

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0051524		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/10/2025	
NAME OF PROVIDER OR SUPPLIER LAKEVIEW REHAB & NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 735 WEST DIVERSEY , CHICAGO, Illinois, 60614			
(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				
	Facility Reported Incident of 9/4/25/2637084						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610a)						
	300.1210b)						
	300.3240a)						
	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 personal care needs of the resident.						
	Section 300.3240 Abuse and Neglect						

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 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) No POC or revisit required, Past non-compliance survey. These requirements were not met as evidenced by: Based on observation, interview and record review, facility failed to protect a resident from physical abuse. This failure affected one resident (R1) of 3 residents reviewed for physical abuse. This failure resulted in V4 (certified nursing assistant) physically attacking R1 by pulling R1's ear and dragging R1 out of his chair by his arms, resulting in R1 sustaining bruising on his upper arms, and R1 being scared to go to the dining room. Findings Include: The surveyor confirmed by observation, interview, and record review that the deficiency practice occurred 09/04/2025 and was corrected on 09/09/2025, prior to the start of this survey and was therefore Past noncompliance. The facility suspended and fired the perpetrator, reviewed footage on additional days past 09/04/2025, to make sure no other resident was abused. Skin checks were conducted for every resident on the third floor to make sure there were no other injuries or signs of abuse. All staff were educated on the abuse policy and were educated on tips for maintaining health and safety on residents with dementia. The facility created a questionnaire for their staff pertaining to abuse and witnessing abuse. The facility created a quality control tool to inspect for bruising and abuse. Monthly abuse training is now conducted during their all staff meeting. The facility is encouraging an open door policy to prevent staff burnout. R1's Face Sheet documents resident is a 60-year-old with diagnoses including but not limited to: Disorder of the brain, dysphagia, oropharyngeal phase, cognitive communication deficit, unspecified lack of coordination, weakness, unspecified abnormalities of the gait and mobility, bipolar disorder. Minimum Data Set Section (MDS) section C (dated Sep. 25, 2025) documents that R1 has an Interview for Mental Status (BIMS) score of 4, indicating that R1's cognition is severely impaired.	S9999					

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S9999	Continued from page 2 high risk for elopement/wandering R/T: Wandering tendencies, Impulsive, agitation, wander-guard per order. R1 is at risk for increasing confusion secondary to dementia, memory problems, usually understood and usually understands. Facility's Final Investigation Report (dated 09/19/2025) documents in part: R1 alleged V4 (certified nursing assistant) made contact in the dining room. The facility completed its investigation through medical record review and statements. R1 alleged that V4 made contact with him in the dining room. V4 was immediately suspended pending investigation, and the police were notified. A body assessment revealed bruising on R1's upper arms. The investigation determined the bruise resulted from contact by V4. R1 reports feeling safe, shows no sign of pain, distress, or discomfort, and does not recall the incident. V4 has been terminated from the facility. Other residents and staff were interviewed and expressed no concerns. Background and training records for V4 were reviewed, with no prior issues noted. The allegation of abuse is substantiated. On 10/08/2025, surveyor viewed a video tape of an incident that took place on 09/04/2025, involving V4 (certified nursing assistant) and a resident, R1, in the 3rd floor dining room of the facility. In the video, surveyor observed, V4 walking up to R1, V4 grabbing and pulling on R1's ear. Surveyor observed that after V4 pulled on R1's ear, V4 forcibly snatched R1 out of the dining room chair, resulting in R1 falling to the ground, and V4 forcibly picking R1 up. Surveyor observed that after V4 picked R1 up from the ground, V4 continued to forcibly push R1 out of the dining room. The video tape of the incident does not show any more footage of what occurred after V4 and R1 left the dining room. On 10/08/2025 at 10:17AM, V1 (Administrator) stated, "On 09/04/2025, a certified nursing assistant noticed a scratch to R1's ears and notified V3 (registered nurse). V3 asked R1 what happened, and R1 did not know what happened. V3 noticed that R1's nails were long, and V3 trimmed R1's nails. On 09/05/2025, R1 was receiving a shower, and a certified nursing assistant noticed bruising on R1's arms. The certified nursing assistant reported the bruises to the nurse on duty, V3 (registered nurse). The nurse examined the bruises and noted that R1 had discoloration to the upper arms. V3 asked R1 what happened and R1 said that R1 bumped into the wall. On 09/07/2025, R1 appeared upset and alleged	S9999					

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S9999	Continued from page 3 that some dude touched him. The resident refused to sit in the dining room. V3 reported her concerns to the manager on duty. V3 was suspicious and wanted to know if anything had happened to R1 because he was refusing to sit in the dining room and acting strange. I (V1) am the abuse prevention coordinator, and this allegation was reported to me on 09/07/2025. I started the abuse investigation immediately. The manger on duty started to look through the footage to determine if anything happened. The manager on duty found a footage from 09/04/2025, which showed V4 (certified nursing assistant) pulling R1's ear and forcibly dragging R1 out of the dining room. We do not know where V4 was dragging R1 to or for what reason. We got statements from staff; however, nobody saw anything. The only thing that staff noticed was bleeding from R1's ear and bruising on the arms. After I received the footage, I did the reportable and reported this incident to the state agency. V4 (certified nursing assistant) was suspended immediately, on 09/07/2025, when we saw the footage. I spoke to V4 on 09/09/2025. I explained to V4 that I was conducting an investigation. V4 said to me that V4 did not know why V4 got suspended. I asked if V4 recalled any inappropriate interaction with a resident. V4 said, "This is about R1. Most interactions are inappropriate with R1. Not on the staff's part but on R1's part. That day I did not let R1 get away with it." V4 then asked if we have a union representative on the phone and I said no, and that I would have to arrange it, and the call was disconnected. We spoke to the staff that worked on the shift, and nobody saw anything. V4 was terminated on 09/11/2025 for substantiated abuse, which is a violation of policy and a violation of code of conduct. V4 knew what we were talking about and admitted that there was an inappropriate interaction with R1. The police were called, and this incident was reported. V4 has worked in this facility from 10/04/2022. There were no previous incidents or complaints involving V4. All the employees that work in the facility receive abuse prevention training. V4 signed a copy of the abuse prevention training on 10/04/2022. V4 was not assigned to R1. V4 was the person that was assigned to watch the residents in the dining room. I (V1) am devastated by this incident. I provided the staff with abuse education. I educated the staff to make sure they understand different types of abuse and I went through the facility's policy on abuse. I educated the staff that they must report the allegation immediately. The abuse policy is talked about during every all-staff meeting. Sometimes I will focus on a particular area and educate the staff what the obligation is from the staff. I made sure that R1 is safe, and my immediate action is to suspend V4 and to make sure that he did	S9999					

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S9999	Continued from page 4 not return to the building. If there is any suspicion of abuse, we don't wait to investigate. In this instance we follow our abuse policy. As part of the abuse prevention training, staff are educated on how to deal with residents with dementia. R1 is a resident with dementia. We checked all the residents on the 3rd floor for signs of abuse. We did not find any other residents who had any signs of abuse. R1's family and physician were notified." On 10/08/2025 at 11:55AM, V3 (Registered Nurse) stated, "On 09/04/2025, I saw R1 scratching his ear, and he was bleeding from the ear. R1's nails were long so that is when I trimmed his ears. I notified the nurse practitioner, and she gave the order to put Bacitracin and leave the area open to air. The next day, on 09/05/2025, R1 had a shower, and some discoloration was noted. When I asked R1 what happened, R1 said that he bumped himself. Then I told the doctor about the discoloration. The doctor said for me to put margins on the discoloration and monitor to see if it spreads or changes color, or if it will stay the same. The doctor wanted the nurses to monitor it. On 09/07/2025, the discoloration stayed the same. The manger on duty was in R1's room with me and we were looking at R1's curtains, and that's when R1 reported that some man beat him. That's when we reported this allegation to the administrator. R1 reported that a man hit him, and the nurse manager reported this to the administrator right away. I never suspected V4 (certified nursing assistant) of abuse and I never had any negative encounters with V4." On 10/08/2025 at 12:15PM, V6 (certified nursing assistant) stated, "I found bruising on R1 while giving him a shower. I was giving R1 a shower and I saw bruising on both of R1's forearms. They looked like fresh bruises. One arm looked purple reddish, and the other arm looked solid purple, and they appeared to be fresh bruises. I reported these bruises to V3 (registered nurse)." On 10/08/2025 at 12:22PM, R1 stated, "I don't remember what happened. I feel safe here." On 10/08/2025 at 12:44PM, V7 (Manager on Duty) stated, "On 09/07/2025, I was the manager on duty. One of the nurses from the 3rd floor reported concerns that something may have happened to R1 in the dining room. V3 (registered nurse) asked me to review the cameras		S9999				

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S9999	Continued from page 5 from the dining room. V3 put me in a separate room away from everybody and asked me to review the cameras from the dining room. After we reviewed the cameras, we saw that R1 was grabbed inappropriately by a staff member. I immediately called V1 (administrator) to report the misconduct that was caught on tape. In the video, I saw V4 (certified nursing assistant) walking into the dining room, then turn towards R1 and grabbed him inappropriately by the ear, then dragged R1 by his arms out of the chair. I remember R1 slipping to the floor while being dragged and I saw V4 picking R1 back up by his arms, in a forceful manner. I was shocked when I saw this. I know that R1 and V4 have interacted many times before and when the incident occurred it kind of seemed like it was out of nowhere. V3 got emotional when she saw how R1 was treated. We immediately made sure that R1 is safe. V4 did not work anymore after that incident occurred. All the residents were kept safe. I never had any negative encounters with V4 prior to this incident." On 10/08/2025 at 10:45AM, 11:43AM and 1:27PM, surveyor called to interview V4 (certified nursing assistant) and left a voicemail. Surveyor did not receive a call back from V4. On 10/09/2025 at 1:00PM, V12 (nurse practitioner) stated, "I am not too familiar with the incident that occurred with R1 and V4 (certified nursing assistant). If an employee grabs a resident by the arms, a possible arm dislocation could occur. It would be a concern for dislocation and possible fracture. Those are the injuries that come to mind. It is never okay for an employee to grab a resident in that manner. It is never okay for any employee to grab a resident in that manner." R1's Progress Note (dated 09/05/2025) documents, "Resident observed with small scratch in his right outer ear (fossa) area, small amount of blood noted, pressure dressing applied with effective, MD updated with orders. The area was cleansed with NS and bacitracin ointment applied. DON, POA made aware, continue to monitor the resident." R1's Progress Note (dated 09/07/2025) documents, "Resident alleged clinical staff made inappropriate contact during care. Resident was immediately assessed with old discoloration noted on bilateral arms, ROM tolerate and denies pain. Resident expressed he feels	S9999					

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S9999	Continued from page 6 safe in the facility. POA notified of clinical updates with police notification requested. Physician contacted with no additional orders to be given. Resident displays no mental/emotional distress. Facility protocol implemented. Wellbeing checks to be implemented." R1's Progress Note (dated 09/09/2025) documents, "Resident is verbally alert, writer assessed discoloration to bilateral upper arm with no changes observed, resident denies pain or discomfort, resident is able to move all extremities at baseline. Resident consumed meals with good appetite, writer provided the resident with a nighttime snack when requested by the resident. Resident is currently resting in bed, rise and fall of the chest observed. Safety and comfort measures in place, call light within reach. Care continues." Abuse Prevention Policy (revised 03/01/2021) documents in part: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment, and misappropriation of resident property and a crime against a resident in the facility. (B)		S9999				