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	05/15/2025

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 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** 33330 Based on interview and record review, the facility failed to protect a resident's right to be free from physical abuse by another resident. This failure resulted in R2 experiencing a right medial orbital (eye socket) wall blowout fracture when R1 became physically aggressive towards R2. This applies to 1 of 3 residents (R1) reviewed for resident-to-resident abuse in the sample of 5. The findings include: The facility's Final Incident Investigation Report Form submitted to IDPH (Illinois Department of Public Health) on May 9, 2025 shows, The incident happened on May 3, 2025 at 11:00 PM. The incident was reported to abuse coordinator by [V6] (RN-Registered Nurse), and a preliminary report was sent. The alleged perpetrator is [R1], and the alleged victim is [R2]. It was reported that [R1] was physically aggressive towards [R2]. [R1] was sent out for psych evaluation and [R2] was sent out for medical evaluation. The local police were called and on site. Although there were plans for [R1] to be sent out for psych evaluation, he was arrested instead. When [R2] came back from the hospital, hospital records indicate that [R2] has a fracture of the medial wall of the right orbit. [R1] was released from [local county jail] but has a court order that he isn't allowed within 900 feet of the facility Based on the known facts from medical record review and interviews, the following conclusions have been determined about the original allegation: With the available information, this incident is substantiated. Abuse is substantiated as follows: [R2] stated that [R1] came to his room and was swearing and calling [R2] racial slurs. [R1] left, then came back and slammed [R2's] door. Then he was swearing and using racial slurs towards [R2]. [R1] got up in [R2's] face and proceeded to hit [R2] across the face. [R2] hit the ground. Then [R1] got on top of [R2] and held him by his neck while swearing, yelling, and using racial slurs towards [R2]. A nurse/CNA (Certified Nursing Assistant) came rushing in the room and that is when [R1] stopped being physically aggressive towards [R2] and being distress by claiming that he was the victim. [R2] states his nose still hurts from the incident, and he is afraid [R1] will come back and hurt him again. [R2] stated prior to the incident [R1] was texting him; using racial slurs and threatening that he would hurt him. [R1] was upset with someone that isn't a resident at the facility and he was upset that [R2] would not provide him with this person's phone number, even though he told [R1] that he had nothing to do with situation. (continued on next page)

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	R2's hospital records dated May 3, 2025 at 11:51 PM show the following CT (Computed Tomography) scan results: CT of R2's face shows a right medial orbital wall blowout fracture. Patient has no entrapment on exam or visual field deficits. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on [DATE]. The EMR continues to show R1 left the faciity on [DATE] in the custody of the police, following a physical altercation with another resident, and did not return to the facility. R1 had multiple diagnoses including, ischemic heart disease, hypertension, low back pain, rheumatoid arthritis of the left knee, gout, anxiety disorder, PTSD (Post-Traumatic Stress Disorder), and heart disease. R1's MDS (Minimum Data Set) dated March 5, 2025 shows R1 was cognitively intact, required setup with personal hygiene, and was independent with all other ADLs (Activities of Daily Living). R1 was always continent of bowel and bladder. The EMR shows R2 was admitted to the facility on [DATE]. R2 has multiple diagnoses including, Type 2 diabetes, gastritis, cocaine abuse, cannabis abuse, schizophrenia, encephalopathy, alcohol abuse, bipolar disorder, and asthma. R2's MDS dated [DATE] shows R2 is cognitively intact, is independent with eating, requires setup assistance with oral hygiene and bed mobility, and supervision with all other ADLs. R2 is always continent of bowel and bladder. On May 14, 2025 at 10:37 AM, R2 was lying in bed in his room. The window shades were drawn, and the room was dimly lit. R2 did not wake up when his name was called or while speaking to R5 (R2's roommate). On May 14, 2025 at 1:17 PM, R2 was lying in bed in his room. R2 did not have any visible facial bruising or swelling. R2 denied vision problems. R2 said, On Saturday night (May 3, 2025), [R1] was upset about someone else, and he took it out on me. He argues a lot to get his point across. He was texting me from his room and saying he was coming down to my room. I told him not to, that it was late at night, around 11:00 PM, and I was already trying to sleep for the night. He came into my room and called me the N word. I yelled at him to get out of my room. He choked me and punched me in the face, and I fell from my bed to [R5's] side of the room, and [R5] tried to break things up. The CNA heard it all happening through the wall from next door and came running in. They sent me to the hospital, and I got a scan of my head and that's how they found the broken eye socket. I am very afraid he will come back to the facility and do the same thing to me again. He always broke the rules, so what is to stop him from breaking the rules and coming back here? I am afraid to go outside of the facility because he might come here and he knows where I like to go, so I haven't gone out. On May 14, 2025 at 1:25 PM, R5 came to R2's room and said he is R2's roommate and was present on May 3, 2025 when R1 came to the room and was physically aggressive with R2. R5 said he heard R1 yelling at R2 and saw R1 hit R2. On May 14, 2025 at 12:53 PM, V7 (LPN-Licensed Practical Nurse) said, I was the night shift nurse taking care of [R2]. The incident happened at change of shift. We were doing report and the CNA alerted me that something had happened between [R1] and [R2]. I did not see any visible injury. I called the police to help with the incident, and also the physician. The police called the paramedics for backup, and they took [R2] to the hospital. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On May 14, 2025 at 3:09 PM, V6 (RN) said, I was working the afternoon shift on May 3, 2025. I was caring for [R1]. It was change of shift when the incident happened, and I was still at the facility. I gave [R1] medication at 11:00 PM, and then I went to the medication room. I was setting up my cart for the next shift, and they came and told me there was an incident. They took [R1] out of the facility in handcuffs. On May 14, 2025 at 5:22 PM, V10 (CNA) said, I normally work night shift, and I pick up afternoon shifts quite often. I was working afternoon shift that day (May 3, 2025). I was watching [R1]. He was talking to someone at the nurse's station, and he went down [R2's] hallway. We have to keep an eye on him, but not make it obvious because he got mad when we followed him. I went to go check on my residents one last time and I was in the room next to [R2's] room, where [R1] had just entered. All of a sudden, I heard what sounded like a body being slammed against the wall and hit the floor. I ran into that room and caught the end of the altercation. We got [R1] to leave the room, and I stayed outside of the room to make sure [R1] didn't go back in the room. Someone else called the police. On May 14, 2025 at 1:06 PM, V8 (NP-Nurse Practitioner) said, she was familiar with R2. V8 said, The orbital fracture was as a result of the altercation. V8 continued to say she attempted to examine R2 following his hospitalization for the injury sustained following the physical altercation, but R2 was sleeping at the time of her visit and did not wake up to be examined. The facility's undated Abuse Prevention Program Policy, number 71146759.3 shows, Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This includes but is not limited to corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Definition: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means.Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.