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	04/17/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement fall preventive measures for R1 who require floor mats next to bedside for safety precautions. This deficiency affects one (R1) of three residents reviewed for Falls prevention program. Findings include:R1 is a [AGE] year-old, alert and orientated to person, place and time, with the following diagnosis in part but not limited to: Chronic obstructive pulmonary disease, atherosclerotic heart disease of native coronary artery without angina pectoris, chronic combined systolic congestive and diastolic congestive heart failure, unspecified asthma, insomnia, epilepsy, unspecified, Chron's disease, muscle wasting and atrophy.Facility incident reported dated 3/31/26 documents unwitnessed fall episode. Resident noted on floor lying in supine position bleeding from head, staff applied first aid to head. Upon assessment R1 remains alert and oriented x 3 (person, place and time), neuro-checks within normal range. Vital signs stable. Small laceration noted to right side of head. On 4/14/26 at 12:04 PM, R1 observed in room, lying in bed. R1 said he does recall fall on 3/31/26 and said he was asleep and must have rolled out of bed. R1 said floor mats were not in place during fall. R1 said the facility placed floor mats after the fall. R1 said he had two staples to back of head from the fall.On 4/14/26 at 12:10PM, V5 (Certified Nurse Aide) stated V5 has been working with R1 for a while prior to fall and prior to fall R1 did not have any floor mats in place. R1 now has floor mats in place after fall on 3/31/26 occurred. On 4/14/26 at 12:19PM, V9 (Certified Nurse Aide) said she heard R1 screaming for help on 3/31/26 and entered room and saw R1 on the floor on his back on the left side of the bed. R1 was bleeding from back of his head. V9 said R1 had both side rails up. V9 said she thinks the floor mats were in place.On 4/15/26 at 11:30 AM, V2 (Director of Nursing) said R1 should have had floor mats in place prior to fall. R1's fall intervention was updated for PT/OT for strengthening post fall on 3/31/26. V2 said R1's fall investigation was completed by restorative nurse, restorative nurse not available for interview.On 4/15/26 at 1:25PM, V11 (Agency Nurse), said she worked on 3/31/26 and said the nurse in charge of R1 had stepped off the floor when R1 had a fall. V11 said she heard V9 screaming for help and when she arrived at R1's room she saw R1 on the floor laying on his back with lots of blood on the floor. V11 said she does not recall seeing any floor mats in place. V11 gave first aid to R1 and left V9 with R1 and called 911 to transfer R1 due to head injury.On 4/16/26 at 12:01 PM, V1 (Administrator) said R1 did not have floor mats in place during fall.4/16/26 at 12:03 PM, V2 said R1 did not have floor mats in place during fall. V2 said her expectations are for all staff to follow fall prevention interventions in residents' care plan to promote resident safety.The Minimum Data Set (MDS) dated [DATE] section C- Cognitive Patterns- Brief Interview for Mental Status (BIMS) documents R1 score of 14.The Fall Risk Review assessment dated [DATE] documents R1 at High Risk for Fall.The Care Plan dated 12/08/22 documents R1 is at HIGH RISK for Falls as evidenced by the following risk factors and potential contributing Diagnosis: Decreased Strength and Endurance, Diabetes Mellitus, has episodes of Incontinence of Bladder & Bowel, Impaired Gait and Balance, Seizure Disorder, CHF, cardiac distress, COPD, asthma, Crohn's disease, G tube, neuropathy, Anxiety Disorder, Tachycardia, Major Depressive Disorder. Use of psychotropics. Enteral feeding. Interventions in place include 11/27/23- Floor (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 - Minimal harm or potential for actual harm Residents Affected - Few	Landing Mats when resident is in bed.Facility Policy on Falls Occurrence- revised 8/2024.Purpose: To consistently identify and evaluate residents at risk for falls and those who have fallen to treat or refer for treatment appropriately and develop an organization-wide ownership for all prevention to:To achieve each resident's maximum potential of physical functioning.To prevent or reduce injuries related to falls.To enhance residents dignity and self-worthTo rehabilitate residents to their fullest potential of function. The intent of this guideline is to ensure this facility provides an environment that is free from hazards over which the facility has control and provide appropriate supervision to each resident as identified through the following process.Identification of hazards and risksEvaluationImplementationMonitoringAnalysisResponsible Party.Fall risk evaluation: A fall evaluation is used to identify individuals who have predicting factors for fall this evaluation is completed upon admission, quarterly, annually and with significant change in condition, resident evaluated as at risk for falls will be identified and ritualized fall precautions developed for each resident's preventative measures shall be taken to decrease the number of falls whenever possible.Purpose:To consistently identify and evaluate residents who fall and to treat or refer for treatment appropriately.To achieve each residence maximum potential of physical functioning.To prevent or reduce injuries related to falls.To enhance residents' dignity and self-worth.To rehabilitate residents to their fullest potential of function. individualized interventions for each resident. If the evaluation finds the resident at risk, implement resident's specific interventions/ precautions.Fall Prevention is achieved through an IDT approach of managing predicting factors and implementing appropriate interventions to reduce risk for falls. Facility staff across all departments together with resident representatives and residents provide results for information with individualized care and approaches.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to follow their Staffing Policy by not having the appropriate staff available to meet the needs of the residents resulting in a resident (R1) fall. This failure affected one (R1) of three residents reviewed staffing.Findings include:On 4/14/26 at 12:19PM, V9 (Certified Nurse Aide) said the facility was short staffed on 3/31/26 because the facility always has three certified nurse aides for the second floor and that day there were only two certified nurse aides on the floor. V9 said the nurse for R1 was not on the floor when fall occurred, returned after 911 paramedics arrived at facility. On 4/15/26 at 11:30AM, V2 (Director of Nursing) said due to last minute call off, they were short staff on 3/31/26 only had 2 certified nurse aids on the floor, but they were scheduled to have three certified nurse aids. On 4/15/26 at 1:25PM, V11 (Agency Nurse), said the nurse for R1 was not on the floor when fall occurred. V11 said that day on 3/31/26 the second floor only had two certified nurse aides and V11 was the nurse on the opposite side of the unit. V11 said she called 911 for R1 and provided first aid. Facility Policy on Posting Direct Daily Staffing Numbers- Revised 8/2008Policy Statement I'm property will post on a daily basis for each ship the number of nursing personnel responsible providing direct care to residents. Policy interpretation and implementation At the beginning of each shift the facility shall post the nurse staffing that is as required by state and federal regulations. The information should be clear and readable format the information should be posted in a prominent place accessible to residents and visitors.Directly responsible for resident care means that individuals are responsible for resident's total care or some aspect of the residents care including but not limited to assisting with activities of daily living performing (ADLs), gastric intestinal feeds, giving medications, supervising care given by CNA's, and performing nursing assessment to admit residents or notify physicians of changes of conditions.Information shall be recorded on the form provided by the facilities administrator for each shift the information recorded on the form shall include:Name of the facilitythe date for which information is postedthe resident senses at the beginning of the shift for which the information is posted24 hour shift schedule operated by the facility the shift for which the information is postedthe type (RN, LPN, LVN, or CNA) And category licensed or non-licensed of nursing staff working during that shiftthe actual time worked during that shift for each category and the type of nursing stafftotal number of licensed and non-licensed nursing staff working for the posted shift. Computing hours of direct care staff working split shifts count only the total number of hours the individual is actually scheduled to work for the shift information being posted. (Example: You are posting data for the day shift. CNA reports to work and is scheduled to work for hours on the day shift and four hours on the evening shift. In computing the number of hours worked for that shift count only the four-hour schedule for the day shift. The remaining 4 hours would be counted toward the total on the evening shift.) The form may be typed or handwritten. If completed by typewriter or word processor, the recorded information shall be in a minimum font size of 12 points. Should the information be handwritten, it must be legible printed in black ink and must be written so that staffing data can be easily seen and read by residents, staff, visitors or others who are interested in our facility's daily staffing information. Review shifts forms shall be maintained with the current shift form for a total of 24 hours of staffing information in a single location once a form is removed it shall be forwarded to the director of nursing services office and filed as a permanent record. Records of staffing information for each shift will be kept for a minimum of 18 months or as required by state law (whichever is greater). Staffing information during the reported time period shall be made available to residents, family members, and the public within 24 hours of a written or verbal request. The fee for the requested information shall not exceed the cost of copying and clerical time to retrieve the information. Inquiries concerning our direct care staffing information shall be referred to the director of nursing services or to the administrator.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review the facility failed to ensure facility's daily nurse staffing information form posted at the front desk. This failure has the potential to affect 102 residents receiving care in the facility. Findings include:On 4/15/26 at 1:00PM, V10 (Receptionist) said the daily staff post last updated on 2/17/26, and stated it should be updated daily, said the person responsible for updating but has not been here.On 4/15/26 at 1:17PM, V2 (Director of Nursing) said that daily staff posting hours should be posted daily by staffing coordinator. V2 made aware the last daily staff posting was on 2/17/26. On 4/15/26 at 2:00 PM, V1 (Administrator) said the facility schedules staff based on the minimum required hours allowed, and it should reflect on the facility posting for daily staffing numbers. V1 said the daily staff posting hours should be updated daily and posted in front area, said he is aware the daily staff posting has not been updated since 2/17/26. V1 said there has been miscommunication on who is to update it since change of staff position of scheduler and new scheduler was unaware. Facility Policy on Posting Direct Daily Staffing Numbers-Revised 8/2008Policy Statement I'm property will post on a daily basis for each ship the number of nursing personnel responsible providing direct care to residents. Policy interpretation and implementation At the beginning of each shift the facility shall post the nurse staffing that is as required by state and federal regulations. The information should be clear and readable format the information should be posted in a prominent place accessible to residents and visitors.Directly responsible for resident care means that individuals are responsible for resident's total care or some aspect of the residents care including but not limited to assisting with activities of daily living performing (ADLs), gastric intestinal feeds, giving medications, supervising care given by CNA's, and performing nursing assessment to admit residents or notify physicians of changes of conditions. Information shall be recorded on the form provided by the facilities administrator for each shift the information recorded on the form shall include:Name of the facilitythe date for which information is postedthe resident senses at the beginning of the shift for which the information is posted24 hour shift schedule operated by the facility the shift for which the information is postedthe type (RN, LPN, LVN, or CNA) And category licensed or non-licensed of nursing staff working during that shiftthe actual time worked during that shift for each category and the type of nursing stafftotal number of licensed and non-licensed nursing staff working for the posted shift. Computing hours of direct care staff working split shifts count only the total number of hours the individual is actually scheduled to work for the shift information being posted. (Example: You are posting data for the day shift. CNA reports to work and is scheduled to work for hours on the day shift and four hours on the evening shift. In computing the number of hours worked for that shift count only the four-hour schedule for the day shift. The remaining 4 hours would be counted toward the total on the evening shift.) The form may be typed or handwritten. If completed by typewriter or word processor, the recorded information shall be in a minimum font size of 12 points. Should the information be handwritten, it must be legible printed in black ink and must be written so that staffing data can be easily seen and read by residents, staff, visitors or others who are interested in our facility's daily staffing information. Review shifts forms shall be maintained with the current shift form for a total of 24 hours of staffing information in a single location once a form is removed it shall be forwarded to the director of nursing services office and filed as a permanent record. Records of staffing information for each shift will be kept for a minimum of 18 months or as required by state law (whichever is greater). Staffing information during the reported time period shall be made available to residents, family members, and the public within 24 hours of a written or verbal request. The fee for the requested information shall not exceed the cost of copying and clerical time to retrieve the information. Inquiries concerning our direct care staffing information shall be referred to the director of nursing services or to the administrator.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview and record review the facility failed to ensure medications were administered as ordered by the physician for one of three residents (R3) reviewed for medication administration. Findings include:On 4/14/2026 at 12:40pm V12 (Nurse) observed administering medication. The electronic medication administration record on 4/14/2026 at 09:00 for R3's medications were not signed as administered.On 4/14/2026 at 12:44pm V12 and this writer observed R3 09:00am medications were not signed. V12 said, I was running late this morning I did not have a chance to sign out (R3's) medications. I know I should sign as I administer.On 4/15/2026 at 10:00am V2 (Director of Nursing-DON) said, I expect the nurses to sign out all medications as they are administered.A resident information document indicates R3 is alert and oriented two to three with forgetfulness, bed bound and dependent on staff. A diagnosis of dysphagia, cerebral infarction, dementia, hypertension, major depressive disorder. An order summary report dated 4/15/2026 for cholecalciferol 1000 units two tabs daily, clonidine 0.3mg every twelve hours, gabapentin 300mg three times a day, heparin 5000 units every twelve hours, hydralazine 10mg every eight hours hold if systolic blood pressure below 110mmHG, Keppra 100mg two times a day, a care plan intervention to administer medications as ordered and monitor for any side effects.Facility Policy: Medication Administration PolicyEffective date: NonePolicy: It is the policy of this facility to authorize licensed nursing personnel and Qualified Medication Aides to prepare and administer drugs and biologicals.Policy Specifications: To establish authorization for personnel in the administration of drugs and biologicals.Responsibility: Director of Nursing, Licensed Nursing Staff Personnel and Qualified Medication Aides.Standards:1.Drugs will be administered in accordance with orders of licensed medical practitioners in this state.17. Medications shall be recorded on the medication record promptly after each administration by the individual who administered drug.