

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 04/02/2026
NAME OF PROVIDER OR SUPPLIER River View Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Minimal harm or potential for 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** Based on observation, interview and record review, the facility failed to prevent the physical and verbal abuse of residents at the facility for five of six residents (R1, R2, R4, R5, and R6) reviewed for abuse in a sample of 9. This failure resulted in R6 experiencing psychosocial harm, feeling unsafe and expressing desire to leave the facility. The findings include: 1. MDS, dated [DATE], shows R1's cognition was moderately impaired.MDS, dated [DATE], shows R2's cognition was intact.On 3/30/26 at 11:40 PM, R2 stated while she and R1 were laying in their beds R2 [NAME] water on R1 to wake her up because R1 was antagonizing R2 throughout that day and telling R2 that R1 was going to send her to jail. R2 stated R1 then began hitting R2 on the left side of her face / head/ chin. R2 stated her head still hurt from being hit and that she had multiple prior surgeries on her head. R2 stated she was hit by R1 during the altercation and identified her left temple, left cheek, left side of her chin, and along both sides of her face as areas that were hit by R1. R2 stated R1 also bit her on her third and fourth fingers and pulled back her fingernail. R2 stated a nurse came in and stopped R1 from hitting R2. On 3/30/26 at 12:11 PM, R1 stated she woke up wet and did not know why and then realized R2 threw water on her when R1 was asleep. R1 stated she hit R2 three times after R2 hit R1. R1 stated R2 also hit R1 in the face causing visible bruising area above R1's right eyebrow and one across the bridge of R1's nose at the time of the altercation.On 3/30/26 at 12:29 PM, V3 (Registered Nurse - RN) stated she heard a commotion from R1 and R2's room and went to investigate. V3 stated when she entered R1 and R2's room during the altercation, she was focused on R1 standing without assistance, was concerned R1 was going to fall, and called for help but did not see the residents hit each other. V3 stated R1 was wet and she saw a mark on R1's face but was unsure if the mark was caused by an altercation. V3 stated she did not see the mark on R1's face prior to the altercation. V3 stated she did not see any injuries on R2.Hospital Emergency Department Note regarding R2, dated 3/7/26, shows, Presenting with left hand swelling / pain right facial scratches, and right hand bite marks after an altercation with her roommate. According to the petition filled out by nursing home, patient poured a cup of water on her roommate which started the altercation. Patient also complaining of facial pain in her cheeks due to being punched. EXAM. HEAD Small abrasion to right cheek. Patient complains of tenderness to bilateral cheeks upon palpation. Right hand: 1 mm superficial skin flap abrasion to right 4th dorsal middle phalanx. No bleeding. Dried blood underneath right 3rd fingernail. Fingernail intact. Patient with tiny superficial wound to finger that she says is from a human bite. Treated with local wound care and bacitracin. Review of nursing progress notes, dated 3/7/26 and 3/8/26, fail to show documentation of any injuries sustained by R1 or R2 during their altercation on 3/7/26. Physician Progress notes, dated 3/8/26, shows, [R2] has a tiny scratch along her jaw.Tiny superficial scratch noted along the jaw/face area following altercation with roommate, no bleeding, drainage, or signs of infection.Final Incident Investigation Report Form regarding the 3/7/26 incident, shows R2 alleged R1 was threatening to take R2 to jail so R2 threw water on R1. The report shows R1 approached her and began swatting at her and [R2] pushed [R1]. The investigation interviews show R1 denied hitting or being hit by R2. The report shows the facility did not substantiate the allegation of resident physical (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 - Minimal harm or potential for actual harm Residents Affected - Few	abuse. The final report fails to show if R2 was asked if she was hit or if she was injured. The report indicated a full head to toe assessment was completed to assess for resident injury, but no documentation of R1 or R2's injuries were identified in the facility clinical record other than the facility physician and emergency department notes. The investigation failed to show review of the hospital records or physical/skin assessments of R2 to identify any injuries. On 4/1/26 at 10:30 AM, V3 (PRSD - Psychiatric Rehabilitation Services Director) stated she did not review the physician reports regarding R1 and R2's altercation and usually uses the resident interviews to determine if abuse was substantiated. After reviewing the emergency department documentation for R2, V3 stated if she had reviewed the documentation at the time of the investigation she would have substantiated that abuse did occur between R1 and R2 on 3/7/26. V3 stated she utilized the word swatting as meaning attempting to hit and that neither R1 or R2 used the word swatting during the investigation. V3 stated she could not remember if she asked R2 if R1 made contact with R2 when R2 was swatting. V3 was also not confident if she asked R2 if R2 was injured during the incident. V3 stated she was not aware of any pain to R2's face or any bite marks or blood was identified on R2's hands at the hospital as she did not review the hospital documentation during the investigation. On 4/1/26 at 3:15 PM, V1 (Administrator) stated he was aware that R2 hit R1 during the altercation but V1 thought that the altercation was not an incident of abuse because R2 had dementia. 2. MDS, dated [DATE], shows R4's cognition was intact. MDS, dated [DATE], shows R5's cognition was intact. Final Incident Report Form shows on 3/23/26 R5 alleged R4 pushed R5 and scratched her face because R4 did not like R5. The report shows R4 alleged that R5 pulled R4's hair but R5 denied pulling R4's hair. The investigation fails to include a physical assessment of any injuries to R5's face. The report shows V5 (Marketing) reported she witnessed R4 having her hand wrapped around R5's hair, V6 (CNA- Certified Nursing Assistant) stated she witnessed the two residents come off the elevator and noticed R5 had a scratch on her face and V7 (Monitor) witnessed R5 push R4 and R4 reached and grabbed R5's hair. R9 reported he saw R4 try to swing at R5 and pull R5's hair. R7 stated he saw a scratch on R5's face after the incident. R8 stated he witnessed R4 try to pull R5 back into the elevator. The report shows the allegation of abuse was substantiated. Involuntary petition, dated 3/23/26, shows R4 was involuntarily admitted to the hospital due to becoming physically aggressive toward another resident and pulling the resident's hair. On 3/30/26 at 12:05 PM, R5 stated she and R4 were the only residents in the elevator when R4 reached up and scratched R5's face while she was standing next to R4 in her wheelchair. R5 stated she still had marks from the altercation and pointed to a faint red superficial streak on R5's left cheek perpendicular to the side of R5's mouth. The streaks measured approximately one inch long. R5 pointed to another faint red streak perpendicular to her jaw line approximately one inch long. R5 stated R4 yelled F***ing [NAME] Rican B***** when R4 reached up and attacked her. On 3/31/26 at 11:00 AM, R4 stated R5 attacked her out of nowhere. R4 had several superficial scratch marks on her right inner forearm. R4 stated she was not sure why the altercation occurred. R4 stated R5 being [NAME] Rican had nothing to do with the altercation and R4 stated she scratched and pulled R5's hair. On 3/31/26 at 11:09 AM, R8 stated he witnessed R4 trying to pull R5 backwards when they were fighting. Physician progress note, dated 3/24/26, shows R5 had a right side superficial facial scratch from an altercation the day prior. Nursing progress note, dated 3/23/26, shows R5 had an altercation with a resident resulting in a scratch on the left side of her face. Physician progress note, dated 3/24/26, shows R4 was seen regarding her behaviors and ongoing medication refusals. The note shows R4 sustained a small scratch to her right hand. The note shows the facility staff were to Continue behavior watch and close nursing supervision. 3. MDS, dated [DATE], shows R6's cognition was intact. Preliminary Incident Investigation Report Form, dated 3/30/26, shows R4 and R6 were involved in a physical altercation in which both residents scratched each other, and the investigation was pending. On 3/31/26 at 11:27 AM and 3:30 PM, R6 stated she was trying to exit the elevator and R4 was blocking the elevator door. R6 stated when she tried to move past R4, R4 backed up into R6 and prevented her from exiting. R6 stated she again attempted to (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exit and R4 again backed into R6. R6 stated she hit R4's arm lightly and told her to stop. R6 stated R4 grabbed R6's arm and began to scratch R6. R6 had several scratches on her right arm located above her wrist (approximately one inch long), above her right inner elbow (four small scratches in a row with the two outside scratches both having longer scratches approximately two inches in length), mid upper arm above her inner elbow (three superficial abrasions), on the side of her right upper arm (a bruise with a scab over a scrape approximately two inches long), and under her upper arm (a dark purple bruise approximately two inches long.) R6 stated R4 was a bully and that R4 purposely backed up into R6 before, and R6 wanted to press charges against R4. R6 stated she no longer felt safe in the facility and felt R4 did not have the right to physically or verbally abuse her. R6 stated she was in a previous physical altercation with R4 over a year ago and that R4 continues to make verbal insults, shows (R6) her middle finger, and antagonizes (R6). On 3/31/26 at 11:00 AM, R4 stated R6 attacked her out of no where and was not sure why the altercation occurred. Nursing Progress Note, dated 3/30/26, shows R4 had an altercation with a resident and had minor scratches on her right forearm with no bleeding noted. Nursing progress notes, dated 3/31/26, show R6 had partial thickness lines of dried fibrinous exudates on bilateral arms length of 0.5 to 1.8 cm. The record shows R6 received physician orders for topical antibiotics. The progress notes show R6 verbalized the wounds were a result of a scratch. The progress notes show R6 expressed a desire to leave the facility. On 3/31/26 at 11:09 AM, R8 stated R4 bullied R6 at the facility for some time and he witnessed the two fighting and tried to break them up. R8 stated R6 was trying to step off the elevator and R4 tried to push her way through R6. R8 stated R6 became very upset and exploded like she could not take it anymore. She just let go and blew up. Abuse Prevention and Reporting document, undated, shows, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. This will be done by: .Implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury. The term 'willful' in the definition of abuse' means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. An example of deliberate ('willful') action would be a cognitively impaired resident who strikes out at a resident within his/her reach, as opposed to a resident with a neurological disease who has involuntary movements (e.g., muscle spasms, twitching, jerking, writhing movements) and his/her body movements impact a resident who is nearby. Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. 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.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to report resident injuries sustained during altercations and perform thorough investigations of resident abuse allegations. This applies to 4 of 4 residents (R1, R2, R4, R5) reviewed for abuse in a sample of 9. The findings include: 1. MDS, dated [DATE], shows R1's cognition was moderately impaired. MDS, dated [DATE], shows R2's cognition was intact. On 3/30/26 at 11:40 PM, R2 stated during an altercation R2 threw water on R1 and R1 then began hitting R2 on the left side of her face / head/ chin. R2 identified her left temple, left cheek, left side of her chin, and along both sides of her face as areas that were hit by R1. R2 stated R1 also bit her on her third and fourth fingers and pulled back her fingernail. On 3/30/26 at 12:11 PM, R1 stated during the altercation she hit R2 three times after R2 hit R1. R1 stated R2 also hit R1 in the face causing visible bruising area above R1's right eyebrow and one across the bridge of R1's nose at the time of the altercation. On 3/30/26 at 12:29 PM, V3 (Registered Nurse - RN) stated R1 was wet and she saw a mark on R1's face but was unsure if the mark was caused by an altercation. V3 stated she did not see the mark on R1's face prior to the altercation. V3 stated she did not see any injuries on R2. Hospital Emergency Department Note regarding R2, dated 3/7/26, shows, Presenting with left hand swelling / pain right facial scratches, and right hand bite marks after an altercation with her roommate. According to the petition filled out by nursing home, patient poured a cup of water on her roommate which started the altercation. Patient also complaining of facial pain in her cheeks due to being punched. EXAM. HEAD Small abrasion to right cheek. Patient complains of tenderness to bilateral cheeks upon palpation. Right hand: 1 mm superficial skin flap abrasion to right 4th dorsal middle phalanx. No bleeding. Dried blood underneath right 3rd fingernail. Fingernail intact. Patient with tiny superficial wound to finger that she says is from a human bite. Treated with local wound care and bacitracin. Review of nursing progress notes, dated 3/7/26 and 3/8/26, fail to show documentation of any injuries sustained by R1 or R2 during their altercation on 3/7/26. Physician Progress notes, dated 3/8/26, shows, [R2] has a tiny scratch along her jaw. Tiny superficial scratch noted along the jaw/face area following altercation with roommate, no bleeding, drainage, or signs of infection. Final Incident Investigation Report Form regarding the 3/7/26 altercation between R1 and R2, shows R1 approached her and began swatting at her and [R2] pushed [R1]. The investigation interviews show R1 denied hitting or being hit by R2 but fails to show if R2 was asked if she was hit or if she was injured. The report indicated a full head to toe assessment was completed to assess for resident injuries, but no documentation of R1 or R2's injuries were included in the report. The investigation failed to show review of the hospital records or facility physical/skin assessments of R2 to identify any injuries sustained during the altercation. On 4/1/26 at 10:30 AM, V3 (PRSD - Psychiatric Rehabilitation Services Director) stated she did not review the physician reports regarding R1 and R2's altercation and usually uses the resident interviews to determine if abuse was substantiated. V3 stated she was not aware that any pain to R2's face or any bite marks or blood was identified on R2's hands at the hospital as she did not review the hospital documentation during the investigation. After reviewing the emergency department documentation for R2, V3 stated if she had reviewed the documentation at the time of the investigation she would have substantiated that abuse did occur between R1 and R2 on 3/7/26. V3 stated she utilized the word swatting as meaning attempting to hit and that neither R1 or R2 used the word swatting during the investigation. V3 stated she could not remember if she asked R2 if R1 made contact with R2 when R2 was swatting. V3 was also not confident if she asked R2 if R2 was injured during the incident. Abuse Prevention and Reporting document, undated, shows, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. This will be done by: .Implementing systems to promptly and (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences. The Administrator or Designee will initiate an investigation to the allegation which may include (1) interviewing all persons who may have knowledge (2) Review medical records, review of all circumstances surrounding the incident. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents. The initial report to Department of Public Health shall include the following information, if known at the time of the report: .Any obvious injurie or complaints of injury. 2. MDS, dated [DATE], shows R4's cognition was intact. MDS, dated [DATE], shows R5's cognition was intact. Final Incident Report Form shows on 3/23/26 R5 alleged R4 pushed R5 and scratched her face. The report shows V6 (CNA- Certified Nursing Assistant) stated she witnessed R5 had a scratch on her face. The report shows R7 stated he saw a scratch on R5's face after the incident. The investigation fails to include a physical assessment of any injuries to R5's face or R4's arm. On 3/30/26 at 12:05 PM, R5 stated during the altercation, R4 reached up and scratched R5's face. R5 stated she still had marks from the altercation and pointed to a faint red superficial streak on R5's left cheek perpendicular to the side of R5's mouth. The streaks measured approximately one inch long. R5 pointed to another faint red streak perpendicular to her jaw line approximately one inch long. On 3/31/26 at 11:00 AM, R4 stated R5 attacked her and R4 had several superficial scratch marks on her right inner forearm. R4 stated she scratched and pulled R5's hair. Nursing progress note, dated 3/23/26, shows R5 had an altercation with a resident resulting in a scratch on the left side of her face. Physician progress note, dated 3/24/26, shows R5 had a right side superficial facial scratch from an altercation the day prior. Physician progress note, dated 3/24/26, shows R4 sustained a small scratch to her right hand.		