

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0052092		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/20/2026	
NAME OF PROVIDER OR SUPPLIER PARK VIEW REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5888 NORTH RIDGE , CHICAGO, Illinois, 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) COMPLETION DATE	
S0000	Initial Comments		S0000			03/05/2026	
	Complaint Investigation 2681188 / 2728841						
S9999	Final Observations		S9999			03/05/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.690b)						
	300.1210b)						
	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 300.690 Incidents and Accidents						
	b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.						
	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						

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 provided to each resident to meet the total nursing and personal care needs of the resident. These requirements are not met as evidenced by: Based on interview and record review, the facility failed to follow their policy to notify Illinois Department of Public Health for one (R2) resident who left the facility unauthorized on 1/14/26. The findings include: R2's admission record / face sheet showed admit date on 1/12/26, with diagnoses not limited to Acute respiratory failure with hypoxia, Biliary acute pancreatitis without necrosis or infection, Other pulmonary embolism without acute cor pulmonale, Generalized anxiety disorder, Insomnia, Major depressive disorder, Essential (primary) hypertension, Extrapyramidal and movement disorder, Gastro-esophageal reflux disease, Alcohol dependence, Opioid dependence, Other chronic pain, Obstructive and reflux uropathy, History of falling, Muscle weakness (generalized), Other abnormalities of gait and mobility, Unsteadiness on feet, Encephalopathy, Gastrointestinal hemorrhage, and Other psychoactive substance abuse. R2's MDS (Minimum Data Set), dated 1/19/2026, showed R2's cognition was intact. On 2/11/26 At 10:55AM, R2 was up and about, ambulatory, alert and oriented x 3, verbally responsive. R2 said on 1/14/26, around evening time, it was already dark outside, he left the facility unauthorized. He stated nobody told him that he was in Chicago, and he did not feel safe. He said he had paranoia because of his history of taking drugs. He said he did not feel safe / comfortable in the facility and the staff, and he thought somebody was after him, so he exited the facility without telling the staff. R2 said staff were behind him and saying, "you can't leave the facility." He said it was after dinner when he left the facility. He said the staff were closely monitoring him and were "on him" because he wanted to leave. R2 said he told staff they couldn't hold him and left the facility. He said he thought there was an alarm going off when he left the facility. He said he was not sure which floor the alarm went off. R2 said he thought there was a female facility staff running after him, and probably could not catch him, because he was running as fast as he could. He said he did not realize he was Chicago, and it was very cold outside, raining ice / snowy. He said he was wearing the same type of clothes when he		S9999				

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S9999	Continued from page 2 left the facility. He said he was wearing a sweater, pants, and shoes with no socks on. Observed R2 wearing gray sweater, pants, and shoes. R2 said his sweater was not a winter jacket and should have a coat over it. He said he walked outside of the facility for a while and when he noticed that he was hit by ice / snow, he felt very cold. He said he was walking and running a little bit. R2 said he was maybe a couple blocks or about a half mile away from the facility and saw an apartment building. He said he sat in the lobby of the apartment building to shelter because he felt very cold already. R2 said he was not in the proper state of mind. He said he felt his mind was telling him that people around him were trying to hurt him and wanted to leave the facility. R2 said he was walking and running for about an hour in the cold. He said he probably was running as fast as he could to leave the facility. R2 said he was staying in the lobby of the apartment maybe for more than 2 hours to shelter, then a random person helped him and called the police. He said 2 policemen came, called an ambulance, and he was brought to the hospital. R2 said there was some bruising on his left foot, pain medicine (Tylenol) was given, compression wrap was applied on his foot, and nonskid socks were provided in the hospital. R2 said he stayed in the ER for about 2 hours. He said female staff from the facility came and brought him back to the facility. R2 said it was cold and probably when he was running, he twisted his left leg and there was bruising. He thought the alarm went off; he heard a sound by the stairwell that he used when he exited the facility. He said maybe the staff got tired of him trying to get him to stay in the facility. He said nobody was watching him when he left the facility. There was a male staff working in the facility and was trying to stop him as much as he could. R2 said maybe if a male staff ran after him then maybe he would have been caught. He said he was limping at that time because he twisted his left leg. On 2/18/26 At 9:47AM, V2 (DON / Director of Nursing) said she was on vacation at the time of the incident on 1/14/26. She said she read R2's progress notes and she spoke with V13 (nurse on duty) regarding the incident. She said R2 was wandering to another resident's room, and she was not aware R2 had attempted to leave the floor / unit prior to elopement on 1/14/26. V13 was passing medication in resident's room and heard CNA saying "STOP" to R2. V13 immediately came out of the room and saw R2 going out by the back door stairwell. She said the alarm went off and V13 ran down the stairs following R2, but she lost him because he was running. V13 was not wearing a coat / jacket. V2 said she didn't believe R2 was in proper clothes for the winter. V2 said V13 called ADON (Assistant Director of Nursing)		S9999				

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S9999	Continued from page 3 while she was still out of the building. When V13 came back to the facility, the CNA started to search for the resident. The Administrator, MD (Medical Doctor), R2's sister, and police were informed. The police found him maybe about 2 hours later and transferred R2 to the hospital for evaluation, and he came back to the facility. She said V1 (Administrator) picked up R2 in the hospital. There was no hospital records provided during discharge. She said a potential risk of R2's unauthorized departure from the facility was that he could sustain hypothermia, frost bite. V2 said elopement is considered an unusual occurrence and it is reportable to IDPH (Illinois Department of Public Health). Unusual occurrence / elopement would need an investigation. She said there was an investigation done. She said she did not report the incident because she was on vacation during that time. V2 said R2's elopement was not reported to IDPH; it should have been reported. She said elopement incidents should be reported to state agency / IDPH because it is a requirement; it is an unusual occurrence. On 2/18/26 At 10:46AM, V1 (Administrator) stated she has been working in the facility since 2013 as a CNA, she worked her way up and transitioned into an Administrator role in 2020. She said on 1/14/26 at 6:30 PM, she was at home and received a call from the ADON informing her the nurse on duty had called her that R2 had left the facility via 2nd floor stairwell and exited through the back door. She said the nurse was in pursuit of him going down (street name). V1 said Elopement Code was initiated so staff members went outside to locate R2. She said some staff were in cars and some were on foot. V1 said she notified ADON that she was on her way to the facility and instructed them to call the police. She said she started searching the area on her way to the facility, driving around to locate R2. V1 said she had just arrived at the facility when the police called to inform her that R2 was found. She said R2 was found just about quarter to a half mile away from the facility. V1 said the police informed her they would take R2 to hospital and she told them she would meet R2 at the hospital. V1 said R2 was found about 2.5 to 3 hours after he left the facility unauthorized. She said she went to the hospital and picked up R2 and stayed for a while due to R2 still being evaluated in the ER (Emergency Room). V1 said they came back to the facility about 11-11:30 PM. V1 said she drove R2 back to the facility. V1 said there was no apparent injury when she saw R2 in the hospital. V1 said R2 was wearing sweater with a hood, it was cold outside, and his clothes were not appropriate for the cold weather. She said routine checks or evaluation were done in the ER with no information about frost			S9999			

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S9999	Continued from page 4 bites or hypothermia. V1 said R2 left the facility unauthorized, there was no indication that he would elope that day. She said she was not aware R2 had already attempted to leave the facility, and staff was able to redirect him before the elopement incident. V1 said the incident was investigated but was not reported because they located R2 and protocol was followed. She said internal investigation was done. Reviewed facility policy with V1 and she said with any unusual occurrence or unauthorized departure, the incident should be reported to IDPH. V1 said the purpose of Reporting to IDPH is to make sure that state agency is aware of the incident / unusual occurrence. Facility's elopement binder kept in the reception room reviewed. R2 was included in elopement risk, dated 1/13/2, with R2's picture and face sheet. Facility's reportable or unusual occurrence 24-hour report form for January 2026 reviewed. No reportable completed for R2. Facility's policy on Elopement prevention and location of missing residents dated January 2013 showed: Within 24 hours of an elopement / unauthorized departure, whether or not the resident has been located and returned to safety, the Illinois Department of Public Health shall be notified of the incident. Facility's Incident/Accident Report policy dated 9/14 showed: The Incident/Accident Report is completed for all accidents or incidents where there is injury or the potential to result in injury. An incident/accident report will be completed for: Leaving premises without authorization (elopement). Public Health is to be notified of the following: any incident or accident which has, or is likely to have, a significant effect on health, safety, or welfare of a resident or residents (serious injury). (B)			S9999			