

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145654	(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, IL 60614	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [AGE] 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. Care plan (dated 09/25/2025) documents that R1 is at a 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 that some [NAME] 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 on 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</p>		