STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145308	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River View Rehab Center	50 North Jane Elgin, IL 60123

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34410 Based on interview and record review, the facility failed to protect R1 from physical abuse from R2. This failure resulted in R1 needing emergency medical care and treatment after R1 was assaulted by R2. This applies to 1 of 5 residents (R1) reviewed for abuse. The findings include: The Electronic Health Record (EHR) showed that R1 had diagnoses including Schizophrenia, Bipolar, and anxiety disorder. The Minimum Data Set (MDS) dated [DATE] showed R1's cognition intact. The EHR showed that R2 had a diagnosis of paranoid schizophrenia. The MDS dated [DATE] showed R2's mental status of inattention and disorganized thinking behavior fluctuated and would come and go with changes in severity. The Brief Interview for Mental Status could not be completed. A care plan showed R2 was an Identified Offender with interventions including closer supervision and more frequent observation than standard or routine for most residents in an open facility. 1. A Facility Reported Incident reportable dated 9/12/24 documented a physical altercation between R1 and R2. On 9/25/24 at 9:40 AM, R1 was observed in his room with a small, glued laceration on the outer edge of his left eyebrow. R1 stated, he had a fight with R2 approximately a week ago. R1 didn't know why R2 hit him. R2 said there was urine on the floor in the bathroom. When R1 said there wasn't, R2 started hitting him. R1 went to the nurse's station to tell the nurse. R1 was sent to the hospital for a small left eyebrow laceration which was glued in the hospital and had a right eyebrow skin tear. (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/25/24 at 3:46 PM, V5 (Registered Nurse/RN) stated that she was the night nurse on 9/12/24 caring for both R1 and R2 when R2 hit R1. R1 came to the nurse's station with blood on his forehead, a left eyebrow laceration and a right eye eyebrow scratch. R2 accused R1 of urinating on the bathroom floor. R1 was sent to the hospital and returned before the end of my shift with his left eyebrow laceration glued. V5 stated R2 has had an altercation with staff of pushing or slapping them. R2 has pushed me with both his both hands on my shoulder when V5 was trying to give R2's medication. V5 also stated R2's behavior is unpredictable and V5 would instruct the CNAs to check on R2 for aggressive behaviors. V5 stated all the residents should be monitored for their behaviors every two-to-three hour with no specific timing on how often they should be monitored. V5 said there was no extra monitoring for someone being readmitted from the hospital after having behavior issues. On 9/26/24 at 11:21 AM, V20 (CNA) stated he was on break and the incident was already happened when V20 came back from break. V20 was told R2 walk up to R1 and punched R1. R2 was aggressive at times, and he hit a CNA (V6) in his face. On 9/25/24 at 3:20 PM, V15 (CNA) stated on 9/12/24, R1 came to the nurse's station and said his roommate R2 punched him. V15 saw a cut on his R1's left eye, right lip and right forehead. V15 stated R2 was not right in the head. V15 was not aware of having any previous incidents/altercations with other residents or staff. V15 also stated R2 was not on any special supervision/monitoring than any other residents. V15 added that R2 did not have any special supervision or monitoring. On 9/26/24 at 10:25 AM, V7 (Nurse Practitioner/NP) stated R2 was very psychotic. V7 said for the last few weeks, R2 has refused to talk to V7. V7 stated R2 has decompensated significantly and probably required a higher level of care and supervision. On 9/26/24 at 3:30 PM, V22 (CNA) stated R2 can be aggressive at times and sometimes he threw his trays, slam the trays on the rack, and take the hand sanitizers off from the wall. V22 said they monitor residents every two hours. V22 said he doesn't know of any residents who need more frequent supervision except for those who need one-to-one monitoring. On 9/26/24 at 3:00 PM, V17 (RN) stated R2 was not able to be redirected all the time when he does have behaviors. V17 said R2 was laughing, singing, and making noises to be distracting to other residents. Sometimes R2 would throw water on the floor. V17 also stated R2's cognition was moderately impaired and wasn't aware of any care plan with interventions to monitor R2's behaviors more frequently than other residents. On 9/26/24 at 2:24 PM, V23 (Psychiatric Rehab Services Coordinator/PRSC) stated R2 has had an incident of aggressive behavior; most recently with R1. R2's behavior has been escalating over the past several months. V23 also stated R2 sometimes acknowledge what we were said to him about his behaviors and respond O.K, but V23 doesn't know if R2 understands what he is agreeing to. 2. A Nursing Progress Notes by V8 (RN) dated 7/15/24 at 12:55 AM, documented that R2 was walking in the hallway with no underpants on; V8 was trying to persuade the resident to wear a gown, but he refused. R2 walked to a co-resident sitting in the dining area and attempted to kiss the co-resident. V8 tried to re-direct the resident, and the resident took his shirt off and was completely naked. The resident walked into the 2500 hallway and entered one of the resident's rooms. Staff tried to stop him from entering the room; then, he punched the male CNA (V6) in the face. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/26/24 at 3:10 PM, V8 (RN) stated that she saw the incident where R2 was going to kiss R5 on 7/15/24. On 9/26/24 at 3:50 PM, V6 (CNA) stated that on 7/15/24 at around midnight, R2 hit him in V6's face when V6 prevent him to enter another resident's room. The facility's Abuse Prevention Program Policy dated 11/22/2017 includes: Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34410 Based on the interview and record review, the facility failed to report abuse allegations to the state agency. This applies to 2 of 5 residents (R5 and R6) reviewed for abuse in a sample of 5. The findings include: 1. On 9/25/24 at 2:55 PM, V21 (Certified Nursing Assistant/CNA) stated during evening shift in June 2024, V21 was on one-to-one supervision with R5 in the dining room. R2 entered the dining room and held up some sugar packets for R5. When R5 reached sugar packet, R2 grabbed R5's buttocks. V21 said he was about to eight feet away from the direct observation of this incident. V21 said he reported it to V17 (Registered Nurse/RN), and she said she would report it. On 9/26/24 at 12:34 PM, V17 stated she couldn't recall any incidents between R2 and R5 in June 2024. A review of facility reportable incidents failed to show that this incident was reported to the state agency. The Electronic Health Record (EHR) showed R5 had diagnoses including dementia and major depression. The Minimum Data Set (MDS) dated [DATE] showed R5's cognition was severely impaired. The EHR showed that R2 had a diagnosis of paranoid schizophrenia. The MDS dated [DATE] showed R2's mental status of inattention and disorganized thinking behavior fluctuated and would come and go with changes in severity. The Brief Interview for Mental Status could not be completed. 2. A Nurse Practitioner (NP) progress note dated 6/23/24 by V7 (NP) documents R2 was found touching a peer in their room. Notably, R2 is reported to be in a relationship with this peer. On 9/26/24 at 10:10 AM, V7 (NP) stated she didn't witness R2 touching his peer, but the facility staff reported it to her. V7 did not know who the peer was R2 had been touching. V7 did not know why the nurse would have reported it to her if the two residents were in a relationship. V7 could not recall who the nurse was who reported the information to her. V7 was unaware of any relationships R2 was in and said it would not have been up to her to determine if R2 was capable of being in a relationship with another resident. 3. The Nursing Progress Note dated 7/13/24 at 22:55, written by V19 (Registered Nurse/RN), documented that R2 was observed hugging another male resident (R5), then moving his hands down and clutching his buttocks. On 9/27/24 at 1:50 PM, V19 (RN) stated they were the nurse for R2 on 7/13/24. V19 said when she returned from break, V8 (RN) told her about the incident of R2 hugging and groping R5's buttocks. V19 said she did not report the inappropriate touching to the administrator since it was reported to her by V8, and she felt it was V8's responsibility to report it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/24 at 2:10 PM, V8 (RN) stated that she couldn't recall the incident of R2 inappropriately touching R5. V8 said that since V19 was R2's nurse, she should have been the one to report it to V1(Administrator/abuse coordinator). 4. A Nursing Progress Note by V8 (RN) dated 7/15/24 at 12:55 AM documented that R2 was walking in the hallway with no underpants on; V8 was trying to persuade the resident to wear a gown, but (R2) refused. R2 walked to R5, who was sitting in the dining area and attempted to kiss the co-resident. V8 tried to re-direct the resident, and the resident took his shirt off and was completely naked. The resident walked into and entered R6's room. When V6 (Certified Nursing Assistant/CNA) tried to stop R2 from entering the room, R2 punched (V6) in the face. On 9/26/24 at 3:10 PM, V8 (RN) stated she saw the incident where R2 was going to kiss R5 on 7/15/24. V8 said she stopped R2 before he made contact with R5 and separated them. V8 said, she reported it to V1. On 9/26/24 at 3:50 PM, V6 (CNA) stated that on 7/15/24 at around midnight, R2 came out of his room without having on any underpants, took off his shirt, walked down the 2500 hallway, and tried to enter R6's room. V6 stated he first tried to cover R2 with a sheet. When V6 tried to stop R2 from entering the R6's room, R2 pushed V6 out of the way causing V6 to fall to the floor. When V6 was on the floor, R2 started swinging at V6 and hit him in the face. R2 began pointing and yelling at R6 saying R6 took something from him, but didn't say what it was. V6 said R2 was difficult to understand and could not discern what he was talking about. V6 said it was reported to the nurse and the police were called. On 9/26/24 at 9:00 AM, V1 (Administrator/Abuse Coordinator) stated he didn't report the inappropriate touching from R2 to another unknown resident on 6/23/24, 7/13/24, and 7/15/24 to public health until 9/26/2024. V1 said in reference to V7's progress note dated 6/23/24, V7 should have reported the incident to him. V1 stated his staff should have reported all these abuse allegations. The facility's Abuse Prevention Program Policy dated 11/22/2017 includes employees are required to report any allegation of potential abuse, neglect, exploitation, mistreatment, or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator. Reports will be documented and a record kept of the documentation. Should an act of aggression or violent behavior occur in the facility, a facility internal incident reports must be completed in accordance with the facility's policy. In cooperation with his or her supervisor, the internal incident report must be filed by the person who experienced the act of aggression.