

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/30/2018
--------------------------------------------------	---------------------------------------------------------------------	-----------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER PARK VIEW REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5888 NORTH RIDGE CHICAGO, IL 60660
------------------------------------------------------------	--------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

S 000	Initial Comments Complaint Investigation : #1886583/IL106369 #1886796/IL106607	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 300.3240f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

11/27/18

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/30/2018
--------------------------------------------------	----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER PARK VIEW REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5888 NORTH RIDGE CHICAGO, IL 60660
-------------------------------------------------------------------	----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

S9999	<p>Continued From page 1</p> <p>each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)</p> <p>These requirements were not met as evidenced by:</p>	S9999		
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/30/2018
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER PARK VIEW REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5888 NORTH RIDGE CHICAGO, IL 60660
-------------------------------------------------------------------	----------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

S9999	<p>Continued From page 2</p> <p>Based on interview and record review, the facility failed to follow their Abuse Prevention Policy in not preventing a physical altercation resulting in allegation of physical abuse for two residents (R1, R2) of three residents reviewed for abuse. This failure resulted in one resident (R2) sustaining a left lateral tibial plateau fracture requiring hospitalization.</p> <p>Findings Include:</p> <p>R1 is a 47 year old resident with diagnoses of, but not limited to schizophrenia, major depressive disorder, and hypertension.</p> <p>R2 is a 61 year old resident with diagnoses of, but not limited to dementia, schizophrenia, hypertension, and arthritis.</p> <p>The facility Final Incident Report sent to IDPH (Illinois Department of Public Health) dated 10/10/18 documents on 10/3/18 at 8:33 AM a physical altercation took place between two residents (R1, R2). R1 was the aggressor, R2 was sent to the hospital for evaluation and it was determined that R2 required treatment for a left knee fracture.</p> <p>10/3/18 at 8:51 by V8 LPN (Licensed Practical Nurse) Progress Note: Resident was hit by another resident ; immediate intervention was done resident; neurological checks initiated - no loss of consciousness and remains at baseline orientation; VS (vital signs) BP (blood pressure)= 98/70 ; P(pulse)=82 ; T= 96 Oxygen Saturation= 95% . Head to toe assessment with ROM (range of motion) impaired to Left Knee with c/o pain in attempt to assess - area immobilized, Emergency medical services (911) activated and arrived to</p>	S9999		
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/30/2018
--------------------------------------------------	---------------------------------------------------------------------	-----------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER PARK VIEW REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5888 NORTH RIDGE CHICAGO, IL 60660
------------------------------------------------------------	--------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

S9999	<p>Continued From page 3</p> <p>transport to hospital via stretcher. MD paged; DON and Administrator aware; Guardian called back . Resident was sent to St. Frances Hospital. Will follow up for resident status .</p> <p>On 10/26/18 at 11:30 AM, R2 stated: " I was walking down the hall, R1 bumped into me, I said "watch where you are going." I don't remember after that. I do remember being on the ground, R1 kicked me. I don't remember who came to help, I don't remember much."</p> <p>On 10/26/18 at 1:00 PM R1, stated through interpreter V9 ,Physician Assistant (PA), they bumped each other. R2 tried to hit me, I was trying to defend myself and R2 fell. R2 got in my way, they started to fight. I hurt my wrist a little, ok now.</p> <p>On 10/25/18 at 2:20 PM, V7 ,Restorative Aide, stated : "They (R1, R2) passed me in the hall, I turned back around, they were swinging their fists at each other. R1 hit first. I was holding R1 and R1 got away and hit R2 again and R2 fell. I told the receptionist to call a code. V5, Social Service Director, came after R2 fell. The nurse came and assessed R2."</p> <p>On 10/25/18 at 2:00 PM V1, Administrator/Abuse Coordinator, stated; " It happened on the first floor just past the Nursing Station. I was coming through the entrance, they were walking side by side from the Dining Room. R1 crossed over in front of R2 and R2 said f*** you. R1 hit R2 in the lip then R2 fell down into the shower room. We kept R2 down on the floor until the nurse came. They were both sent out for evaluation."</p> <p>On 10/25/18, V5, Social Service Director, stated; " I was in the first floor Conference Room, I</p>	S9999		
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002315	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/30/2018
--------------------------------------------------	---------------------------------------------------------------------	-----------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER PARK VIEW REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5888 NORTH RIDGE CHICAGO, IL 60660
------------------------------------------------------------	--------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

S9999	<p>Continued From page 4</p> <p>heard a commotion, R2 was on the floor, R1 was on top of R2, hitting him. We separated them. I had another Social Service staff sit with R1 in his/her room. R1 was always on a 1 on 1 until sent out to the hospital. Since July (2018), when I started, R2 has not shown any physical aggression. There were no verbal behaviors for either. R1 did have some physical aggressiveness before July, earlier this year. R1 is in the smoking cessation, symptoms behavioral management and social skills groups. R1's attendance is sporadic. R1 does get one to one counseling when he/she doesn't attend group."</p> <p>The facility Abuse Prevention Policy documents; This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals.</p> <p>Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish to a resident. Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.</p> <p>(B)</p>	S9999		
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--