

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0051516		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/17/2025	
NAME OF PROVIDER OR SUPPLIER FOREST VIEW REHAB & NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 535 SOUTH ELM , ITASCA, Illinois, 60143			
(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) COMPLETION DATE	
S0000	Initial Comments		S0000			11/21/2025	
	Complaint Investigations 25710889/2662241, 25710877/2662158						
S9999	Final Observations		S9999			11/21/2025	
	Statement of Licensure Violation:						
	300.610a)						
	300.1210b)						
	300.1210c)						
	300.1210d)6)						
	300.1220b)3)						
	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.						
	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 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						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a resident with a history of elopement was appropriately assessed and/or monitored to prevent elopement, failed to identify and assess residents who actively seek exits or display elopement behaviors, failed to ensure all exit doors/windows were secured/monitored, failed to promptly/effectively respond to triggered door alarms and perform a resident head count, and failed to maintain a current list of residents at risk for elopement at the front door exit per facility policy and resident care plans.	S9999					

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S9999	Continued from page 2 This failure applies to 10 of 10 residents (R1-R10) reviewed for elopement in a sample of 10. The findings include: 1. Face sheet, printed 11/13/25, shows R1 was admitted to the facility on 10/7/25 and R1's diagnoses included an unspecified injury of the head, mild cognitive impairment, chronic kidney disease stage 3, congestive heart failure, dysphagia, unsteadiness on feet, weakness, need for assistance with personal care, and cardiac pacemaker. Pre-admission hospital records, dated 10/7/25, shows R1 left his assisted living facility alone at 4:00 AM with a cart and then hit his head against a concrete wall. The note shows R1 was seen by psychiatry during his hospitalization who deemed R1 to be lacking in decisional capacity. Hospital Record Psychiatry Consult Note, dated 10/5/25, shows, "[Patient] presently lacks medical decision-making capacity. He is fully oriented at time of evaluation but is unable to discuss anything about treatment or disposition plan for him since he's been in the hospital. He has poor insight and does not have an appropriate understanding of his limitations in his ability to care for himself independently and believes that he can care for himself completely independently, expressing desire to go to work on a farm in southern Illinois. Patient unable to appropriately discuss his chronic medical issues or the medications he typically takes. He denies having been diagnosed with anything psychiatrically though his friend reported past [diagnosis] of bipolar disorder. Patient is tangential and hyperverbal during evaluation... Suspect mild cognitive decline/early dementia.... Patient has primary neurocognitive disorder...." Facility Wander Risk Assessment, dated 10/14/25, shows R1 was at high risk for wandering. Elopement risk assessment dated 10/7/25 and completed by V5 (LPN- Licensed Practical Nurse), shows R1 was assessed as not exhibiting wandering or pacing behaviors, as having the ability to be mobile without assistance from staff, and as having no history of elopement in the prior three months. On 11/7/25 at 11:02 AM, V5 (LPN – Licensed Practical Nurse) stated on 10/12/25 at approximately 9:30 PM R1 packed all his belongings, placed them by the locked exit of the memory care unit, and stated he wanted to	S9999					

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S9999	Continued from page 3 leave. V5 stated he attempted to redirect R1 but was unable to do so. V5 stated he called R1's physician and obtained an order for Haldol to calm R1 down but R1 remained upset he was on the memory care unit and wanted to leave. V5 stated he reported the incident to V2 (Director of Nursing) and V16 (Assistant Director of Nursing) as well as the next shift nurse V6 (RN-Registered Nurse). Progress notes, dated 10/12/25 and written by V5, show R1 attempted to elope after packing his belongings and putting them by the door of the locked memory care unit. The note shows R1 was provided a new order for Haldol as needed due to agitation and sitting at the nursing station with all of his belongings. Behavior Monitoring records, dated 10/12/25, failed to show R1 had any wandering or elopement behaviors. On 11/7/25 at 1:28 PM, V6 (Registered Nurse) stated she was notified at approximately 12:30 AM on 11/5/25 by V10 (CNA) that R1's window was open, R1's window lock was removed, and the window could open 1.5 feet. V6 stated there were sheets tied into a rope with knots and one end of the sheet rope was attached to the foot of the bedside drawer which was located close to the open window. V6 stated the rope of sheets led to the ground. V6 stated R1's personal possessions were removed from the room and there were pillows placed under R1's bed linens resembling a body sleeping in the bed. V6 stated there were no alarms alarming in the facility at the time she observed R1 was no longer in his room. V6 stated she was not aware that R1 had a history of elopement from his prior facility or that he attempted to elope from the facility on 10/12/25. On 11/7/25 at 7:48 AM, V15 (Police) stated the police were notified on 11/5/25 at 12:38 AM that R1 was missing from the facility. V15 stated a search was initiated, including 10 bloodhounds and 2 drones, and R1 was tracked to a local train station. V15 stated he had no further leads as to R1's whereabouts. Video footage of R1's elopement, dated 11/4/25 at 10:23 PM, shows R1 climbing down the side of the facility utilizing bed sheets and carrying belongings. The video shows R1 walked north in the courtyard until out of sight and then did not reappear in any of the cameras. On 11/6/25 at 12:37 PM, V9 (Dementia Care Coordinator) stated R1 removed the left window lock to exit the window when he eloped. V9 stated he witnessed a screw sitting near the window and sheets wadded up on the windowsill when he arrived the next morning. V9 stated		S9999				

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S9999	Continued from page 4 he was unaware of R1's prior attempts to elope until 11/5/25 when staff informed him R1 packed his belongings and attempted to leave through the locked unit door. On 11/10/25 at 2:04 PM, V11 (Maintenance) stated on 10/21/25 he received a text from a nurse asking V11 to replace R1's missing right window lock early in the morning V11 stated he replaced the right lock and ensured the left lock was in place on the window. V11 stated he was not aware R1 eloped from his prior facility and if he were aware, he would have spoken with V1 and V3 regarding the missing window lock in R1's room to request more supervision for R1. On 11/7/25 at 12:59 PM, V3 (Social Services Director) stated she was not aware of any prior attempts by R1 to elope from the dementia unite including R1's 10/12/25 attempt to leave the unit. V3 stated R1 was never placed at risk for elopement and was never placed in the elopement binder located at the reception desk and never received an electronic wander guard. On 11/6/25 at 1:28 PM, V14 (VP Clinical), V10 (Consultant) and V1 (Administrator) stated R1 was not considered an elopement risk while at the facility and was never included in the facility elopement binder provided to the receptionist. On 11/7/25 at 10:50 AM, V1 stated R1 was found at the assisted living facility in which R1 resided prior to living at the current facility. On 11/7/25 at 11:16 AM, V15 (Police) stated when he found R1 in the parking lot of R1's prior assisted living facility, R1 was disoriented and was sent to the hospital. Hospital records, dated 11/7/25, show "...feet are dirty from being on the road for the last 2 days. Reportedly jumped out of a second story window to escape his living facility, though he used bedsheet to let himself down. Per external chart review, was seen by psychiatry last month, deemed to be non-decisional and thus was placed in this facility." On 11/6/25 at 11:10 AM, V1 (Administrator) stated he did not file a reportable incident because there had not been any reports of injury to R1. 2. Elopement risk binder located at the front door reception desk of the facility, observed on 11/6/25, 11/7/25, 11/10/25, showed only 6 residents, (R4, R5, R6, R7, R8 and R10) were identified at the facility as		S9999				

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S9999	Continued from page 5 at risk for elopement. On 11/6/25 at 1:05 PM, V2 (Director of Nursing) provided a list of only 5 residents in the facility who were identified as exit seeking which included R4-R8. On 11/6/25 at 11:25 AM, V7 (Housekeeping) propped external door open to dispose of trash, left view of door for minutes while door alarm was alarming, and no staff were present. At 11:27 PM, V3 (Social Services) arrived at the door which was still propped open and alarming. V7 closed the door but the alarm continued to sound. V11 (Maintenance) arrived and turned off the door alarm. V3 and V11 left the external door area without looking outside for residents who may have eloped. On 11/6/25 at 11:55 AM, V1 (Administrator), V2 (Director of Nursing), V3 (Social Services), V8 (Consultant) and V13 (MDS) all stated there were no concerns regarding potential elopements or regarding missing residents that morning. At 12:18 PM, V1 and V8 (Consultant) both stated there were no concerns regarding potential elopements or regarding missing residents that morning. On 11/7/25 at 11:56 AM, V3 (Social Services) stated if a door alarm sounds, staff are to go outside and search for a resident. V3 stated if no resident is seen outside, the staff are responsible for performing a resident head count to check for all residents in the building. V3 stated if a resident is identified as missing, the staff were to overhead page a Code 99 for staff to begin searching for the missing resident. Face sheet, printed 11/13/25, shows R4's diagnosis included anxiety, insomnia, and unsteadiness on feet. MDS, dated 10/13/25, shows R4's cognition was severely compromised. Elopement Risk Review, dated 11/5/25, shows R4 was at high risk for elopement. Face sheet, printed 11/13/25, shows R5's diagnoses included psychosis, depression, anxiety, schizoaffective disorder, bipolar disorder and dementia. MDS, dated 10/16/25, shows R5's cognition was intact. Elopement Risk Review, dated 11/5/25, shows R5 was at risk for elopement. Face sheet, printed 11/13/25, shows R6's diagnoses included hemiplegia and hemiparesis following cerebral infarction, dementia, depression, and falls. MDS, dated 8/15/25, shows R6's cognition was severely impaired. Elopement Risk Review, dated 11/5/25, shows R6 was at high risk for elopement.	S9999					

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S9999	Continued from page 6 Face sheet, printed 11/13/25, shows R7's diagnoses included dementia, depression, weakness, difficulty walking, anxiety, bipolar disorder, and a history of falling. MDS, dated 10/1/25, shows R7's cognition was severely impaired. Elopement Risk Review, dated 11/5/25, shows R7 was at high risk for elopement. Face sheet, printed 11/13/25, shows R8's diagnoses included Alzheimer's disease, dementia, kidney transplant status, schizoaffective disorder bipolar type, hallucinations, weakness, unsteadiness on feet, depression, dementia, and anxiety. MDS, dated 8/1/25, shows R8's cognition was severely compromised. Elopement Risk Review, dated 11/5/25, shows R8 was at high risk for elopement. 3. Face sheet, printed 11/13/25, shows R9's diagnoses included dementia, schizoaffective disorder, weakness, cognitive communication deficit, unsteadiness on feet, history of falling, and need for assistance with personal care. MDS, dated 8/22/25, shows R9's cognition was severely impaired. Elopement Risk Assessment, dated 11/5/25, shows R9 did not pace or wander, did not try to get outdoors or perceive the need to be somewhere else, had no history of elopement, and was not at risk for elopement. Wandering Care Plan, initiated/revised 2/26/25, shows R9 demonstrated movement behavior that may be interpreted as wandering, pacing or roaming related to dementia. The care plan shows R9 became agitated, oppositional and combative when redirected or exit-seeking. The care plan shows, "post a picture of the resident at/near the front desk and/or nursing station in a discrete place identifying possible elopement risk.... Implement 'preventative' intervention strategies: Make rounds/room checks per facility protocol to minimize chance of unauthorized leave.... Use/apply electronic monitoring device with appropriate consent." On 11/10/25 at 12:20 PM on the locked memory care unit, R9 independently walked through the halls and toward the locked exit of the memory care unit. R9 attempted to follow V18 (Speech Language Pathologist) through the exit door of the dementia unit. V18 attempted to redirect R9 back into the unit and out of the doorway and then quickly exited through the door closing the door behind her. R9 continued to stand at the door looking at the door until staff removed R9 from the area. On 11/10/25 at 12:27 PM, V9 (Dementia Care Coordinator) stated if staff witnesses a resident attempted to exit the door of the locked dementia unit, the staff should redirect the resident and inform V9 of the behavior. V9 stated the resident should then be reassessed for elopement risk. V9 stated he was unaware		S9999				

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S9999	Continued from page 7 R2 attempted to push the dementia unit door open recently. Review of R9's clinical record as of 11/12/25 at 10:00 AM, showed R9 was not reassessed for elopement risk since his last risk assessment on 11/5/25. 4. Face sheet, printed 11/14/25, shows R2's diagnoses included dementia, weakness, difficulty walking and unsteadiness on feet, insomnia and restlessness and agitation. MDS, dated 10/1/25, shows R2's cognition was severely impaired. Wandering Risk Scale, dated 10/15/25, shows R2 wandered in the past month, had a history of wandering, could move without assistance while in a wheelchair, and was at high risk for wandering. Face sheet, printed 11/13/25, shows R3 had diagnoses which included metabolic encephalopathy, depression, dementia, unsteadiness on feet, weakness, need for assistance with personal care, and suicidal ideations. MDS, dated 8/8/25, shows R3's cognition was severely impaired. Wandering Risk Scale, dated 8/8/25, shows R3 had no history of wandering, can move without assistance while in a wheelchair, had no reported episodes of wandering in the past 6 months, and was at low risk for wandering at the time of the assessment. Elopement Risk Reviews, both dated 11/5/25, show both R2 and R3 had no history of elopement attempts in the past three months, did not try to get outdoors or perceive the need to leave, accepted their nursing home placement, and were at low risk for elopement. On 11/7/25 at 3:39 PM, V17 (LPN- Licensed Practical Nurse) stated R2 was known to try to leave the locked memory care unit and R2 attempted to exit through the dementia unit door even that day. V17 also stated she was aware of R3 also pushing on the memory care unit exit doors to attempt to leave. As of 11/10/25 at 12:36 PM, R2 and R3 were not reassessed for elopement since 11/5/25 and not included on the list of residents at risk for elopement at the reception desk. On 11/10/25 at 3:14 PM with V2 (DON), V17 again stated R2 tried to exit the dementia unit locked door on 11/7/25 V17 stated she had to retrieve R2 before he left the unit. V17 also stated R3 also attempts to push the locked memory care door open at times. V2 stated V17 should have reported the elopement attempts to her supervisor. 5. R10's care plan shows R10 had diagnoses which included mild cognitive impairment, bipolar disorder,			S9999			

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S9999	Continued from page 8 dementia, delusional disorders, psychosis, and mood disturbance and anxiety. Elopement Prevention Program Care Plan, initiated 5/13/22 and updated 8/4/23, shows R10 demonstrated behavior that may be interpreted as wandering, pacing, or roaming related to diagnoses of schizophrenia. The care plan shows R10 attempted to leave the facility without a responsible escort, paced, and roamed or wandered in and out of peer's rooms. The care plan shows, "Implement 'preventative' intervention strategies: Post a picture of the resident at/near the front desk and/or nursing station in a discrete place identifying possible elopement risk. Notify staff of risk potential...." Elopement assessment, dated 11/5/25, shows R10 "has a history of elopement, is currently wearing a wander guard, face sheet and resident's picture place din binders on each unit. Facility document Exit Seeking Residents, provided on 11/6/24 and 11/12/25, show R10 was not identified as an exit seeking resident. Review of the resident elopement risk binder located at the front door reception desk of the facility, observed on 11/6/25, showed 6 residents (R4-R8 and R10) were identified by the facility as at risk for elopement. Forest View Nursing & Rehabilitation Center Policy and Procedure Regarding Missing Residents and Elopement, undated and provided with the facility elopement binder on 11/6/25 at 2:00 PM, showed, "All door alarms will be tested and documented daily. At no time will any door alarm be deactivated without direct visual supervision of the exit. The individual responsible for turning the alarm off will be responsible for resetting the alarm.... All residents shall be assessed for behaviors that place them at risk of elopement utilizing an elopement risk assessment upon admission, quarterly, annually and upon significant change of condition. Any resident identified to be at risk of elopement will be placed on a resident "at Risk List" which shall be posted at each nurses' station and at the reception area. The At-Risk List" will be updated whenever a new resident safety concern is identified. Residents with identified elopement risk will be documented in the resident's plan of care.... Should an alarm on one of the exits to the outside of the facility sound, staff will immediately respond to determine the cause of the alarm. After the facility staff investigate an exit door and no reason can be found for the sounding of the alarm, staff will be informed of the possible elopement, and a facility head count will be initiated. The Director of Nursing or designee shall coordinate the accounting of all residents. After all residents are accounted for and the cause of the alarm is	S9999					

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S9999	Continued from page 9 undetermined, the Director of Nursing or designee will continue to reasonable investigation to determine the cause of the alarm.... In the event a resident s discovered missing, the following procedures shall be followed: ...report to the State Department of Health if the incident meets reportable criteria. Should a resident attempt an elopement, a review of the individualized care plan will be completed for identified changes." (A)			S9999			