

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2025
NAME OF PROVIDER OR SUPPLIER Rivaya Care of Des Plaines		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 Ballard Road Des Plaines, IL 60016	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781</p> <p>Based on observation, interview, and record review the facility failed to ensure ongoing assessment, monitoring is implemented to identify new skin impairment to resident who is at risk and to notify physician for appropriate wound treatment. The facility failed to follow wound care treatment as ordered by physician. The facility failed to update wound care plan for newly identified wound and notify the family member. The facility failed to follow manufacturer recommendation in using low air loss mattress. This deficiency affects all four (R2, R3, R4, R5) residents reviewed for Pressure ulcer/Wound Prevention and Treatment Management.</p> <p>Findings include:</p> <p>1. On 4/8/25 at 9:48AM, V9 family member complaint of facility providing improper wound care to R2.</p> <p>On 4/8/25 at 10:12AM, Reviewed R2's medical records with V5 Wound Care Nurse (WCN) and V4 Infection Preventionist (IP). R2 was admitted on [DATE] with diagnosis listed in part but not limited to Type 2 Diabetes Mellitus with hyperglycemia, Unstageable Pressure ulcer of right buttock, Severe Morbid obesity due to excess calories, Peripheral vascular disease, Chronic obstructive pulmonary disease. Braden scale/skin assessment dated [DATE] indicated R2 is at high risk for skin impairment. Wound care physician wound assessment dated [DATE] indicated R2 acquired new identified skin impairment on Right hip, Left buttocks and Sacral. Right hip DTI pressure ulcer measures 5cmx5cmx0.1cm 80% maroon, 20% open dermis, light serosanguinous drainage. Left buttock skin tear measures 3cmx2cmx0.1cm, 100% dermis. Sacral diaper dermatitis (MASD), 100% patchy redness and excoriation. Physician order sheet indicated: Sacral cleanse with normal saline, apply zinc oxide or vit A&D ointment every shift and as needed ordered 11/5/24. R hip cleanse with normal saline, apply Medi honey, Adaptic cover with a foam or bordered gauze dressing ordered 11/6/24. Left buttocks cleanse with normal saline, apply xeroform, cover with a bordered gauze dressing ordered 11/5/24.</p> <p>R2's comprehensive care plan indicated R2 has alteration in skin integrity and is at risk for additional skin breakdown related to comorbidities, decreased mobility, diabetes unavailability due to condition. Care plan was not updated, and no new intervention was formulated when R2 had 2 newly acquired skin impairment on 11/5/24 during wound rounds with physician. No documentation was found V9 Family member was notified of change in R2's skin condition. Informed V5 WCN of concern identified. V5 said V10 Wound care coordinator (WCC) usually notify the family member of any skin changes and updates the wound care plan.</p> <p>(continued on next page)</p>		

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/8/25 at 10:48AM, Informed V2 DON (Director of Nursing) of above concerns. V2 said R2's wound care plan should be updated and with new interventions for newly acquired skin impairments/pressure ulcers. V9 family member should also notify of new identified skin impairments and wound treatment management.</p> <p>On 4/8/25 at 12:46PM, Informed V6 Care Plan Coordinator (CPC) of above concerns. V6 CPC said she initiated wound care plan upon resident admission but V11 WCC updates the care plan and does MDS/Resident assessment wound coding. V6 said V11 should update R2's wound care plan and notify and update V9 Family member of changes in skin conditions.</p> <p>On 4/8/25 at 1:15PM, Informed V10 Wound Care Coordinator of above concerns. V10 said he should update R2's care plan and formulates new interventions for the new identified skin impairments on 11/5/24 during rounds with wound care physician. V10 said he did not notify V9 Family member of R2's acquired new skin impairments because R2 is alert and oriented x3. V10 said he should notify R2's family member for any changes in R2's medical condition including new acquired skin impairments and update with new wound treatment management.</p> <p>On 4/8/25 at 3:00PM, Informed V1 administrator of above concerns.</p> <p>2. On 4/8/25 at 1:31PM, Observed R3 lying in bed with low air loss mattress. R3 was connected to oxygen via nasal cannula at 2 LPM (liters per minute). R3 is alert and oriented x 3, able to express and verbalize needs to staff. V5 and V12 repositioned R3 to her left side lying position. V5 removed bordered gauze dressing on sacral area with minimal serosanguinous drainage. V5 cleansed with NSS (Normal saline solution). V5 said R3 has stage 4 sacral pressure ulcer with clean wound 100% reddish pink tissue granulation. V5 applied hydrogel then apply Permacol/collagen and covered with foam dressing. Informed V5 of observation made during wound dressing bordered gauze dressing removed from R3 prior to wound care and he applied foam dressing. V5 was also informed no soft gel like sheet was observed when he removed the bordered gauze dressing. (Gauze dressing is absorbent and used for covering and protecting wounds while foam dressing creates moist environment, absorb moderate to heavy exudate, and provide cushioning, particularly for wounds with bony prominences). Permacol/collagen dressing absorb wound exudate and convert into soft gel like sheet which helps maintain a moist wound environment conducive for healing). V5 said R3 should have foam dressing as ordered instead of gauze dressing.</p> <p>R3 was admitted on [DATE] with diagnosis listed, in part, but not limited to Stage 4 Sacral pressure ulcer, Diaper dermatitis, Type 2 Diabetes Mellitus, Severe morbid obesity, End stage renal disease, Acute respiratory failure. Admission Braden scale/skin assessment indicated at R3 is at risk for skin impairment. Physician order sheet indicated Sacrum cleanse with NSS, apply wound gel and cover with collagen sheet, secure with bordered foam dressing.</p> <p>On 4/9/25 at 9:37AM, Informed V2 DON and V4 IP of above concern. V2 DON said they should be following physician order in providing wound treatment to resident.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. On 4/8/25 at 1:50PM, Observed R4 lying in bed with low air loss mattress. R4 is alert and oriented x 3, able to express and verbalize needs to staff. He has right upper PICC line connected to IVPB (Intravenous piggy bag) antibiotic. He has right heel dressing connected to wound vac machine. He has right heel boot. V5 said R4 is recently admitted from hospital with IVPB antibiotics due to infected vascular wound on right heel. Observed V12 CNA entered the room without proper PPE for EBP, she did not wear gown. V5 WCN and V12 repositioned R4 to his left side lying position. V5 removed sacral bordered gauze dressing soaked with heavy greenish brown wound drainage. V5 cleansed all 3 wounds with NSS. V5 said R4 has stage 4 on the following locations: Right ischium and sacral area has 90% granulation tissue and 10% of slough formation. Left ischium has 80% tissue granulation and 20% slough formation. V5 apply the following to all 3 wounds: Medi honey, then calcium alginate and covered with foam dressing. Informed V5 of observation made during wound care bordered gauze dressing was removed from all wound dressing prior to wound care, and he applied foam dressing. Informed V5 that V12 did not wear proper PPE during wound care. V5 said R4 should have gauze dressing as ordered instead of foam dressing. V5 said V12 should wear gown in addition to gloves and mask.</p> <p>R4 was admitted on [DATE] with diagnosis listed in part but not limited to Acute osteomyelitis, Stage 4 sacral pressure ulcer, Paraplegia, Acute embolism, and thrombosis of deep vein of lower extremities, Atrial fibrillation, Congestive heart failure. Admission Braden scale/skin assessment dated [DATE] indicated at risk for skin impairment. Active physician order sheet indicated: Left ischium cleanse with NSS, pat dry, apply medical grade honey, calcium alginate and cover with bordered gauze dressing every day and PRN. Right ischium cleanse with NSS, pat dry, apply medical grade honey, calcium alginate and cover with bordered gauze dressing every day and PRN. Sacrum cleanse with NSS, pat dry, apply medical grade honey, calcium alginate and cover with bordered gauze dressing every day and PRN. Low air loss mattress.</p> <p>On 4/9/25 at 9:37AM, Informed V2 DON and V4 IP of above concern. V2 DON said they should be following physician order in providing wound treatment to resident.</p> <p>4. R5 was admitted on [DATE] with diagnosis listed, in part, but not limited to Idiopathic peripheral autonomic neuropathy, Type 2 Diabetes Mellitus, Methicillin resistant staphylococcus infection, Hypertension with chronic kidney disease with heart failure, Chronic venous insufficiency, Dependence on renal dialysis. Braden scale/skin assessment dated [DATE] indicated at risk for skin impairment. Active physician order sheet indicated: Right lower abdomen cleanse with NS, apply skin prep cover with hydrocolloid every MWF and as needed for skin tear. Scrotum cleanse with NS, apply collagen and calcium alginate leave open to air every other day and PRN. Metro cream external cream 0.75% apply to sacral topically every day shift and PRN for MASD cleanse with NS, apply metro cream, Vit A & D ointment and Zinc oxide leave open to air. Nystatin powder 100,000 unit/gm apply to scrotum topically two times a day for Candida scrotum. Zinc oxide ointment apply to affected area topically two time as day and PRN. Wound care plan indicated he is at risk for alteration in skin integrity related to incontinence of bladder and bowel, impaired mobility status, decreased sensory perception, comorbidities, failure to thrive, PVD, End stage disease process. Interventions: Skin will be checked during routine care on a daily basis and during the weekly/biweekly bath or shower schedule. Any skin integrity tissue concerns will be conveyed to the charge nurse for further evaluation and or treatment changes/new interventions and the MD will be called PRN. Provide low air loss mattress.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/8/25 at 2:07PM, Observed R5 lying in bed with low air loss (LAL) mattress. R5 had flat sheet and folded thick cloth bath blanket in quarters over the mattress. Observed Nystatin topical power bottle 100,000 units per gram at bedside, labeled indicated apply to scrotal area twice a day. R5 wears disposable brief. Showed observation to V5 WCN and V12 CNA/Wound Tech. Both said R5 should only be on flat sheet over the LAL mattress. R5 said he did not request to have folded bath blanket over the mattress. R5 is alert and oriented x 3, able to express and verbalize needs to staff. R5 has morbid obese abdomen. R5 said his abdominal folds hurts, left hip and sacral area. R5 said they apply zinc oxide to his sacral area. R5 said they apply nystatin powder to his abdominal folds. R5 said he did not receive wound treatment yesterday. V12 said nystatin power is left at bedside for the CNA to apply. V5 said nystatin powder should not be left at bedside and CNA cannot apply it. V5 said treatment was not done because R5 was in dialysis yesterday. V5 said R5 has MASD on sacral area and healed right side abdominal skin tear. V12 repositioned R5 to his right side. Observed excoriation on sacral area with bleeding. Blood stained observed on disposable brief and folded bath blanket. Observed excoriation on left side of the abdominal folds and open wound on left hip. V5 said the excoriation on left side of abdomen and open left hip are new to him. V5 said R5 has metro cream, zinc oxide and Vit A & D ointment to his sacral area. Observed V5 prepare wound treatment for R5. Observed metro cream prepared obtained from another resident's medication. Informed V5 of observation made. V5 searched the treatment cart but could not find R5's metro cream medication. V5 said it's probably in another treatment cart. V5 left the treatment cart with open drawer and unlocked. V5 returned and said he could not find R5's metro cream medication. Informed V5 he left his treatment cart opened and unlocked. V5 said, treatment cart should be kept locked when not in sight. V5 took single use packet of zinc oxide and Vit A & D ointment from the cart. V5 apply zinc oxide to sacral area without cleansing with NSS. Called attention of V5 he applied the treatment without cleaning. V5 apologized and cleansed the sacral wound with NSS, apply zinc oxide and Vit A & D. V5 said R5 did not have metro cream medication.</p> <p>On 4/8/25 at 2:15PM, V5 said left excoriation of left abdominal fold and open wound on left hip are new. Surveyor requested to assess the entire abdominal folds. R5 has obese abdomen. V12 lifted the abdominal folds and observed accumulation of dried powered in the abdominal folds with foul odor. V12 cleansed abdominal folds with wipes. Observed excoriation in the entire abdominal folds with bleeding. R5 said he has had these excoriations for almost 2 weeks, and it hurts. R5 said V11 WCN and CNAs applied nystatin powder to his abdominal folds. V5 obtained measurement of 48cm x 3cm x 0.1cm. V5 applied calcium alginate and covered with bordered gauze dressing. V12 repositioned R5 to his right side. V5 measured left hip open wound and obtained 1cm x 1.5 x 0.1cm, 100% red tissue granulation with minimal bleeding. V12 repositioned R5 to his back. Observed red, swollen, and excoriated scrotum with minimal bleeding. R5 has indwelling catheter with greenish brown sediments with blood visible to the tubing connected to urinary drainage bag. V5 cleansed with NSS, apply collagen, calcium alginate and leave it open to air.</p> <p>On 4/8/25 at 2:49PM, V13 LPN said he is the assigned nurse for R5. V13 said the treatment nurses do the wound treatment for R5. V13 is not aware of new skin impairment on R5's abdominal folds excoriations and left hip open wound. V13 said V14 CNA is the assigned CNA for R5 and did not report any new skin impairments to V13.</p> <p>On 4/8/25 at 3:00PM, Informed V1 of above concerns identified.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/8/25 at 4:46PM, V14 CNA said she has taken care of R5. V14 said she just returned to work from vacation yesterday. V14 said she applied zinc oxide to R5's sacral area and nystatin powder to abdominal folds. V14 said he observed R5's excoriation on abdominal folds 2 weeks ago with V11 WCN. V14 said she did not inform the floor nurse of abdominal excoriation because V11 is aware of it. V14 said she is aware any resident's new skin impairment should be reported to the nurse.</p> <p>On 4/9/25 at 9:37AM, Informed V2 DON and V4 IP of above concerns identified they failed to fail to ensure ongoing assessment, monitoring are implemented to identify new skin impairment to resident who is at risk and to notify physician for appropriate wound treatment The facility failed to follow wound care treatment as ordered by physician. The facility failed to update wound care plan for newly identified wound and notify the family member. The facility failed to follow manufacturer recommendation in using low air loss mattress. V2 DON said they should implement their policy in wound/skin assessment, prevention, treatment management.</p> <p>On 4/9/25 at 11:25AM, V11 WCN said he provided wound care to R5 on 4/6/25. V11 observed redness on abdominal folds not excoriation and applied zinc oxide ointment. V11 denied applying nystatin powder. V11 said he did not document his observation on abdominal folds. Reviewed R5's physician order for wound/skin treatment and facility's policy in wound care.</p> <p>On 4/9/25 at 1:30PM, Informed V1 Administrator of above concerns.</p> <p>Facility's policy on Wound Care reviewed 8/1/24 indicated:</p> <p>Policy statement: To provide wound care treatments/services based on standards of care under the direction of a physician.</p> <ol style="list-style-type: none"> 1. Risk assessment and prevention: b. Skin checks will be performed on a routine basis and PRN (As needed) 2. Wound assessment and documented tool <ol style="list-style-type: none"> a. Assess when a wound I identified, weekly and or as needed. 4. Continued/ongoing treatment <ol style="list-style-type: none"> a. The nurse will provide wound care per <D/NP for orders/treatment. c. Wound cleansing may be performed to removed foreign debris and surfaces contaminants from the wound. Wound may be cleansed prior to the administration of topical treatments as per MD/NP orders. <p>Facility's policy on Skin management: Specialty mattress</p> <p>Guidelines for the use of specialty mattresses</p> <p>Low air loss:</p> <p>(continued on next page)</p>		

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