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

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to provide adequate weekend staff for the facility. The facility's weekend short staffing has the potential to affect all 116 residents residing in the facility.Findings Include:On 9/11/25 at 11:30 AM, V15, Assistant Director of Nursing, stated, During the third quarter of April 1,2025 to June 30,2025, the facility was short staff sometimes on the weekends, mainly due to call offs. The nursing staffing schedules are as follows:First floor day, evening and night shift; There is one nurse and two certified nurse assistants [CNA].Second floor day and evening; There is one nurse and four CNA's, night shift one nurse and two CNA's.Third floor day, evening, and night shift; There is one nurse and two CNAs on all shifts.On 9/11/25 at 11:50 AM, V15 the nurse staffing schedules for April to June were reviewed. V15 stated the following:4/5/25: First floor third shift there was one certified aide, [two was needed].4/6/25: First floor third shift there was one certified aide, [two was needed].4/12/25: First Floor second shift was three certified aides [three was needed]. First Floor third shift one certified aide [two was needed].5/10/25: Second floor first shift was three certified aides [four was needed]. First floor, third shift was one certified aide [two was needed].5/11/25 First floor day shift was one certified aide [two was needed], move one of the first-floor aides to the second floor and the first floor was short. Second shift moved one aide to the second floor again but left the first floor short an aide. Second floor, second shift there were three aides [four was needed].5/25/25: Second floor, second shift there were three aides [Four was needed].First floor third shift there was one aide, [there were two needed].6/7/25: Second floor, day shift there was three aides [four was needed].6/14/25: Second floor, second shift there were three aides [four was needed].First floor, third shift there was one aide [two was needed].6/15/25: Second floor, second shift there was three aides [four was needed].First floor, third shift there was one aide, [two was needed].6/21/25: Second floor, second shift there was three aides [four was needed].6/28/25: Second floor, first shift there were three aides [four was needed].First floor third shift was one aide, [two was needed].6/29/25: Second floor, first shift there was three aides [four was needed].On 9/11/25 at 12:01 PM, V15 stated, I move Certified Nurse Assistants around to cover the floors much as possible, due to call offs. During the time period of April 2025 to June 2025 the facility was short staffed 12 times on the weekends.On 9/1125 at 2:24 PM V1 [Administrator] stated, The facility does not have a staffing policy.

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
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to label and date stored food; failed to cover and label open food; and failed prepare food in a clean area. These failures have the potential to affect all 114 residents receiving food prepared for the nursing skilled facility.Findings include:On 9/9/25 at 9:21 AM, during initial kitchen tour with V11 [Dietary Manager], the following items were found in walk-in refrigerator:Observed open plastic bag with undated with open sandwich baggie, cheese, and yogurt. V11 stated, That belongs to an employee. It was not in here earlier; I will remove it. Employee personal items should not be in the walk-in cooler, it potentially could cause cross contamination.On 9/9/25 at 9:30 AM, during initial kitchen tour with V11 [Dietary Manager], the following items were found in walk-in freezer: open uncovered to environment box of turkey breakfast sausage sitting in an open plastic bag with no open nor expiration date. V11 stated, The food is to be covered dated, with a label including an expiration date once the package is opened to prevent cross contamination and possible food borne illness.On 9/9/25 at 9:45AM, V11 [Dietary Manager], surveyor observed the following:Garbage can in the kitchen that was not in use was filled with garbage without lid in the food preparation area. The floor had multiple open drank cartons of milk, napkins, food crumbs, and bread on the floor throughout the kitchen. Two bags of filled garbage was siting on the floor. V11 [Dietary Manager] stated, All garbage cans should always have a lid on. Once the garbage is full of garbage, the staff need to take out the garbage. Garbage cans not covered could potentially cause cross contamination and food borne illness.Policy documents in part:Food Safety and Sanitation dated 2017.Refrigerated food prepared in the healthcare community is labeled with the date to discard or used by date. If opened the food item is labeled with date opened an date which is discard or use by.Labeling and Dating Foods dated 2021.Date the items opened and the date by which the item should be discarded or use by date,

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Put firmly secured handrails on each side of hallways. Based on observation, interview, and record review, facility failed to ensure corridor handrails used by residents are firmly secured on all floors (1st, 2nd and 3rd). These failures have the potential to affect all 116 residents in the facility.Findings include: On 09/10/2025 at 10:26 AM with V12 (Maintenance Manager) on the 2nd floor, a total of 4 handrails were identified as loose. V12 took out brown hard plastic cover using screwdriver to tighten the screws. After placing back the cover, 1 out 3 handrail was still loose upon placing slight pressure. With V12 on the 3rd floor, 4 handrails were identified as loose. V12 took hard brown cover using the same method to tighten the screws. V12 stated that he does not have any documentation that he checked equipment including corridor handrails. Surveyor and V12 went to 1st floor and identified 2 loose handrails, 1 of which cover detached to its base that can easily remove after applying pressure. V12 stated that he checked last Monday but failed to identify loose handrails. All floors occupied by residents were seen to have handrails that are not completely secure.Facility provided Preventative Maintenance Program, dated 07/25, documents purpose to conduct regular environment tours/safety audits to identify areas of concern within the facility. Preventative Maintenance Program will review the following areas during random rounds that includes handrails present and in working conditions.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to a.) ensure physician orders for Advanced Directives were obtained and railed to ensure Advanced Directives were properly documented and accessible for 4 (R1, R8, R11, R12) residents reviewed for advance directives in a sample of 25.Findings Include:1.R1 was admitted to the facility on [DATE], with diagnoses not limited to Nonspecific Abnormal Finding of Lung Field, Pain In Right Leg, Primary Osteoarthritis, Aortic Aneurysm of Unspecified Site, Unspecified Psychosis, Auditory Hallucinations, Encephalopathy, Elevated [NAME] Blood Cell Count, Dysphagia, Pneumonia, Gastrointestinal Hemorrhage, Essential (Primary) Hypertension, Pressure Ulcer of Left Hip, Stage 3, Pressure Ulcer of Left Buttock, Stage 3, Chronic Kidney Disease, Stage 5, Altered Mental Status, Metabolic Encephalopathy, Hypothyroidism, Rhabdomyolysis, Benign Neoplasm of Cerebral Meninges, Acute Respiratory Failure with Hypoxia, Anemia and Schizoaffective Disorder.R1's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) indicate resident is rarely/never understood.Review of R1's Uniform Practitioner Order for Life-Sustaining Treatment (POLST) Form, dated [DATE], documents: CPR (Cardiopulmonary Resuscitation): Attempt cardiopulmonary resuscitation. Full Treatment.Review of R1's Order Summary Report, dated [DATE], has no order for Advanced Directive (Code Status).R1's care plan documents: Focus: Pursuant to resident rights & the individual's desire to retain control & autonomy over his/her health care decisions, the individual has: Executed a FULL CODE/CPR ADMINISTERED. Date Initiated: [DATE] Revision on: [DATE]. Goal: R1 wishes for FULL CODE/CPR ADMINISTERED status as specified in his/her advance directive documents will be honored & clearly delineated in the medical record in compliance with state law, (goal is on-going) Date Initiated: [DATE] Revision on: [DATE]. Interventions: The resident &/or responsible party has been provided a copy of the facility's policy to implement advanced directives, resident's rights to accept or refuse medical or surgical treatment, and at the individual option, formulate advance directives. Date Initiated: [DATE]. Continue to educate the resident about his/her options addressing life sustaining care throughout the stay as long as the individual remains coherent & able to understand this information. Date Initiated: [DATE].2.R8 was admitted to the facility on [DATE], with diagnoses not limited to Functional Dyspepsia, Suicidal Ideations, Chest Pain, Seizures, Gastro-Esophageal Reflux Disease, Vitamin D Deficiency, Schizoaffective Disorder, Pain in Left Lower Leg, Morbid (Severe) Obesity, Lymphedema, Major Depressive Disorder, Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure, Asthma, Polyneuropathy, Polyosteoarthritis, Acute and Subacute Hepatic Failure, Fibromyalgia, Chronic Respiratory Failure with Hypercapnia, Obstructive Sleep Apnea, Overactive Bladder, Localized Swelling, Mass and Lump, Lower Limb, Bilateral and Glycogen Storage Disease.R8's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15, indicating intact cognitive response.Review of R8's Uniform Practitioner Order for Life-Sustaining Treatment (POLST) Form, dated [DATE], documents: CPR: Attempt cardiopulmonary resuscitation. Full Treatment.Review of R8's Order Summary Report, dated [DATE], has no order for Advanced Directive (Code Status).R8?s Care Plan documents: Focus: Pursuant to resident rights & the individual's desire to retain control & autonomy over his/her health care decisions, the individual has: Executed a FULL CODE/CPR ADMINISTERED. Date Initiated: [DATE]. Goal: R8 wishes for FULL CODE/CPR ADMINISTERED status as specified in his/her advance directive documents will be honored & clearly delineated in the medical record in compliance with state law, (goal is on-going) Date Initiated: [DATE]. Interventions: The resident &/or responsible party has been provided a copy of the facility's policy to implement advanced directives, resident's rights to accept or refuse medical or surgical treatment, and at the individual option, formulate advance directives. Date Initiated: [DATE]. Continue to educate the resident about his/her options addressing life sustaining care throughout the stay as long as the (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	individual remains coherent & able to understand this information.3.R11 was admitted to the facility on [DATE], with diagnoses not limited to Seizures, Bilateral Primary Osteoarthritis of Knee, Essential (Primary) Hypertension, Hypothyroidism, Vitamin D Deficiency, Constipation, Insomnia, Hypokalemia, History of Falling, Abnormalities of Gait and Mobility, Unsteadiness on Feet, Muscle Weakness (Generalized), Morbid (Severe) Obesity and Schizoaffective Disorder.R11's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 14, indicating intact cognitive response.Review of R11's Uniform Practitioner Order for Life-Sustaining Treatment (POLST) Form, dated [DATE], documents: CPR: Attempt cardiopulmonary resuscitation.Review of R11's Order Summary Report, dated [DATE], has no order for Advanced Directive (Code Status).R11's Care Plan documents: Focus: Pursuant to resident rights & the individual's desire to retain control & autonomy over his/her health care decisions, the individual has: Executed a FULL CODE/CPR ADMINISTERED. Date Initiated: [DATE]. Goal: R11 wishes for FULL CODE/CPR ADMINISTERED status as specified in his/her advance directive documents will be honored & clearly delineated in the medical record in compliance with state law, (goal is on-going): Date Initiated: [DATE] Revision on: [DATE]. Interventions: The resident &/or responsible party has been provided a copy of the facility's policy to implement advanced directives, resident's rights to accept or refuse medical or surgical treatment, and at the individual option, formulate advance directives. Date Initiated: [DATE]. Continue to educate the resident about his/her options addressing life sustaining care throughout the stay as long as the individual remains coherent & able to understand this information. Date Initiated: [DATE].4.R12 was admitted to the facility on [DATE], with diagnoses not limited to Atrial Fibrillation, Decreased [NAME] Blood Cell Count, Obesity, Bipolar Disorder, Major Depressive Disorder, Insomnia, History of Falling, Muscle Weakness, r Abnormalities of Gait and Mobility and Unsteadiness on Feet.R12's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15, indicating intact cognitive response. Review of R12's Uniform Practitioner Order for Life-Sustaining Treatment (POLST) Form, dated [DATE],documents: CPR: Attempt cardiopulmonary resuscitation. Full Treatment. Review of R12's Order Summary Report, dated [DATE], has no order for Advanced Directive (Code Status).R12's Care Plan documents: Focus: Pursuant to resident rights & the individual's desire to retain control & autonomy over his/her health care decisions, the individual has: Executed a FULL CODE/CPR ADMINISTERED. Date Initiated: [DATE]. Goal: The resident's wishes for FULL CODE/CPR ADMINISTERED status as specified in his/her advance directive documents will be honored & clearly delineated in the medical record in compliance with state law, (goal is on-going): Date Initiated: [DATE]. Interventions: The resident &/or responsible party has been provided a copy of the facility's policy to implement advanced directives, resident's rights to accept or refuse medical or surgical treatment, and at the individual option, formulate advance directives. Date Initiated: [DATE]. Continue to educate the resident about his/her options addressing life sustaining care throughout the stay as long as the individual remains coherent & able to understand this information. Date Initiated: [DATE].On [DATE] at 09:13 AM, V2 (Director of Nursing) stated, If nothing came from the hospital for the resident for a resident's Advanced Directives, they are a full code. The nurse will transcribe the resident as a full code until the family or resident deem, they want to have some type of POLST. There is supposed to be an order in the resident medical record if they are a full code or DNR (Do Not Resuscitate). If the resident doesn't have an order and there is a change in condition, and they (resident) did not come with a POLST form, we would initiate the code process. If a resident is a DNR and the Advanced Directives order is not entered, there is a potential the resident wishes won't be granted. Maybe the resident did not want any lifesaving or intubation; we would not have followed the wishes of the resident and family.On [DATE] at 09:46 AM, V2 (Director of Nursing) stated, The Social Service Department gets the POLST information, and the nurse enters the order.Policy:Titled Advance Directives, dated 07/25, documents: Purpose: To establish guidelines to assure each resident is provided information on advance directives. Policy: It is the policy of this facility to allow the resident or authorized legal representative to make decisions regarding health care as well as refusal of (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	service. Standards: 3. The resident, legal representative, or the individual who has been authorized as the resident's health care representative will be asked if an Advance Directive, as recognized under state law, has been executed. Documentation concerning this inquiry and the individual response shall include the date the entry was made and the individual making this inquiry. This information shall then be included in the resident's medical record in the Social Service Progress notes. 9. A written physician's order is required in response to the resident's Advanced Directive(s). Physician's orders shall be specific and address each Advanced Directive(s). 12. Advanced Directive(s) shall be addressed on the resident's plan of care, physician progress notes, and physician's orders and in Social Service Progress Notes.

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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. 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 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 (Nurse) prepared R1's noon medications. One of the medications was Sucralfate 100 MG / ML (milliliter) oral suspension. V13 stated the order was for 1 gram / 10 ML of Sucralfate. V13 held a medication cup in the air and poured the medication into the medicine cup. The medication when held in the air was at the 10 ML mark; however, when V13 placed the medicine cup on top of the medication cart, the medicine cup read 15 ML. At 12:10 PM, V13 went into the room and told R1 which medications V13 had prepared. V13 was asked to review Sucralfate medicine cup on a flat, stable surface. V13 took out 5 ML and administered 10 ML to R1. 3.On 9/10/2025 at 12:19 PM, V13 prepared medications for R110. V13 did not locate R110's blister pack for Hydroxyzine in the medication cart or medication room. V13 stated V13 administered the last pill from the blister pack in the morning. V13 reordered it from pharmacy via the electronic medical record. V13 then went to R110's room. V13 informed R110 the Hydroxyzine was not in the medicine cup, but V13 had reordered it from pharmacy. V13 informed R110 that pharmacy will deliver it in the evening and R110 will get it during the evening dose. V13 checked 9 in the MAR, and stated V13 will let the oncoming nurse know the medication was not there, but it was reordered. V13 stated R110's medication pass was complete and proceeded to prepare another resident's medications. V13 did not inform R110's physician the medication was not available. 4.R30's ?Order Audit Report' documents: Simethicone Tablet 80 MG Give 2 tablet by mouth three times a day for bloating, give with meals.On 9/10/2025 at 12:32 PM, V13 prepared R30's noon medications. Reading off the MAR on the computer, V13 stated R30 was scheduled to get two Simethicone 80 mg chewable tablets. V13 stated it was a house stock medicine and pulled a bottle of Simethicone on the top right drawer of the medication cart. V13 stated there were two pills left in the bottle, which was exactly how many R30 needed. The bottle read Simethicone 125 MG tablets. V13 was notified of the dosage difference. V13 stated V13 did not notice the dosage difference. V13 searched the medication cart, medication room, and facility stock on the other floors. At 1:12 PM, V13 stated the facility did not have Simethicone 80 MG in the building. V13 stated V13 did administer two pills from the same bottle during morning administration. V13 stated V13did not know the dosage was different. On 9/10/2025 at 11:37 AM, V2 (Director of Nursing) stated the nurses are to administer medications based on the doctors' orders. V2 stated residents' rights with medications include the right patient, right medication, right dosage, right route, and right time. V2 stated nurses have one hour before and one hour after the scheduled time to administer the medications. V2 stated the nurses should reorder medications when they are running low so that there is ample medications and no issues with administration. V2 stated the pharmacy can deliver medications when needed as long as the nurses reorder them. V2 also stated if a nurse holds or does not administer a medication, the nurse is supposed to inform the physician. 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were stored in accordance with professional standards for two of two storage rooms reviewed, and one of two medications carts reviewed for medication storage and labeling.Findings include:On 9/09/2025 at 10:50 AM, V15 (Assistant Director of Nursing) reviewed the third-floor medication cart. V15 stated it contained medications for all 38 residents in the unit. In the second drawer on the left side, the second slot from the left had one white pill with number 211 etched on it. It was loose on the bottom of the drawer and not in its original packaging. There was also another loose white pill on the bottom of the fourth slot with I 125 etched on it. On the right side of the medication cart, the second drawer contained house stock medication bottles. There was a bottle of Loratadine 10 MG (milligram) tablets. The bottle read an expiration date of 02/25 (February 2025). In the same drawer, there was also a bottle of Bisacodyl 5 MG tablets. The expiration month was not legible but it expires in 2025 (/25). At 11:08 AM, V15 stated [V15] could not read the expiration month. V15 stated if we can't read the date, then facility should treat it as expired. On 9/09/2025 at 11:09 AM, V15 reviewed the third-floor medication room. The top left cabinet had multiple house stock medications. There was a bottle of Loratadine 10 MG tablets that expired August 2025 (08/25). There was also a bottle of Oyster Shell Calcium 250 MG tablets that expired July 2025 (07/25). The medication refrigerator had four 8-oz (ounce) nutritional supplement drinks. They were next to a box of Bisacodyl suppositories and insulin pens. On 9/09/2025 at 2:27 PM, V5 (Nurse) stated there were 38 residents on the first floor. At 2:37 PM, V5 reviewed the first-floor medication room. The medication refrigerator had two 8-oz nutritional supplement drinks. They were near suppositories and insulin pens.On 9/10/2025 at 11:33 AM, V2 (Director of Nursing) stated all nurses are responsible for their own medication carts and rooms, but the Sunday night-shift nurses are primarily responsible for checking them. V2 stated the Sunday night-shift nurses are supposed to look for loose pills and expired medications. V2 stated all nurses can do it, but it is a designated role for Sunday nights. On 9/11/2025 at 9:11 AM, V2 stated only medications should be stored in the medication fridge.Facility's ?Medication Administration Policy' (8/15) documentst: Expired medication may not be administered to the resident. Return the medication to the pharmacy for a new supply. Facility's ?Medication Disposal Policy' (2/14) documentst: Most non-controlled substances will be returned to pharmacy. Facility's ?Medication Storage' and ?Medication Disposal Policy' were not specific about protocols/procedures regarding medications not in original packaging and keeping only medications in the medication refrigerator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Park View Rehab Center	5888 North Ridge Chicago, IL 60660

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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 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.

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	145765	A. Building B. Wing	09/12/2025

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on observation, interview, and record review. the facility failed to provide sufficient notification of SNF - ABN (Skilled Nursing Facility - Advance Beneficiary Notice) and NOMNC (Notice of Medicare Non-Coverage) to 3 out of 3 residents (R19, R98 and R112). These failures affect 3 residents (R19, R98 and R112) in exercising their rights and options afforded by notification procedure.Findings include: On 09/10/2025 at 12:28 PM, the facility submitted the following information to residents discharged within the last six (6) months that includes R19, R98, and R122: R19 remained in the facility. Medicare Part A skilled services episode start date: 08/01/2025. Last covered day of Part A service: 08/29/2025. R98 remained in the facility. Medicare Part A skilled services episode start date: 06/03/2025. Last covered day of Part A service: 09/10/2025. R122 discharged to home. Medicare Part A skilled services episode start date: 03/30/2025. Last covered day of Part A service: 05/30/2025. R19's, R98's, and R122's SNF-ABN and NOMNC were not signed by residents for the same reason; refused to sign due to paranoia. All forms (SNF-ABN and NOMNC) of R19, R98, and R122 were signed and witnessed by V7 (Restorative Nurse/MDS Coordinator) and V18 (Psychiatric Rehab Services Director/PRSD). On 09/10/2025 at 12:56 PM, V7 stated confirmed he and V18 signed all SNF-ABN and NOMNC forms. V7 stated it was V18 who explained to residents regarding notification of SNF-ABN and NOMNC. V7 stated he does not know much about insurance. On 09/10/2025 at 1:13 PM, V18 (PRSD) stated, NOMNC is provided at least 2 to 3 days before resident discharged to therapy or Medicare part A. After discharged to Medicare part A, it will basically stop covering therapy. Notice is given 2 to 3 days early to let resident appeal. I have no documentation under Social Service notes that education was provided to R19, R98, and R122. Paranoia means a resident fear, 'it may be because of fear of signing.' V18 stated by not signing of notices (SNF - ABN (Skilled Nursing Facility - Advance Beneficiary Notice) and NOMNC (Notice of Medicare Non-Coverage), residents will not be able to avail their options provided by those notices. On 09/10/2025 at 2:57 PM, R19 was seen in her room, after seeing both (SNF - ABN (Skilled Nursing Facility - Advance Beneficiary Notice) and NOMNC (Notice of Medicare Non-Coverage) forms. R19 stated, I don't even know what that is, my identity was stolen. R19 look at both forms multiple times but was unable to recognize either form. On 09/10/2025 at 3:05 PM in the dining room, after seeing both forms (SNF - ABN (Skilled Nursing Facility - Advance Beneficiary Notice) and NOMNC (Notice of Medicare Non-Coverage), R98 stated, I don't know what that is. As long as I am covered with Medicare and Medicaid, I will be all right. CMS-10123 Form Instructions for Notice of Medicare Provider Non-Coverage documents a Medicare provider must give a completed copy of this notice to beneficiaries receiving services from skilled nursing facilities (SNFs). Providers will note that the notice must be validly delivered. Valid delivery means that the beneficiary must be able to understand the purpose and contents of the notice in order to sign for receipt of it. The beneficiary must be able to understand that he or she may appeal the termination decision. If the beneficiary is not able to comprehend the contents of the notice, it must be delivered to and signed by a representative. CMS-10095 Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) documents a Medicare health provider must give an advance, completed copy of the Notice of Medicare Non-Coverage (NOMNC) to enrollees receiving skilled nursing. The notice must be validly delivered. Valid delivery means that the enrollee must be able to understand the purpose and contents of the notice in order to sign for receipt of it. The enrollee must be able to understand that he or she may appeal the termination decision. If the enrollee is not able to comprehend the contents of the notice, it must be delivered to and signed by a representative.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to ensure qualified personnel submit an accurate Level I PASRR (Pre-admission Screening and Resident Review) assessment for one resident (R7) out of a total sample of 25 residents.Findings include:R7's admission Record documents diagnoses of post-traumatic stress disorder (PTSD) (onset 9/04/2015), anxiety disorder (onset 11/03/2011), and alcohol dependence (onset 11/03/2011).R7's 4/14/2022 ?Illinois PASRR Level I Form' does not include R7's diagnosis of PTSD. The ?Level I Attestation and Signature' box documents V17 (Office Tech / former Assistant Administrator) filled out the form. The ?Level I Attestation and Signature' box documents: By checking this box, I attest that I have reviewed all information contained herein and that I take responsibility for the completeness and accuracy of information reported throughout this submission. I attest that I am a health care professional working in a clinical capacity for this provider. I understand that approved submitters include clinical professionals such as nurses, [Licensed Practical Nurses], social workers (with a [Bachelor of Science] degree or higher), physicians, or home health agency clinical staff. Social service staff are not required to be licensed to submit information. I understand that administrative staff are not permitted to submit clinical information to [company name retracted].I understand that Illinois PASRR considers knowingly submitting inaccurate, incomplete or misleading Level I information to be Medicaid fraud, and I have completed this form to the best of my knowledge.On 9/10/2025 at 3:06 PM, V17 stated V17 has done residents' PASARRs in the past, including R7's form, but now V18 (Psychiatric Rehabilitation Services Director) primarily does them. When asked about qualifications, V17 stated V17 was the former Assistant Administrator. V17 stated V17 was not licensed, was not a Social Worker, and was not clinical in any capacity. On 9/10/2025 at 3:10 PM, V18 stated filling out the PASRR Level I Form involves inputting the resident's demographics, diagnoses, medications, and behaviors like hallucinations, delusions, or suicidal ideations. V18 stated it also involves reviewing the resident's history and physical from the doctors' progress notes and care plans to input all the necessary information in the form. V18 stated if a resident has a diagnosis of PTSD, it should be documented on their PASRR Level I Form. Facility's ?Pre-admission Screening and Resident Review (PASRR)' policy documents: It is the policy of this facility to comply with Federal, State and the appointed screening agency, [company name retracted], in standards addressing the PASRR assessment/screening process.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow policy for self-urethral catheterization on obtaining physician order and failed to provide documentation a urinary catheter was being changed for 1 out of 1 resident (R5) for a total sample of 25 residents. R5 is [AGE] years old, initially admitted on [DATE]. R4 medical diagnosis includes paraplegia, flaccid neuropathic bladder, and neuromuscular dysfunction of the bladder. On 09/09/2025 at 11:28 AM, R5 was seen in his room sitting on his bed. In front was his wheelchair with the urinary catheter bag attached. R5 was alert and verbally able to express thoughts well. R5 has a BIMS (Brief Interview for Mental Status) score of 15 on last MDS review, dated 07/30/2025, which indicates resident cognition is intact. R5 said, I change my own catheter, somebody taught me when I was on the street. R5 pointed to the box full or urinary catheter supplies including urinary catheter. On 09/11/2025 at 10:54 AM, V2 (Director of Nursing) clarified R5 has a urinary catheter to correct physician order written on R5's record. Physician order documents (urinary catheter), suprapubic, Condom catheters. V2 stated R5 has (urinary) catheter. V2 stated R5 is able to change (urinary) catheter. Requested to V2 that V2 provides physician order, assessment, care plan for self-performance of urinary catheter, and policy on changing urinary catheter. On 09/11/2025 at 01:12 PM, V2 stated R5 does not have physician order to perform self-catheterization. V2 said, I cannot remember when (R5) started performing self-catheterization. V2 stated there is no documentation for physician order or clinical notes R5's urinary catheter was being changed. Self-Urethral (Intermittent) Catheterization policy, dated 05/14, reads, physician ordered self-catheterization is considered a clean rather than sterile procedure. Urinary catheter insertion kit (size ordered by physician). Resident will be provided with a sterile catheter every 24 hours. Licensed nurse will assess the resident's tolerance and assist in resolving needs. V2 stated that this is the only policy for self-catheterization.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess and provide a plan of care for the use of enteral feeding and failed to ensure a resident received enteral nutrition feedings via G-tube per physician orders for 3 out of 3 residents (R4, R60, R95) out of a total of 25 residents reviewed for enteral feeding. Findings include: 1.R4 [AGE] years old, initially admitted on [DATE]. R4 medical diagnosis includes encounter for attention to gastronomy as primary diagnosis, dated 11/30/2023. V23 dietary notes, dated 01/23/2025, documents R4 is consuming 76% of all meals per review. V23 recommend hold enteral feeding. Diet order: general/regular diet, regular texture, thin consistency. R4 feeds self with set up and occasional assistance. By mouth intake more than 76%. On 09/09/2025 at 10:53 AM, R4 was seen in her room. R4 showed her gastronomy tube. R4 said, Tube feeding needs to be cut off. I am tired of this thing. On 09/11/2025 at 09:46 AM, V2 (Director of Nursing) stated R4 does not use tube feeding for nutrition purposes. V2 stated R4 eats by mouth and does not use G-Tube (gastronomy tube). V2 stated the only thing R4 uses her gastronomy tube for is medication administration. V2 said R4 refuses her medication; that is the reason the gastronomy tube is necessary. V2 was asked if there was an assessment or care plan to address the concern on refusal of medication. V2 stated she is not sure if there was a care plan or assessment. V2 said, I have to look it up. On 09/11/2025 at 9:52 AM, V23 (Registered Dietitian) stated G-tube feeding of R4 was put on hold because R4 is obese. V23 stated, Right now it is not necessary because (R4) put on some weight. Super-stable weight. V23 state the last time R4 was assessed was on January 23, 2025. V23 stated R4 currently is on no concentrated sweet (NCS) regular thin liquid diet. V23 said, She can tolerate a regular diet. V23 said, Tomorrow we will have a meeting; we will decide going forward. V23 stated since R4 weight remains stable, it is only necessary to have enteral feeding if medication is being refused. On 09/11/2025 at 1:12 PM, V2 stated there is no care plan for R4 refusing medication by mouth. V2 said, I cannot find a care plan that (R4) is refusing medication to show it is necessary to have G-tube. I will check if we have policy regarding medical necessity to have G Tube. V2 stated there is no policy related to determination of necessity for resident to have enteral feeding. V2 provided procedures on gastronomy site care and tube feeding related to infection prevention. 2. On 09/09/2025 at 12:10PM, V6 (Licensed Practical Nurse/LPN) states she has been working at the facility for approximately 1 week and is orientating under V19's (LPN) preceptorship. R60's physician order sheet/POS, documents, Glucerna 1.2 @ 65 cc hr. x 18 hr. 1200- 0600 start date 09/02/2025. R60's care plan documents, Provide diet as ordered. Infuse feeding as ordered on the POS. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/09/2025 at 12:12PM, V19 (LPN) states he has been working at the facility for approximately 9 years, and has 2 residents (identified as R60 and R95) who require g-tube feedings. V19 states he usually starts the g-tube feedings for both residents around 12:00PM every day. On 09/09/2025 at 1:09PM, R60 was lying in bed in her room in a supine position with head of bed elevated at 45 degrees. An enteral feeding pump adjacent to R60's bed. Enteral feeding pump observed turned off, and R60's enteral tube feeding or tube feeding equipment was not seen. On 09/10/2025 at 1:20PM, R60 was lying in bed in her room. An enteral feeding pump adjacent to R60's bed. Enteral feeding pump was observed turned off and R60's enteral tube feeding or tube feeding equipment was not seen. 3.R95's POS documents, Jevity 1.5 at 65 cc/hr. x 20 hours up at 1200pm off at 8am. R95's care plan documents, Infuse feeding as ordered on the POS. On 09/10/2025 at 1:17PM, R95's enteral feeding container was labeled as follows: Jevity 1.5 1000ml dated 09/10/2025 at 12:00PM and rate of 65ml per hour. R95's enteral feeding pump observed with a rate of infusion set to 75ml/hour; enteral feeding was infusing. On 09/10/2025 at 1:23PM, V13, Registered Nurse/RN, stated she is responsible for caring for R60 and R95 today. V13 was asked about R60's enteral feeding scheduled start time. V13 stated she believes R60's enteral feeding is scheduled for a start time of 2:00PM. V13 was made aware of R95's enteral infusion rate on the feeding pump. V13 stated she programmed R95's enteral feeding pump, but must have put the incorrect infusion rate. V19, Licensed Practical Nurse/LPN was then observed decreasing the infusion rate on R95's enteral feeding pump to 65ml/hour. V13 stated if R95's enteral feeding is not infused per physician's orders, there is a chance R95's enteral feeding can infuse too fast and cause her to become too full or to aspirate. On 09/10/2025 at 1:29M, V13 was observed at the nurses' station with R60's electronic health record/EHR on the computer. V13 stated R60's enteral feeding order documents R60's feeding should be infusing every day from 12:00PM-6:00AM. V13 stated if R60's enteral feedings are not infused per physician orders, R60 could potentially not have her nutritional needs met and then lose weight. Facility's policy, undated, titled Physician Orders documents, 2. Any orders given by Physician are carried out.