2 said it was cold and probably when he was running, he twisted his left leg and there was bruising. He thought the alarm went off; he heard a sound by the stairwell that he used when he exited the facility. He said maybe the staff got tired of him trying to get him to stay in the facility. He said nobody was watching him when he left the facility. There was a male staff working in the facility and was trying to stop him as much as he could. R2 said maybe if a male staff had run after him, then maybe he would have been caught. He said he was limping because he twisted his left leg. On 2/11/26 At 3:03PM, V18 (Certified Nursing Assistant / CNA) said she has been working in the facility in July 2024 and was mostly assigned on the 1st and 2nd floor. She said on 1/14/26, she was working on the 2nd floor but was not assigned to R2. V18 said when she arrived at 3 PM on 1/14/26, she noticed R2 was walking from hallway to hallway, dining room to his room. She said R2 was trying to escape using the back door through the stairwells and was redirected by V30 (Social Service staff). R2 was brought back to his room. V18 said after smoke break around 6:35PM, upon entering the 1st floor, the stairwell alarm went off, she went outside of the facility to see if there were any residents outside and did not see anybody, so the alarm was turned off, and she came back to the floor. V18 said she was coming to the 2nd floor using stairwell from the first floor when she saw V13 (Nurse on duty) who told her R2 ran out of the building. She stated V13 told her she was chasing after R2 but R2 did not want to go back to the facility. V18 said there is always 1 staff watching the day room and hallway; CNA rotates hourly to do hallway / dining room watch. V18 said most CNAs / staff went outside of the facility and searched for R2 for more than 2 hours. She said it was very cold outside, and it was snowy.On 2/11/26 At 3:28PM, V19 (CNA) said he has been working in the facility for more 6 years and regularly assigned on the 2nd floor. He said he had worked with R2. V19 said he was working on 1/14/26 but he was not assigned with R2. He said after dinnertime, around 5:50PM - 6PM, R2 was restless, walking / pacing back and forth in the unit hallway, from one end to another end. He said he was coming out from the shower room after giving shower to a resident and heard the alarm go off on the back door of the 2nd floor stairwell and heard V13 (Nurse on duty) saying R2's name going out of the door. He said V13 followed R2 out of the door by the stairwell. V19 stated he could not leave his resident in the hallway, so he put the resident in bed. V19 said he saw V13 come back after putting resident in bed and told him that she could not find R2. V19 said he went out with another CNA (V24) to search for R2 using his car but did not find R2. He said he had been searching for more than two hours. V19 said it was very cold outside, and it was snowing that night. There was overhead paging that resident had eloped, he heard it when he was in the room putting resident to bed after shower. He said there should be staff monitoring the hallway and dining room all the time. V19 said CNA rotates hourly to watch dining and hallway. He said R2 went through the back door stairwell because the alarm went off. Even if there was a staff monitoring the hallway at that time, R2 would have left and would not be caught because he was fast. V19 said there were 4 CNAs and 1 nurse working in the unit on 1/14/26. On 2/11/26 At 4:00PM, V17 (CNA) said she has been working in the facility for almost 3 years and most of the time assigned on the 2nd floor. She said she was assigned to R2 on 1/14/26. After dinner time around 6PM, R2 was observed in and out of his room. V17 said R2 was observed walking back and forth hallway to hallway, dining to his room around 5:30PM - 6PM. She said that same day on 1/14/26, R2 was trying to get out of the building at around 4-5PM, was trying to get out of the stairwell back door. V17 stated R2 pushed the 2nd floor back door and the alarm went off. R2 was redirected by V30 (SS staff) and was brought back to this room. V17 said CNA (continued on next page)

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	02/20/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rotates hourly to watch dining room and hallway continuously. She said it was not her time to monitor the hallway when R2 left the facility. V17 said during that time she was attending to one of the residents in their room. She said when she came out of resident's room, V18 (CNA) told her R2 went out of the facility. She said she did not hear any alarm go off, maybe because she was inside the resident's room, but she heard there was overhead elopement paging. V17 said V13 (nurse on duty) came back to the facility from outside search and did not find R2. She said V13 ran after R2 but did not allow V13 to bring R2 back to the facility. She said they could not force R2 to go back to the facility. V17 said all the staff went out to search for R2. She said they were searching for R2 for more than 2-3 hours. V17 said that day / night was very cold and snowing. On 2/11/26 at 4:27PM, V24 (CNA) stated she has been working in the facility for about 2 years in the facility and mostly assigned on the 2nd floor. She said there is always a staff / CNA continuously watching or monitoring dining room and hallway. V24 said CNA rotates hourly to watch dining and hallway. She said on 1/14/26, she was not assigned to R2 but was working on the 2nd floor. V24 said she was taking vital signs for one of the residents in the room, she heard an overhead paging for elopement code, maybe around after dinner time. She came out of the room and was informed that R2 had left the building and could not be located. V24 said V13 went after or chasing R2 outside of the building and R2 did not want to go back to the facility. She said V13 was not wearing coat, and she was freezing so she came back to the facility to inform them to search for R2. V24 said they searched for R2 around the facility and outside of the facility. It was very cold and snowy at that time. She said she went out 2 times to search for R2 for about 2-3 hours and could not find him. On 2/11/26 At 4:40PM, V13 (LPN / Licensed Practical Nurse) stated she started working in the facility in October 2025 and regularly assigned on the 2nd floor. She said there is always at least 1 staff continuously monitoring dining/ hallway. She said CNAs rotate hourly to watch dining and hallway. V13 said if she is doing med pass in the hallway then CNA can do something else. She said on 1/14/26, before dinner time, R2 was trying to get out of the back door on the 2nd floor, and she could not remember if the alarm went off. V13 said V30 (SS) redirected him to his room and was settled in the room. She said around dinner time, R2 was pacing or walking back and forth in the hallway, room and dining room. V13 said there was no CNA watching the hallway because she was passing medication in the hallway. She said after dinner time around 6:30PM, she was giving medication in the room to one of the residents and heard V19 (CNA) telling R2 stop, where are you going?. V13 said she went outside and heard the alarm go off by 2nd floor back door. V19 was in the hallway standing by linen cart. She said she ran out after R2. V13 said R2 was running by the stairwell then another alarm on the 1st floor went off. V13 said she went outside to the alley, and she was not wearing any coat / jacket. She said she saw R2 wearing a sweater, pants, sneakers. R2 was not wearing appropriate clothes for the cold weather. V13 said she told R2 to come back, and he said NO and then ran away. V13 said she followed him just to find out where he was going to tell staff where R2 was heading. She said she tried to hold R2, but he pulled back and R2 said don't touch me and ran away. V13 said she went back to the facility because she was not wearing a jacket at that time, and it was very cold and snowing. V13 said upon coming back to the facility, there was a group of staff at the back door searching for R2. She said she told the staff which way R2 was going and staff searched for him. V13 said she called V28 (ADON / Assistant Director of Nursing) while she was outside chasing R2 and V28 called the reception. She said she was outside when they announced the elopement code. V13 said staff had searched for 2-3 times; came back around 10PM. She said R2 was missing for more than 2hours; she informed family and Physician. V13 stated she called the police as soon as she could not find R2. V13 said there were 4 CNAs and 1 nurse working on 2nd floor (continued on next page)

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	02/20/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 1/14/26.On 2/17/26 at 10:39AM, V28 (ADON / Assistant Director of Nursing) said on 1/14/26 around 6:30pm, she received a call from V13 informing her R2 had left the building and V13 was chasing him. She said V13 could not catch R2 and could not be found. V28 stated she called the facility to initiate elopement code. She said CNAs were searching for R2. V28 said V1 (Administrator) was also informed. She said they called the police and did police report. V28 said they also called nearby hospitals but R2 was not found. She said around 9-10PM, she received a call from V1 that police found R2 and was sent to the hospital. She said R2 was brought back to the facility around 11PM. V28 said staff are expected to monitor and watch hallway and dining room hourly to quickly assist/help residents with needs, for safety purposes or if a resident is attempting to leave the facility to redirect them right away.On 2/17/26 At 11:40AM, V30 (Social Service staff / PRSC / Psychiatric Rehabilitation Social Services Coordinator, CNA) said he has been working with R2. He said on 1/14/26 around 4-5PM, R2 attempted to leave the back door through the stairwell and the alarm went off. V30 said he was able to redirect R2 and was brought back to this room, stay calm and collected in his room. He said R2 was assessed as elopement risk. V30 said R2 was talking about leaving the facility, he was educated if he wanted to be discharged to follow the protocol so he can be properly discharged from the facility. He said R2 was also asking about the police station. V30 said at around 6:30PM, he was about to leave the facility when he heard an elopement code through overhead paging system. He said R2 left the facility unauthorized, the nurse ran after him. V30 stated he helped search for R2, he checked at the police station as R2 mentioned earlier during their conversation. He also checked the stores / establishments nearby, it was cold outside, and it was snowy. V30 said he looked inside the business establishment; maybe R2 was seeking for shelter. He said he did not find R2. He said R2 was found after he left the facility. V30 said he received a text message R2 was found around 10-11PM. He said he saw R2 the following day on 1/15/26. R2 regretted running away / eloping because it was very cold that night. V30 stated R2 was outside for too long, it was cold. R2 was not wearing winter coat; he was not wearing appropriate clothes for the weather. On 2/18/26 at 9:25AM, V34 (Physician) was interviewed via phone and said R2 is one of his residents in the facility. He stated he saw R2 but could not remember when; R2 is stable. V34 said he was informed by staff regarding R2's elopement incident on 1/14/26. He said nobody would suspect R2 would elope, it was a spontaneous incident, staff followed him but could catch him. V34 said the resident could leave AMA (against medical advice) with informed consent. He said staff could be compassionate with their needs, listen to their needs / customer needs, and give them reassurance that they would be taking care of in the facility. V34 said elopement usually happens within 2-3 days within their admission. V34 said there was no warning sign of R2's elopement. He said R2 was evaluated in the ER, don't think he needed more medical intervention. V34 said R2 with history of depression, psychiatrist is seeing him. He said this is a learning experience, learning over what else facility can do to prevent this incident from happening again. V34 said listen to the residents, saying we care about you, do not single out resident. He said simple words - helps a lot. V34 said R2 leaving the facility unauthorized during wintertime / cold weather could potentially sustain frost bite and hypothermia. V34 said there was no report of frost bite or hypothermia from the hospital and R2 was able to go back to the facility safely.On 2/18/26 At 9:47AM, V2 (DON / Director of Nursing) said she was on vacation at the time of the incident on 1/14/26. She said she read R2's progress notes and she spoke with V13 regarding the incident. She said R2 was wandering to another resident's room, and she was not aware R2 had attempted to leave the floor / unit prior to elopement on 1/14/26. V2 said she interviewed V13 (nurse on duty) regarding R2's incident on 1/14/26. V13 was passing medication in resident's room and heard CNA saying STOP to R2. V13 (continued on next page)

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	02/20/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediately came out of the room and saw R2 going out by the back door stairwell. She said the alarm went off and V13 ran down the stairs and followed R2, but she lost him because he was running. V13 was not wearing a coat / jacket. V2 said she didn't believe R2 had on proper clothes for the winter. V2 said V13 called ADON while she was still out of the building. When V13 came back to the facility, the CNA started to search for the resident, the administrator, MD, R2's sister, and police were informed. The police found him maybe about 2 hours later and transferred R2 to hospital for evaluation and he came back to the facility. She said V1 (Administrator) picked up R2 in the hospital. There was no hospital records provided during discharge. She said Potential risk of R2's unauthorized departure from the facility, he could sustain hypothermia, frost bite. On 2/18/26 At 10:46AM, V1 (ADMINISTRATOR) stated she has been working in the facility since 2013 as a CNA, she worked her way up and transitioned into an administrator role in 2020. She said on 1/14/26 at 6:30PM, she was at home and received a call from the ADON informing her that the nurse on duty had called her that R2 had left the facility via 2nd floor stairwell and exited back door. She said the nurse was in pursuit of him going down (name) Street. V1 said Elopement Code was initiated so staff members went outside to locate R2. She said some staff were in cars, and some were on foot. V1 said she notified ADON that she was on her way to the facility and instructed them to call the police. She said she started searching the area on her way to the facility, driving around to locate R2. V1 said she had just arrived at the facility when the police called to inform her R2 was found. She said R2 was found just about quarter to half miles away from the facility. V1 said the police informed her they would take R2 to hospital and she told them she would meet R2 at the hospital. V1 said R2 was found about 2.5 to 3 hours after he left the facility unauthorized. She said she went to the hospital and picked up R2, stayed for a while due to R2 still being evaluated in the ER (Emergency Room). V1 said they came back to the facility about 11-11:30PM. She said she drove R2 back to the facility. She said there was no apparent injury when she saw R2 in the hospital. V1 said R2 was wearing sweater with a hood, it was cold outside, and his clothes were not appropriate for the cold weather. She said routine checks or evaluation were done in the ER with no information about frost bites or hypothermia. V1 said R2 left the facility unauthorized, there was no indication that he would elope that day. She said she was not aware R2 had already attempted to leave the facility, and staff was able to redirect him before the elopement incident.R2's Elopement risk review, dated 1/13/26, reviewed and showed: The resident is at risk for elopementR2's Community Survival Skills, dated 1/13/26, reviewed and showed: The resident does not appear to be capable of unsupervised outside pass privileges at this time. Social Service will conduct more assessment to determine resident's community access level.Nursing Progress Note, dated 1/13/2026 18:39, showed: R2 remains alert to self and requires constant redirection due to wandering the halls and entering other residents' rooms.Nursing Progress Note, dated 1/14/2026 23:36, showed: R2 returned from hospital, and asked where he was going and why did he leave? R2 states, he doesn't know where he was going, and he just wanted to get out of here.Care plan, dated 1/18/26, showed: R2 demonstrates movement behavior that may be interpreted as wandering, pacing, or roaming. Symptoms are manifested by: Attempting to leave the facility without a responsible escort (elopement), Pacing, roaming or wandering in and out of peers' rooms., Engaging in theme behavior, believes he/she is in another time & place with specific responsibilities. R2 is an ELOPEMENT RISK.Care plan, dated 1/14/2026, showed : R2 expresses the desire to receive an outside, independent pass. R2 requires the support of a long-term care facility secondary to: A substance abuse disorder. R2's Community Access Level-SUPERVISION. R2 can access the community and patio with family and staff.Police report, dated 1/14/26, showed: Name of person missing: R2. Date / time of occurrence: 1/14/26 at (continued on next page)

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	02/20/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6:30PM.Hospital records, dated 1/14/26, showed: (R2) who is in nursing home for multiple issues stemming from alcoholism. (R2) was admitted to nursing home 2 days ago. This morning, he left nursing home and got confused, asked police to help him and they brought him here. The staff from nursing home also arrived and can take him back. (R2) states he has been walking outside today in shoes without socks and has pain to medial aspect of right foot. On exam he has some callous to right great toe medial and slight skin redness. No sign of infection or frostbite. (R2) was given socks, Tylenol, Flexeril and sent back to nursing home with staff.Facility's elopement binder kept in the reception room reviewed. R2 was included in elopement risk, dated 1/13/2, with R2's picture and face sheet. Facility's policy on Elopement prevention and location of missing residents, dated January 2013, showed: It is the policy of this facility to provide appropriate supervision to each individual. Residents are routinely assessed for cognitive impairment, behavior symptoms or other conditions that may place the person at risk for elopement. Elopement - unauthorized departure from the residence by an individual with cognitive impairment when such behavior is likely to result in some type of harm. Residents identified as being at risk should only leave the facility when accompanied by a responsible individual.