STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5105728	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MEMORY CARE COMMUNITY	241 E LAKE STREET BLOOMINGDALE, IL 60108

(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
A 000	Initial Comment Annual Licensure Survey Violation cited: 295.6000a)13) Resident Rights	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; This regulation was not met as evidenced by: Based on interview and record review, the facility failed to ensure that one resident (R4) was free from abuse. This involves 2 of 3 residents (R4,R7) reviewed. This failure resulted in R4 being physically assaulted by R7, which included a right hand contusion. This failure has the substantial probability to cause severe harm to all residents in the establishment.	A6000		

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A6000	Continued From page 1	A6000		

Findings Include:

R4 admitted on 11/28/2022 and continues to reside in the establishment. R4 has multiple diagnoses including but not limited to the following: CAD, dementia, cognitive impairment, and HTN.

R7 admitted to the facility on 10/17/2025. R7 has multiple diagnoses including but not limited to the following: dementia, failure to thrive, osteoarthritis, type II DM, and frequent falls.

Facility Reported Incident dated 10/24/2025 states in part but not limited to the following: R7 was in the dining area with R4. R4 offered her hand to R7 as if to shake or hold hands. R7 grabbed R4's hand and became very aggressive and squeezing her hand very tightly. R4 screamed "let me go" and was yelling in pain. Staff had to forcibly remove R4 hand from R7's grip. R7 continued to be aggressive and tried to grab the nurse on duty. R4's hand was red and swollen.

Hospital records dated 10/24/2025 show R4 experienced a contusion to the right hand.

On 10/27/2025 at 10:45AM, this surveyor observed R4's right hand to be bruised and swollen. R4 is noted to be confused however stated she was uncomfortable and unable to move her right hand normally.

On 10/28/2025 at 9:45AM, E7 (CNA Supervisor) said when the incident occurred, I was across from the dining room in E2's (Director of Nursing) office. I heard R4 scream and E2 and myself ran

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A6000	Continued From page 2	A6000		

into the dining room. E10 (Activity Aide) was in the dining room when we arrived. I saw R7 grasping R4's hand and R4 yelled 'let me go'. I believe E10 separated their hands. E4 does have behaviors where she gently touches other residents with her hands.
E7 said when residents are in the dining rooms or other common areas, they should be supervised. Caregivers and activity aides are responsible to supervise residents when they are in common areas.

At 11:05AM, E10 said I went to the dining room really quickly to either grab or do something. I did not really witness the incident, but I heard R4 scream and when I turned around R7 was squeezing R4's hand. There was an activity going on in the activity room which is where we spend most of our time.

E10 said R4 does propel herself in her wheelchair and we do supervise her.

At 11:45AM, E2 said I was in my office which is across from the dining room. R7 walked in the dining room and sat down. propelled herself into the dining room with R7. I heard R4 scream and E7 and I ran into the dining room. The residents were separated, and they were both sent out to the hospital. R7 was directly admitted to the behavioral health unit.

R4 can get 'handsy' and likes to touch people. R7 admitted to us about a week before this, so we do not know him very well. Aggression is something that residents can exhibit when they have dementia. We are a memory care establishment with residents that have severe dementia.

R7's service plan states in part but not limited to

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A6000	Continued From page 3 the following: R7 requires escorts to all meals and activities. Staff needs to monitor whereabouts throughout the day. R7 requires more cueing and redirection to keep him safe. Establishment Abuse Policy dated 6/1/2025 states in part but not limited to the following: Resident abuse, neglect, and exploitation are prohibited.	A6000		