STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026

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 Note: The nursing home is disputing this citation.	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** Based on interview and record review, the facility to prevent abuse between two residents, resulting in R2 requiring an emergency room evaluation and sustaining bleeding above the eye, lip and bruising to the temple area. This applies to 2 of 5 residents (R1, R2) reviewed for abuse in a sample of 5. The findings include: R1 and R2's final incident report to IDPH (Illinois Department of Public Health) shows the following: (R1) stated that (R2) jumped at him because he was talking to himself. (R1) reported that (R2) threw an object at him but doesn't recall what the object was. (R1) stated that he and (R2) started tussling and that he was defending himself. (R1) acknowledges that he talks to himself and tends to swear. (R1) stated that he is aware of this behavior and is currently waiting for his medication to be adjusted. (R2) stated that (R1) was swearing at him and calling him derogatory names. (R2) stated he had water in his cup and poured it on (R1). (R2) stated that (R1) then began hitting him. Staff immediately intervened and separated both residents. (R2) also reported that he later learned that (R1) talks to himself and understands that (R1)'s derogatory statements were not directed towards him. (R1) was moved to another room. Both residents were educated to remain separated from each other. Based on the known facts from medical record review and interviews, the following conclusions have been determined about the original allegation.On 2/24/26 at 10:50 AM, R1 stated that he had a fight with R2. He said R2 attacked him. He said he has had schizophrenia for 20 years. He was listening to his voices and talking back to them in his room. R2 got annoyed at him and threw a cup at him which had some liquid inside. He stated that he punched R2 because R2 punched him. He said he was trying to hold him back. They both fell in the hallway. Staff separated them. They changed R1 to a different room.R1's face sheet shows the following diagnoses: Bipolar Disorder current episode depressed, severe with psychotic features and suicidal ideations. R1's MDS (Minimum Data Set) dated 1/18/26 shows that he is cognitively intact. R1's care plan dated 1/13/26 with a focus of abuse/neglect/exploitation trauma shows a goal that he will be treated with respect, dignity, and reside in the facility free of mistreatment (i.e., abuse/neglect) through next review. R1's care plan dated 2/12/26 shows a focus of hallucinations where he experiences auditory and visual hallucinations, which may lead to confusion and agitation.R1's progress note dated 2/9/26 at 11:40 PM, Around 8:38 PM, informed by co-nurse that this resident and his roommate had altercation in room. Co nurse separated both residents. Skin alteration noted. First aid treatment given, refused going to the hospital for evaluation despite educating and encouraging. 911 was called. R1's progress note dated 2/10/26 at 12:36 AM shows, (R1) is currently in a different room separated from the roommate. Noted a scratch on the right eyelid, scratch on the right chin and two big scratches on the right forearm. (R1) is still refusing to go to the hospital.On 2/24/26 at 4:26 PM, R2 stated that he was watching TV (Television) in his room. R1 was also watching TV on his side of the room. He was also laughing and talking to his voices. R2 got annoyed and told him if he could keep it down. R1 then walked over (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 Note: The nursing home is disputing this citation.	to R2's side of the room and got in his face. R2 told R1 to back up. Then R1 threw water at R2. R1 hit the side of his head. He received a black eye because R1 gave him a few swings. Then R1pushed him on the floor and he got on top of him and punched him. R2 stated he had to go to the hospital.R2's face sheet shows the following diagnoses: major depressive disorder, recurrent severe without psychotic features, suicidal ideations, and alcohol abuse, uncomplicated. R2's MDS dated [DATE] shows he is cognitively intact. R2's care plan dated 7/24/25 shows he has a history of criminal behavior. R2's care plan dated 7/25/25 with a focus of abuse/neglect has a goal that he will be treated with respect, dignity and reside in the facility free of mistreatment (abuse/neglect).R2's progress notes show the following: On 2/9/26 at 11:28 PM, Around 8:38 PM, informed by co-nurse that this resident and his roommate had an altercation in the room. Co-nurse separated both residents. This RN immediately assessed the resident. First aid treatment was given to his right arm. 911 was called.(R2) sent to hospital for evaluation via 911. On 2/10/26 at 12:25 AM, (R2) back from the hospital. Bruising on the left temple and dry dressing to the right forearm.On 2/24/16 at 10:16 AM, V2 (DON-Director of Nursing) stated that R1 had said that R2 jumped at him because R1 was talking to himself, which is part of illness. R1 reported that R2 threw an object at him. He couldn't recall what it was. They were the only ones their room. R1 stated he and R2 started tussling and he was defending himself. R2 said that R1 was swearing at him and called him derogatory names. R2 stated he had water in his cup and poured it on R1. R2 then stated R1 then began hitting him. Both R1 and R2 were separated. R1 was removed and placed in a different hallway on the same floor. R2 was sent to the ER (Emergency Room) for evaluation. R1 refused to go to the hospital. V2 stated, We did our investigation, and the allegation of abuse was substantiated. Yes, it's our job to prevent abuse here.On 2/24/26 at 12:05 PM, V1 (Administrator) stated that R1 talks to himself. R2 got annoyed and threw some kind of liquid at him. Both of them were separated. V1 stated, Based on our investigation, abuse occurred. It's our job to prevent abuse.On 2/24/26 at 3:10 PM, V4 (RN-Registered Nurse) stated that he worked on 2/9/26 when the incident between R1 and R2 happened. He said he was not their assigned nurse. V14 (RN-Registered Nurse) was their assigned nurse but she was attending to another resident. V4 stated he saw R2 in the corner of the hallway lying on the floor while R1 was on top of him hitting the face of R2. V14 rushed to them and calmed R1 and told him to stop hitting R2. He stated the rest of the staff came and separated them. When he asked R1 why he was hitting R2. He said it was self-defense. V4 told V14 what happened, and she took care of the rest. R2 was sent to the hospital.On 2/24/26 at 3:42 PM, V12 (CNA-Certified Nursing Assistant) stated he didn't see R1 and R2 in their room. He heard a commotion and saw them yelling at each other in the hallway. He saw R1 yelling at R2, but he didn't see them hitting at that moment. He saw R2 was on the floor. He stated he didn't know what actually happened for them to be fighting. V12 helped R1 move to new room. He stated that R2 had some bleeding above his eye and above his lip. R2 was transferred to the hospital.On 2/24/26 at 3:59 PM, V13 (CNA) said she heard some yelling. She saw R2 on the floor and R1 was on top of him. They were punching and fighting with each other. She stated the nurses and CNA's came and helped separate them. R1 was moved to another room. Facility's abuse policy titled Abuse Prevention and Reporting (Undated) shows: Guidelines: This facility affirms the right our residents to be free from abuse, neglect.and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse.Abuse means any physical or mental injury inflicted upon a resident other than by accidental means. Physical abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment. A resident to resident altercation should be reviewed as a potential situation of abuse.