

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007231	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/19/2026
NAME OF PROVIDER OR SUPPLIER PARKVIEW HOME - FREEPORT		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Complaint Investigation: 2613226/IL200821 2613257/IL200842	S 000		
S9999	Final Observations Statement of Licensure Violation: 330.4240d) Section 330.4240 Abuse and Neglect d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter of the department. (Section 3-610 of the Act). This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to prevent resident to resident abuse and failed to report an allegation of abuse to the state health department. This applies to 2 of 4 residents (R1 & R2) reviewed for abuse in the sample of 4. The findings include: R1's Admission Record (Face Sheet) showed an admission date of 5/14/24 with a diagnosis not limited to but including Alzheimer's (dementia). R2's Admission Record (Face Sheet) showed an admission date of 11/14/25 with a diagnosis not limited to but including dementia.	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	Continued From page 1 On 3/18/26 at 7:30 AM, all reported allegations of abuse investigations and reports were requested for the previous three months. The facility provided one incident, which did not involve R1 and R2. R2's 12/7/25 Nurses' Note from 3:16 AM showed, "Resident came out of his room without his walker while the aide was in another resident's room helping them. When the aide came out of the room, this resident was in the kitchen/dining area. The aide asked the resident about his walker and offered to get it out of his room for him. As the aide was coming back with the walker, the resident came around the corner and started yelling at the aide. He woke up three other residents. These other residents voiced concern as to what was going on. Resident raised his fist to try to punch aide. Then when she moved back, he tried to slap her. She moved back again, and he raised his walker and hit her in the lateral right thigh and lower right back ..." R2's 2/26/26 Behavior note from 8:59 AM, showed, "Appears agitated. Resident taking hot chocolate from CNA [Certified Nursing Assistant] and attempting to carry it to his room, resident screaming at staff. Resident spilled some hot chocolate on the floor then threw his cup in the sink ..." R2's 2/27/26 Behavior Note from 11:15 PM, showed he was in the kitchen and punched the CNA in the stomach when she asked R2 to not use the microwave. R2's 2/28/26 Behavior Note from 11:00 PM, showed "Resident was again trying to use the microwave (had 6 minutes on the clock) when the CNA asked him to allow staff to help him with the	S9999			

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S9999	Continued From page 2 microwave. Resident shoved CNA into the counter, ripped the door off the microwave and threw it on the floor ..." R2's 3/8/26 Behavior Note from 4:35 AM, showed R2 had "wandered into another resident's room and turned on the light. Then began to curse at staff." R2's 3/11/26 Behavior Note from 11:22 PM showed, "threw things all over the kitchen, screamed at CNA threw walker at CNA. While aide was cleaning up the mess, he grabbed another resident by the arms, CNA broke that up, called nurse ..." The note showed the incident was reported to V10 (Restorative Nurse/Licensed Practical Nurse-LPN) and V2 (Director of Nursing). R1's 3/11/26 Nurses' Note from 11:56 PM, showed "Resident involved in an altercation initiated by another resident at 2255 [10:55 PM]. Reported to [V10 Restorative Nurse/Licensed Practical Nurse] and [V2 Director of Nursing] at 2317 [11:17 PM]." On 3/19/24 at 6:25 AM, V4 (CNA) stated R2 had thrown several items on the kitchen floor the evening of 3/11/26. (The facility's lower level memory care unit has a small kitchenette area attached to the dining area.) V4 stated she attempted, twice, to have R2 return to his room. V4 stated R2 yelled and attempted to hit her with his walker. V4 said she was able to return R2 to his return and she then went back to the kitchenette to clean. V4 stated a few minutes later she heard "screaming" in the hallway. V4 said she ran to the noise and saw " ...he [R2] had her [R1] pinned against the wall and was holding her arm very tight ...she was terrified ... I took	S9999			

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S9999	Continued From page 3 [R1] to the end of the hallway, she was terrified, she said that several times and she said she wanted to kill him. At 11:00 PM she was sound asleep, so he must have gone into her room and gotten her. I was able to put my body between them [and] that was enough to let go of her. I put myself between them to block him from hitting her. I took [R1] to the end of the hallway because she was not steady and shaking. She was scared." V4 said R2 attempted to get past her and hit R1. V4 said she took care of R1 and V5 (LPN) addressed R2. V4 said, "I've tried telling them they need a second CNA on the unit because if I am with another resident I can't stop him from going into another room." On 3/18/26 at 9:13 AM, V3 (Registered Nurse-RN) stated she was on another unit doing paperwork at the time of the incident between R1 and R2. V3 stated V4 had notified her that R2 had thrown items on the floor of the kitchen and a short time later, "[V4] got on the radio and said now he is attacking [R1]. So I ran down there and when I got there they were screaming at each other. He was grabbing [V4] and trying to get over [V4] to get at [R1]. [R1] told me to get a knife so she could kill [R2] ...Then [R2] tried to get over me to get at [R1] ..." V3 said, "He [R2] wakes up the residents a lot because of screaming so it's possible she came out of her room because of the noise, or he went into her room, I don't know." V3 said, "I reported this to [V10] and [V2], I told them he had grabbed [R1] and told them what had happened. I told them what happened and if anything, else happened I was going to send him to the hospital and they said okay ..." On 3/18/26 at 8:30 AM, V2 (Director of Nursing) stated "...We have had some issues with night	S9999		

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S9999	Continued From page 4 shift. I called here last night and told the CNA [V4], [V4] and [R2] do not mesh well together and I told her she needed to take someone else with her when she goes into his room. Maybe a week or two ago I was told he went towards [R1] but the CNA intervened before he got to [R1]." On 3/19/26 at 9:55 AM, V10 stated "I got a phone call from [V3] and she told me the behaviors [R2] was having and he had grabbed [R1] and [R1] screamed. We talked a little bit and it was determined she had to call [V2] because it had to be reported ...She [V3] did say that [R2] grabbed [R1]. She said they were alerted of the issue when [R1] screamed out and that was why they went to her room ..." On 3/19/26 at 8:55 AM, V1 (Administrator) stated she had not been notified of the incident between R1 and R2 until the initiation of this survey. V1 said, "My understanding of what happened is a CNA intervened and [V2] made the determination that I did not need to be notified... all I heard was a resident moved towards another resident and there was no contact. As far as I know, there was no physical contact between the two residents, a staff member intervened." V1 stated she should have been notified of the incident as described by V3 and V4 and the incident should have been reported to the State Health Department and an investigation into potential resident to resident abuse should have been initiated. The facility's Abuse/Neglect Prevention Program Facility Policy and Procedures showed, "All residents of [the facility] have the right to be free from abuse, neglect, mistreatment, corporal punishment, misappropriation of their personal property, exploitation and/or involuntary seclusion. Accordingly, [the facility] hereby	S9999		

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S9999	Continued From page 5 prohibits the abuse, neglect, mistreatment and corporal punishment of its residents and/or the misappropriation of their personal property. ... These Policies and Procedures apply to all professional and non-professional employees of the facility, as well as to all residents, volunteers, family members, visitors, legal guardians or other individuals entering the facility. It is the responsibility of all facility employees to assure that residents' rights are protected by reporting all incidents or occurrences (or potential occurrences) of Abuse, Neglect, Exploitation and/or Misappropriation of Resident Property to their direct supervisor and to the facility Administrator." The policy defines abuse as, " ... the infliction of injury, unreasonable confinement, intimidation, or punishment other than by accidental means with resulting physical harm, pain or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse, including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The policy stated staff should notify the Director of Nursing and Administrator of any abuse and the facility should comply with any reporting requirements set forth by the state. (B)	S9999			