STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145334	A. Building B. Wing	09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rivaya Care of Des Plaines	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to follow fall policy related to prevention of falls and implementation of resident-centered fall interventions on a resident with cognitive impairment. This failure affected one (R1) of five residents reviewed for accidents and supervision and resulted in R1 falling while walking without staff assistance and sustaining a right intertrochanteric hip fracture with associated intramuscular hemorrhage.Findings include:R1 is a [AGE] year-old, male, originally admitted in the facility on 08/20/25 with diagnoses of End Stage Renal Disease; Unsteadiness on Feet; Other Abnormalities of Gait and Mobility; Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris.According to R1's census report, R1 was admitted in the facility on 08/20/25 and was discharged on 08/22/25. On 09/10/25, he came back in the facility and was considered new admission.MDS (Minimum Data Set) dated 09/19/25 documented R1 has memory problem and his cognitive skills for daily decision making is severely impaired. His functional abilities recorded that he needs supervision or touching assistance when walking 10 feet; and partial/moderate assistance when walking 50 feet with two turns. MDS also indicated that he uses a manual wheelchair.Fall risk assessment dated [DATE] categorized R1 as high risk with a score of 15.R1's admit/readmit evaluation dated 09/11/25 documented:E. Neurological: Comments - confusionM. Mobility/Safety:a. walk in room: self-performance - supervisionb. walk in corridor: self-performance - activity did not occurg. wheelchairi. gait disturbance/unsteady gait Facility's incident report dated 09/19/25 recorded: R1 had an unwitnessed fall in the hallway. R1 was observed laying on the floor on his back with his walker on the side of him. Staff did full body assessment and R1 was complaining of pain. Pain medication was offered and given. Family and on call doctor were notified and order was given to send R1 out for further evaluation. Upon checking on R1's hospital status nurse on duty spoke with emergency room nurse and was informed that R1 was being admitted for a right hip fracture.R1's hospital records dated 09/19/25 documented: Xray of hip 2 views right and pelvis: Final result - Impression: Acute comminuted displaced and angulated right intertrochanteric fracture. CT (Computed Tomography) chest abdomen pelvis without contrast: Findings: Right intertrochanteric hip fracture with associated intramuscular hemorrhage. R1 was diagnosed with closed trochanteric fracture of right femur with nonunion and acute traumatic injury of cervical spine.On 09/24/25 at 2:18 PM, V10 (Certified Nurse Assistant, CNA) stated, On 09/19/25 at 1:30 AM, I was by the nurses' station and just heard a sound like something dropped on the floor. Immediately, I stood up and went to the direction of the sound and saw him (R1) on the floor by his room. I called nurse immediately, who was at the other side of the hallway, on the east side. Nurse came immediately. R1 said he wants to walk around. He complained of pain on his hip, right side. The time he fell, he was walking out from his room. I didn't see if he was using his walker at that time. I don't remember. I didn't hear any alarm. When I did my rounds around 12ish he was sleeping on bed. That time it happened; I was the only staff on that side (west wing) where R1 was. That time it was only me and the nurse worked on the west wing. Normally, he (R1) ambulates with a walker. there's no assistance needed because he can do it by himself. He can walk around by himself. He doesn't need assistance to walk around. He has no chair or bed alarm, not that I know of.On 09/24/25 at 2:53 PM, V11 (Licensed Practical Nurse, LPN) said, That time of incident on 09/19/25, I was on 1 East, because one nurse left at 1 AM and I was the only nurse on the first floor. I had two CNAs - one in west and one in east. CNA was sitting at the nurses' station. I heard CNA called me, I went there, and I saw R1 on the floor. I did assessment. I asked him (R1) and said he was walking. I asked him about pain and showed me his right hip. I gave him PRN (when needed) pain pill. I called physician he was sent out as ordered. V11 said, He is alert, oriented to self, time and place, able to verbalize needs. he never uses call light; always sitting in his room. His room is somehow close to nurse station. At night, sometimes, he was awake and will call nurse, nurse. He usually sits in bed and will call nurse, nurse. When we go to his room, he doesn't say anything. If you tell him to sleep, he will lie in bed. I don't know if he is a fall risk, it was the second time I took care of him. I've never seen him walking with a walker, only time he had was when he had the fall.R1's room was observed across nurses' station (1West). R1's door is on the side across nurses' station.On 09/25/25 at 10:25, V12 (Registered Nurse, RN) stated, R1 is very much confused; he talks nonsense. Not able to use call light. He is very much a fall risk patient. His room was just across the station. We always monitor and check on him at least every two hours. CNAs do their rounds also. RNs and CNAs do monitor at least every two hours. I always tell my CNAs to monitor him. I do my rounds then CNAs, so more or less he is monitored