

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 03/31/2026
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 Facility Reported Incident of 3/23/26/200918 - 330.4240 cited.	S 000		
S9999	Final Observations Statement of Licensure Violation: 330.4240f) 330.4240 Abuse and Neglect f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to protect a resident from physical abuse. This applies to one of four residents (R2) reviewed for abuse on the sample of four. The findings include: The facility face sheet shows R2 was admitted to the facility with diagnoses to include unspecified dementia and osteoporosis. The BIMS (Brief Interview For Mental Status) dated 12/16/25 shows her to have severe cognitive impairment. A	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 risk management note dated 3/23/26 for R2 shows at 6:50 PM, R2 was pushed by another resident, fell backwards and hit her head on the hardwood floor. The note shows a large amount of blood was noted under her head. Pressure was held and the resident was sent to the local emergency room. A general note for R2 dated 3/23/26 at 10:18 PM shows the emergency room called the facility to report R2 has 4 staples to the back of her head, her CAT scan was negative and she would be returning to the facility. On 3/31/26 at 10:19 AM, V4 (Certified Nursing Assistant-CNA) said she was working on the dementia unit on the night of 3/23/26. V4 said she was walking down the hall towards the living room, and she saw R1 push R2 hard, down onto the floor. V4 said R2's head was bleeding a lot. On 3/31/26 at 10:31 AM, V5 (CNA) said she was working on the dementia unit on the night of 3/23/26. V5 said she was in the living room with some of the residents including R1 and R2. V5 said R1 and R2 were talking with another resident, and she was changing the channel on the television, and she had her back to the residents. V5 said she then heard the fall and looked over and saw R2 on the floor with blood coming from her head. On 3/31/26 at 1:05 PM, V2 (Director of Nursing-DON) said she was shocked about the incident since R1 and R2 have never had any altercations before. V2 said R2 does like to get into the space of other residents, and she may been doing that to R1 that night. V2 said the staff have all been in-serviced on keeping the residents busy and keeping R1 and R2 away from each other.	S9999			

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S9999	Continued From page 2 The facility care plan for R2 shows an intervention dated 3/24/26 for staff to monitor R2 behaviors that may provoke conflict with other residents such as intrusive actions and boundary violations. A Nurse Practitioner note dated 3/24/26 shows R2 was seen and it was documented a laceration to the back of R2's head that required staples after a fall at the facility. The facility face sheet for R1 shows he was admitted to the facility with diagnoses to include dementia, depression and anxiety. A BIMS assessment dated 1/9/26 shows R1 to have severe cognitive impairment. The facility investigation into the incident shows V4 stating she saw R1 push R2 to the ground and V5 stating she did not see the fall but heard it. The facility policy for Abuse with a revision date of 3/25/26 shows all residents have the right to be free from abuse. (B)	S9999			