STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007231	A. BUILDING: _____ B. WING _____	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HOME - FREEPORT	1234 SOUTH PARK BOULEVARD FREEPORT, IL 61032

(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 Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violation 330.710a) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review the facility failed to follow their policy regarding resident safety when a resident exited the facility's locked memory care unit without the facility's knowledge. This applies to one of one residents (R100) reviewed for safety in the sample of 3. The findings include: R100's Face Sheet showed diagnoses to include but not limited to dementia, depression, and anxiety. R100's 7/8/25 Elopement Risk Evaluation showed	S9999		

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S9999	Continued From page 1	S9999		

he had cognitive impairment with a Brief Interview for Mental Status score of 8 out of 15. The assessment showed he was "at risk" for elopement.

On 7/22/25 at 11:56 AM, R100 was on the locked memory care unit ambulating per self. R100's gait was steady. R100 had no injuries to his face or hands. R100 was pleasant but confused. R100 stated the right side of his forehead was hurting because he had just taken apart a machine and a saw blade hit him on the side of the head.

R100's Service Plan (Care Plan) showed and Elopement Risk Care plan initiated on 7/13/25. The elopement care plan showed his "safety will be maintained." The care plan showed "staff will assess [R100] for the presence of wandering behavior, noting time, place, and people he may wander with."

R100's 7/17/25 Nurses' Note from 10:26 PM showed, that at 8:00 PM a memory care CNA (Certified Nurses Assistant) left R100 to assist another resident. The note showed at 8:15 PM the CNA noted R100 was "missing;" however, there were no alarms. The note showed maintenance personnel and other staff searched for R100 and found him on the "1st floor in the hallway near the dining room. No apparent injuries, resident walked back to MC (memory care) ..."

On 7/22/25 at 10:18 AM, V8 Memory Care coordinator/Licensed Practical Nurse stated R100 had a proximity alarm that would sound an alarm if he exited the memory care unit. V8 stated there is a door off the kitchenette that does not have this proximity alarm sensor. V8 stated a

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S9999	Continued From page 2	S9999		

maintenance person exited the locked memory care unit and R100 followed him out the door. V8 stated the maintenance person was not aware this happened. V8 stated there are no security cameras on the unit; however, based on interviews this was the most likely scenario how R100 exited the memory care unit without sounding the alarms. V8 said she was not at the facility when the incident occurred; however, the investigation showed R100 did not exit the facility. V8 said the maintenance person should have verified the door shut behind him and that no one followed him off the unit.

On 7/22/25 at 1:06 PM, V2 Director of Nursing stated the investigation showed R100 reported he had followed a man off the memory care unit. V2 stated R100 was found safely in the facility.

On 7/23/25 at 8:45 AM, V1 Administrator stated the maintenance person, V11, from the evening of 7/17/25 was on vacation camping. V1 stated V9 Maintenance Director spoke to V11 following the incident.

On 7/23/25 at 9:05 AM, V9 stated he spoke to V11 following the incident on 7/17/25. V9 stated V11 reported he was taking the garbage of the memory care unit and exited the unit through the kitchenette door. V11 reported he was not aware the resident was behind him. V11 reported he took the garbage outside to the dumpster and upon returning to the building he found R100 off the memory care unit. V9 stated V11's failure was not walking R100 back to the memory care unit, instead, V11 reported he went and found nursing staff. V11 reported upon returning with nursing staff R100 was not where he had been previously; however, he was eventually found within the facility. V9 stated V11 should have

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S9999	Continued From page 3 verified no residents followed him off the unit. The facility's Safety and Supervision of Resident's policy showed, " ...Resident safety and supervision and assistance to prevent accidents are facility-wide priorities ...Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices ...Resident supervision is a core component of the systems approach to safety ..." (B)	S9999		