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	11/17/2025

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess for, report, and document a resident's acquired pressure wounds prior to the wounds becoming unstageable.This failure resulted in R3 acquiring unstageable pressure injuries to the sacrum measuring 8 x 7 x 0.1 cm (centimeters, measuring length x width x depth) and right medial heel measuring 5.5 x 6 cm x unknown depth.This applies to 1 of 3 residents (R3) reviewed for pressure injuries. The findings include:R3's EMR (Electronic Medical Record) said he was admitted to the facility on [DATE] with multiple diagnoses, including paraplegia, degenerative disease of the nervous system, hereditary and idiopathic neuropathy, neuromuscular dysfunction of the bladder, presence of urogenital implant, ataxia, and impaired mobility. R3's EMR said he was dependent on staff for his ADLs (activities of daily living) care needs, including for toileting and transfers. The EMR said R3 was incontinent of bowel and required substantial staff physical assistance with his transfers. R3's admission Braden scale assessment dated [DATE] said he was at risk for pressure injuries, although R3's 5/2/2025 MDS (Minimal Data Set) said based on his clinical assessments and his Braden Scale, he was not at risk for development of pressure injuries and had none present during the look-back period.On 11/17/2025 at 1:15 PM, V9 (R3's Family Member) said R3 was transferred to the facility because his progressive neuromuscular dysfunction disorder required him to need staff assistance with his care, including toileting and transfers. V9 said R3 had a history of pressure injuries to his hip area and right heel prior to admitting to the facility. V9 said she was informed weeks after he admitted that he had acquired extensive wounds to the sacral area and right heel. V9 said R3 was transferred to the hospital on 5/26/2025 and then went to another facility. V9 said R3 was currently receiving ongoing aggressive treatment for his acquired pressure injuries at the facility. On 11/17/2025 at 12 PM, V11 (Wound Care Nurse/WCN) said she was aware of R3's history of pressure injuries prior to admission. V11 said on 5/19/2025, when assessing R3's healed left buttock non-pressure wound, she identified a new wound on his sacral-coccyx area. V11 said the wound was full-thickness and measured 7.6 x 6.8 x 0.1 cm with moderate serous exudate. V11 said she did not classify R3's wound type and did not document the wound's tissue because she wanted to have V16 (Wound Physician) assess R3 on 5/22/2025. V11 continued to say R3 was dependent on staff for his toileting hygiene and, at times was incontinent of bowel. V11 said staff was expected to assess resident's skin daily during care and report any abnormalities to prevent further skin complications. V11 said R3's sacral wound was not reported prior to her identifying it on 5/19/2025.On 11/17/2025 at 11 AM, V19 (Wound Physician) said he assessed R3 on 5/22/2025 and staged his sacral pressure wound as unstageable due to the necrotic tissue present. V19 said the wound measured 8 x 7 x 0.1 cm and had 40% thick necrotic tissue and required debridement. V19 said he then assessed R3's skin and identified a new wound to his right medial heel. V19 said the wound was also unstageable and presented as DTI (deep tissue injury) with a blood-filled blister. V19 said R3's right heel measured 5.5 x 6 cm x unknown depth. V19 said skin breakdown on residents at risk should be identified early to aid in preventing potential deterioration. V19 said he expected the facility staff to follow their pressure injury prevention and wound assessment policy to ensure residents at risk could be managed appropriately. R3's comprehensive care plan did not indicate he was at risk for skin breakdown prior to 5/19/2025. The care plan was updated on 5/19/2025 to indicate R3 had new facility-acquired wounds to his sacrum on 5/19/2025 and right medial heel on 5/22/2025. R3's ADL report from 5/01/2025-5/26/2025 showed he required limited to extensive assistance with his toileting needs. R3's Bath and Skin Report Sheet for May 2025 showed his weekly (every 7 days) comprehensive skin check was last done on 5/12/2025. The following scheduled skin assessment on 5/19/2025 was not documented.R3's Treatment Nurse Initial Skin Alteration Review (Wound Nurse) report dated 5/19/2025 said R3 had a new facility identified open wound to his coccyx area. The wound measured 7.6 x 6.8 x 0.1 cm. The assessment did not indicate the type of wound and the type of tissue present.R3's Specialty Physician Initial Wound Evaluation and Management Summary report dated 5/22/2025 said R3 had a facility-acquired unstageable (due to necrosis) sacrum full thickness wound. The wound had 40% necrotic tissue with moderate serous drainage and measured 8 x 7 x 0.1 cm. The report also said R3 had another facility acquired unstageable DTI of the right medial heel undetermined thickness wound. The wound measured 5.5 x 6 cm x unknown depth due to blood blood-filled blister. The facility's policy titled Pressure Injury and Skin Condition Assessment Policy, dated 09/2016, said the policy was established to provide guidelines for assessing, monitoring, and documenting the presence of skin