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	04/23/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 31327 Based on interview and record review, direct care staff member failed to follow the facility's policy and procedures and immediately notify the nurse after a resident fall. This failure led to a delay of assessment by the nursing staff for the resident within the required time frame. This applies to 1of 3 residents (R1) reviewed for falls in a sample of 8. The findings include: On 4/16/25 at 10:13 AM, V4 (CNA-Certified Nursing Assistant) stated, On 4/7/25 between 10 AM to 10:15 AM, I brought (R1) to the shower room in his wheelchair. I put him on the shower chair. I had (R1) stand up and grab the handlebars. I scrubbed his back and butt with soap and a washcloth. Then I told (R1) to sit back down on his shower chair. Within 1 to 2 seconds, (R1) slides off. I picked him up and put him back on the chair. I asked (R1), does it hurt. He said no and that he has no pain. There were no injuries. I continued the shower. I asked (R1) if he wants me to tell anyone. (R1) said, Na, don't tell anyone right away. I dried him and put him in his gown and wheeled him back to his room. When I got to his room, I dressed (R1) in his regular clothes. I again asked him if he's okay and he said Yeah, I'm okay. I said do you want me to tell anyone about the fall. He said no. I forgot the name of the nurse who was working that day. I didn't tell the nurse. I should have reported it to her because she needed to assess him. I left his room and went to take care of my other residents. After work, I had class. V2 (DON-Director of Nursing) called me on the phone. She asked me what happened with (R1) in the shower room. I told her (R1) fell . She asked me why I didn't tell the nurse. She said she has to discipline me and she wrote me up. I know I should have reported the fall to the nurse. On 4/16/25 at 10:47 AM, V1 (Administrator) stated, (V4) should have reported (R1)'s fall to the nurse right away. (V4) has to call the nurse and she has to do the assessment before he can be picked up from the floor. In the evening, (R1) told (V12--R1's sister) about the fall that happened in morning shift when she came to visit him. Then (V12) told the evening nurse (V6-RN/Registered Nurse) about the fall. (V6) then did the assessment. There were no injuries. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/25 at 11:20 AM, R1 stated, (V4) gave me a shower. I was sitting on the shower bench. I stood up and grabbed the bar. (V4) scrubbed me with soap. Then I sat down in the middle of the bench. I sprayed myself with water. I think I may have dozed off. I slid off the bench. (V4) tried to pick him up. Then he put me back on the bench. He told me if I was gonna say anything to anyone. I said no. No nurse came and saw me in the morning. Then in the evening I told my sister (V12). Then she told the nurse. I don't know her name. The nursed asked me my name. They didn't do any vitals. I had no pain or injuries. On 4/16/25 at 12:06 PM, V6 (RN) stated, I worked on 4/7/25. I picked up a shift and started at 3 PM. The morning nurse never told me that (R1) fell because (V4) never told her about the fall. After I was done with the medication pass, (V12-R1's sister) came to the nursing station and wanted to talk to me. She told me that (R1) told her that he fell in the morning. I told her that the morning nurse never told me that. I checked the risk management in the computer to see if a fall happened. Nothing was there. I went to (R1)'s room. I asked (R1) what happened. He told me that he fell . I assessed him. (R1) told me that he didn't want to make a big deal about it and that's why he didn't tell the nurse. He told me he landed on his buttocks. He said (V4) helped or assisted him back to the chair. He was confused and and then said he thought (V4) pushed him. He had no pain during the time of the fall and when I assessed him. He had no injuries. When I gave (R1) his medication and checked his blood sugar at 4 PM, he didn't tell me anything about the fall then. I then notified nurse practitioner and the psychiatric nurse practitioner, (V1) and (V2). Yes, when a resident has a fall, the CNA has to report it to the nurse right away. On 4/16/25 at 12:40 PM, V7 (RN) stated, I worked in the morning on Monday 4/7/25 on the 400 unit from 7 AM To 3:30 PM. I was the nurse for (R1). (V4) was my CNA and he was assigned to (R1). (V4) never told me that (R1) fell . (R1) never told me that he fell also. If a resident falls, the CNA or whoever saw the fall has to call the nurse immediately. The nurse has to watch and see the position of the resident. The nurse has to assess for pain and range of motion. On 4/16/25 at 2:33 PM, V2 (DON-Director of Nursing) stated, (V4) was supposed to leave (R1) on the floor for safety reason when he fell in the shower room. Then he was supposed to inform the nurse, so the nurse could assess (R1) and determine if he could be safely transferred back to the shower chair and then his wheelchair. I talked to him on the phone. He told me that (R1) fell in the shower room, but he never reported it to the nurse. I did counseling over the phone. On 4/16/25 at 2:48 PM, V3 (ADON-Assistant Director of Nursing) stated she did a disciplinary with V4). She confirmed that V4 should have notified the nurse right away after the fall. V3 submitted the corrective action form dated 4/11/25 for V4. It shows he received counseling for not reporting a fall incident to the nurse in a timely manner and that it was an informal warning. R1's face sheet shows diagnoses of: cerebral infarction, adjustment disorder with depressed mood, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. R1's MDS (Minimum Data Set) dated 2/19/25 shows a BIMS (Brief Interview for Mental Status) score of 12 which means moderate cognitive impairment. R1 has impairments on one side of his upper and lower extremities. For showers, R1 was assessed as a 3, which means he needs partial/moderate assistance. For tub/shower transfer, he was assessed as a 2, which means he needs substantial/maximal assistance. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan dated 12/4/24 shows he is at risk for falls related to used of antidepressants, decreased safety awareness, and left sided weakness. Intervention: Anticipate and intervene to prevent recurrence. R1's progress notes and incident report dated 4/7/25 shows the following: Writer reported by (R1)'s sister that (R1) had fall this morning in 300 hall shower room. Per CNA who was with giving shower to (R1), CNA was soaping (R1)'s back while (R1) was standing and holding the grab bar. (R1) proceeded to sit down on the shower chair and slid off the chair because (R1) was not seated right and was still soapy. (R1) told CNA to pick him up from the floor and continue with the shower and not make a big deal about it. (R1) stated, After applying soap, I slid off from my wheelchair and landed on my buttocks, assigned CNA assisted me back to wheelchair. I didn't report it to my morning nurse. (R1) doesn't remember the exact time of fall incident. Writer assessed (R1) from head to toe with limited range of motion in lower and upper extremities; left side weakness as per usual due to CVA, denied hitting his head, no injuries were noted. Denied any pain and discomfort. Vitals done .Reminded (R1) to ask for help if needed and pull the call light for help. Facility's policy titled Falls (Undated) shows: Observed or unobserved and reported by staff member. Licensed nurse should conduct assessment immediately, including events leading up to the fall to determine when possible and causative factors 1. Observe positioning and overall conditioning. If head and neck are bent forward or backward in an extreme degree, do not move until seen by a physician .CNA: 1. Call for nurse and stay with resident. 3. Do not move.