STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´c		(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		IL6007231	B. WING		02/2	, 8/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PARKVIE	W HOME - FREEPOR	?T	TH PARK BO RT, IL 61032			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Z 000	COMMENTS		Z 000			
	Facility Reported In	cident of 2/20/25/IL187263				
Z9999	FINDINGS		Z9999			
	Statement of Licens	sure Violations:				
	300.610a) 300.1020a) 300.1020b) 300.1210b)					
	Section 300.610 R	esident 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 300.1020 (Policies	Communicable Disease				
		comply with the Control of eases Code (77 III. Adm. Code				
	as having any common infectious disease,	s suspected of or diagnosed municable, contagious or as defined in the Control of eases Code, shall be placed in				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6007231	B. WING			C 28/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
PARKVI	EW HOME - FREEPOF	? T	UTH PARK BO RT, IL 61032	DULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
Z9999	isolation, if required Control of Communifacility believes that necessary infection initiate an involunta pursuant to Article I Section 300.620 of whether a transfer oburden of proof research section 300.1210 (Nursing and Person b) The facility shall and services to attapracticable physical well-being of the reeach resident's complan. Adequate and care and personal or resident to meet the care needs of the resident to ensure transmission based exhibiting respirator and failed to ensure transmission based required personal presidents (R1, R2, I based precautions). The findings included 1. R1's face sheet seems and the control of the control	I, in accordance with the nicable Diseases Code. If the tit cannot provide the control measures, it must ry transfer and discharge II, Part 4 of the Act and this Part. In determining or discharge is necessary, the ts on the facility. General Requirements for nal Care provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with aprehensive resident care I properly supervised nursing care shall be provided to each total nursing and personal esident. Tas NOT MET as evidenced fon, interview, and record ailed to immediately initiate I precautions for residents ry illness signs and symptoms a visitor to a room with I precautions was wearing the protective equipment for 3 of 3 R3) reviewed for transmission in the sample of 6.	Z9999			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			ATE SURVEY DMPLETED	
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		IL6007231	B. WING		02/2	8/2025	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
PARKVII	EW HOME - FREEPOI	₹ T	TH PARK BO RT, IL 61032				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
Z9999	Continued From pa	age 2	Z9999				
		nnxiety disorder, vascular onic atrial fibrillation.					
		5 Physician Order Sheet ecautions were in place as of					
	On 2/28/25 at 9:18 AM, the signage on R1's door showed, "Stop. Everyone must clean their hands before entering and when leaving room." The sign showed R1 was on droplet precautions and anyone entering the room should make sure their eyes, nose and mouth were fully covered.						
	On 2/28/25 at 10:47 AM, V10 (R1's visitor) was telling R1 goodbye. The door to R1's room was partially open. V10 was observed wearing only a surgical mask (no gown, gloves, face shield, or goggles were on). V10 had on a pair of reading glasses, however, there were not side shields on the glasses. V10 was asked about the signage on R1's door, and if she had worn a gown, gloves, face mask, face shield or goggles. V10 said no one in the facility has ever said anything to her about needing to wear any additional PPE (personal protective equipment) when visiting R1. V10 said she comes into the facility every day to visit R1 and usually stays about an hour. V10 said staff have come into the room while she was in visiting with R1 and no one mentioned anything about PPE.						
	Practical Nurse) sa room with just a su visitors should be v isolation rooms bed infection by touchir	6 AM, V3 LPN (Licensed hid she saw V10 exiting R1's rgical mask on. V3 said exearing PPE when going into cause they can spread the hig surfaces in the environment door knobs, and elevator					

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
			A. BUILDING:		С	
		IL6007231	B. WING			, 8/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Z9999	Continued From pa	ige 3	Z9999			
	a surgical mask wh 2. R2's face sheet s facility on 5/14/24 v cardiac arrhythmia, localized edema, a	O AM, R1 said V10 only wears ten she comes to see her. showed he was admitted to the with diagnoses to include long term anticoagulant use, and congestive heart failure. ment dated 9/11/24 showed to impairment.				
	R2's Nursing Note dated 2/21/25 at 8:42 AM showed, "Resident with non-productive cough, resident spontaneously put himself in wheelchair this AM to come out to breakfast instead of walking Rapid covid test was negative. Received order for portable chest x-ray"					
	showed, " 02 sats nasal cannula. Res weaker and needed his wheelchair, and Occasional non-pro	dated 2/21/25 at 7:53 PM s 95% with oxygen therapy per ident ate in his room. He is d help with two assist to get to with bathroom care. Eductive cough noted. Chest cults were faxed to the NP"				
	showed, "[R2] remarkable all of his lunch & br	dated 2/23/25 at 1:13 PM ained in his room today. He ate eakfast. I did not hear him eeps the head of his bed up"				
	showed, "Resident	dated 2/24/25 at 1:03 PM continues with intermittent neals in his room. Respiratory				
		Infection Note dated 2/24/25 R2's respiratory panel swab uenza A.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		(X3) DATE COMF	SURVEY PLETED
			A. BOILDING.			C
		IL6007231	B. WING			28/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PARKVI	EW HOME - FREEPOR	₹Т	TH PARK BO RT, IL 61032			
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Z9999	R2's medical recomprecautions were sthe onset of his rest the facility on 3/19/2 chronic kidney dise incontinence, and a facility assessment has no cognitive im R3's Nursing Note showed, "Resident lack of appetite, fat negative. Received x-ray" R3's Nursing Note showed, "[R3] stayed appetite. Cough noted only a she is afebrile. [R3' just does not feel were want anything for hencouraged to drin [R3] stayed in her recliner most R3's Nursing Note showed, "Resident meals, using call lig continues to feel "using call lig continues to feel "using call lig continues to feel "using call stayed in her reals, using call lig continues to feel "using call lig continues to feel "using call stayed in her reals, using call lig continues to feel "using call lig continues to feel "using call stayed in her reals, using call lig continues to feel "using call stayed in her reals, using call lig continues to feel "using call stayed in her reals, using call lig continues to feel "using call stayed in her reals, using call lig continues to feel "using call stayed in her reals, using call stayed in her reals, using call lig continues to feel "using call stayed in her reals, using call stayed in her reals, using call lig continues to feel "using call stayed in her reals, using	d showed Isolation started on 2/24/25 (2 days after piratory symptoms). showed she was admitted to 24 with diagnoses to include case, hypertension, urinary acute kidney failure. R3's dated 11/20/24 showed she apairment. dated 2/21/25 at 9:37 AM with productive cough this AM, igue Rapid Covid test order for portable chest dated 2/22/25 at 1:20 PM ed in bed until after lunch, poor after she sat up in her recliner, so only complaint is that she well." dated 2/23/25 at 1:08 PM has a cough and is throat today. She does not er sore throat, she is k. Her appetite remains poor oom again today, but was up to f the shift" dated 2/24/25 at 1:00 PM tremains in her room for ght appropriately. Resident approductive cough.	Z9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
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		IL6007231	B. WING		02/2	8/2025	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
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	T		RT, IL 61032				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
Z9999	Continued From pa	ge 5	Z9999				
	PM showed R3's respiratory panel swab was positive for Influenza A. R3's medical record showed Isolation						
		tarted on 2/24/25 (2 days after spiratory symptoms).					
	Nursing) said, "R1, isolation precaution flu season resident and symptoms sho influenza, COVID, cout. Visitors should (personal protective the resident's room mask, gloves, gown with side shields so and spread the viru and the building. The door regarding her haven't heard anyth Usually if there are control policies the usually the one that was not aware of [F symptoms until I call have been kept in the isolation to prevent other residents. The have notified a nurs respiratory symptoms.						
	The facility's undated policy and procedure titled Infections Control Policy and Procedure as Based on CDC Guidelines showed, " A. Transmission based precautions will be used on all residents known or suspected to be infected or colonized with pathogens that can be transmitted by droplet, contact, or airborne b. Droplet precautions are						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	· · · · · · · · · · · · · · · · · · ·		TE SURVEY MPLETED	
			A. BUILDING:				
		IL6007231	B. WING		02/2	: 8/2025	
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	W HOME EBEEDOE	1234 SOU	TH PARK B				
PARKVIE	W HOME - FREEPOF	FREEPOF	RT, IL 61032				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
Z9999	Continued From pa	ge 6	Z9999				
29999	used in addition to a residents with a know spread by respirator secretions from the passages generate sneezes, laughs family and resident document in nurses post a stop sign on the required isolation side The charge reprecautions need to the facility's policy date of August 2009 Influenza Outbreak index of suspicion flicensed nursing standard by when suspicion of there is an influer measures should be the considered an outborse of suspicion flicensed nursing standard by when suspicion flicensed nursing standard by when suspicion flicensed nursing standard by the same sures should be the considered an outborse of suspicion flicensed nursing standard by the suspicion flicensed nursing standard by the suspicion flicensed nursing standard by the suspicion flicensed in a Long Toonsidered an outborse of suspicions for the suspicion flicense fli	standard precautions for own or suspected pathogen ry secretions. Droplets are oral, nasal, and respiratory d when the resident coughs, 3. Charge nurse will notify of need for precautions and a notes 5. Charge nurse will the resident's door which has on printed on the reverse nurse will also notify staff what to be followed" and procedure with revision 9 showed, "Control of s 3. when there is a high for influenza outbreaks, the aff will prepare to perform The licensed nursing staff will a nasal swab for Influenza A ion of influenza is present 4. In a outbreak, the following taken to limit transmission med influenza by any testing form Care Facility is typically reak) Implement Droplet residents with suspected or	29999				

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